**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning Family Planning Services, Section 8.730.
Rule Number: MSB 19-03-12-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen / 303-866-4441 / Melanie Reece / 303-866-3693

# 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 19-03-12-A, Revision to the Medical Assistance Act Rule concerning Family Planning Services, Section 8.730. |
| 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) 8.730, 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 8.730.1 with the proposed text beginning at 8.730.1 through the end of 8.730.1. Replace the current text at 8.730.3 with the proposed text beginning at 8.730.3.A through the end of 8.730.3.B. Replace the current text at 8.730.4 with the proposed beginning at 8.730.4.A through the end of 8.730.4.A. Replace the current text at 8.730.4.C with the proposed text beginning at 8.730.4.C.1. Replace the current text at 8.730.6 through the end of 8.730.8. This rule is effective May 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**DO NOT PUBLISH THIS PAGE**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 Family Planning Services, Section 8.730.
Rule Number: MSB 19-03-12-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen / 303-866-4441 / Melanie Reece / 303-866-3693

## STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this rule revision is to bring the rule in line with current Department practice regarding contraceptive coverage, remove an obsolete provider type, and make other miscellaneous updates to promote rule clarity. Specifically, the revision will remove the exclusion of spermicide and female condoms as covered benefits under the Family Planning Services rule and will remove the Family Planning Clinic provider type, PT 29.

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 § 440.210

4. State Authority for the Rule:

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

| | | | |
|---|---|---|---|
| Initial Review | **[date]** | Final Adoption | **[date]** |
| Proposed Effective Date | **[date]** | Emergency Adoption | **[date]** |

**DOCUMENT #**

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Family Planning Services, Section 8.730.
Rule Number: MSB 19-03-12-A
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## REGULATORY ANALYSIS

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

   Providers providing family planning services and members utilizing family planning services will be impacted by the proposed rule revision.

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 Department anticipates that affected members and providers will benefit from this rule update, which will add clarity, including with respect to covered benefits and eligible provider types.

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 anticipate an increase in utilization as a result of this 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 cost of inaction is the continued inaccuracy of the Department's coverage policy with respect to contraceptives. The benefit of the proposed rule revision is increased clarity of Family Planning Services policy for both members and providers.

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 amendments to the Family Planning Services rule.

**DO NOT PUBLISH THIS PAGE**

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

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

## 8.730 FAMILY PLANNING SERVICES

### 8.730.1 Definitions

**Family Planning Services** mean those services provided to individuals of child-bearing age, including sexually active minors, ~~with~~ where the intent of that service is to delay, prevent, or plan for a pregnancy. Family Planning Services may include physical examinations, ~~diagnoses,~~ evaluation, treatments, counseling, supplies ~~(including all FDA-approved contraceptives),~~ ~~with the exception of spermicides and female condoms)~~, prescriptions, and follow-up services.

**Institutionalized Individual** means an individual who is (a) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility (including a ~~mental~~ psychiatric hospital or other facility) for the care and treatment of a mental illness; or (b) confined, under a voluntary commitment in a ~~mental~~ psychiatric hospital or other facility, for the care and treatment of a mental illness.

**Mentally Incompetent Individual** means an individual who has been declared mentally incompetent by a federal, state, or local court for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

**Sterilization** means any medical procedure, treatment, or operation (except for a hysterectomy) for the purpose of rendering an individual permanently incapable of reproducing and that requires informed consent.

### 8.730.3 Provider Eligibility

8.730.3.A. The following Medicaid enrolled providers may offer family planning services:

1. Physician
2. Osteopath
3. Nurse Practitioner
4. Certified Nurse-Midwife
5. Physician Assistant

~~6. Clinical Nurse Specialist~~

6.~~7.~~ Certified Registered Nurse Anesthetist

~~8. Family Planning Clinic~~

~~9~~8~~7~~. Public Health Agency

~~10~~89. Non-physician Practitioner Group

8.730.3.B. Eligible places of service include:

1. Office

2. Clinic

~~3. Family Planning Clinic~~

~~4~~3. Public Health Agency

~~5~~4. Home

~~6~~5. School

~~7~~6. School-based Health Center

~~8~~7. Federally Qualified Health Center

~~9~~8. Rural Health Center

~~10~~9. Hospital

~~11~~10. Ambulatory Surgery Center

**8.730.4 Covered Services**

8.730.4.A. Office Visits

1. A comprehensive, annual family planning visit (where the intent of the visit is related to pregnancy prevention or planning) is covered only once per state fiscal year, no less than ten months apart, and may include: physical examinations, ~~diagnoses~~evaluation, treatments, counseling, supplies, contraceptives and prescriptions. Additional family planning follow-up visits and services are covered when medically necessary.

8.730.4.C. Contraceptives

1. All FDA-approved contraceptives, including emergency contraceptives, are a covered benefit ~~(with the exclusion of spermicides and female condoms)~~.

**8.730.~~5~~6. Non-covered Services**

8.730.~~5~~6.A. The following services are not covered benefits for Medicaid clients:

~~1. Spermicide~~

~~2. Female Condoms~~

~~3~~1. Sterilization reversal

~~4~~2. Infertility treatment and testing

**8.730.~~6~~7. Prior Authorization**

8.730.~~6~~7.A. Prior authorization is not required for family planning services.

**8.730.~~7~~8. Reimbursement**

8.730.~~7~~8.A. Reimbursement for family planning services requires an appropriate Family Planning diagnostic code along with use of the family planning (FP) modifier.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Children's Habilitation Residential Program (CHRP) waiver, Section 8.500
Rule Number: MSB 19-11-21-A
Division / Contact / Phone: Benefits and Services Management / Michele Craig / 303-866-5147

# 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 19-11-21-A, Revision to the Medical Assistance Act Rule concerning the Children's Habilitation Residential Program (CHRP) waiver, Section 8.500
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) 10 CCR 2505-10 8.500, Colorado Department of Health Care Policy and Financing, Child Health Plan *Plus* (10 CCR 2505-3).
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 8.508 with the proposed text beginning at 8.508.20 through the end of 8.508.190. This rule is effective May 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 the Children's Habilitation Residential Program (CHRP) waiver, Section 8.500
Rule Number: MSB 19-11-21-A
Division / Contact / Phone: Benefits and Services Management / Michele Craig / 303-866-5147

## 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 basis of this rule change is to align the CHRP rules with the waiver amendment approved by the Centers for Medicare and Medicaid Services (CMS) effective January 1, 2020. The purpose is to amend the rule to allow for family members who are not parents or legally responsible parties to be reimbursed for certain services as specified in the waiver. Additionally, the revision is to make technical changes including updated regulatory citations and spelling errors.

