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Title of Rule: Revision to the Medical Assistance Rule concerning Federally Qualified Health Centers, Section 8.700
Rule Number: MSB 19-01-17-A
Division / Contact / Phone: Payment Reform / Erin Johnson / 303-866-4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 19-01-17-A, Revision to the Medical Assistance Rule concerning Federally Qualified Health Centers, Section 8.700
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.700 Federally Qualified Health Center, 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 8.700 with the proposed text beginning at 8.700.1 through th end of 8.700.8.B. This rule is effective May 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Federally Qualified Health Centers, Section 8.700
Rule Number: MSB 19-01-17-A
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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 revision is to reimburse Federally Qualified Health Centers (FQHCs) separately for the administration of antagonist injections for medication-assisted treatment for substance use disorders. FQHCs are currently reimbursed an all-inclusive encounter rate for one-on-one, face-to-face services between a member and an eligible provider. For the administration of antagonist injections for medication assisted treatment for substance use disorders, FQHCs can currently bill as an FQHC and be reimbursed at the FQHC encounter rate as these drugs are administered by a physician. Pursuant to House Bill (HB) 18-1007, if a pharmacy or pharmacist has entered into a collaborative pharmacy practice agreement with one or more prescribers to administer antagonist injections for medication-assisted treatment for substance use disorders, the pharmacist administering the drug must receive an enhanced dispensing fee that aligns with the administration fee paid to a provider in a clinical setting. Therefore, FQHCs that have an in-house pharmacy may bill for the administration of the drug if provided by a pharmacist in the pharmacy. This rule revision will allow FQHCs to bill separately from the encounter rate for the administration of the drug similar to a provider in a non-FQHC clinical setting. This rule revision is necessary to align with the policy implemented due to HB 18-1007 and to incentivize the administration of antagonist injections for medication-assisted treatment for substance use disorders.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:
4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   HB 18-1007;
   25.5-5-510 C.R.S. (2018)

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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 revision will impact clients that receive services at FQHCs who have a substance use disorder and may benefit from medication assisted treatment.

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 is not expected to have an economic impact. This rule will make it easier for clients to receive medication assisted treatment for substance use disorder in the clinic setting instead of having to either walk down the hall to an in-house pharmacy or be sent to a separate pharmacy.

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

   This rule is not expected to cost the Department any additional money. The new reimbursement for FQHCs is the same amount that would have been paid at a pharmacy.

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

   The benefit of the proposed rule is for easier coordination of care and continuance of services for clients with substance use disorders. The cost of inaction is that the Department will not be aligned with HB 18-1007 and it will be more difficult for clients to receive medication assisted treatment for substance use disorder.

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 for achieving the purpose of the proposed rule since this rule is not expected to cost the Department any additional money.

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

   The Department considered not reimbursing FQHCs separately for the provision of this service. However, this would not align with HB 18-1007 and potentially make it more difficult for clients with substance use disorders to receive life changing services.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

1. 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:

2. 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, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the services set forth in Section 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

    a. A visit includes a one-on-one, face-to-face encounter between a center client and a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado providing services set forth in Section 8.700.3.A. The supervised person must hold a candidate permit as a licensed professional counselor or a candidate permit as a licensed marriage and family therapist, or a candidate permit as a psychologist, or a be a licensed social worker. 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, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor or supervised person pursuing mental health licensure as defined in their respective practice acts.

      i. Outpatient primary care services that are furnished by a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado as defined in their respective practice acts.

   c. Part-time or intermittent visiting nurse care.

   d. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under Section 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 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 Section 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, clinical social worker, licensed marriage and family therapist, licensed professional counselor and licensed addiction counselor and licensure candidates for

clinical psychologist, clinical social worker, licensed marriage and family therapist, and licensed professional counselor 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, clinical social worker, licensed marriage and family therapist, licensed professional counselor or licensed addiction counselor.

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 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 separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. 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: physical health encounter, dental encounter, or specialty behavioral health encounter. Distinct dental encounters are allowable only when rendered services are covered and paid by the Department's dental Administrative Service Organization (ASO). Distinct specialty behavioral health encounters are allowable only when rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy.

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.

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. An 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. Antagonist injections for substance use disorders provided at the FQHC~~by a physician~~ shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department.

8.700.6.C A physical health encounter, a dental encounter, and a specialty behavioral 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.

8.700.6.D Encounter rates calculations

a) Effective July 1, 2018, FQHCs will be paid three separate encounter rates for three separate services: physical health services, dental services, and specialty behavioral health services. Physical health services are covered services reimbursed through the Department's MMIS, except the short-term behavioral health services in the primary care setting policy. Dental services are services provided by a dentist or dental hygienist that are reimbursed by the Department's dental ASO. Specialty behavioral health services are

behavioral health services covered and reimbursed by either the RAE or by the MMIS through the short-term behavioral health services in the primary care setting policy. The Department will perform an annual reconciliation to ensure each FQHC has been paid at least their per visit Prospective Payment System (PPS) rate. If an FQHC has been paid below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.

