DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Long-Acting Reversible Contraceptives, Section 8.300.5
Rule Number: MSB 18-01-09-A
Division / Contact / Phone: Operations Section / Russ Zigler / 303-866-5927

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 18-01-09-A, Revision to the Medical Assistance Rule concerning Long-Acting Reversible Contraceptives, Section 8.300.5
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, 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 8.3005.E. This rule is effective April 30, 2020.

*to be completed by MSB Board Coordinator

Title of Rule: Revision to the Medical Assistance Rule concerning Long-Acting Reversible Contraceptives, Section 8.300.5
Rule Number: MSB 18-01-09-A
Division / Contact / Phone: Operations Section / Russ Zigler / 303-866-5927

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 Diagnosis Related Group (DRG) method of payment assigns a bundled DRG payment to an inpatient hospital claim based on the principal diagnosis for which the patient was treated, surgical procedures involved, and complication of the illness. The DRG relative weight is a numerical value reflecting the relative resource consumption for the DRG to which it is assigned. The DRG relative weight is multiplied by the base rate for the hospital to generate the payment amount. The proposed rule excludes long-acting reversible contraceptives (LARC) devices, inserted following a delivery or implanted prior to inpatient hospital discharge following a delivery, from the DRG bundled payment. Instead, LARC devices will be paid according to the Department's fee schedule. Fee Schedule reimbursement for these expensive devices will exceed the reimbursement for LARCs when included and bundled in the delivery DRG payment, thus incentivizing increased utilization by inpatient hospitals. The intent of the rule revision is to increase access to, and utilization of LARCs following a delivery by providing separate and more accurate reimbursements for these devices rather than including reimbursement within the DRG payment. Increased utilization of LARCs aligns with Colorado family planning initiatives by decreasing the incidence of unintended pregnancies and supporting a woman's choice of when, or if, she becomes a parent.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 447.253

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   25.5-4-402, C.R.S.

Title of Rule: Revision to the Medical Assistance Rule concerning Long-Acting Reversible Contraceptives, Section 8.300.5
Rule Number: MSB 18-01-09-A
Division / Contact / Phone: Operations Section / Russ Zigler / 303-866-5927

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 Colorado Medicaid enrolled inpatient hospitals who provide IPP-LARCs, support obstetric providers offering this service, and support clients seeking and consenting to LARC provision following delivery.

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 intent of the rule revision is to increase access to, and utilization of, IPP-LARCs by providing separate and higher fee schedule reimbursement for the device rather than bundling it in the DRG payment. Fee Schedule reimbursement for this expensive device will exceed the reimbursement for IPP-LARCs bundled in the DRG payment for an individual claim, incentivizing increased utilization. Increased utilization of IPP-LARCs aligns with the Colorado Family Planning Initiative, which helps women choose if, or when, to become a parent.

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 change is anticipated to be budget neutral overall. The Department reduced the inpatient hospital rates through the DRG methodology across all deliveries to offset the cost of paying for the IPP-LARCs through the fee schedule. A hospital, however, would receive a higher payment for the LARC through the carve out than if it was bundled in the DRG for an individual claim.

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

   There is no cost to this rule change, as it is shifting payment from the DRG methodology to the fee schedule. The benefit of the proposed rule is reduced unintended pregnancies due to increased utilization of IPP-LARCs. The cost of

inaction is potential lower utilization of IPP-LARCs, anticipated to result in more unintended pregnancies and associated costs. There is no benefit of inaction.

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

   LARCs are the most effective, easily reversible contraceptive method available to women, providing long lasting protection from unplanned pregnancies. Colorado Medicaid currently pays for all Food and Drug Administration (FDA) approved contraceptive methods, including LARCs. While there are less costly and less intrusive contraceptive methods, LARCs are considered more effective. There are not less costly or less intrusive methods for achieving the purpose of the proposed rule.

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

   There are no alternative methods for removing LARCs from the bundled DRG payment.

8.300 HOSPITAL SERVICES

[EXISTING SECTION 8.300.5.C AND ABOVE ARE UNAFFECTED BY THIS RULE REVISION]

8.300.5.D Long-Acting Reversible Contraceptives Exclusion

1. Long-acting reversible contraceptives (LARC) devices, inserted following a delivery, are excluded from the DRG Relative Weight calculation and are paid according to the Department's fee schedule.

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

[EXISTING SECTIONS 8.300.5.D (NOW 8.300.5.E) AND BELOW ARE UNAFFECTED BY THIS RULE REVISION]

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Outpatient Speech Therapy, Section 8.200.3.D.2.
Rule Number: MSB 19-09-05-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927 / Alex Weichselbaum / 303-866-5931

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 19-09-05-A, Revision to the Medical Assistance Act Rule concerning Outpatient Speech Therapy, Section 8.200.3.D.2.

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 8.200.3.D.2., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.200.3.D.2.f with the proposed text beginning at 8.200.3.D.2.f through the end of 8.200.3.D.2.f. This rule is effective April 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Outpatient Speech Therapy, Section 8.200.3.D.2.
Rule Number: MSB 19-09-05-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927 / Alex Weichselbaum / 303-866-5931

STATEMENT OF BASIS AND PURPOSE

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

   The proposed revision to this rule will allow providers appropriate flexibility in selecting a documentation format for recording visit notes under the Outpatient Speech Therapy benefit. As the rule is currently written, providers are restricted to using only the Subjective, Objective, Assessment and Plan (SOAP) tool. With this revision, providers will have discretion to use any tool that includes all of the SOAP elements, which are written into the rule text. The rule revision will remove the administrative burden for providers using documentation formats other than SOAP that are otherwise appropriate and sufficient.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR § 440.110

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);

Initial Review **02/14/2020** Final Adoption **03/13/2020**
Proposed Effective Date **04/30/2020** Emergency Adoption

DOCUMENT # 02

Title of Rule: Revision to the Medical Assistance Act Rule concerning Outpatient Speech Therapy, Section 8.200.3.D.2.
Rule Number: MSB 19-09-05-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927 / Alex Weichselbaum / 303-866-5931

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 of Outpatient Speech Therapy services will benefit from this rule revision, which increases provider flexibility to select an appropriate documentation tool.

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 anticipated impact of the proposed rule is relief of an administrative burden for providers using appropriate documentation formats other than the Subjective, Objective, Assessment, and Plan (SOAP) format, while maintaining the requirement to include subjective, objective, assessment and plan elements in the selected documentation format. There is no anticipated economic impact from this change.

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 does not expect an increase in utilization as a result of the proposed rule revision, and thus no fiscal impact is anticipated.

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

   The probable cost of inaction is a continued unnecessary administrative burden for providers of Outpatient Speech Therapy services, and the benefit of the proposed revision is relief of this burden.

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

   There are no less costly or less intrusive methods for achieving the purpose of the proposed revision to the Outpatient Speech Therapy rule.

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

   There are no alternative methods for achieving the purpose of the proposed rule.

8.200 PHYSICIAN SERVICES

8.200.3. BENEFITS

8.200.3.D Physician Services

Note: 8.200.3.D.1 Podiatry Services was moved to §8.810 01/2015.

2. Speech – Language and Hearing Services

f. DOCUMENTATION

i. General Requirements for Client's Record of Service:

1. Rendering providers shall document all evaluations, re-evaluations, services provided, client progress, attendance records, and discharge plans. All documentation must be kept in the client's records along with a copy of the referral or prescribing provider's order.

2. Documentation shall support both the medical necessity of services and the need for the level of skill provided.

3. Rendering providers shall copy the client's prescribing provider and medical home/primary care provider on all relevant records.

ii. Documentation shall include all of the following:

1. The client's name and date of birth.

2. The date and type of service provided to the client.

3. A description of each service provided during the encounter including procedure codes and time spent on each.

4. The total duration of the encounter.

5. The name(s) ~~or names~~ and title(s) of the person(s) providing each service and the name and title of the therapist supervising or directing the services.

iii. Documentation categories

1. Provider shall keep documentation for the following episodes of care: Initial Evaluation, Re-evaluation, Visit/Encounter Notes, and Discharge Summary.

2. Written documentation of the Initial Evaluation shall include the following:

a. The reason for the referral and reference source.

b. Diagnoses pertinent to the reason for referral, including:

i. Date of onset;

ii. Any cognitive, emotional, or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses;

iii. Current functional limitation or disability as a result of the above loss, and the onset of the disability;

iv. Pre-morbid functional status, including any pre-existing loss or disabilities;

v. Review of available test results;

vi. Review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.

c. Assessment: Include a summary of the client's impairments, and functional limitations and disabilities, based on a synthesis of all findings gathered from the evaluation. Highlight pertinent factors which influence the treatment diagnosis and prognosis, and discuss the inter-relationship between the diagnoses and disabilities for which the referral was made must be discussed.

d. Plan of Care: A detailed Plan of Care must include the following

i. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured.

e. Proposed interventions/treatments to be provided during the episode of care.

f. Proposed duration and frequency of each service to be provided.

g. Estimated duration of episode of care.

7. The therapist's Plan of Care must be reviewed, revised if necessary, and signed, as medically necessary by the client's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days. The ~~care plan~~Plan of Care must not cover more than a 90-day period or the time frame documented in the Individual Family Service Plan (IFSP). (27-10.5-702(7), C.R.S. (2017) states the IFSP "shall qualify as meeting the standard for medically necessary services." Therefore no physician is required to sign a work order for the IFSP.)

8. A P~~p~~lan of C~~c~~are must be certified. Certification is the physician's, physician's assistant or nurse practitioner's approval of the ~~p~~Plan of C~~c~~are. Certification requires a dated signature on the P~~p~~lan of ~~c~~Care or some other document that indicates approval of the P~~p~~lan of C~~c~~are. If the service is a Medicare covered service and is provided to a recipient who is eligible for Medicare, the P~~p~~lan of ~~c~~Care must be reviewed at the intervals required by Medicare.