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:

   Legal Basis Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a (2011). The waiver was granted under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n (2011). 42 U.S.C. § § 1396a and 1396n are incorporated by reference.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   25.5-5-306, C.R.S. and 25.5-6-903 (2018)

Initial Review **03/13/2020** Final Adoption **04/10/2020**
Proposed Effective Date **05/30/2020** Emergency Adoption

**DOCUMENT #08**

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Children's Habilitation Residential Program (CHRP) waiver, Section 8.500
Rule Number: MSB 19-11-21-A
Division / Contact / Phone: Benefits and Services Management / Michele Craig / 303-866-5147

## REGULATORY ANALYSIS

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

   The proposed rule will affect children and youth with intellectual and developmental disabilities and complex behavior support needs, as well as the family of those children and youth. The benefit of the proposed to rule to expand provider capacity for Residential and Respite services and to allow relatives to provide these services which supports families to stay together.

   The technical changes to rule to correct errors and regulatory citations and ensures that Service Agencies and Case Management Agencies provide services in a manner that ensures the health, safety, and well-being of waiver participants.

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

   With the changes to the CHRP waiver pursuant to HB 18-1328, children and families are able to access medically necessary services without having to go through the child-welfare system. Children also now have access to Home and Community-Based crisis prevention services with the goal of decreasing the use of more acute, high cost services such as: residential, psychiatric hospitalization, crisis-system, etc. The proposed rule enhances and expands the options for children and families to access Residential and Respite services. These changes will improve member outcomes and decrease use of high-cost services.

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

   The Department received an appropriation from the Colorado General Assembly for the increased costs of expanded waiver participation and additional services in accordance with HB 18-1328. It is not anticipated that the proposed rule will increase utilization of waiver services as the eligibility criteria for the waiver has not changed. The proposed rule increases choice of provider for current and projected enrollees. It is anticipated that the changes to the CHRP waiver will reduce the

financial impact on other systems such as Child Welfare, emergency crisis services, and the juvenile justice system.

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

   Improved system efficiency and investment in services to help mitigate crises will improve access and outcomes for members. Additionally, increasing the potential provider pool allows for more options for children and youth receiving Residential and Respite services. It is anticipated that this will result in decreased utilization of high cost Residential services, including out of state services, and supporting children and youth to remain in the family home using Respite services.

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

   Many changes have been made to the waiver to meet the needs of this population. However, there are still limited Residential and Respite providers across the state. As a result, families may still have to engage the child-welfare system, emergency services, hospitalization, and out of state services which are must more costly and intrusive than 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 not any alternative methods to achieve the purpose for the proposed rule. In order to ensure compliance with Federal and State requirements for reimbursement of waiver services, the authority for provider qualifications and reimbursement needs to be a regulatory requirement to align with the Federally approved waiver.

## 8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

### 8.508.10 LEGAL BASIS

The Home and Community Based Services- Children's Habilitation Residential Program (HCBS-CHRP) is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a. The waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n.

### 8.508.20 DEFINITIONS

Abuse: As defined at §25.5-10-202 (1) (a)-(c), C.R.S.

Adverse Action: A denial, reduction, termination, or suspension from a Llong-Tterm Ssservices and Ssupports (LTSS) program or service.

Applicant: A child or youth who is seeking a Long-Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

Caretaker: As defined at § 25.5-10-202(1.6)(a)-(c), C.R.S.

Caretaker neglect: As defined at § 25.5-10-202(1.8)(a)-(c), C.R.S.

Case Management Agency (CMA): A public or private not-for-profit for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to sections 25.5-10-209.5 C.R.S. and pursuant to a provider participation agreement with the state department.

Child Placement Agency: As defined at ~~12 CCR 2509-8.7.710.1.~~ 12 CCR 2509-8; § 7.701.2 (F).

Client: A child or youth who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community Based Services (HCBS)

Client Representative: A person who is designated to act on the Client's behalf. A Client Representative may be: (a) a legal representative including, but not limited to a court-appointed guardian, or a parent of a minor child; or (b) an individual, family member or friend selected by the client to speak for an/or act on the client's behalf.

Community Centered Board: A private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of state funded programs for individuals with intellectual and developmental disabilities.

Complex Behavior: Behavior that occurs related to a diagnosis by a licensed physician, psychiatrist, or psychologist that includes one or more substantial disorders of the cognitive, volitional or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior.

Complex Medical Needs: Needs that occur as a result of a chronic medical condition as diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12) months, requires skilled care, and that without intervention may result in a severely life altering condition.

Comprehensive Assessment: An initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the client experiences significant change in need or in level of support.

Cost Containment: Limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services, and Medicaid State Plan benefits including long- term home health services and targeted case management.

Criminal Activity: A criminal offense that is committed by a person; a violation of parole or probation; and any criminal offense that is committed by a person receiving services that results in immediate incarceration.

Crisis: An event, series of events, and/or state of being greater than normal severity for the Client and/or family that becomes outside the manageable range for the Client and/or their family and poses a danger to self, family, and/or the community. Crisis may be self-identified, family identified, and/or identified by an outside party.

Critical Incident: Incidents of Mistreatment; Abuse; Neglect; Exploitation, Criminal Activity; Damage to Client's Property/Theft; Death unexpected or expected; Injury/Illness to Client; Medication Mismanagement; Missing Person; Unsafe Housing/Displacement; and/or Other Serious Issues.

Department: The Colorado Department of Health Care Policy and Financing the single state Medicaid agency.

Damage to Client's Property/Theft: Deliberate damage, destruction, theft or use a Client's belongings or money. If the incident involves Mistreatment by a Caretaker that results in damage tor Client's property or theft in the incident shall be listed as Mistreatment.