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) Each alternative payment rate shall be the lower of the service specific annual rate or the service specific base rate. The annual rate and the base rate shall be calculated as follows:

   1. The annual rate for the physical health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for physical health services and visits. The annual rate for the dental rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for dental services and visits provided by a dentist or dental hygienist. The annual rate for the specialty behavioral health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for behavioral health services and visits either covered and reimbursed by the RAE or by the short-term behavioral health services in the primary care setting policy.

   2. The new base rates shall be the audited, calculated, inflated, and weighted average encounter rate for each separate rate, for the past three years. Base rates are recalculated (rebased) annually. Initial Base rates shall be calculated when the Department has two year's data of costs and visits.

   3. Beginning July 1, 2020, A portion of the FQHCs physical health and specialty behavioral health alternative payment methodology rates are at-risk based on the FQHC's quality modifier. An FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year.

3. a) New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set reimbursement base rates for the first year. The base rates shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as an FQHC. These shall be the FQHCs base rates until the FQHC's final base rates are set.

   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 and hospital-based FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. An extension of up to 75 days may be granted based upon circumstances. 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 encounter rates for FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement encounter rates (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 encounter rates are more than the new rate, the new rates shall be effective the 120th day after the FQHCs fiscal year end.

5. a) If an 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) An 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.D.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) An 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.D.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. An 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.D.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.D.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) An 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, an 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 an 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 The Department shall notify the FQHC of its rates.

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. Beginning with the 2019 Cost Report Cycle, this outstationing payment shall be made based upon actual cost and is included as an allowable cost in an FQHC cost report.

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.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medial Assistance Rule concerning Long Term Acute Care and Rehabilitation Per Diem Reimbursement, Sections 8.300.5.D.3
Rule Number: MSB 19-01-28-A
Division / Contact / Phone: Finance / Kevin Martin / 303-866-2842 / Elizabeth Quaife / 303-866-2083

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 19-01-28-A, Revision to the Medial Assistance Rule concerning Long Term Acute Care and Rehabilitation Per Diem Reimbursement, Sections 8.300.5.D.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) 8.300.5.D3, 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 8.300.5.D with the proposed text beginning at 8.300.5.D through the end of 8.300.5.D. This rule is effective May 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medial Assistance Rule concerning Long Term Acute Care and Rehabilitation Per Diem Reimbursement, Sections 8.300.5.D.3
Rule Number: MSB 19-01-28-A
Division / Contact / Phone: Finance / Kevin Martin / 303-866-2842 / Elizabeth Quaife / 303-866-2083

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).

   As the rule is currently written, the use of the term 'Freestanding' will incorrectly exclude two Long Term Acute Care locations. To leave the language as is will eliminate the budget neutral implementation of the new per diem reimbursement methodology. To correct this, the Department is removing the term “Freestanding” and specifying that the categories of Long-Term Care Hospital, Rehabilitation Hospital, and Spine/Brain Injury Specialist Hospital exclude distinct part units and satellite locations. The update will ensure all intended Long Term Acute Care Hospitals and Rehabilitation Hospitals are included in the new reimbursement methodology while distinct part units and satellite locations remain on their existing reimbursement methodology outlined in rule 10 CCR 2505-10; Section 8.300.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   Sections 25.5-4-402(1), C.R.S. (2018)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medial Assistance Rule concerning Long Term Acute Care and Rehabilitation Per Diem Reimbursement, Sections 8.300.5.D.3
Rule Number: MSB 19-01-28-A
Division / Contact / Phone: Finance / Kevin Martin / 303-866-2842 / Elizabeth Quaife / 303-866-2083

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.

   Long Term Acute Care Hospitals or Rehabilitation Hospitals providing Inpatient Hospital Services which do not fit the definition of 'Freestanding' will be impacted. The term 'Freestanding' implied a hospital that owned/rented an entire building on independently owned land. Hospitals that rented a floor or building located on a hospital campus were incorrectly excluded by the use of 'Freestanding'. By specifying that the categories of Long-Term Care Hospital, Rehabilitation Hospital, and Spine/Brain Injury Specialist Hospital exclude hospital distinct part units and hospital satellite locations the rule will clearly define hospitals that are and are not included in the per diem reimbursement methodology and ensure there are no conflicts with existing reimbursement methodology language.

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 goal of the specialty hospital per diem implementation is to create a better reimbursement model that benefits both the Department and Specialty Hospitals while allowing an even distribution of Medicaid clients among the specified Hospital groups. Under the APR-DRG methodology, disparities in base rates among hospitals incentivizes over-utilization in some hospitals and under-utilization in others. By creating a standardized per diem for each group the disparities will be eliminated and there will no longer be an adverse incentive that will impact utilization in this way. Unfortunately, in MSB 18-07-23-A the term "freestanding" was used to exclude distinct part units and satellite locations which inappropriately excluded some specialty hospitals that are located within another hospital but that are still a unique entity.

   This proposed rule corrects the language from MSB 18-07-23-A so that the intended quantitative and qualitative impacts from that earlier rule are realized.

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.

DO NOT PUBLISH THIS PAGE

This proposed rule should have no costs to the Department, any other agency, or state revenues as it only corrects language from MSB 18-07-23-A.