9. Re-evaluation. A re-evaluation must be done whenever there is an unanticipated change in the client's status, a failure to respond to interventions as expected or there is a need for a new Plan of Care based on new problems and goals that require significant changes to the Plan of Care. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following: Reason for re-evaluation; ~~C~~client's health and functional status reflecting any changes; findings from any repeated or new examination elements; and, c~~C~~hanges to P~~p~~lan of C~~c~~are.

iv. Visit/Encounter Notes

1. Written documentation of each encounter must be in the client's record of service. These visit notes document the implementation of the P~~p~~lan of ~~c~~Care established by the therapist at the initial evaluation. Each visit note must include the following:

a. The total duration of the encounter.

b. The type and scope of treatment provided, including procedure codes and modifiers used.

c. The time spent providing each service. The number of units billed/requested must match the documentation.

d. Identification of the short- or long-~~-~~term goals being addressed during the encounter.

2. ~~Documentation must include the following elements from the Subjective, Objective, Assessment and Plan (SOAP) documentation format.~~ In addition to the above required information, the visit note must include the following elements:

   a. A *subjective* element which includes the reason for the visit, the client or caregiver's report of current status relative to treatment goals, and any changes in client's status since the last visit;

   b. An *objective* element which includes the practitioner's findings, including abnormal and pertinent normal findings from any procedures or tests performed;

   c. An *assessment* component which includes the practitioner's assessment of the client's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals; and

   d. A *plan* component which states the plan for next visit(s).

v. Discharge Summary

   1. At the conclusion of therapy services, a discharge summary must be included in the documentation of the final visit in an episode of care. This may include the following:

      a. Highlights of a client's progress or lack of progress towards treatment goals.

      b. Summary of the outcome of services provided during the episode of care.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Community Mental Health Centers, Section 8.750.3.B
Rule Number: MSB 19-12-06-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 19-12-06-B, Revision to the Medical Assistance Act Rule concerning Community Mental Health Centers, Section 8.750.3.B

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.750.3.B, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.750.3 with the proposed text beginning at 8.750.3.B.3 through the end of 8.750.3.B.3. This rule is effective April 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Community Mental Health Centers, Section 8.750.3.B
Rule Number: MSB 19-12-06-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 revision removes the fee-for-service thirty-five visit per State fiscal year limit for individual psychotherapy services to align the rule with current policy. There is no visit limitation for individual psychotherapy in a community mental health center.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. §440.130(d) (2019)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   Sections 25.5-5-202(1)(g), and 27-66-101(1.5)(b)(2), C.R.S. (2019)

Initial Review **02/14/2020** Final Adoption **03/13/2020**
Proposed Effective Date **04/30/2020** Emergency Adoption

DOCUMENT #03

Title of Rule: Revision to the Medical Assistance Act Rule concerning Community Mental Health Centers, Section 8.750.3.B
Rule Number: MSB 19-12-06-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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.

   Because this revision aligns the rule with current policy, there will be no costs or benefits to Community Mental Health Centers, or the Health First Colorado clients served in them.

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

   Because this revision aligns the rule with current policy, there are no probable quantitative or qualitative impacts of the proposed rule upon Community Mental Health Centers or the Health First Colorado clients served in them.

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.

   Because this revision aligns the rule with current policy, there are no probable costs to the Department or to any other agency to implement or enforce the proposed rule. Likewise, there is no anticipated effect on state revenues.

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

   There are no probable costs to the proposed rule. The benefit of the proposed rule is aligning the rule with current Health First Colorado policy. The cost of inaction is continued misalignment between the rule and Health First Colorado policy. There are no probable benefits of inaction.

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

   There are no less costly methods or less intrusive methods to align the rule with Health First Colorado policy.

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

   There are no alternative methods for aligning the rule with Health First Colorado policy.

8.750 COMMUNITY MENTAL HEALTH CENTERS/CLINICS

8.750.3 COVERED SERVICES

8.750.3.A. Services shall include but are not limited to prevention, diagnosis and treatment of emotional or mental disorders. Such services shall be rendered primarily on an outpatient and consultative basis for clients residing in a particular community in or near the facility so situated.

8.750.3.B. Community Mental Health Centers/Clinics shall provide medically necessary rehabilitation services in an outpatient setting. Covered services shall include:

1. Case management services, including but not limited to:

    a. Service planning and program linkage.

    b. Referral recommendations.

    c. Monitoring and follow up.

    d. Client advocacy.

    e. Crisis management.

2. Group psychotherapy services shall be face-to-face services that are insight-oriented, behavior modifying, and that involve emotional interactions of the group members. Group psychotherapy services shall assist in providing relief from distress and behavior issues with other clients who have similar problems and who meet regularly with a practitioner.

3. Individual psychotherapy services shall be face-to-face services that are tailored to address the individual needs of the client. Services shall be insight-oriented, behavior modifying and/or supportive with the client in an office or outpatient facility setting. ~~Individual psychotherapy services are limited to thirty-five visits per State fiscal year.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment - Oxygen and Oxygen Equipment, Sections 8.580 & 8.585
Rule Number: MSB 19-10-30-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 19-10-30-A, Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment - Oxygen and Oxygen Equipment, Sections 8.580 & 8.585

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) 8.580 and 8.585, 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 8.580 with the proposed text beginning at 8.580 through the end of 8.580.8.A.6.d. Delete the text beginning at 8.585 through the end of 8.585.06. This rule is effective April 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment - Oxygen and Oxygen Equipment, Sections 8.580 & 8.585
Rule Number: MSB 19-10-30-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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).

   In the 2015 Durable Medical Equipment Oxygen (DME Oxygen) Benefits Collaborative process, a DME Oxygen benefits coverage standard was created in collaboration with stakeholders for the Colorado Medicaid DME Oxygen benefit. The Department is in the process of retiring benefit coverage standards that exist separate from rules. Therefore, the rules implementing the DME Oxygen benefit, at 10 C.C.R. 2505-10, Sections 8.580 and 8.585, are being revised to remove the incorporation of the DME Oxygen benefit coverage standard and to move several requirements from the DME Oxygen benefit coverage standard into rule. The billing guidelines of the benefit coverage standard transferred into rule have been changed to require retention of all oxygen and oxygen equipment orders, prescriptions, or Certificates of Medical Necessity (CMN), rather than just the original and the current order, prescription, or CMN. Moreover, Sections 5.580 and 8.585 are being consolidated and reorganized as a single rule to promote regulatory clarity, including new subsections for definitions, client eligibility, provider eligibility, covered services and equipment, prior authorization, non-covered services, and reimbursement.

2. An emergency rule-making is imperatively necessary3

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

   Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. 440.70(b)(3) (2019)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   Section 25.5-4-416 (2019)

Initial Review **02/14/2020** Final Adoption **03/13/2020**
Proposed Effective Date **04/30/2020** Emergency Adoption

DOCUMENT #04

Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment - Oxygen and Oxygen Equipment, Sections 8.580 & 8.585
Rule Number: MSB 19-10-30-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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.

   Durable medical equipment (DME) providers who provide oxygen and oxygen equipment, and the clients receiving such services, will be affected by the proposed rule. The proposed rule moves current policy from the DME oxygen benefit coverage standard sub-regulatory policy document into rule and is not intended to change current policy (except for requiring retention of all oxygen and oxygen equipment orders, prescriptions, and Certificates of Medical Necessity, rather than just the original and the current). As such, any impact to providers or clients should be non-existent or minimal. Both providers and clients will benefit from having DME oxygen policies codified in rule where they are accessible and hold the force and effect of law. The consolidation and reorganization of Sections 8.580 and 8.585 should promote clarity for both providers and clients. The Department will benefit from having it's DME oxygen policy codified in rule rather than sub-regulatory policy documents.

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 qualitative impact of the rule is to remove the incorporation by reference of the DME oxygen benefit coverage standard from rule and to transfer DME oxygen policy from a benefit coverage standard into rule. As this transfer is not intended to change current policy (except for requiring retention of all oxygen and oxygen equipment orders, prescriptions, and Certificates of Medical Necessity, rather than just the original and the current), there is no significant quantitative impact to the affected classes of persons. The consolidation and reorganization of Sections 8.580 and 8.585 should promote clarity for both providers and clients.

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

   The proposed rule transfers policy in the DME oxygen benefit coverage standard into rule without substantive changes (except for requiring retention of all oxygen and

oxygen equipment orders, prescriptions, and Certificates of Medical Necessity, rather than just the original and the current). As such, there are no significant costs to the Department or any other agency to implement and enforce the proposed rule. There is no anticipated effect on state revenues.

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

   There is no probable significant cost to the propose rule because it does not substantively change DME oxygen policy (except for requiring retention of all oxygen and oxygen equipment orders, prescriptions, and Certificates of Medical Necessity, rather than just the original and the current). The benefit of the proposed rule is moving DME oxygen policy from sub-regulatory documents into rule. The cost of inaction would be keeping DME oxygen policy in sub-regulatory documents rather than in rule. There is no benefit to inaction.

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

   There are no less costly methods or less intrusive methods to move DME oxygen policy from sub-regulatory documents into rule.

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

   There are no alternative methods for moving DME oxygen policy from sub-regulatory documents into rule.

8.580 ~~OXYGEN AND OXYGEN EQUIPMENT~~DURABLE MEDICAL EQUIPMENT – OXYGEN AND OXYGEN EQUIPMENT

8.580.1 DEFINITIONS

8.580.1.A. Certificate of Medical Necessity means the Medicare CMN-484 Oxygen form or the Colorado Medicaid Certificate of Medical Necessity for Oxygen Benefits form.

8.580.1.B. Concentrator means an oxygen delivery system that operates electrically to concentrate oxygen from room air.

8.580.1.C. Hypoxemia means deficient oxygenation of blood.

8.580.1.E Nursing Facility means nursing facilities, intermediate nursing facilities, and skilled nursing facilities that receive facility payment reimbursement for care.

8.580.1.F. Oxygen Concentrator is the same as a concentrator.

8.580.1.G. Oxygen Delivery System means the method by which oxygen is delivered to the client.