Developmental Delay: A child who is:

Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:

Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age;

Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development;

Has an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or

Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a CCB.

Early and Periodic Screening Diagnosis and Treatment (EPSDT): As defined in Section 8.280.1.

Exploitation: As defined in §25.5-10-202(15.5)(a)-(d), C.R.S.

Extraordinary Needs: A level of care due to Complex Behavior and/or Medical Support Needs that is provided in a residential child care facility or that is provided through community based programs, and without such care, would place a child at risk of unwarranted child welfare involvement or other system involvement.

Family: As defined at § 25.5-10-202)(16)(a)(I)-(IV)(b), C.R.S.

Foster Care Home: A family care home providing 24-hour care for a child or children and certified by either a County Department of Social/Human Services or a child placement agency. A Foster Care Home, for the purposes of this waiver, shall not include a family member as defined in § 25.10-202(16)(a)(I)-(IV)(b), C.R.S.

Guardian: An individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not guardian ad litem.

Guardian ad litem or GAL": A person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963", set forth in article 33 of Title 22, C.R.S.

Home and Community Based Services (HCBS) Waivers: Services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

Increased Risk Factors: Situations or events that when occur at a certain frequency or pattern historically have led to Crisis.

Informed Consent: An assent that is expressed in writing, freely given, and preceded by the following:

A fair explanation of the procedures to be followed, including an identification of those which are experimental;

A description of the attendant discomforts and risks;

A description of the expected benefits;

A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

An offer to answer any inquiries regarding the procedure(s);

An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

A statement that withholding or withdrawal of consent shall not prejudice future availability of services and supports.

Injury/Illness to Client: An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, and skin wounds; an injury or illness requiring immediate emergency medical treatment to preserve life or limb; an emergency medical treatment that results in admission to the hospital; and a psychiatric crisis resulting in unplanned hospitalization.

Institution: A hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the State Plan.

Intellectual and Developmental Disability: A disability that manifests before the person reaches twenty-two (22) years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15001 et seq., does not apply.

"Impairment of general intellectual functioning" The person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. when an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

"Adaptive behavior similar to that of a person with intellectual and developmental disabilities" The person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

"Substantial intellectual deficits" An intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID): A publicly or privately operated facility that provides health and habilitation services to a client with developmental disabilities or related conditions.

Kin: As defined in 12 CCR 2509-1, Section 7.000.2.A.

Kinship Foster Care Home: As defined in 12 CCR 2509-1, Section 7.000.2.A.

Level of Care (LOC): The specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

Level of Care Determination: An eligibility determination by a CCB of an Individual for a Long-Term Services and Supports (LTSS) program.

Level of Care Evaluation: A comprehensive evaluation with the Individual seeking services and others chosen by the Individual to participate, conducted by the case manager utilizing the Department's prescribed tool, with supporting diagnostic information from the Individual's medical providers, for

the purpose of determining the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports (LTSS) programs.

Licensed Child Care Center (less than 24 hours): As defined in§ 26-6-102 (5), C.R.S. and as described in 12 CCR 2509-8; §7.701.2.1.

Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Clients of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

Medicaid Eligible: The Applicant or Client meets the criteria for Medicaid benefits based on the financial determination and disability determination.

Medicaid State Plan: The federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or there is a risk to public safety.

"Mistreated" or "Mistreatment": As defined at § 25.5-10-202(29.5)(a)-(e), C.R.S.

Natural Supports: Unpaid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.

Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or lesser likelihood of success of Crisis interventions.

Prior Authorization: Approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the CMA.

Professional: Any person, not including family, performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

Professional Medical Information Page (PMIP): The medical information form signed by a Licensed Medical Professional used to verify that a Client needs institutional Level of Care.

Relative: A person related to the Client by blood, marriage, adoption or common law marriage.

Residential Child Care Facility: As defined in 12 CCR 2509-8.7.705.1.

Retrospective Review: The Department's review after services and supports are provided to ensure the Client received services according to the service plan and standards of economy, efficiency and quality of service.

Separation: The restriction of a Client for a period of time to a designated area from which the is not physically prevented from leaving, for the purpose of providing the Client an opportunity to regain self-control.

Service Provider: A Specialized Group Facility, Residential Child Care Facility, Foster Care Home, Kinship Foster Care Home, Child Placement Agency, Licensed Child Care Facility (non-24 hours), and/or Medicaid enrolled provider.

Service Plan: The written document that specifies identified and needed services, to include Medicaid and non-Medicaid covered services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with Department regulations.

Service Planning: The process of working with the Client receiving services and people chosen by the Individual, to identify goals, needed services, and appropriate service providers based on the Comprehensive Assessment and knowledge of the available community resources. Service planning informs the Individual seeking or receiving services of his or her rights and responsibilities.

Specialized Group Facility: As defined in 12 CCR 2509-8; § 7.701.2(B).~~9.1.~~

Support: Any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

Support Level: A numeric value determined by the Support Need Level Assessment that places Clients into groups with other Clients who have similar overall support needs.

Support Need Level Assessment: The standardized assessment tool used to identify and measure the support requirements for HCBS-CHRP waiver participants.

Targeted Case Management (TCM): Has the same meaning as in S~~s~~ection 8.761.

Third Party Resources: Services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to community resources, services provided through private insurance, non-profit services and other government programs.

Unsafe Housing/Displacement: An individual residing in an unsafe living condition due to a natural event (such as fire or flood) or environmental hazard (such as infestation)~~,~~ and is at risk of eviction or homelessness.

Waiver Service: Optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

Wraparound Facilitator: A person who has a Bachelor's degree in a human behavioral science or related field of study and is certified in a wraparound training program. Experience working with LTSS populations in a private or public social services agency may substitute for the Bachelor's degree on a year for year basis. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field. The wraparound certification must include training in the following:

Trauma informed care.

Youth mental health first aid.

Crisis supports and planning.

Positive Behavior Supports, behavior intervention, and de-escalation techniques.

Cultural and linguistic competency.

Family and youth serving systems.

Family engagement.

Child and adolescent development.

Accessing community resources and services.

Conflict resolution.

Intellectual and developmental disabilities.

Mental health topics and services.

Substance abuse topics and services.