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

   MSB 18-07-23-A was intended to be budget neutral, however, if the language from that rule is not updated with this proposed rule then it will no longer be budget neutral. Inaction would lead to an increase in Department expenditure and perpetuate the disparities that were intended to be fixed by MSB 18-07-23-A.

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

   The proposed update in language is the least costly option for the Department.

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

   No alternative methods were considered.

8.300 HOSPITAL SERVICES

8.300.5 Payment for Inpatient Hospital Services

8.300.5.D Payments to Non-DRG Hospitals for Inpatient Services

1. Payments to Psychiatric Hospitals

   a. The Department shall reimburse Psychiatric Hospitals for inpatient services provided to Medicaid clients on a per diem basis.~~Inpatient services provided to Medicaid clients in Psychiatric Hospitals shall be reimbursed on a per diem basis~~. The per diem rates shall follow a step-down methodology. Each step has a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. Criteria for each step are described below:

      i Step 1: D~~d~~ay 1 through D~~d~~ay 7

      ii Step 2: D~~d~~ay 8 through remainder of care at acute level

   b. Hospital rates may be adjusted annually on July 1 to account for changes in funding by the General Assembly and inflationary adjustments as determined by the Medicare Economic Index.

2. Payment to State-Owned Psychiatric Hospitals

   The Department shall reimburse State-Owned Psychiatric Hospitals on an interim basis~~State-owned Psychiatric Hospitals shall receive reimbursement on an interim basis~~ according to a per diem rate. The Department will determine the per diem rate based on~~The per diem rate shall be determined based on~~ an estimate of 100% of Medicaid costs from the Hospital's Medicare cost report. Periodically, the Department will audit actual costs and may require a cost settlement to insure reimbursement is 100% of actual audited Medicaid costs.~~A periodic cost audit is conducted and any necessary cost settlement is done to bring reimbursement to 100% of actual audited Medicaid costs.~~

3. Payments to ~~Freestanding~~ Long-Term Care and ~~Freestanding~~ Rehabilitation Hospitals (e~~E~~xcludes ~~Hospital D~~distinct ~~P~~part ~~U~~units and ~~Hospital S~~satellite ~~L~~locations as defined under 10 CCR 2505 10 8.300) ~~(Excludes Hospital Distinct Part Units and Hospital Satellite Locations)~~ shall be divided into three (3) subgroups: Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital.

   The Department shall reimburse Long-Term Care, Rehabilitation, and Spine/Brain Injury Treatment Specialist Hospitals for inpatient services provided to Medicaid patients on a per diem basis~~Inpatient services provided to Medicaid clients in Freestanding Long-Term Care Hospital, Freestanding Rehabilitation Hospital or Spine/Brain Injury Treatment Specialist Hospital (Excludes Hospital Distinct Part Units and Hospital Satellite Locations~~

~~as defined under 10 CCR 2505-10 8.300) (Excludes Hospital Distinct Part Units and Hospital Satellite Locations) shall be reimbursed on a per diem basis~~. The per diem rates shall follow a step-down methodology based on length of stay, with a decrease of five (5) percent with each step. Each step shall be assigned a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. The Department may adjust hospital rates annually on July 1 to account for changes in funding by the General Assembly. The criteria for each of the steps are described below:

a. Payments to ~~Freestanding~~ Long-Term Care Hospitals ~~as defined in 8.300.1~~:

   i. Step 1: Day 1 through Day 21

   ii. Step 2: Day 22 through Day 35

   iii. Step 3: Day 36 through Day 56

   iv. Step 4: Day 57 through remainder of stay

b. Payments to ~~Freestanding~~ Rehabilitation Hospitals ~~as defined in 8.300.1~~:

   i. Step 1: Day 1 through Day 6

   ii. Step 2: Day 7 through Day 10

   iii. Step 3: Day 11 through Day 14

   iv. Step 4: Day 14 through remainder of stay

c. Payments to Spine/Brain Injury Treatment Specialty Hospitals ~~as defined in 8.300.1~~:

   i. Step 1: Day 1 through Day 28

   ii. Step 2: Day 29 through Day 49

   iii. Step 3: Day 50 through Day 77

   iv. Step 4: Day 78 through remainder of stay

d. The Classification-specific ~~base~~ per diem for 2019, the year of this methodology implementation shall be calculated using the following method:

   i. The Department shall assign the claims submitted by each hospital for fiscal year 2017 to one of the following peer groups ~~based on definitions from 8.300.1 (Excludes Hospital Distinct Part Units and Hospital Satellite Locations)~~:

      1) ~~Freestanding~~ Long-Term Care Hospital

      2) ~~Freestanding~~ Rehabilitation Hospital

      3) Spine/Brain Injury Treatment Specialty Hospital

ii. The Department shall process Medicaid inpatient hospital claims from state fiscal year 2017 through the methodology described in Section 8.300.5.D.3 a-c. This will create per diems that are budget neutral to fiscal year 2017.