8.580.1.H. Portable Oxygen System means an oxygen delivery system, utilizing either concentrators or tanks, that can be easily moved with the client on a frequent basis.

8.580.1.I. Post-Acute Oxygen Therapy means providing short term oxygen lasting three months or less to address a client's acute condition that is expected to resolve.

8.580.1.J. Stationary Oxygen Delivery System means an oxygen delivery system that cannot be easily moved with the client on a frequent basis and does not concentrate oxygen from room air.

8.580.1.K. Ventilator means a device to assist or control ventilation for a client who is unable to maintain spontaneous ventilation unassisted.

8.580.2 CLIENT ELIGIBILITY

8.580.2.A. All Colorado Medicaid clients are eligible for oxygen therapy and oxygen equipment deemed medically necessary, as defined in Section 8.076.1.8.

8.580.3 PROVIDER ELIGIBILITY

8.580.3.A. Ordering, Prescribing, Referring (OPR) Providers

1. The following providers are eligible to order, prescribe, or refer oxygen therapy and oxygen equipment when the provider is enrolled with Colorado Medicaid and licensed by the Colorado Department of Regulatory Agencies, or the licensing agency of the state in which they are licensed:

    a. Doctors of Medicine (MD)

    b. Doctors of Osteopathy (DO)

    c. Physician Assistants

    d. Nurse Practitioners

8.580.3.B. Rendering Providers

1. The following providers are eligible to render oxygen therapy and oxygen equipment when the provider is enrolled with Colorado Medicaid and licensed by the licensing agency of the state in which they do business:

   a. Durable Medical Equipment (DME) Providers enrolled in Colorado Medicaid, otherwise referred to as "suppliers."

8.580.4 PLACES OF SERVICES

8.580.4.A. Eligible Places of Services

1. The following places are eligible for a client to receive oxygen and oxygen equipment:

   a. Home

   b. Nursing Facilities and group homes

   c. Intermediate care facilities for individuals with intellectual disabilities

   d. Hospitals

      i. Oxygen contents and oxygen equipment provided to hospitalized clients must be provided by the hospital and cannot be submitted for direct payment by the supplier. Reimbursement for oxygen and oxygen equipment in hospitals is provided under Section 8.580.8.A.5.

8.580.5 COVERED SERVICES AND EQUIPMENT

8.580.5.A. The following clients require a prescription for oxygen therapy and oxygen equipment, but are otherwise exempt from the coverage requirements of this subsection at Section 8.580.5:

1. Ventilator-dependent clients; and

2. Clients covered under the child health component of Medicaid known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT), as identified in Section 8.280.

8.580.5.B. Post-Acute Oxygen Therapy

1. Post-Acute Oxygen Therapy may be provided to clients for up to ninety days with a prescription from an OPR provider identified in Section 8.580.3.A.

   a. Post-Acute Oxygen Therapy requires a documented assessment of Hypoxia.

8.580.5.C. Long Term Oxygen Therapy Certificate of Medical Necessity

1. Long Term Oxygen Therapy may be provided to clients for greater than ninety days with a prescription from an OPR provider identified in Section 8.580.3.A and a Certificate of Medical Necessity.

   a. The Certificate of Medical Necessity must:

      i. Be obtained by the rendering provider within one hundred twenty days of the client beginning oxygen therapy;

ii. Be signed by a physician or licensed professional responsible for care of the client, which includes the medical director of a Nursing Facility;

iii. Include the most recent blood gas study or oxygenation assessment, obtained within thirty days of the initial oxygen provision date on the Certificate of Medical Necessity.

b. Recertification of the CMN required under Section 8.580.5.C.1 is required every twelve months or when the client's condition changes, whichever comes first.

i. Clients certified for twenty-four consecutive months no longer require a Certificate of Medical Necessity for oxygen.

2. Suppliers must have a completed and current Certificate of Medical Necessity on file to support claims for oxygen therapy and oxygen equipment for non-ventilator dependent clients aged twenty and older requiring long term oxygen therapy lasting ninety days or more. For clients certified for twenty-four consecutive months, the most recent certified Certificate of Medical Necessity must be on file.

8.580.5.D. Portable Oxygen Systems

1. Clients aged twenty-one and above may qualify for a Portable Oxygen System either by itself or to use in addition to a Stationary Oxygen Delivery System if the following requirements are met:

a. The Section 8.580.5.B or Section 8.580.5.C requirements are satisfied, and

b. The medical documentation indicates the client is mobile in their residence or mobile in the community and would benefit from the use of a Portable Oxygen System.

2. Portable Oxygen Systems are not covered for clients who qualify for oxygen solely based on blood gas studies obtained during sleep unless the client resides in a Nursing Facility.

3. If a client resides in a Nursing Facility and receives portable oxygen while sleeping outside their room, the client should be assessed for continuous oxygen need.

8.580.6 PRIOR AUTHORIZATION REQUIREMENTS

8.580.6.A. There are no prior authorization requirements for oxygen therapy and oxygen equipment.

8.580.7.A NON-COVERED SERVICES

1. Oxygen therapy and oxygen equipment is not covered if a client exhibits any of the following conditions:

a. Chronic angina pectoris in the absence of Hypoxemia.;

b. Breathlessness without cor pulmonale or evidence of Hypoxemia.

8.580.8.A REIMBURSEMENT

1. To receive reimbursement, provider records must include, but are not limited to:

a. All oxygen therapy and oxygen equipment orders, prescriptions, and Certificates of Medical Necessity;

i. Oxygen therapy and oxygen equipment provided for Post Acute Oxygen Therapy of less than ninety days does not require a Certificate of Medical Necessity, but does require a documented assessment of Hypoxia under Section 8.580.5.B.1.a.

b. Record of oxygen-related items provided;

c. Documentation that the client, or the client's caregiver, was provided with manufacturer instructions, warranty information, service manual, and operating instructions for the rendered oxygen therapy and oxygen equipment.

2. Medicaid will not reimburse as primary payer for DME oxygen for clients that are:

a. Dually eligible for Medicare and Medicaid,

b. Aged twenty-one or above, and

c. Not receiving benefits in a Nursing Facility or intermediate care facility for individuals with intellectual disabilities.

3. Medicaid will not reimburse as a primary payer for DME oxygen for clients that are:

a. Dually eligible for Medicare and Medicaid,

b. Aged twenty-one or above, and

c. Receiving Medicare-covered skilled nursing services in a Nursing Facility.

4. Oxygen therapy and oxygen equipment provided in a client's home~~s~~:

a. Suppliers must directly bill the Department for medically necessary liquid or gaseous oxygen equipment provided in a client's home or place of residence, not to include Nursing Facilities.

b. Reimbursement to a rendering provider for Oxygen Therapy or Oxygen Equipment must be the lower of the provider's billed charge or the Department's fee schedule.

5. Oxygen therapy and oxygen equipment provided to hospitalized clients

a. Oxygen therapy and oxygen equipment, when medically necessary and prescribed by an OPR provider for any form of oxygen for a client a hospital setting, inpatient or outpatient, must be provided by the hospital and is included in the Medicaid payment for inpatient hospital services.

6. Oxygen therapy and oxygen equipment provided to Nursing Facility and group home clients

a. Suppliers must bill the Department directly for medically necessary liquid or gaseous oxygen therapy, and oxygen equipment needed for the administration of liquid or gaseous oxygen, if provided to clients residing in Nursing Facilities that are reimbursed at a per diem amount.

b. Oxygen Concentrators for use by clients residing in a Nursing Facility or group home being reimbursed at a per diem rate must be provided in one of the following ways:

i. Oxygen Concentrators purchased by the Nursing Facility or group home must be included in the facility cost report and reimbursed through the per diem rate. All necessary oxygen-related supplies must be provided by the facility in accordance with Section 8.441.5.K.

ii. Clients residing in Nursing Facilities or group homes that do not purchase oxygen Concentrators must obtain equipment and supplies from an authorized supplier. The supplier must provide equipment, oxygen and supplies for use by a specific client, as ordered by the client's OPR provider, and must bill on the state approved form.

c. Nursing Facilities and group homes must provide the following information in a certification statement to suppliers within twenty (20) days of the date the supplier delivers the oxygen therapy or oxygen equipment:

i. The name and Medicaid identification number for all Medicaid clients provided liquid or gaseous oxygen, or the equipment or supplies necessary for administration by the supplier;

ii. An indication of whether any Medicaid clients identified in (i) have Medicare Part A or Medicare Part B, or any other third-party resources;

iii. The name and state identification number for all Medicaid clients identified in (i) that utilize an oxygen concentrator rented, but not purchased, from the supplier. This applies only to clients in Nursing Facilities or group homes that do not purchase oxygen Concentrators;

iv. A certification guaranteeing that oxygen therapy and oxygen equipment obtained from the supplier was used only by the individual Medicaid client for which it was supplied. Where centralized oxygen systems are utilized, each Medicaid client's oxygen usage must be documented and identified in the certification statement in liters.

d. Rendering providers (suppliers) must bill the Department for oxygen therapy and oxygen equipment based on the information provided by the Nursing Facility or group home in the Certification Statement, as required by Section 8.580.8.A.6.c. A rendering provider's reimbursement rate for oxygen therapy and oxygen equipment must be the lower of the provider's billed charges or the Department's fee schedule.

~~**8.580.1 OXYGEN AND OXYGEN EQUIPMENT PROVIDED IN CLIENT HOMES**~~

~~8.580.1.A. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician, are a Medicaid benefit if provided in the client's home, or place of residence, not to include intermediary or skilled nursing facilities.~~

~~8.580.1.B. The oxygen provider shall directly bill the Department for medically necessary liquid or gaseous oxygen equipment and supplies provided in a client's home or place of residence, not to~~

include intermediary or skilled nursing facilities. Reimbursement shall be the lower of the provider's billed charge or the Department's fee schedule.

8.580.2 OXYGEN, AND OXYGEN EQUIPMENT, PROVIDED TO HOSPITAL CLIENTS

8.580.2.A. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician for any form of oxygen for a client in an inpatient hospital setting are a benefit.