Psychotropic medications.

Motivational interviewing.

Prevention, detection, and reporting of Mistreatment, Abuse, Neglect, and Exploitation.

Wraparound Transition Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a transition to the family home after out of home placement.

Wraparound Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a plan to maintain stabilization, prevent Crisis, and/or for de-escalation of Crisis situations.

Wraparound Support Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

Wraparound Transition Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

**8.508.30 SCOPE OF SERVICES**

A. The HCBS-CHRP waiver provides services and supports to eligible children and youth with Intellectual and Developmental Disability, and who are at risk of institutionalization pursuant to 25.5-6-903, C.R.S. The services provided through this waiver serve as an alternative to ICF/IID placement for children from birth to twenty-one years (21) of age who meet the eligibility criteria and the Level of Care as determined by a Level of Care Evaluation and Determination. The services provided through the HCBS-CHRP waiver are limited to:

1. Habilitation

2. Hippotherapy

3. Intensive Support

4. Massage Therapy

5. Movement Therapy

6. Respite

7. Supported Community Connection

8. Transition Support

B. HCBS-CHRP waiver services shall be provided in accordance with these rules and regulations.

**8.508.40 ELIGIBILITY**

A. Services shall be provided to Clients with an Intellectual and Developmental Disability who meet all of the following eligibility requirements:

1. A determination of developmental disability by a CCB which includes developmental delay if under five (5) years of age.

2. The Client has Extraordinary Needs that put the Client at risk of, or in need of, out of home placement.

3. Meet ICF-IID Level of Care as determined by a Level of Care Evaluation.

4. The income of the Client does not exceed 300% of the current maximum SSI standard maintenance allowance.

5. Enrollment of the Client in the HCBS- CHRP waiver will result in an overall savings when compared to the ICF/IID cost as determined by the State.

6. The Client receives at least one waiver service each month.

B. A Support Need Level Assessment must be completed upon determination of eligibility. The Support Need Level Assessment is used to determine the level of reimbursement for Habilitation and per diem Respite services.

C. Clients must first access all benefits available under the Medicaid State Plan and/or EPSDT for which they are eligible, prior to accessing funding for those same services under the HCBS-CHRP waiver.

D. Pursuant to the terms of the HCBS-CHRP waiver, the number of individuals who may be served each year is based on:

1. The federally approved capacity of the waiver;

2. Cost Containment requirements under section 8.508.80;

3. The total appropriation limitations when enrollment is projected to exceed spending authority.

**8.508.50 WAITING LIST PROTOCOL**

A. Clients determined eligible for HCBS-CHRP services who cannot be served within the appropriation capacity limits of the HCBS-CHRP waiver shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the Client's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.508.40 were determined to have been met and the Department was notified.

3. As openings become available within the appropriation capacity limits of the federal waiver, Clients shall be considered for services based on the date of their waiting list placement.

**8.508.60 RESPONSIBILITIES OF THE CCB**

A. The CCB shall make eligibility determinations for developmental disabilities services to include the Level of Care Evaluation Determination for any Applicant or Client being considered for enrollment in the HCBS-CHRP waiver.

B. Additional administrative responsibilities of CCBs as required in 8.601.

**8.508.70 CASE MANAGEMENT FUNCTIONS**

A. Case management services will be provided by a CMA as a Targeted Case Management service pursuant to sections 8.761.14 and 8.519 and will include:

1. Completion of a Comprehensive Assessment;

2. Completion of a Service Plan (SP);

3. Referral for services and related activities;

4. Monitoring and follow-up by the CMA including ensuring that the SP is implemented and adequately addresses the Client's needs.

5. Monitoring and follow-up actions, which shall

   a. Be performed when necessary to address health and safety and services in the SP;

   b. Services in the SP are adequate; and

   c. Necessary adjustments in the SP and service arrangements with providers are made if the needs of the Client have changed.

6. Face to face monitoring to be completed at least once per quarter and to include direct contact with the Client in a place where services are delivered.

**8.508.71 SERVICE PLAN (SP)**

A. The CMA shall complete a Service Plan for each Client enrolled in the HCBS-CHRP waiver in accordance with ~~Section 8.761.14.b.1-4~~ Section 8.519.11.B and will:

1. Address the Client's assessed needs and personal goals, including health and safety risk factors either by HCBS-CHRP waiver services or any other means;

2. Be in accordance with the Department's rules, policies, and procedures;

3. Be entered and verified in the Department prescribed system within ten (10) business days;

4. Describe the types of services to be provided, the amount, frequency, and duration of each service and the provider type for each service;

5. Include a statement of agreement by the Client and/or the legally responsible party; and

6. Be updated or revised at least annually or when warranted by changes in the Client's needs.

B. The Service Plan shall document that the Client has been offered a choice:

1. Between HCBS waivers and institutional care;

2. Among HCBS-CHRP waiver services; and

3. Among qualified providers.

**8.508.72 PRIOR AUTHORIZATION REQUESTS (PAR)**

A. The case manager shall submit a PAR in compliance with applicable regulations and ensure requested services are:

1. Consistent with the Client's documented medical condition and Comprehensive Assessment.

2. Adequate in amount, frequency, scope and duration in order to meet the Client's needs and within the limitations set forth in the current federally approved HCBS-CHRP waiver.

3. Not duplicative of another service, including services provided through:

a. Medicaid State Plan benefits;

b. Third Party Resources;

c. Natural Supports;

d. Charitable organizations; or

e. Other public assistance programs.

B. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to Section 8.058.4.

**8.508.73 REIMBURSEMENT**

A. Only services identified in the Service Plan are available for reimbursement under the HCBS-CHRP waiver. Reimbursement will be made only to licensed or certified providers, as defined in

Section 8.508.160 and services will be reimbursed per a fee for service schedule as determined by the Department through the Medicaid Management Information System (MMIS).

B. Only those services not available under Medicaid EPSDT, Medicaid State Plan benefits, Third Party Resources, or other public funded programs, services or supports are available through the CHRP Waiver. All available community services must be exhausted before requesting similar services from the waiver. The CHRP Waiver does not reimburse services that are the responsibility of the Colorado Department of Education.