~~ii. The Department shall process Medicaid Inpatient hospital claims from state fiscal year 2017, known as the Base Year, though the methodology described in 8.300.5.D.3 a-c. The base per diems shall be budget neutral to fiscal year 2017.~~

iii. The Department shall adjust the per diems annually to reflect budget changes. For state fiscal year 2018, rates~~Additionally, the base per diem~~ shall be increased ~~by~~ 1.4%. For state fiscal year 2019, rates ~~to reflect budget increases for state fiscal year 2018, increase by~~shall be increased 1%. The Department shall adjust rates in subsequent years ~~to reflect budget increases for state fiscal year 2019 and adjusted~~ by the percentage changes in the budget ~~for future fiscal years~~ as appropriated by the General Assembly.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Reimbursement Rate Increase for Direct Support Professional Workforce Stabilization, Section 5.505
Rule Number: MSB 19-01-02-A
Division / Contact / Phone: Benefits and Services Management Division/ Office of Community Living / Bryan Fife / 303-866-6433

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 19-01-02-A, Revision to the Medical Assistance Rule concerning Reimbursement Rate Increase for Direct Support Professional Workforce Stabilization, Section 5.505
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) 10 CCR 2505-10, section 8.505, 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*

Insert the newly proposed text at 8.505 with the proposed text beginning at 8.505 through the end of 8.505.4. This rule is effective May 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Reimbursement Rate Increase for Direct Support Professional Workforce Stabilization, Section 5.505
Rule Number: MSB 19-01-02-A
Division / Contact / Phone: Benefits and Services Management Division/ Office of Community Living / Bryan Fife / 303-866-6433

STATEMENT OF BASIS AND PURPOSE

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

   This rule implements House Bill 18-1407, which requires the Department to increase specific services in specific waivers by 6.5%. The increased funding must be reserved and used to increase compensation of direct support professionals. The rule establishes the requirement for the use of the funds, the reporting requirements, and the Department's ability to audit provider reported information.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   Section 25.5-6-406

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Reimbursement Rate Increase for Direct Support Professional Workforce Stabilization, Section 5.505
Rule Number: MSB 19-01-02-A
Division / Contact / Phone: Benefits and Services Management Division/ Office of Community Living / Bryan Fife / 303-866-6433

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.

   Providers and direct support professionals will be affected by this rule. The providers must bill for the increase funding and expend cost to implement increased compensation to direct support professionals and wages. Medicaid members will receive better access to services due to a stabilization in the workforces.

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

   Increase compensation to direct support professionals will lead to a stabilization of the workforce allowing better access to services for Medicaid members.

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 Department will bear the cost of the increased reimbursement rate with federal matching.

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

   N/A

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

   N/A

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.

   This rule implements a house bill passed through legislation.

8.505 INCREASE OF THE REIMBURSEMENT RATE RESERVED FOR COMPENSATION OF DIRECT SUPPORT PROFESSIONALS

8.505.1 DEFINITIONS

Definitions below only apply to Section 8.505.

A. Compensation means any form of monetary payment, including bonuses, employer-paid health and other insurance programs, paid time off, payroll taxes that are proportionate to the increase in compensation, and all other fixed and variable benefits conferred on or received by all direct support professionals providing services as enumerated below.

B. Direct Support Professional means a worker who assists or supervises a worker to assist a person with intellectual and developmental disabilities to lead a fulfilling life in the community through a diverse range of services, including helping the person get ready in the morning, take medication, go to work or find work, and participate in social activities. Direct Support Professional includes all workers categorized as program direct support professionals and excludes workers categorized as administrative, as defined in standards established by the financial accounting standards board.

C. Direct Benefit means compensation that is directly conferred onto a direct support professional for their sole benefit and does not include direct benefits to the employing or contracting service agency which may have an indirect benefit to the direct support professional.

D. Plan of Correction means a formal, written response from a employing or contracting service agency to the Department on identified areas of non-compliance with requirements listed at Section 25.5-6-406, C.R.S. or 10 CCR 2505-10, Section 8.505.

E. Payroll tax means taxes that are paid or withheld by the employer on the employee's behalf such as Social Security tax, Medicare tax, and Medicare surtax.

8.505.2 REIMBURSEMENT RATE INCREASE

A. Effective March 1, 2019, the Department increased reimbursement rates by six and a half percent which is to be reserved for compensation to direct support professionals above the rate of compensation that the direct support professionals received as of June 30, 2018. The six and a half percent rate increase must be used as a direct benefit for the direct support professional within 60 days from the close of the State Fiscal Year. The following services delivered through Home and Community Based Waivers for Persons with Developmental Disabilities, Supported Living Services, and Children's Extensive Supports will receive the six and half percent increase to reimbursement rates:

1. Group Residential Services and Supports;
2. Individual Residential Services and Supports;
3. Specialized Habilitation;
4. Respite;
5. Homemaker Basic;
6. Homemaker Enhanced;

7. Personal Care;

8. Prevocational Services;

9. Behavioral Line Staff;

10. Community Connector;

11. Supported Community Connections;

12. Mentorship;

13. Supported Employment- Job Development; And

14. Supported Employment- Job Coaching.

B. Funding from the reimbursement rate increase may not be used for the following:

1. Executive Salaries

2. Administrative Expenses

3. Human Resource Expenses

4. Information Technology

5. Oversight Expenses

6. Business Management Expenses

7. General Record Keeping Expenses

8. Budget and Finance Expenses

9. Workers' Compensation Insurance

10. Contract Staffing Agency Expenses

11. Employee Appreciation Events

12. Gifts

13. Activities not identifiable to a single program.

8.505.3 REPORTING REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONAL RATE INCREASE

A. On or before December 31, 2019, and two (2) years thereafter, employing or contracting service agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-406, C.R.S. were used, including information about increased compensation for all Direct Support Professionals, how the employing or contracting service agency maintained the increase, and how the employing or contracting service agency stabilized the direct support professional workforce.