8.580.2.B. Oxygen and oxygen equipment, and/or supplies, when medically necessary and prescribed by the physician for any form of oxygen for a client in an inpatient hospital setting shall be provided by the hospital and is included in the Medicaid payment for inpatient hospital services.

8.580.3 OXYGEN, AND OXYGEN EQUIPMENT PROVIDED TO NURSING HOME CLIENTS

8.580.3.A. Oxygen, oxygen equipment and/or supplies when medically necessary and prescribed by the physician for clients residing in an intermediary or skilled nursing facility are a benefit.

8.580.3.B. Oxygen equipment and/or supplies for clients residing in a nursing facility being reimbursed a per diem amount, shall be provided by the nursing facility, except when the facility orders oxygen equipment and/or supplies specifically for the unique needs of an individual client. In such cases, the oxygen equipment and/or supply provider shall bill the Department directly.

8.580.3.C. Oxygen concentrators for use by clients residing in a nursing facility being reimbursed a per diem rate shall be provided in one of the following ways:

1. Oxygen concentrators purchased by the facilities shall be included in the facility cost report and reimbursed through the per diem. All necessary oxygen-related supplies shall be provided by the facility in accordance with 10 C.C.R. 2505-10, Section 8.441.5.K.

2. Clients residing in facilities that do not purchase oxygen concentrators shall obtain equipment and supplies from an authorized Medicaid oxygen provider. The oxygen provider shall provide equipment, oxygen and supplies for use by a specific client, as ordered by the client's physician, and shall bill on the state approved form.

8.580.3.D. The oxygen provider shall bill the Department directly for medically necessary liquid or gaseous oxygen provided to clients residing in intermediary or skilled nursing facilities that are reimbursed a per diem amount.

8.580.3.E. The oxygen provider shall bill based on the information provided by the nursing facility. Claims shall be coded appropriately as defined by the Department. Reimbursement shall be the lower of the provider's billed charges or the Department's fee schedule.

8.580.4 DME Oxygen Benefit Coverage Standard Incorporation by Reference

8.580.4.A Standard Incorporated by Reference

All eligible providers of DME oxygen enrolled in the Colorado Medicaid program shall be in compliance with the Colorado Medicaid DME Oxygen Benefit Coverage Standard (approved September 1, 2011), which is hereby incorporated by reference. The incorporation of the DME Oxygen Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved

Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.585 OXYGEN, OXYGEN EQUIPMENT, AND SUPPLIES

Medically necessary oxygen, oxygen equipment, and supplies are a benefit of the Colorado Medicaid Program. Medical necessity shall be provided in a manner approved by the Department, and shall be maintained in the provider's files for a minimum of six (6) years. The Department reserves the right to request copies of documentation of medical necessity.

.01 With the exception of liquid or gaseous oxygen provided in a nursing facility, and the supplies and equipment necessary to administer each, medical equipment and/or supplies for Medicaid clients residing in a nursing facility, or group home receiving daily Medicaid reimbursement, must be provided by the facility. Costs of equipment and/or supplies unrelated to the use of gaseous or liquid oxygen are included in the facility's cost report and reimbursed through the Medicaid per diem.

.02 Any form of oxygen for use by clients in an inpatient hospital setting must be provided by the hospital and is included in the Medicaid payment. Oxygen concentrators for use by clients residing in a nursing facility, or group home receiving daily Medicaid reimbursement, may be provided in one of two ways.

A. Nursing facilities or group homes committed to a program of purchasing concentrators for use by their Medicaid residents may bill a monthly fee to the Department using the Nursing Home Claim Form, in accordance with 8.465. All necessary oxygen- related disposable supplies shall also be provided by the facility.

B. Residents of facilities which do not wish to purchase concentrators for patient use shall obtain needed equipment from an authorized Medicaid oxygen supplier. The oxygen supplier shall bill a monthly fee using the Supply Claim. Reimbursement will be the lower of billed charges or the Department's fee schedule.

.03 Liquid and gaseous oxygen, as well as equipment and supplies provided by the medical equipment supplier for administration in a nursing facility or group home, shall be billed directly to the Department's fiscal agent by a Medicaid supply provider, in accordance with Department policy.

.04 Medical suppliers providing oxygen to Medicaid clients shall provide equipment, supplies and oxygen for use by a specific client, based upon the physician's prescription.

.05 In order to assure accurate and appropriate billing by the medical supplier, the nursing facility or group home shall be responsible for providing the following information to the medical supplier within 20 days following the date the supplier delivers the item to be billed. The required information shall be in the form of a certification statement and shall contain the following, as a minimum:

A. the name and state ID number for all Medicaid clients provided liquid or gaseous oxygen, or the equipment/supplies necessary for administration by the medical supplier.

B. an indicator of Medicare Part A or B, or other third party resources.

C. the name and state ID number for all Medicaid clients utilizing an oxygen concentrator being rented from the oxygen supplier. This applies only to patients in those facilities which choose not to commit to the purchase of concentrators.

D. certification guaranteeing that equipment, supplies, and oxygen were used only by the patient for which they were supplied; or in the case of centralized oxygen systems, each client's oxygen usage, expressed in liters.

.06 The medical supplier shall bill the Medicaid program based upon the above information provided by the nursing facility, using the appropriate HCPCS coding. Reimbursement shall be made in accordance with the Department's fee schedule or the provider's usual and customary charges, whichever is lower.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Hospital Back Up Level of Care, Section 8.470
Rule Number: MSB 19-02-12-B
Division / Contact / Phone: Benefits and Services Division OCL / Hufnagel / x5993

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 19-02-12-B, Revision to the Medical Assistance Rule concerning Hospital Back Up Level of Care, Section 8.470
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) 8.470.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.470 with the proposed text beginning at 8.470 through the end of 8.470.9.B.2. This rule is effective April 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Hospital Back Up Level of Care, Section 8.470
Rule Number: MSB 19-02-12-B
Division / Contact / Phone: Benefits and Services Division OCL / Hufnagel / x5993

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 change is to define each existing category with greater clarity and include detailed explanations of the documents necessary for verifying clinical eligibility for the HBU program. The desired outcome of this change would be to reduce delays to Client admission and decrease any financial burdens placed on the State as a result of these delays.

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:

   Section 1919(e)(5) of the Social Security Act

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2019);

Initial Review **02/14/2020** Final Adoption **03/13/2020**
Proposed Effective Date **04/30/2020** Emergency Adoption

DOCUMENT #05

Title of Rule: Revision to the Medical Assistance Rule concerning Hospital Back Up Level of Care, Section 8.470
Rule Number: MSB 19-02-12-B
Division / Contact / Phone: Benefits and Services Division OCL / Hufnagel / x5993

REGULATORY ANALYSIS

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

   The Proposed rule change will directly impact the hospitals discharging clients in to the HBU program. There will be no additional cost to the hospitals for providing clarifying documentation that is already available in the Client's progress notes. The Client will ultimately benefit from the rule change, as the hospital referral and supporting documentation provided to the State will allow us to make an eligibility determination more quickly and ensure that the accepting HBU SNF is able to coordinate a safe transfer for the Client.

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

   Quantitatively, over time we could expect to see a significant reduction in the Client's inpatient stays/days of admission. Qualitatively, we will see a streamlining of the admission process, reducing stress and transfer trauma for the Client and their families.

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

   There will be no changes to State and County operations as a result of this rule revision. Medicaid expenditures related to hospital transitions may decrease over time because of reduced delays to admission and transfer to the SNF. Additionally, we expect to see a reduction in the time our contractors must spend on eligibility reviews resulting from insufficient documentation.

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

   The revision of the rule can only improve upon the HBU program and benefit all entities involved in the Client's care continuum. Inaction will continue to hinder the State's ability to service Clients in need of HBU level care and drive up costs as a result of extended inpatient stays and/or ongoing re-admissions.

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

   For Individuals needing HBU level care, the need for safe discharge into a SNF is critical to their health and well-being. Additionally, the HBU level program is designed to support Client and Family decision making and whenever possible, stabilize and transition the Client out of the HBU- SNF and into a step down or home -based care setting.

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 HBU Policy analyst has worked extensively with the hospitals, SNF and our clinicians to review potential pathways we may take to achieve this end goal. Ultimately, it was determined that this rule revision is the most sound option for implementing positive changes to the HBU program.

8.470 HOSPITAL BACK UP LEVEL OF CARE~~a ULTC 100.2 program eligibility assessment completed by the SEP agency~~

~~**Verified long term care Medicaid approval**~~

~~**SURC reviewed HBU application verifying the Client meets the clinical admission criteria of vent dependent, complex needs requiring hospital level care, or complex wound care needs.**~~

~~**8.470 Hospital Back Up Level of Care**~~

8.470.1 DEFINITION

The Hospital Back Up (HBU) Program is a long~~-~~ term care program that provides hospital level care in a skilled nursing facility (SNF) setting. ~~Health First members~~Clients who no longer need acute care in a hospital but require 24-hour monitoring and life sustaining technology for complex medical conditions may apply to receive long term care in an HBU certified facility.