C. Reimbursement for Habilitation service does not include the cost of normal facility maintenance, upkeep and improvement. This exclusion does not include costs for modifications or adaptations required to assure the health and safety of Client or to meet the requirements of the applicable life safety code.

D. Medicaid shall not pay for room and board.

E. Claims for Targeted Case Management are reimbursable pursuant to Section 8.761.4-.5.

**8.508.74 COMPLIANCE MONITORING**

A. Services provided to a client are subject to compliance monitoring by the Department pursuant to Section 8.076.2.

**8.508.80 COST CONTAINMENT**

Cost Containment is to ensure, on an individual Client basis, that the provision of HCBS-CHRP services is a cost effective alternative compared to the equivalent cost of appropriate ICF/IID institutional Level of Care. The Department shall be responsible for ensuring that, on average, each Service Plan is within the federally approved Cost Containment requirements of the waiver. Clients enrolled in the HCBS-CHRP waiver shall continue to meet the Cost Containment criteria during subsequent periods of eligibility.

**8.508.100 SERVICE DESCRIPTIONS**

A. Habilitation

1. Services may be provided to Clients who require additional care for the Client to remain safely in home and community based settings. The Client must demonstrate the need for such services above and beyond those of a typical child of the same age.

2. Habilitation services include those that assist Clients in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

3. Habilitation services under the HCBS-CHRP waiver differ in scope, nature, supervision, and/or provider type (including provider training requirements and qualifications) from any other services in the Medicaid State Plan.

4. Habilitation is a twenty-four (24) hour service and includes the following activities:

a. Independent living training, which may include personal care, household services, infant and childcare when the Client has a child, and communication skills.

b. Self-advocacy training and support which may include assistance and teaching of appropriate and effective ways to make individual choices, accessing needed

services, asking for help, recognizing Abuse, Neglect, Mistreatment, and/or Exploitation of self, responsibility for one's own actions, and participation in meetings.

c. Cognitive services which includes assistance with additional concepts and materials to enhance communication.

d. Emergency assistance which includes safety planning, fire and disaster drills, and crisis intervention.

e. Community access supports which includes assistance developing the abilities and skills necessary to enable the Client to access typical activities and functions of community life such as education, training, and volunteer activities. Community access supports includes providing a wide variety of opportunities to develop socially appropriate behaviors, facilitate and build relationships and Natural Supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the Client's Service Plan. These activities are conducted in a variety of settings in which the Client interacts with non-disabled individuals (other than those individuals who are providing services to the Client). These services may include socialization, adaptive skills, and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement and are based on the interest of the Client.

f. Transportation services are encompassed within Habilitation and are not duplicative of the non-emergent medical transportation that is authorized in the Medicaid State Plan. Transportation services are more specific to supports provided by Foster Care Homes, Kinship Foster Care Homes, Specialized Group Facilities, and Residential Child Care Facilities to access activities and functions of community life.

g. Follow-up counseling, behavioral, or other therapeutic interventions, and physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

h. Medical and health care services that are integral to meeting the daily needs of the Client and include such tasks as routine administration of medications or providing support when the Client is ill.

B. Habilitation may be provided in a Ffoster Cceare Hhome or Kinship Foster Care Home certified by a licensed Child Placement Agency or County Department of Human Services, Specialized Group Facility licensed by the Colorado Department of Human Services, or Residential Child Care Facility licensed by the Colorado Department of Human Services.

1. Habilitation capacity limits:

a. A Foster Care Home or Kinship Foster Care Home may serve a maximum of one (1) Client enrolled in the HCBS-CHRP waiver and two (2) other foster children, or two (2) Clients enrolled in the HCBS-CHRP waiver and no other foster children, unless there has been prior written approval by the Department. Placements of three (3) Clients approved for the HCBS-CHRP waiver may be made if the Service Provider can demonstrate to the Department that the Foster Care Home provider has sufficient knowledge, experience, and supports to safely meet the needs of all of the children in the home. In any case, no more than three (3)

Clients enrolled in the HCBS-CHRP waiver will be placed in the same foster home. Emergency placements will not exceed the maximum established limits. Foster Care Homes that exceed established capacity at the time the rule takes effect will be grandfathered in; however, with attrition, capacity must comply with the rule.

Foster Care Home Maximum Capacity

| HCBS-CHRP waiver | Non HCBS-CHRP | Total Children |
|---|---|---|
| 1 | 2 | 3 |
| 2 | 0 | 2 |
| 3 | 0 | 3 |

b. Placement of a Client in a Specialized Group Facility is prohibited if the placement will result in more than eight (8) children including one (1) Client enrolled in the HCBS-CHRP waiver, or five (5) foster children including two (2) Clients enrolled in the HCBS-CHRP waiver, unless there has been prior written approval by the Department. If placement of a child in a specialized group Facility will result in more than three (3) Clients enrolled in the HCBS-CHRP waiver, then the total number of children placed in that specialized group Facility must not exceed a maximum of six (6) total children. Placements of more than three (3) Clients enrolled in the HCBS-CHRP waiver may be made if the Service Provider can demonstrate to the he Department hat the facility staff have sufficient knowledge, experience, and supports to safely meet the needs of all of the children in the facility.

Specialized Group Facility Maximum Capacity

| HCBS-CHRP waiver | Non HCBS-CHRP waiver | Total Children |
|---|---|---|
| 1 | 8 | 9 |
| 2 | 5 | 7 |

c. Only one (1) HCBS-CHRP Client and two (2) HCBS- Persons with Developmental Disabilities (DD) or HCBS- Supported Living Services (SLS) waiver participants; or two (2) HCBS-CHRP participants and one HCBS-DD or HCBS-SLS waiver participant may live in the same foster care home.

C. The Service Provider or child placement agency shall ensure choice is provided to all Clients in their living arrangement.

D. The Ffoster Ccare Hhome or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all Clients living in the home.

E. The Service Provider shall provide the CMA a copy of the Ffoster Ccare Hhome or Kinship Foster Care Home certification before any child or youth can be placed in that- homefoster care home. If emergency placement is needed outside of business hours, the Service Provider Agency or child placement agency shall provide the CMA a copy of the Ffoster Ccare Hhome or Kinship Foster Care Home certification the next business day.