1. The employing or contracting service agencies must report to the Department, in the manner prescribed by the Department, by December 31 of each year.

2. The Department has ongoing discretion to request information from service agencies demonstrating how they maintained increases in compensation for Direct Support Professionals beyond the reporting period.

3. Failure to provide adequate and timely reports may result in recoupment of the funds.

8.505.4 AUDITING REQUIREMENTS FOR DIRECT SUPPORT PROFESSIONAL RATE INCREASE FOR COMPENSATION

A. Each employing or contracted service agency shall keep true and accurate work records to support and demonstrate use of the funds. Such records shall be retained for a period of not less than three (3) years and shall be open to inspection by the Department and are made available to be copied by the Department or its authorized representatives at any reasonable time and as often as may be necessary.

B. Employing or contracting service agencies shall submit to the Department upon request, all records showing that the funds were used as a direct benefit for Direct Support Professionals, including but not limited to:

1. Federal Employment Forms

a. W2's -Wage and Tax Statement

b. W3 -Transmittal of Wage and Tax Statement

c. 941's -Employer's Quarterly Federal Tax Return

d. 940 -Employer's Annual Federal Tax Return

2. State Employment Forms

a. UITR 1's – State Unemployment Insurance Tax Report

b. UITR 1A's - State Unemployment Insurance Tax Report Wage List

3. Business/Corporate Tax Returns

4. Independent Contractor Forms

a. 1099's- Miscellaneous Income

b. 1096 - Annual Summary and Transmittal of U.S. Information Returns

5. Payroll Records

a. Payroll Detail

b. Payroll Summary

6. Accounting Records

a. Chart of Accounts

b. General Ledger

c. Profit & Loss Statements

d. Check Register

7. Bank Statements

8. Timesheets

9. Benefits Records

a. Health Insurance Records

b. Other Insurance Records

c. Paid Time Off Records

C. In the event that a Direct Support Professional was hired after June 30, 2018, the employing or contracting service agency shall use the lowest compensation paid to a Direct Support Professional of similar functions and duties as of June 30th, 2018. This is the base rate that the increased compensation will be applied to.

D. If the Department determines that the employing or contracting service agency did not use the increased funding as a direct benefit to the Direct Support Professional, within one year after the close of each reporting period, the Department shall notify the service agency in writing of the Department's intention to recoup funds. The service agency has forty-five (45) days after issuance of the notice of the determination to complete any of the following actions:

1. challenge the determination of the Department;

2. provide additional information to the Department demonstrating compliance;

3. submit a Plan of Correction to the Department.

E. When the Department determines that an employing or contracting service agency is not in compliance, a Plan of Correction shall be developed, upon written notification by the Department. A Plan of Correction shall include, but not be limited to:

1. A detailed description of actions to be taken to resolve issues and supporting documentation demonstrating completion.

2. A detailed timeframe specifying the actions to be taken.

3. Employee(s) responsible for implementing the actions.

4. The implementation timeframes and date(s) for completion.

F. The employing or contracting service agency must submit the Plan of Correction to the Department within forty-five (45) business days of the issuance of a written request from the Department. The employing or contracting service agency must notify the Department in writing, within five (5) business days of the receipt of the written request from the Department, if it will not be able to submit the Plan of Correction by the due date. The employing or contracting service agency must explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the employing or contracting service agency's compliance.

G. Upon receipt of the Plan of Correction, the Department will accept, request modifications, or reject the proposed Plan of Correction. Modifications or rejections will be accompanied by a written explanation. If a Plan of Correction is rejected, the employing or contracting service agency must resubmit a new Plan of Correction along with any requested documentation to the Department for review within five (5) business days of notification.

H. The Department shall notify the employing or contracting service agency in writing of its final determination after affording the employing or contracting service agency the opportunity to take the actions specified in Section 8.505.4.E. The Department shall recoup one hundred percent of the increased funding received but did not use for a direct benefit for direct support professionals if the employing or contracting service agency:

1. fails to respond to a notice of determination of the Department within the time provided in Section 8.505.4.E;

2. is unable to provide documentation of compliance; or

3. the Department does not accept the Plan of Correction submitted by the service agency, or is not completed within the established timeframe pursuant to Section 8.505.4.F.