8.470.2 PROGRAM ELIGIBILITY

In order to be eligible for the hospital back up program, a client shall:

1. Meet ULTC 100.2 level of care eligibility for long term care as determined by the appropriate single-entry point agency (SEP); and

2. Meet the client clinical eligibility requirements as identified in 8.470.3 as determined by the State Utilization Review Contractor (SURC);

3. Be medically stable in a chronically acute state;

4. Be in a hospital or **long-term** acute care facility prior to approval; or

5. Be in An HBU skilled facility under a qualified Medicare stay

~~8.470.1 ELIGIBILITY~~8.470.3 CLIENT CLINICAL ELIGIBILITY

All prospective ~~Health First C~~clients must meet the ~~all~~ requirements of ~~at least~~ at least one of the following three categories in the clinical eligibility criteria in to participate in the ~~h~~Hospital ~~b~~Back ~~u~~Up ~~p~~Program:

1. Complex Wound as outlined in 8.470.3.A;

2. Ventilator Dependent as outlined in 8.470.3.B; or

~~1.~~3. Medically Complex as outlined in 8.470.3.C

~~"Complex wound care" means that the client meets the following criteria:~~

~~1. At least one stage 3-4 pressure ulcer or injury, second- or third-degree burns, or a Medicare rated wound group of 2-3 pressure relieving support surface to heal.~~

~~as evidenced by symptoms including, (but not limited to), extensive skin loss, active infection, compromised blood flow, sloughing, tunneling, fistulae, undermining of surrounding tissue, or necrosis with potential extension to underlying fascia. Plus one of the following:~~

~~a. Full thickness wound graft surgery Negative pressure wound therapy, electromagnetic therapy, compression therapy or hyperbaric oxygen therapy~~

~~b. Debridement (surgical, mechanical, chemical, autolytic or larval biotherapy).~~

~~c. Dressings with growth factors, silver/alginates, hyauluronic acid or collagens; and~~

~~2. Nutritional deficiencies requiring care, with documentation showing:~~

~~a. Identification of diagnostic markers and specific nutritional deficiencies~~

~~b. A plan of treatment to address underlying conditions such as malabsorption or excess loss of nutrients.~~

~~c. Dietary modifications such as the use of nutritional supplements to promote intake of nutrients and wound healing.~~

~~d. The modality of supplementation, either oral, intramuscular or intravenously.~~

8.470.3.A. Complex Wound Care means the ~~C~~client must meet all the following criteria:

1. At least one stage 3-4 pressure ulcer or injury, second- or third-degree burns, or a Medicare "pressure relieving support surface" rating of 2-3 to heal or prevent skin breakdown;~~.~~

2. Documentation of ~~(but not limited to)~~ extensive skin loss, active infection, compromised blood flow, sloughing, tunneling, fistulae, or undermining of surrounding tissue or necrosis with potential extension to underlying fascia;

3. Documentation of nutritional deficiencies including:

   a. Identification of diagnostic markers and specific nutritional deficiencies;

   b. A plan of treatment to address underlying conditions such as malabsorption or excess loss of nutrients; and

   c. The modality of supplementation: oral, intramuscular or intravenous, and~~.~~

4. Documentation of at least one of the following:

   a. Full thickness wound graft surgery;

   b. Negative ~~P~~pressure wound therapy, electromagnetic therapy, compression therapy or hyperbaric oxygen therapy;

   c. Debridement (surgical, mechanical, chemical, autolytic or larval biotherapy); or

   d. Advanced ~~D~~dressings with growth factors, silver/alginates, hyaluronic acid or collagens.

~~"Medically complex" eligibility clients shall meet 5 of the 8 following criteria:~~

~~a. Has difficulty communicating needs to others and/or requires assistance from trained staff to set up adaptive equipment, or is unable to seek assistance due to physical or cognitive impairment.~~

~~b. Require on-site assessment by a rounding physician or sub specialist once per week;~~

~~c. Require artificial nourishment via a gastro-intestinal tube (G-tube or NG-tube), and/or jejunostomy tube (J-tube), to be administered by clinical staff;~~

~~d. Is ventilator dependent or has a tracheostomy requiring suction and/or airway maintenance at least every 4 hours by a respiratory therapist or pulmonary trained registered nurse (under the supervision of a respiratory therapist)~~

~~e. Require total parenteral nutrition with or without lipids;~~

~~f. Require central line in active use for fluids and/or medications, excluding total parenteral nutrition~~

~~g. Requires rehabilitative therapies, such as physical therapy, occupational therapy, speech language pathology when applicable, or skilled nursing notes for assessment, monitoring, and intervention at a greater frequency than is usually provided in a class I skilled nursing facility.~~

~~h. Requires a plan of treatment for managing complex pain including frequency of dose adjustment, changing medication administration or skilled intervention for uncontrolled pain.~~

~~" A "ventilator-dependent" client is one who meets all of the requirements in one of the following three subsections:~~

~~1. If the client is actively weaning from the ventilator, the client must:~~

~~a. Require ongoing ventilator support at least two hours each day; and~~

~~b. Require the support of a respiratory therapist or pulmonary trained registered nurse for ventilator assessment and care at least 12 hours a day as part of the weaning process.~~

~~c. Require physical therapy, occupational therapy, speech therapy or combination at least five days per week; and~~

~~d. Have documented rehabilitation potential and a plan of treatment in place at time of referral including (but not limited to) respiratory and speech language pathology notes, respiratory pulmonary function tests, blood gas lab results, and results of standard breathing trials.~~

~~2. If active weaning fails, the client must:~~

~~a. Have documented of failed weaning efforts by a respiratory therapist and a plan of treatment with prognosis for liberation from a pulmonologist and respiratory therapist.~~

~~b. Require continuous ventilator support at least 8 hours per day and respiratory therapy at least 3.5 hours per day in order to remain medically stable; and~~

~~c. Have one of the following scores on the ULTC 100.2 assessment form:~~

~~i) A score of at least two, in a minimum of two activities of daily living; or~~

~~ii) A score of at least two, in one category of supervision; and~~

~~d. Have difficulty communicating needs~~

~~to others and/or requires assistance from trained staff to set up adaptive equipment, or unable to speak due to physical or cognitive impairment.~~

~~3. If the client has been weaned off the ventilator and is actively weaning to reduce oxygen needs and/or remove the tracheotomy tube, the client must:~~

~~a. Have one of the following scores on the ULTC 100.2 assessment form:~~

~~i) A score of at least two, in a minimum of two activities of daily livings; or~~

~~ii) A score of at least two, in one category of supervision; and~~

~~b. Have documentation from a respiratory therapist and pulmonologist indicating that client has been weaned off active ventilation or is expected to have a further reduction to standard home oxygen levels (1-6 LPM); and~~

~~c. Respiratory therapist support under the supervision of a pulmonologist at least 3.5 hours a day in order to remain medically stable and/or show progress toward decannulation.~~

~~d. Receive speech language pathology therapy to evaluate successful completion of dysphagia test and ongoing speech therapy and~~

~~e. Have minimal difficulty communicating needs and be able to follow simple commands and/or manage trach care and respiratory hygiene.~~

8.470.3.B. Ventilator ~~D~~dependent ~~C~~clients must meet all requirements in at least one of the following three subsections:

1. If the c~~C~~lient is actively weaning off the ventilator, the client must:

   a. Require direct assessment and monitoring of weaning at least 2 hours each day by a respiratory therapist;

   b. Require supportive care at least 12 hours a day by a respiratory therapist or pulmonary trained nurse (under the supervision of a respiratory therapist) for ventilator management;

   c. Require physical therapy, occupational therapy, speech therapy, or a combination of such therapies at least 5 days per week; ~~and~~

d. Have documented rehabilitation potential and a plan of treatment by a respiratory therapist in place at the time of the HBU referral; and

e. Have ~~C~~clinical documentation including (but not limited to) arterial bloods gas labs, standard breathing and capping trial results, pulmonary function tests, capnography, respiratory and speech language pathology progress notes and any other documentation to support active weaning efforts.

2. If active weaning fails, the client must:

a. Have documentation of failed weaning efforts by a respiratory therapist and a plan of treatment with prognosis for liberation from a respiratory therapist or pulmonologist;

b. Require continuous ventilator support at least 8 hours per day and skilled respiratory care at least 3.5 hours per day to remain medically stable;

c. Have difficulty communicating needs to others and/or requires assistance from skilled staff to set up adaptive equipment, or is unable to speak due to physical or cognitive impairment; and

d. Have one of the following scores on the ULTC 100.2 assessment form:

i. A score of at least 2 in a minimum of two activities of daily living (ADL); or

ii. A score of at least 2 in one category of supervision.

3. If the c~~C~~lient has been successfully weaned off the ventilator and is actively working to reduce oxygen levels and/or removal of the tracheostomy tube, the ~~C~~client must:

a. Have one of the following scores on the ULTC 100.2 assessment form:

i. A score of at least 2 in a minimum of two activities of daily living (-ADL); or

ii. A score of at least 2 in one category of supervision;

b. Have documentation from a respiratory therapist and pulmonologist verifying the client has been weaned off active ventilation and/or is working to have a further reduction to standard home oxygen levels (1-6 LPM); ~~and~~

c. Require ~~T~~the support of a respiratory therapist under the supervision of a pulmonologist at least 3.5 hours a day to remain medically stable and/or show progress toward decannulation; and

d. ~~Have minimal difficulty communicating needs and be able to follow simple commands and/or manage trach care and respiratory hygiene~~Be capable of:

i. Communicating needs and following simple commands; and/or

ii. Managing~~e~~ basic tracheostomy care or respiratory hygiene.

8.470.3.C. Medically c~~C~~omplex clients include ventilator dependent individuals and individuals successfully weaned off the ventilator~~or post wean individuals~~ with co-morbidities. To be deemed

medically complex under the HBU program, clients ~~shall~~must meet all of the following requirements:

1. Have a score of at least 2 in a minimum of 2 activities of daily living or a score of at least 2 in one category of supervision ~~one of the following scores~~ on the ULTC 100.2 assessment form;~~:~~

~~A score of at least 2 in a minimum of 2 activities of daily living or a score of at least 2 in one category of supervision;~~

2. Have difficulty communicating needs to others and requires assistance from skilled staff to set up adaptive equipment or ~~is~~be unable to seek assistance due to cognitive or physical impairment;

3. Require on~~-~~site assessment by a rounding physician or sub-specialist at least once a week to remain stable;

4. Require artificial nourishment to be administered by registered nurse, including but not limited to~~:~~ a gastro-intestinal tube (G~~-~~ tube or NG tube) and/or jejunostomy tube (~~-~~J tube), total parenteral nutrition (~~-~~TPN) with or without lipids, or central line in active use for fluids or medication (excluding TPN);

5. Require documentation of rehabilitative therapies including physical, occupational and speech language therapy, and/or skilled nursing notes documenting assessment, monitoring and intervention at a greater frequency than is provided in a class 1 nursing facility;

6. Require suctioning and/or airway maintenance at least every four hours by a respiratory therapist or pulmonary trained nurse under the supervision of a respiratory therapist for ventilator dependent clients or clients with a tracheostomy~~.~~;

7. Physician documentation of life limiting disease which will require ongoing care in the HBU skilled nursing facility; and

8. Documentation of quarterly updates to~~Physician~~ plan of treatment, ~~with~~ prognosis, ~~and ongoing documentation of quarterly~~ status evaluation, ~~family~~ care conference and/or palliative consult.~~; or~~

~~Physician documentation of life limiting disease which will require ongoing care in the HBU skilled nursing facility~~

~~8.470.2 CLIENT ELIGIBILITY~~

~~8.470.2.A. In order to be eligible for the hospital back up level of care, a client shall:~~

~~1. Meet level of care requirements for long term care as determined by the appropriate Single Entry Point (SEP) agency;~~

~~2. Meet the criteria for one of the following categories:~~

a. complex wound care;

b. medically complex; or

c. ventilator dependent.