F. Hippotherapy

1. Hippotherapy is a therapeutic treatment strategy that uses the movement of a horse to assist in the development/enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavioral, and communication skills.

2. Hippotherapy may be provided only when the provider is licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

3. Hippotherapy must be used as a treatment strategy for an identified medical or behavioral need.

4. Hippotherapy must be an identified need in the Service Plan.

5. Hippotherapy must be recommended or prescribed by a licensed physician or therapist who is enrolled as a Medicaid provider. The recommendation must clearly identify the need for hippotherapy, recommended treatment, and expected outcome.

6. The recommending therapist or physician must monitor the progress of the hippotherapy treatment ~~al~~ at least quarterly.

7. Hippotherapy is not available under CHRP benefits if it is available under the Medicaid State Plan, ~~benefits if it is available under~~ EPSDT, or from a Third Party Resource.

8. Equine therapy and therapeutic riding are excluded.

G. Intensive Support

1. This service aligns strategies, interventions, and supports for the Client, and family, to prevent the need for out of home placement.

2. This service may be utilized in maintaining stabilization, preventing Crisis situations, and/or de-escalation of a Crisis.

3. Intensive support services include:

   a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the child or youth and family.

   b. Identification of needs for Crisis prevention and intervention including, but not limited to:

      i. Cause(s) and triggers that could lead to a Crisis.

      ii. Physical and behavioral health factors.

      iii. Education services.

      iv. Family dynamics.

      v. Schedules and routines.

      vi. Current or history of police involvement.

      vii. Current or history of medical and behavioral health hospitalizations.

      viii. Current services.

ix. Adaptive equipment needs.

x. Past interventions and outcomes.

xi. Immediate need for resources.

xii. Respite services.

xiii. Predictive Risk Factors.

xiv. Increased Risk Factors.

4. Development of a Wraparound Plan with action steps to implement support strategies, prevent, and/or manage a future Crisis to include, but not limited to:

a. The unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and family.

b. Environmental modifications.

c. Support needs in the family home.

d. Respite services.

e. Strategies to prevent Crisis triggers.

f. Strategies for Predictive and/or Increased Risk Factors.

g. Learning new adaptive or life skills.

h. Behavioral or other therapeutic interventions to further stabilize the Client emotionally and behaviorally and to decrease the frequency and duration of any future behavioral Crises.

i. Medication management and stabilization.

j. Physical health.

k. Identification of training needs and connection to training for family members, Natural Supports, and paid staff.

l. Determination of criteria to achieve stabilization in the family home.

m. Identification of how the plan will be phased out once the Client has stabilized.

n. Contingency plan for out of home placement.

o. Coordination among Family caregivers, other Family members, service providers, Natural Supports, Professionals, and case managers required to implement the Wraparound Plan.

p. Dissemination of the Wraparound Plan to all individuals involved in plan implementation.

5. In-Home Support.

a. The type, frequency, and duration of in-home support services must be included in a Wraparound Plan.

b. In-Home Support Services include implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the child or youth with self-care, learning self-advocacy, and protective oversight.

c. Service may be provided in the Client's home or community as determined by the Wraparound Plan.

6. Follow-up services.

a. Follow-up services include an evaluation to ensure that triggers to the Crisis have been addressed in order to maintain stabilization and prevent a future Crisis.

b. An evaluation of the Wraparound Plan should occur at a frequency determined by the Client's needs and include at a minimum, visits to the Client's home, review of documentation, and coordination with other Professionals and/or members of the Wraparound Support Team to determine progress.

c. Services include a review of the Client's stability, and monitoring of Increased Risk Factors that could indicate a repeat Crisis.

d. Revision of the Wraparound Plan should be completed as necessary to avert a Crisis or Crisis escalation.

e. Services include ensuring that follow-up appointments are made and kept.

7. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the Client, their Family, and their Wraparound Support Team.

8. All service and supports providers on the Wraparound Support Team must adhere to the Wraparound Plan.

9. Revision of strategies should be a continuous process by the Wraparound Support Team in collaboration with the Client, until the Client is stable and there is no longer a need for Intensive Support Services.

10. On-going evaluation after completion of the Wraparound Plan may be provided if there is a need to support the Client and his or her Family in connecting to any additional resources needed to prevent a future Crisis.

H. Massage Therapy

1. Massage therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation, and muscle tension including WATSU.

2. Children with specific developmental disorders often experience painful muscle contractions. Massage has been shown to be an effective treatment for easing muscle contracture, releasing spasms, and improving muscle extension, thereby reducing pain.

3. Massage therapists must be licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

4. The service must be used as a treatment strategy for an identified medical or behavioral need and included in the Service Plan.

5. ~~A~~ Massage therapy services must be recommended or prescribed by a therapist or physician who is an enrolled Medicaid Provider. The recommendation must include the medical or behavioral need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the massage therapy treatment at least quarterly.

6. Massage therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, ~~benefits, if it is available under~~ EPSDT or from a Third Party Resource.

I. Movement Therapy

1. Movement therapy is the use of music therapy and/or dance therapy as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills.

2. Movement therapy providers must be meet~~s~~ the educational requirements and is certified, registered and/or accredited by an appropriate national accreditation association.

3. Movement therapy is only authorized as a treatment strategy for a~~n~~ specific medical or behavioral need and identified in the Client's Service Plan.

4. Movement therapy must be recommended or prescribed by a therapist or physician who is enrolled Medicaid provider. The recommendation must include the medical need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the movement therapy at least quarterly.

5. Movement Therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, ~~benefits, if it is available under~~ EPSDT or from a Third Party Resource.

J. Respite

1. Respite services are provided to children or youth living in the Family home on a short term basis because of the absence or need for relief of the primary Caretaker(s)

2. Respite services may be provided in a certified Foster Care Home, Kinship Foster Care Home, Licensed Residential Child Care Facility, Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours), in the Family home, or in the community.

3. Federal financial participation is not available for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

4. Respite care is authorized for short-term temporary relief of the Caretaker for not more than seven (7) consecutive days per month, not to exceed twenty-eight (28) days in a calendar year.