I. All recoveries will be conducted pursuant to Section 25.5-4-301, C.R.S. and 10 CCR 2505-10, Section 8.076.3.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Healthcare Affordability and Sustainability Fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 18-09-05-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

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 18-09-05-A,
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) 8.3000, 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 8.3003 with the proposed text beginning at 8.3003.A through th end of 8.3003.B Replace the current text at 8.3004 with the proposed text beginning at 8.3004.D through the end of 8.3004.F.6. This rule is effective May 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Healthcare Affordability and Sustainability Fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 18-09-05-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

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).

   Make necessary changes for the FFY 18-19 time frame. Updates healthcare affordability and sustainability fee amounts and payments amounts.

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:

   None

3. Federal authority for the Rule, if any:

   42 CFR 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   25.5-4-402.4(4)(g), C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Healthcare Affordability and Sustainability Fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 18-09-05-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

REGULATORY ANALYSIS

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

   Colorado hospitals benefit from increased Medicaid and CICP reimbursement made possible through the healthcare affordability and sustainability fee and matching federal funds and the reduction in the number of uninsured Coloradans from expanded Medicaid and CHP+ eligibility. Low-income persons benefit by having health care coverage through the expanded Medicaid and CHP+ eligibility

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 healthcare affordability and sustainability fee and matching federal funds will result in more than $2 billion in annual health care expenditures for more than 500,000 Coloradans and will provide more than $200 million in net new federal funds to Colorado hospitals.

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

   While there are administrative costs associated with CHASE, such costs are funded with fees and federal matching funds and no state general funds are expected to be used.

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

   If no action is taken, CHASE will not have the ability to fund Medicaid and CHP+ expansions, affecting over 500,000 currently enrolled persons. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+ and reduce the federal revenue to hospitals.

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

   The State does not have alternative resources to fund hospital payments and health coverage for the populations as provided under CHASE; therefore, no other methods are available to achieve the purpose of the proposed rule.

DO NOT PUBLISH THIS PAGE

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 CHASE Act directs the Medical Services Board to promulgate rules for the implementation of the healthcare affordability and sustainability fee; therefore, no alternatives to rule making are available.

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

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

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as ~~2.0208~~1.8119% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

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

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $93.07~~87.52~~ per day for Managed Care Days and $~~391.15~~416.07 per day for all Non-Managed Care Days with the following exceptions:

    a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $~~45.69~~48.59 per day for Managed Care Days and $217.23~~204.22~~ per day for all Non-Managed Care Days, and.

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~35.01~~37.23 per day for Managed Care Days and $~~156.46~~166.43 per day for Non-Managed Care Days.

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

   a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or ~~is~~ are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A)(ii) are qualified to receive this payment.

   b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or ~~is~~ are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A)(ii) are qualified to receive this payment.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

   a. Total funds for the Disproportionate Share Hospital payment shall be equal to the Disproportionate Share Hospital allotment as published by CMS annually ~~during the first quarter of the federal fiscal year~~.

   b. A Pediatric Hospital shall receive a payment equal to 45.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A Respiratory Hospital shall receive a payment equal to 75.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A new CICP hospital shall receive a payment equal to 10.00% of its estimated hospital-specific Disproportionate Share Hospital limit. A low MIUR hospital shall receive a payment equal to 10.00% of its estimated hospital-specific Disproportionate Share Hospital limit.~~CICP-participating hospitals with CICP write-off costs, as published in the most recent CICP Annual Report, greater than or equal to a percentage of the statewide average shall receive a payment equal to a proportion of their estimated hospital-specific Disproportionate Share Hospital limit. A Respiratory Hospital shall receive a payment equal to a proportion of their estimated hospital-specific Disproportionate Share Hospital limit.~~

      i. A new CICP hospital is a hospital approved as a CICP provider between July 1, 2017 and June 30, 2018.

      ii. A Low MIUR hospital is a hospital with a MIUR less than or equal to 15.00%.

c. All remaining qualified hospitals shall receive a payment calculated as their percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining Disproportionate Share Hospital funds.

d. No hospital shall receive a payment exceeding ~~their~~ its hospital-specific Disproportionate Share Hospital limit as specified in federal regulation. If upon review, the Disproportionate Share Hospital Supplemental payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified hospital, that hospital's payment shall be reduced to the hospital-specific Disproportionate Share Hospital limit. The ~~reduction~~ amount of the reduction shall then be redistributed to the other qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital Limit.

8.3004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. General Hospitals and Critical Access Hospitals shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. A qualified Essential Access Hospital shall receive a payment based on ~~their~~ its percentage of beds to total beds for all qualified Essential Access Hospitals. A qualified non-Essential Access Hospital shall receive a payment based on ~~their~~ its percentage of Uninsured Costs to total Uninsured Costs for all qualified non-Essential Access hospitals.