3. Be medically stable in a chronically acute state;

4. Be in the hospital or long term acute care hospital prior to approval; and

5.

;; ; or

Be in a HBU facility on a qualified Medicare stay.

8.470.3 CLIENT INITIAL ELIGIBILITY DETERMINATION

8.470.3.A. receipt of completed application and clinical documentation, the State Utilization Review Contractor (SURC) shall:

1. Conduct an eligibility review to determine whether the client meets the hospital back up level of care criteria and may be successfully treated in a nursing facility; and

2. Consider all other Medicaid programs and services and determine whether those programs would fail to meet the client's needs if the client were to be returned to the home.

8.470.3.B. When a hospital contacts a nursing facility regarding a potential client's eligibility for the hospital back up level of care, the nursing facility shall:

1. Conduct a face to face assessment with the client and the hospitalist and review clinical documentation to determine if the nursing facility can provide the appropriate level of care for the client.

2. Notify the SURC and the Department that it is considering admitting the client.

3. Prepare a care plan and submit it to the SURC for eligibility review.

4. Secure a transfer agreement with the Hospital and notify the department of the transfer date.

8.470.3.C. The initial care plan submitted to the SURC shall demonstrate that thenursing facility proposing to provide hospital back up level of care can meet the clinical needs of the prospective client. 8.470.3.D. The SURC shall review the medical documentation, the nursing facility care plan and the Single Entry Point (SEP) ULTC 100.2to determine whether or not the client meets the established hospital back up level of care criteria. The SURC may request any medical information and any other demographic information that the SURC deems necessary to make such determination. The SURC shall notify the Department in writing whether the client can be successfully treated in the nursing facility.

8.470.3.E. The SURC shall obtain a physician review for all clients who are considered to meet the hospital back up level of care criteria on initial evaluation. The physician's determination upon review shall be in writing and submitted to the SURC and the Department.

~~8.470.3.F. The SURC shall submit the care plan and supporting documentation to the Department with the written determination of approval or denial.~~

~~8.470.3.G. The SURC shall notify the client and the hospital, in writing, of the final determination. .~~

~~8.470.3.H If SURC determines the client meets eligibility requirements, a 90-day initial length of stay approval letter shall be sent to the nursing facility and the provider shall be notified.~~

8.470.4 INITIAL ELIGIBILITY DETERMINATION AND ADMISSION

8.470.4.A. SURC ~~r~~Review for Initial ~~h~~Hospital ~~e~~Eligibility D~~d~~etermination

Upon receipt of the completed Hospital Back Up Application, patient choice form and the ULTC 100.2~~.~~ assessment ~~from the hospital or long term acute care facility~~, the SURC nurse reviewer shall:

1. Conduct a program eligibility review to determine whether the client meets the hospital back up level of care criteria and may successfully be treated in the requested skilled nursing facility~~(ies)~~;

2. Review the ULTC 100.2 assessment by the SEP ~~agency~~;

   ~~Consider all other Medicaid programs and services to determne if those programs would fail to meet the client's care needs outside of the HBU skilled nursing facility~~

3. Provide initial assessment for secondary review by SURC physician reviewer;

4. ~~The SURC may~~ R~~r~~equest additional medical documentation deemed necessary to make such determination;

5. Notify the Department of final eligibility determination;

6. Document ~~The SURC shall document~~ all final physician determinations and maintain these records for the Department;

7. ~~If the prospective client does not meet HBU level of care, the SURC shall issue~~Issue a denial letter to the Department and referring provider~~hospital~~ within 10 business days of determination if the prospective client does not meet HBU level of care;~~.~~

8. ~~If the SURC determines the Client meets HBU level of care,~~ N~~the SURC will notify the~~ Department in writing within 10 days of determination i~~I~~f the SURC determines the Client meets HBU level of care; and~~.~~

9. ~~Within 24 hours of approval from the Department, the SURC shall I~~issue a 90~~-~~day initial length of stay letter to the client and skilled nursing facility within 24 hours of approval from the Department, in accordance with the criteria specified below in subsection 8.470.4.C.

~~8.470.4 90 DAY LENGTH OF STAY~~

~~8.470.4.A. Prior authorization for the 90-day length of stay of hospital back up nursing facility clients shall not exceed 90 days.~~

~~8.470.4.B The nursing facility must provide to the Department a status report for all hospital back up programs clients admitted to or residing in the facility, the preceding month's report due on the last business day of the month.~~

8.470.4.B. Hospital Back Up Skilled Nursing Facility Requirements

Upon receipt of a new client referral ~~from a hospital or long term acute care facility~~, the hospital back up ~~S~~skilled ~~N~~nursing ~~F~~facility shall:

1. Conduct a face to face assessment with the client and current care provider ~~hospitalist~~ and~~and~~ review clinical documentation to determine if the hospital back up skilled nursing facility can provide the appropriate level of care for the client;~~.~~

2. Notify the SURC and Department that it is considering admitting the client to the hospital back up skilled nursing facility;

3. Prepare a care plan and provide this to the SURC and Department for review;

4. Verify the status of the Client's~~at the Client has existing~~ enrollment in Health First Colorado LTC Medicaid;

5. Notify the Department of date of transfer and arrange for secure transport of client;

6. Maintain the HBU approval letter for the SEP and County to initiate services and payment for the ~~HBU~~ client;

7. P~~p~~rovide to the D~~d~~epartment a monthly status report on the last business day of each month for all ~~h~~Hospital ~~b~~Back ~~u~~Up ~~p~~Program clients admitted to or residing in the hospital back up skilled nursing facility during the preceding month.~~. , Tthe preceding month's report due on the last business day of the month~~

8. Failure to provide a status report each month could result in a temporary cessation of payment to the hospital back up skilled nursing facility.

8.470.4.C. ~~90 -~~Day Initial Length ~~O~~of Stay ~~Health First Colorado clients who meet long term care eligibility requirements and HBU program criteria will be issued a 90 -day initial length of stay letter. The 90- day initial length of stay shall:~~

1. The 90-day initial length of stay letter issued by the SURC nurse reviewer in accordance with subsection 8.470.4.A shall ~~P~~provide prior authorization for the ~~90-day~~initial length of stay in the hospital back up skilled nursing facility ~~and shall~~ not to exceed 90 days.

2. 15 days before the end of each hospital back up client's 90-day initial length of stay, ~~T~~the SURC nurse shall conduct an on~~-~~site review for each ~~hospital back up~~ client ~~15 days prior to the end of the client's 90 day initial length of stay~~, which will determine if:

   ~~The 90 day initial length of stay review shall determine if:~~

   a. The client continues to meet the hospital back up level of care criteria;

   b. The ~~C~~client's care needs are being adequately met in the hospital back up skilled nursing facility;

   c. The hospital back up skilled nursing facility has updated the existing plan of treatment to reflect any change in the client's condition; and

d. The appropriate level of care and services are being provided and documented in the client's record.;

1. The SURC nurse shall report the results of the on-site visit to the SURC physician reviewer within 24 hours of completion of the visit.

2. The SURC shall notify the Department and the hospital back up skilled nursing facility of the final determination in writing within 10 business days of the on site visit and include supporting documentation for this determination.

3. If the client continues to meet the hospital back up program level of care, the SURC shall issue annual continued stay letters to the hospital back up skilled nursing facility and client within 24 hours of approvalrequest from the dDepartment.

4. If the SURC physician reviewer determines that the client no longer meets the hospital back up level of care criteria or the nursing facility fails to provide documentation to support level of care and services provided, the SURC shall notify the hospital back up nursing facility administrator in writing within 24 hours of the determination and reimbursement for the client's stay shall be reduced to the nursing facility class one rate within 60 days of receipt of the letter.

5. The Department shall notify the client in writing of the SURC determination and appeal rights as outlined in 10 CCR 2505-10 section 8.057.

6. The SURC shall maintain all records for eligibility determinations and provide these documents upon request to the Department for contract reporting and client appeals.

8.470.5 ANNUAL CONTINUED STAY REVIEW FOR HOSPITAL BACK UP LEVEL OF CARE NURSING FACILITY CLIENTS

8.470.5.A. The SURC shall conduct an on-site continued stay review for each hospital back up level nursing facility client 15 days prior to the end of the client's currently approved stay. All site reviews will be completed by a registered nurse and reported to the SURC within 24 hours of completion.

8.470.5.B. A continued stay review shall be conducted at least annually. The Department may request the SURC to conduct an unscheduled continued stay review at any time during the length of stay.

8.470.5.C. The continued stay review shall determine:

1. The client continues to meet the hospital back up level of care criteria for hospital-level care in a nursing facility.

2. The Client's care needs are being adequately met.The nursing facility has updated the existing plan of treatment to reflect any change in client condition. Appropriate level of care and services are being provided and documented in the client record.