5. During the time when Respite care is occurring, the ~~Family~~ Foster Care Home or Kinship Care Home may not exceed six (6) foster children or a maximum of eight (8) total

children, with no more than two (2) children under the age of (two) 2. The respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.

6. Respite is available for children or youth living in the Family home and may not be utilized while the Client is receiving Habilitation services.

K. Supported Community Connection

1. Supported community connection services are provided one-on-one to deliver instruction for documented Complex Behavior that are exhibited by the Client while in the community, such as physically or sexually aggressive behavior towards others and/or exposing themselves.

2. Services must be provided in a setting within the community where the Client interacts with individuals without disabilities (other than the individual who is providing the service to the Client).

3. The targeted behavior, measurable goal(s), and plan to address must be clearly articulated in the Service Plan.

4. This service is limited to five (5) hours per week.

5. A request to increase service hours can be made to the Department on a case-by-case basis.

L. Transition Support

1. Transition support services align strategies, interventions, and Supports for the Client, and Family, when a Client transitions to the Family home from out-of-home placement.

2. Services include:

a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and Family.

b. Identification of transition needs including, but not limited to:

i. Cause(s) of a Crisis and triggers that could lead to a Crisis.

ii. Physical and behavioral health factors.

iii. Education services.

iv. Family dynamics.

v. Schedules and routines.

vi. Current or history of police involvement.

vii. Current or history of medical and behavioral health hospitalizations.

viii. Current services.

ix. Adaptive equipment needs.

x. Past interventions and outcomes.

xi. Immediate need for resources.

xii. Respite services.

xiii. Predictive Risk Factors.

xiv. Increased Risk Factors.

3. Development of a Wraparound Transition Plan is required, with action steps to implement strategies to address identified transition risk factors including, but not limited to:

a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and Family.

b. Environmental modifications.

c. Strategies for transition risk factors.

d. Strategies for avoiding Crisis triggers.

e. Support needs in the Family home.

f. Respite services.

g. Learning new adaptive or life skills.

h. Counseling/behavioral or other therapeutic interventions to further stabilize the Client emotionally and behaviorally to decrease the frequency and duration of future Crises.

i. Medication management and stabilization.

j. Physical health.

k. Identification of training needs and connection to training for Family members, Natural Supports, and paid staff.

l. Identification of strategies to achieve and maintain stabilization in the Family home.

m. Identification of how the Wraparound Plan will terminate once the child or youth has stabilized.

n. Coordination among Family, service providers, natural supports, professionals, and case managers required to implement the Wraparound Transition Plan.

o. Dissemination of a Wraparound Transition Plan to all involved in plan implementation.

4. In-Home Support

a. The type, frequency, and duration of authorized services must be included in the Wraparound Plan.

b. In-home support services include~~s~~ implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the Client with self-care, learning self-advocacy, and protective oversight.

c. Services may be provided in the Client's home or in community, as provided in the Wraparound Transition Plan.

d. ~~In-Home Support services are provided after the Client's has transitioned to the family home from out-of-home placement.~~

5. Follow-up services are authorized and may include:

a. Evaluation to ensure the Wraparound Transition Plan is effective in the Client achieving and maintaining stabilization in the Family home.

b. Evaluation of the Wraparound Transition plan to occur at a frequency determined by the Client's needs and includes but is not limited to, visits to the Client's home, review of documentation, and coordination with other professionals and/or members of the Wraparound Transition Support Team to determine progress.

c. Reviews of the Client's stability and monitoring of Predictive Risk Factors that could indicate a return to Crisis.

d. Revision of the Wraparound Plan as needed to avert a Crisis or Crisis escalation.

e. Ensuring that follow-up appointments are made and kept.

6. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the Client~~-~~, their family, and their Wraparound Transition Team.

7. All service providers and supports on the Wraparound Transition Team must adhere to the Wraparound Transition Plan.

8. Revision of strategies should be a continuous process by the Wraparound Transition Team in collaboration with the Client, until stabilization is achieved and there is no longer a need for Transition Support Services.

9. On-going evaluation after completion of the Wraparound Transition Plan may be provided based on individual needs to support the Client and their family in connecting to any additional resources needed to prevent future Crisis or out of home placement.

**8.508.101 USE OF RESTRAINTS**

A. The definitions contained at 12 CCR 2509-8~~:~~ § 7.714.1 (2019~~8~~) are hereby incorporated by reference. The definition for "Client Representative" in 12 CCR 2509-8.7.714.1 is specifically excluded. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

B. Service Providers shall comply with the requirements for the use of Restraints in 12 CCR 2509-8~~:~~ §§ 7.714.53 through 7.714.537 (2019~~8~~) which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety,

available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

C. All records of restraints shall be reviewed by a supervisor of the Service Provider within 24 hours of the incident. If it appears that the Client has been restrained excessively, frequently in a short period of time, or frequently by the same staff member, the Client's Service Plan must be reviewed.

**8.508.102 RIGHTS MODIFICATIONS**

A. Cruel and aversive therapy, or cruel and unusual discipline is prohibited.

B. Service Providers shall comply with the requirements for Client Rights in 12 CCR 2509-8~~:~~, §7.714.52 (2019~~8~~) which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

C. Rights modifications are based on the specific assessed needs of the child or youth, not the convenience of the provider.

D. Rights modifications may only be imposed if the Client poses a danger to self, Family, and/or the community.

E. The case manager is responsible for obtaining Informed Consent and other documentation supporting any rights modifications/limitations and must maintain these materials in their file as a part of the Service Plan.

F. Any rights modification must be supported by a specific assessed need and justified in the Service Plan. The following must be documented in the Service Plan:

1. Identification of a specific and individualized need.

2. Documentation of the positive interventions and supports used prior to any modifications Service Plan.

3. Documentation of less intrusive methods of meeting the Client's needs that have been tried, and the outcome.

4. A description of the rights modification to be used that is directly proportionate to respond to the specific assessed need.

5. The collection and review of data used to measure the ongoing effectiveness of the modification.

6. Established time limits for periodic reviews, no less than every six (6) months, to determine if the modification is still necessary or if it can be terminated.