~~a. The base measures for the quality incentive payment are:~~

~~i. Emergency department process measure, which includes communicating information about the Medicaid nurse advice line, primary care providers, and Regional Care Collaborative Organizations (RCCO) to Medicaid clients when they are seen in the emergency department and establishing emergency department policies or guidelines for prescribing opioids,~~

~~ii. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,~~

~~iii. Rate of thirty (30) day all-cause hospital readmissions,~~

~~iv. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and~~

~~v. Culture of safety.~~

~~b. The optional measures for the quality incentive payment are:~~

~~i. Active participation in the RCCO,~~

~~ii. Advance care planning, and~~

~~iii. Screening and intervention for tobacco use.~~

~~4. The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive~~

Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.,

5. Calculation methodology for payment.

a. Determine available points by hospital to a maximum of 10 points per measure.

i. Available points are defined as the number of measures for which a hospital qualifies multiplied by the number of points designated for the measure.

b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department.

c. Normalize the total points awarded by dividing total points earned by total points eligible, multiplied by 50.

d. Calculate adjusted Medicaid discharges by hospital.

i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by gross Medicaid billed charges divided by gross inpatient Medicaid billed charges.

ii. For hospitals with fewer than 200 annual Medicaid discharges, the total number of discharges is multiplied by 125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare prospective payment system calculation.

e. Calculate total adjusted discharge points

i. Adjusted discharge points are defined as the total number of points earned for all measures multiplied by the number of adjusted Medicaid discharges.

f. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality point scores receive higher points per discharge. The dollar amount per discharge point for five tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	$5.95
2	11-20	$8.93
3	21-30	$11.90
4	31-40	$14.88
5	41-50	$17.85

g. Calculate payment by hospital by multiplying the adjusted discharge points for that hospital by the dollars per discharge point.

5. The total funds for the quality incentive payment for the year ending September 30, 2017 is eighty-nine million six hundred sixty-nine thousand five hundred two dollars ($89,669,502).

8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. General Hospitals and Critical Access Hospitals are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals are not qualified are not qualified to receive this payment.

3. Measures. Quality incentive payment measures include ~~seven~~ nine measures~~.~~. Qualified hospitals must report for the first and second measures. A hospital ~~must~~ then reports for the remaining measures ~~in sequential order~~in which they are eligible~~. If a hospital is not eligible for a measure, then the next measure is reported.~~

    a. The measures for the quality incentive payment are:

        i. Active participation in the Regional Care Collaborative Organizations (RCCO) or Regional Accountable Entities (RAE)~~Culture of safety~~,

        ii. ~~Active participation in the Regional Care Collaborative Organizations (RCCO)~~ Culture of Safety/Patient Safety,

        iii. Discharge Planning (Advance Care Planning (ACP)/Transition Activities)~~Rate of Cesarean section~~,

        iv. Rate of Cesarean Section~~Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey~~,

        v. Breastfeeding Practices~~Emergency department process~~,

        vi. Tobacco and Substance Use Screening and Follow-Up,~~Advance care planning, and~~

        ~~v.~~vii. Emergency Department Process,

        viii. Percentage of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and

        ~~vi.~~ix. 30-Day All-Cause Readmission.

4. The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

5. Calculation methodology for payment.

a. Determine total points earned~~Determine available points by hospital to a maximum of 10 points per measure~~.

i. Total points earned are the sum of the points earned for the first and second measures and the next three sequential measures for which the hospital is eligible~~Available points are defined as the number of measures for which a hospital qualifies multiplied by the number of points designated for the measure~~.

~~c~~b. Normalize the total points for hospitals that are exempted from reporting requirements or have limited data available for certain measures~~awarded by dividing total points earned by total points eligible, multiplied by 50~~.

~~d~~c. Calculate adjusted Medicaid discharges~~ by hospital~~.

i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by ~~gross Medicaid billed charges divided by gross inpatient Medicaid billed charges~~a discharge adjustment factor.

~~i.~~ii. The discharge adjustment factor is calculated as gross Medicaid billed charges divided by gross inpatient Medicaid billed charges. The Discharge Adjustment Factor is limited to 5.

~~ii.~~iii. For hospitals with fewer than 200 annual Medicaid discharges, the total number of discharges is multiplied by 125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare prospective payment system calculation.

~~e~~d. Calculate total adjusted discharge points.

i. Adjusted discharge points ~~are defined as~~are calculated as the total ~~number of~~ points earned for all measures multiplied by the ~~number of~~ adjusted Medicaid discharges.

~~f~~e. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality points earned receive more dollars per discharge point than hospitals with lower quality points earned. There are five tiers delineating the dollar value of a discharge point with each tier assigned at ~~ten~~ certain quality point increments. For each tier increase, the dollars per discharge point increase by a multiplier.

ii. The multiplier for the five tiers of quality points ~~between 1 and 50~~ are shown in the table below:

Tier	Hospital Quality Points Earned	Multiplier
1	1-~~10~~19	~~1x~~$0.00
2	~~11~~20-~~20~~35	~~1.5x~~$3.13
3	~~21~~36-~~30~~50	~~2x~~$6.26
4	~~31~~51-~~40~~65	~~2.5x~~$9.39
5	~~41~~66-~~50~~80	~~3x~~$12.52

g. Calculate payment by hospital by multiplying the adjusted discharge points ~~for that hospital~~ by the dollars per discharge point.

6. The dollars per discharge point for tier ~~1~~ 2 will be set to an amount so that the total quality incentive payments made to all qualified hospitals will equal seven percent of the total reimbursement made to hospitals in the previous state fiscal year.