8.470.5.D. If the SURC determines, during the on-site continued stay review, that the client no longer meets the hospital back up level of care criteria or the nursing facility is unable to provide documentation to support level of care and services provided:

1. The SURC physician reviewer shall conduct an additional review to confirm the determination of the registered nurse reviewer and notify the Department in writing within 10 business days of the determination.

2. If the physician review confirms that the client no longer meets the hospital back up level of care criteria, the SURC shall notify the nursing facility in writing of the determination and that the reimbursement for the client's stay shall be reduced to the nursing facility's calss 1 rate within 60 days of receipt of the letter. The SURC shall notify the client in writing of their determination and This letter shall include client appeal rights as outlined in 10 CCR 2505-10 section 8.057.

3. The SURC shall notify the Department in writing if both the physician review and the SURC determine the client no longer meets the hospital back up level of care criteria and shall include supporting documentation for this determination.

4. Within 15 days from the date of notice, the nursing facility shall notify the department in writing whether it shall provide care for the client under the standard nursing facility class 1 rate.

   a. If the nursing facility chooses to transfer or discharge a client who ceases to meet the hospital back up level of care criteria, the nursing facility shall comply with notification requirements of, section 8.057.1.D. and E, including notifying the client of the right to appeal the transfer or discharge.

   b. The discharging nursing facility shall adhere to Colorado Department of Health and Environment's rules regarding client discharge or transfer as outlined in 6 CCR 1011-1, Chapter V, Section 12.6.

5. If the individual's care needs may be met by another HBU nursing facility, both nursing facilities must notify the Department of their intent to transfer the client and a new plan of treatment and transfer date must be provided by the accepting HBU facility for the SURC to review. 6. A new approval letter will be issued to the accepting nursing facility and the nursing facility must provide this acceptance letter to the SEP agency for their records. The back transport of the client may be billed to their Medicaid by the medical services company.

8.470.5.D. Annual Continued Stay Review

1. The SURC nurse shall conduct an on-site continued stay review for each hospital back up client 15 days prior to the end of the client's currently approved annual stay.

2. The SURC may conduct an unscheduled on-site review at any time during the length of stay for client clinical change of condition or at the request of the Department.

3. The SURC shall observe the same review criteria and determination requirements as outlined in 8.470.4.C of the 90-day initial eligibility criteria for determining ongoing annual eligibility.

4. A new ULTC 100.2 assessment must be completed annually by the SEP agency. The nursing facility shall provide a current ULTC 100.2 to the SURC as part of the annual eligibility assessment.

5. If the SURC determines that the client no longer meets the hospital back up level of care criteria or the nursing facility fails to provide documentation to support level of care and services provided, the SURC shall notify the Department within 24 hours of completion of the eligibility review.

6. The SURC shall observe the same determination and notification requirements as outlined in 8.470.4.C.6-7 of the 90-day initial eligibility criteria for determining ongoing annual eligibility.

~~**8.470.6 NURSING FACILITY QUALIFICATION FOR HOSPITAL BACK UP LEVEL**~~

~~8.470.6.A. In order to participate as a hospital back up level nursing facility, the nursing facility shall submit a letter of intent to the Department that demonstrates:~~

~~1. The nursing facility is Medicaid certified and licensed to provide skilled care;~~

~~2. Financial stability for corporate and individual nursing facility;~~

~~3. The nursing facility can provide skilled nursing services 24 hours per day;~~

~~4. Staff stability;~~

~~5. A history of survey compliance;~~

~~6. Compliance with the direct client care regulations "Chapter II – General Licensure Standards" and "Chapter V – Long Term Care Facilities" administered by CDPHE; and~~

~~7. A recommendation from CDPHE for the nursing facility to participate in the hospital back up level of care program.~~

~~8. The facility has the desired number of swing beds to be designated for hospital back up level of care program.~~

~~8.470.6.B. The Department may request evidence of financial stability and survey compliance periodically throughout the nursing facility's participation.~~

~~8.470.6.C. If the nursing facility has applied to admit clients who are ventilator dependent, the nursing facility shall meet the following additional requirements:~~

~~1. Maintain clinical staff trained in pulmonary and/or critical care medicine dedicated to the ventilator unit 24 hours a day, 7 days a week.~~

~~2. Have a generator that is capable of providing heating, cooling and continuous electricity for needed equipment in the event of power outages;~~

~~3. Maintain staff that has experience and current training in the care of clients who are ventilator dependent;~~

~~4. Have a verified wound care consultant available as needed; and~~

~~5. Maintain 24 hour on-site coverage by a respiratory therapist The respiratory therapist shall monitor any client weaning off of a ventilator. Registered Nurses participating in vent care shall consult with a respiratory therapist prior to changing any ventilator settings or modalities for ventilator dependent clients.~~

~~8.470.6.D. If the nursing facility has applied to admit clients with complex wounds, the nursing facility shall meet the following additional requirements:~~

~~1. Have a wound care specialist or nurses trained in providing the wound care required by the clients with complex wounds in the facility on a 24 hour basis; and~~

2. Have access in the facility to specialized wound care equipment necessary to meet the needs of the clients with complex wounds.

8.470.6.E. If the nursing facility has applied to admit clients who are medically complex, the nursing facility shall meet the following additional requirements:

1. Maintain sufficient skilled nursing staff experienced and trained in the care of clients who are medically complex;

2. Have 24-hour on-site coverage by a respiratory therapist or therapists to meet the assessed respiratory therapy needs of each medically complex client;

3. Have access to respiratory equipment necessary to meet the assessed needs of each medically complex client;

4. Have a wound care consultant available as needed; and

5. Provide physician support necessary for onsite monitoring at least once per week of clients who are medically complex.

8.470.6.F. A nursing facility participating in the hospital back up level of care program shall:

1. Use the forms approved by the Department to document the care of clients who meet the hospital back up level of care.

2. Evaluate the clinical needs of clients upon admission to ensure the facility can meet and is meeting the client's care needs, whenever there is a change in the client's condition, and as required by the Department for 90-day and annual continued stay reviews.

3. Immediately Notify the Department of a client's change of condition, discharge or death, and document these changes in the monthly status report due to the Department the last day of each month.

8.470.6.G. The Department may deny a nursing facility's request to participate as a hospital back up level of care nursing facility if the nursing facility does not meet the nursing facility criteria for participation.

8.470.6.H. The Department may revoke a nursing facility's authorization to participate in the hospital back up level of care program if the nursing facility is not in compliance with the hospital back up nursing facility criteria.

8.470.6 CLIENT TRANSFERS AND DISCHARGES FROM THE HBU PROGRAM

8.470.6.A. Requirements for HBU skilled nursing facility discharges

1. If a hospital back up skilled nursing facility receives CSR denial letter ~~notice~~ that a client ceases to meet hospital back up level of care criteria~~letter of denial is received~~, the hospital back up skilled nursing facility must notify the Department within 15 days of the date of the notice whether it may continue to provide care for the client under the standard nursing facility class 1 rate.

2. If the hospital back up skilled nursing facility chooses to discharge or transfer a client who ceases to meet hospital back up level of care criteria, the skilled nursing facility shall comply with the notification requirements of section 8.057.1.D and E, including notifying the client of their right to appeal the transfer or discharge.

3. The discharging skilled nursing facility shall adhere to the Colorado Department of Public Health and Environment's rules regarding client discharge or transfer as outlined in 6 CCR 1011-1, Chapter V, Section 12.6.

8.470.6.B. Requirements for HBU transfers within participating HBU ~~p~~Program facilities

1. If a client requests a~~to~~ transfer to another hospital back up skilled nursing~~HBU~~ facility~~ies~~ and~~or~~ the individual's care needs may be met by another hospital back up skilled nursing facility, ~~both~~each nursing facility~~ies~~ must notify the Department of their intent to transfer the client.

2. A new plan of treatment and must be provided by the accepting nursing facility to the SURC for review prior to transfer and the SURC shall notify the Department ~~will be notified~~ of the eligibility determination within 10 business days of review of the plan of treatment.

3. The SURC will issue a new approval letter to the accepting nursing facility, with change of billing effective on the date of transfer ~~on~~stated in the letter.

4. The accepting facility is responsible for arranging medical transport and notifying the SEP and ~~c~~County of the transfer for their records.

8.4707 ~~-~~NURSING FACILITY REQUIREMENTS FOR PARTICIPATION IN THE HBU PROGRAM

8.470.7.A In order to participate in the ~~h~~Hospital ~~b~~Back ~~u~~Up ~~p~~Program, the nursing facility shall submit a letter of intent to the Department that demonstrates the nursing facility:

1. ~~The nursing facility is~~ Is Medicaid certified and licensed to provide skilled care;~~.~~

2. ~~The nursing facility~~ is f~~F~~inancially stable;~~.~~

3. ~~The nursing facility~~ can provide skilled nursing facility services 24 hours a day;~~.~~

~~Respiratory Therapist present 24/7~~

4. Has ~~S~~staff stability;

5. Has a~~A~~ history of survey compliance;

6. ~~Compliance~~ Complies with the direct client care regulations administered by CDPHE as outlined in 6 CCR 1011-1 "~~-~~Chapter ~~I~~2: General ~~The~~ Licensure Standards" and "Chapter ~~V~~5~~-~~: ~~Long Term~~ Nursing Care Facilities" ~~administered by CDPHE~~; ~~and~~

7. Has ~~A~~a recommendation from CDPHE for the nursing facility to participate in the hospital back up level of care program.

8. Has ~~Availability the~~~~of~~ desired number of beds available to be designated for the HBU Program, not to exceed 25 beds.

8.470.7.B. The Department may request evidence of financial stability and survey compliance at any time during the nursing facility's participation.

8.470.7.C. The Department may deny or revoke authorization of a nursing facility to participate as a hospital back up level of care facility if they do not meet the requirements outlined in section 8.470.7.A.