DO NOT PUBISH THIS RULE

Title of Rule: Revision to the Medical assistance Rule concerning the Exception to the Waiting List Protocol, Section 8.500.7
Rule Number: MSB 18-11-16-A
Division / Contact / Phone: Case Management and Quality Performance / Karli Cheatham / 4032

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 18-11-16-A, Revision to the Medical assistance Rule concerning the Exception to the Waiting List Protocol, Section 8.500.7
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.500.7, 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 8.500.7 with the proposed text beginning at 8.500.7.F through the end of 8.500.7.F. Insert newly proposed text at 8.500.7.I with the proposed text beginning at 8.500.7.I through the end of 8.500.7.I. This rule is effective May 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBISH THIS RULE

Title of Rule: Revision to the Medical assistance Rule concerning the Exception to the Waiting List Protocol, Section 8.500.7
Rule Number: MSB 18-11-16-A
Division / Contact / Phone: Case Management and Quality Performance / Karli Cheatham / 4032

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).

   House Bill 18-1407 requires the Department to promulgate rules regarding the criteria for reserve capacity waiver enrollments for individuals with intellectual and developmental disabilities (I/DD). The criteria must include but is not limited to the age of the custodial parent or caregiver, the loss of the custodial parent or caregiver, incapacitation of the custodial parent or caregiver, any life-threatening or serious persistent illness of the custodial parent or caregiver and a threat to the health or safety that the custodial parent or caregiver places on the person with I/DD. The Department has solicited feedback from persons with I/DD, family members, guardians, advocates, and other stakeholders through contract work completed by the LNUSS group in May of 2017 and Department facilitated meetings in January 2019 regarding the current reserve capacity criteria and proposed changes.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   25.5-10-207.5(6)(b)

DO NOT PUBISH THIS RULE

Title of Rule: Revision to the Medical assistance Rule concerning the Exception to the Waiting List Protocol, Section 8.500.7
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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.

   Individuals who are on the waiting list for the Home and Community Based Services for Persons with Developmental Disabilities waiver (HCBS-DD) who are at risk of experiencing a crisis due to the advanced age, reduced capacity and illness of their caregivers will benefit from the proposed rule as they will have access to entrance to the waiver.

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 improve quality of life for individuals with intellectual and developmental disabilities, they will no longer have to go through a crisis to access HCBS-DD waiver services. It will decrease the cost of emergency services used by individuals without the access to the waiver such as emergency room visits and crisis centers. It will provide services to individuals at the time they most need them. It will prevent unintentional neglect and consequences to the health and welfare of individuals and the involvement of other state departments and local agencies such as Adult Protective Services (APS) or the Department of Corrections (DOC).

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

   This rule will increase the expenses for the HCBS-DD waiver as more individuals have the ability to gain access to the waiver. Case Management Agencies (CMA) will be required to enroll and provide case management to a higher number of individuals which could result in additional costs for staff. With increased enrollment into the waiver there will be an increased need for providers.

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

DO NOT PUBISH THIS RULE

The proposed rule if approved may increase HCBS-DD waiver expenditures but without it more costly services, Medicaid and otherwise, could be used on a more frequent basis to meet the individual's needs. Without action, individuals are more likely to access services that do not actually meet their needs, are more costly and on a more frequent basis.

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

   The Department believes this is the most cost-effective way to move into compliance with statute.

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.

   Alternative methods were considered however the statute requires the department to promulgate rules regarding the criteria for reserve capacity enrollments.

8.500 HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD) WAIVER

8.500.7 WAITING LIST PROTOCOL

8.500.7.F Persons whose name is on the waiting list shall be considered for enrollment to the HCBS-DD Waiver in order of placement date on the waiting list. Exceptions to this requirement shall be limited to:

1. An emergency situation where the health and safety of the person or others is endangered and the emergency cannot be resolved in another way. Persons at risk of experiencing an emergency ~~Emergencies~~ are defined by the following criteria:

   a. Homeless: ~~the person does not have a place to live or is in imminent danger of losing the person's place of abode.~~ the person will imminently lose their housing as evidenced by an eviction notice; or whose primary residence during the night is a ~~supervised~~ public or private facility that provides temporary living accommodations; or any other unstable or non-permanent situation; or is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.

   b. Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in the person's present living situation and the person's health, safety or well-being is in serious jeopardy.

   c. Danger to others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure safety of the person in the community.

   d. Danger to self: a person's medical, psychiatric or behavioral challenges are such that the person is seriously injuring/harming self or is in imminent danger of doing so.

   e. Loss or Incapacitation of Primary Caregiver: a person's primary caregiver is no longer in the person's primary residence to provide care; or the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or the primary caregiver is age 65 years or older and continuing to provide care poses an imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.

8. 500.7.I. A person shall accept or decline the offer of enrollment within thirty (30) calendar days from the date the enrollment was offered. Reasonable effort shall be made to contact the person, family, legal guardian, or other interested party.

1. Upon a written request of the person, family, legal guardian, or other interested party an additional thirty (30) calendar days may be granted to accept or decline an enrollment offer.

2. If a person does not respond to the offer of enrollment within the allotted time, the offer is considered declined and the person will maintain their order of placement date.