8.470.7.D.~~C.~~ If the nursing facility has applied to admit clients who are ventilator dependent, the nursing facility shall also meet the following additional requirements:

1. Maintain clinical care staff trained in critical care and/or pulmonary medicine on the ventilator unit 24 hours a day, 7 days a week;

2. Have a back-~~-~~up generator ~~that is~~ capable of providing heat, cooling and continuous electricity for needed equipment in the event of power outages; and

3. Maintain 24-hour on-site coverage by a respiratory therapist, who shall monitor any client weaning off of a ventilator and adjust ventilator settings as needed.

~~**8.470.7 REIMBURSEMENT OF NURSING FACILITIES SERVING CLIENTS WHO MEET THE HOSPITAL BACK UP LEVEL OF CARE**~~

~~**8.470.7.A. Medicaid reimbursement for services provided to a hospital back up (HBU) level of care nursing facility client shall be based upon the Resource Utilization Group (RUG) classification determined through the client's minimum data set (MDS) resident assessment that has been transmitted to and accepted by the Centers for Medicare and Medicaid Services (CMS).**~~

~~**1. The Medicaid reimbursement for each client shall correspond to the RUG IV Case Mix Adjusted Federal RUG reimbursement rate prior to the application of any wage index component determined from a client's CMS accepted MDS resident assessment and related RUG classification.**~~

~~**2. All HBU facilities will receive an interim rate for 60 days after the admission of the client to the facility.**~~

~~**a. The interim rate will be the average RUG IV Case Mix Adjusted Federal RUG reimbursement rates for all clients enrolled in HBU, and will be recalculated annually. All claims billed during the interim rate payment period will be retroactively mass adjusted to reflect the permanent Medicaid reimbursement rate assigned to the client's RUG classification.**~~

~~**b. No later than 60 days post-admission the HBU facility must complete an MDS resident assessment that has been accepted by CMS.**~~

~~**c. No later than 60 days post-admission the provider must assign a RUG classification determined by the MDS resident assessment.**~~

~~**d. If no MDS resident assessment has been accepted by CMS within 60 days post admission, the Department shall withhold all future payments until the assessment has been accepted by CMS.**~~

~~**3. Medicaid reimbursement for a client who meets the HBU level of care shall not be based upon or related to the audited, cost-based reimbursement for a nursing facility's class I nursing facility residents. The appeal rights and procedures applicable to the Department's determination of a nursing facility's class I rate shall not apply to the reimbursement the Department offers or pays for a client who meets the HBU level of care.**~~

~~**4. If the Department determines that the client's third-party coverage (private insurance or Medicare) will cover the cost of the client's care in either a hospital or nursing facility, Medicaid payment under this program shall be approved only after utilization of third-party benefits.**~~

~~8.470.7.B. Providers shall bill for drugs and oxygen separately from the per diem rate as fee-for-service claims.~~

~~8.470.7.C. Twice yearly, the Department's contractor shall audit and validate all MDS resident assessments and related RUG classifications that have been utilized to set Medicaid reimbursement rates for HBU clients.~~

~~1. Audit and validation will occur each June and December.~~

~~2. 3. The contractor shall report all invalid MDS resident assessment scores to the Department and the facility.~~

~~4. For any score identified as invalid, the Department will adjust the rate to reflect the validated MDS resident assessments and corresponding RUG-IV reimbursement rate retroactively to the date of the previous validation. Claims will be reprocessed to reflect the corrected RUG-IV reimbursement rate.~~

~~5. In the event the facility disputes the Contractor's determination of the RUG classification the facility may file an informal reconsideration related to the RUG classification in accordance with, Section 8.050.~~

~~a. The Department must receive a request for informal reconsideration of a disputed RUG classification in writing within 30 days of the Contractor's notice of the disputed RUG classification. The request shall state, with specificity, each error in the disputed RUG classification. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.~~

~~b. The Department will notify the facility of the final determination of the disputed RUG classification within 45 days of the receipt of the request for informal reconsideration.~~

~~c. The facility may file an appeal of the Department's final determination of the disputed RUG classification with the Office of Administrative Courts within 30 days from the date of the Department's notice.~~

~~8.470.7.D. Each month, the HBU facility must report the status of every HBU clients residing in the facility utilizing the Department's approved reporting form.~~

~~1. The HBU facility shall report all discharges, whether permanent or temporary, the death of a client, all changes in status, or no change in status.~~

~~2. Reports must be submitted by no later than 5:30 p.m. on the last day of the month. If no report is received by the deadline, then the Department will notify the facility that payment will be immediately suspended until the facility submits the required status report, and will immediately suspend all HBU payments to the facility.~~

~~8.470.8 REPORTING ON MED-13~~

~~8.470.8.A. The Medicaid reimbursement for clients who meet the hospital back up level of care (hereafter referred to in this paragraph as "hospital-level reimbursement") shall not impact the Medicaid per diem cost and rate set for the nursing facility's class I Medicaid clients based on the MED-13 cost reporting process. The hospital-level reimbursement shall be reported on the MED-13 cost report form in the following manner so that it does not impact the class I Medicaid per diem rate established by the cost report:~~

~~1. The hospital-level reimbursement shall be included on the appropriate line in columns 1 through 8 on Schedule C.~~

~~2. Offset of the hospital-level reimbursement shall be made on Schedule B with a detailed supplemental schedule attached.~~

8.407.8 REIMBURSEMENT OF NURSING FACILITIES FOR PARTICIPATING CLIENTS WHO MEET HOSPITAL BACK UP LEVEL OF CARE

8.470.8.A Medicaid reimbursement for services provided to a hospital back up ~~(HBU)~~ level of care nursing facility client shall be based upon the Resource Utilization Group IV (RUG-IV) classification determined through the client's minimum data set (MDS) resident assessment as transmitted to and accepted by the Centers for Medicare and Medicaid services (CMS).

1. The Medicaid reimbursement for each client shall correspond to the RUG IV case mix adjusted federal RUG reimbursement rate prior to the application of any wage index component determined from a client's CMS accepted resident assessment and related RUG classification.

2. All HBU ~~F~~facilities will receive a 60-~~-~~day interim rate after the admission of the client to the facility.

    a. The interim rate will be the average RUG-IV case mix adjusted federal RUG reimbursement rates for all clients enrolled in HBU and will be recalculated annually.

    b. All claims billed during the interim rate payment period will be retroactively mass adjusted to reflect the permanent Medicaid reimbursement rate assigned to the client's RUG classification.

    c. The HBU facility must complete an MDS resident assessment accepted by CMS no later than 60 days post admission.

    d. The nursing facility must assign a RUG classification determined by the MDS resident assessment no later than 60 days post-admission.

    e. If no MDS resident assessment has been accepted by CMS within 60 days post admission, the Department shall withhold all future payments until the assessment has been accepted by CMS.

3. Medicaid reimbursement for a client who meets HBU level of care shall not be based upon or related to the audited, cost-based reimbursement for a nursing facility's class 1 residents.

4. The appeals rights and procedures applicable to the Department's determination of a nursing facility's class 1~~'s~~ rate shall not apply to the reimbursement the Department offers or pays for a client who meets HBU level of care criteria.

5. If the Department determines the client's third party coverage (~~-~~private insurance or Medicare) will cover the cost of the client's care in either a hospital or nursing facility, the Medicaid payment under this program shall be approved only after utilization of third party benefits.

8.470.8.B Providers shall bill for drugs and oxygen separately from the per diem rate as fee-~~-~~for-service claims.

8.470.8.C Twice yearly, the Department's contractor shall audit and validate all MDS resident assessments and related RUG classifications that have been utilized to~~t~~ set Medicaid reimbursement rates for HBU clients.

1. ~~1.~~ Audit and validation will occur each June and December.

2. ~~2.~~ The contractor shall report all invalid MDS resident assessment scores to the Department and the facility.

3. ~~3.~~ For any score ~~as~~ identified as invalid, the Department will adjust the rate to reflect the validated MDS resident assessments and corresponding RUG-IV reimbursement rate retroactively to the date of the previous validated MDS; claims will be reprocessed to reflect the corrected RUG-IV reimbursement rate.

8.470.8.D In the event the facility disputes the contractor's determination of the RUG classification, the facility may file an informal reconsideration related to the RUG classification in accordance with Section 8.050.

1. ~~1.~~ The Department must receive a request for informal consideration of a disputed RUG classification in writing within 30 days of the date of the contractor's notice of the disputed RUG classification.

2. ~~2.~~ The request shall state, with specificity, each error disputed in the RUG classification.

3. ~~3.~~ Requests that do not comply with the requirements of this section shall be considered incomplete and denied.

4. ~~4.~~ The Department will notify the facility of the final determination of the disputed RUG classification within 45 days of the receipt of the request for informal reconsideration.

5. ~~5.~~ The facility may file an appeal of the final informal reconsideration determination of the disputed RUG classification with the Office of Administrative Courts within 30 days from the date of the Department's notice of final determination of the informal reconsideration.

8.470.8.E Each month, the HBU facility must report the status of every HBU client in the facility using the Department's approved reporting form.

1. ~~1.~~ The HBU facility shall report all discharges, whether permanent or temporary, the death of a client, all changes in status, or no changes in status.

2. ~~2.~~ Reports must be submitted by no later than 5:30 p.m. on the last day of the month.

3. ~~3.~~ If no report is received by the deadline, the Department will notify the facility that payment will be immediately suspended until the facility submits the required status report, and will immediately suspend all HBU payments to the facility.

8.470.9 REPORTING ON THE MED-13 FORM

8.470.9.A The Medicaid reimbursement for clients who meet the hospital back up level of care (hereafter referred to in this paragraph as "-hospital level reimbursement") shall not impact the

Medicaid per diem cost and rate set for the nursing facility'~~'~~s class 1 Medicaid clients based on the Med-13 cost reporting process.

8.470.9.B ~~1.~~ The hospital level reimbursement shall be reported on the Med-13 cost report form in the following manner so that it does not impact the class 1 Medicaid per diem rate established by the cost report:

1. ~~2.~~ The hospital level reimbursement shall be included on the appropriate line in columns 1 through 8 on Schedule C; and

2. ~~3.~~ Offset of the hospital level reimbursement shall be on Schedule B with a detailed supplemental schedule attached.