7. The Informed Consent of the Individual.

8. An assurance that interventions and Support will cause no harm to the Individual.

G. Specialized Group Facilities, Foster Care Homes, Kinship Foster Care Home, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours), and Child Placement

Agencies must also ensure compliance with the Colorado Department Human Services rules regarding the use of restrictive interventions at 12~~0~~ CCR 2509-8.

**8.508.103 MEDICATION ADMINISTRATION**

A. If medications are administered during the course of HCBS-CHRP service delivery by the waiver service provider, the following shall apply:

1. Medications must by prescribed by a Licensed Medical Professional. Prescriptions and/or orders must be kept in the Client's record.

2. HCBS-CHRP waiver service providers must complete on-site monitoring of the administration of medications to waiver participants including inspecting medications for labeling, safe storage, completing pill counts, reviewing and reconciling the medication administration records, and interviews with staff and participants.

3. Specialized Group Facilities, Residential Child Care Facilities, ~~Foster Care Homes,~~ Licensed Child Care Facilities (less than 24 hours) ~~and Child Placement Agencies~~ must ensure compliance with the Colorado Department of Human Services rules regarding ~~monitoring of~~ medication administration practices ~~in~~ at 12~~0~~ CCR 2509-8; § 7.702.52 (C).

4. Foster Care Homes and Kinship Foster Care Homes must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; §~~.~~708.41~~14.81~~.J.

5~~4~~. Persons administering medications shall complete a course in medication administration through an approved training entity approved by the Colorado Department of Public Health and Environment.

**8.508.110 MAINTENANCE OF CASE RECORDS**

A. CMAs shall maintain all documents, records, communications, notes and other materials for all work performed related to HCBS-CHRP. CMAs shall maintain records for six (6) years after the date a Client discharges from a waiver program.

**8.508.121 REASSESSMENT AND REDETERMINATION OF ELIGIBILITY**

A. The CMA shall conduct a Level of Care Evaluation and Determination to redetermine or confirm a Client's eligibility for the HCBS-CHRP waiver, at a minimum, every twelve (12) months.

B. The CMA shall conduct a Comprehensive Assessment to redetermine or confirm a Client's individual needs, at a minimum, every twelve (12) months.

C. The CMA shall verify that the child or youth remains Medicaid Eligible at a minimum, every twelve (12) months.

**8.508.140 DISCONTINUATION FROM THE HCBS- CHRP WAIVER**

A. A Client shall be discontinued from the HCBS-CHRP waiver when one of the following occurs:

1. The Client no longer meets the criteria set forth in section 8.508.40;

2. The costs of services and supports provided in the community exceed the Cost Effectiveness exceeds ICF-IID costs;

3. The Client enrolls in another HCBS waiver program or is admitted for a long-term stay beyond 30 consecutive days in an Institution; or

4. The Client reaches his/her 21st birthday.

5. The Client does not receive a waiver service during a full one-month period.

**8.508.160 SERVICE PROVIDERS**

A. Service providers for habilitation services and services provided outside the Family home shall meet all of the certification, licensing and quality assurance regulations related to their provider type (Respite Service providers that provide supported community connection, movement therapy, massage therapy, hippotherapy, intensive support, and transition support in the family home must:

1. Meet the required qualifications as defined in the federally approved HCBS-CHRP waiver.

2. Maintain and abide by all the terms of their Medicaid Provider Agreement and section 8.130.

3. Comply with all the provisions of this section 8.508; and

4. Have and maintain any required state licensure.

B. Service providers shall maintain liability insurance in at least such minimum amounts as set annually by the Department.

C. A Family member may not be a Service Agency ~~Provider~~ for another Family member. A Family member may be reimbursed for certain services as approved in the waiver. ~~When a qualified provider contracts with or utilizes the services of a Professional, individual, or vendor to augment a Client's services under the waiver the definitions and qualifications contained in Section 8.508 *et seq.* apply.~~

D. Service Providers shall not discontinue or refuse services to a Client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

E. Service Providers must have written policies that address the following:

1. Access to duplication and dissemination of information from the child's or youth's records in compliance with all applicable state and federal privacy laws.

2. How to response to alleged or suspected abuse, mistreatment, neglect, or exploitation. The policy must require immediate reporting when observed by employees and contractors to the agency administrator or designee and include mandatory reporting requirements pursuant to sections 19-3-304, C.R.S. and 18-6.5-108, C.R.S.

3. The use of restraints, the rights of Client's, and rights modifications pursuant to sections 8.508.101 and 8.508.102.

4. Medication administration pursuant to Section 8.508.103.

5. Training employees and contractors to enable them to carry out their duties and responsibilities efficiently, effectively and competently. The policy must include staffing

ratios that are sufficient to meet the individualized support needs of each Client receiving services.

6. Emergency procedures including response to fire, evacuation, severe weather, natural disasters, relocation, and staffing shortages.

F. Service Provides must maintain records to substantiate claims for reimbursement in accordance with Department regulations and guidance.

G. Service Providers must comply with all federal and state program reviews and financial audits of HCBS-CHRP waiver services.

H. Service Providers must comply with requests by the Department to collect, review, and maintain individual or agency information on the HCBS-CHRP waiver.

I. Service Providers must comply with requests by the CMA to monitor service delivery through Targeted Case Management.

**8.508.165 TERMINATION OR DENIAL OF HCBS-CHRP MEDICAID PROVIDER AGREEMENTS**

A. The Department may deny or terminate an HCBS-CHRP waiver Medicaid provider agreement in accordance with section 8.076.5.

**8.508.180 CLIENT'S RIGHTS**

A. Service Providers shall comply with the requirements for Client's Rights in 12 CCR 2509-8; ~~§~~ 7.714.31 (2019~~98~~) which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

B. Every Client has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, gender identity, political affiliation, sexual orientation, financial status or disability.

C. Every Client has the right to access age appropriate forms of communication including text, email, and social media.

D. No Client, his/her Family members, Guardian or Client Representative may be retaliated against in their receipt of services or supports as a result of attempts to advocate on their own behalf.

E. Each Client receiving services has the right to read or have explained in each Client's and Family's native language, any policies and/or procedures adopted by the Service Agency.

**8.508.190 APPEALS**

A. The CCB shall provide a Long-Term Care notice of action form (LTC 803) to Applicants and Clients and their parent(s) or Guardian in accordance with section 8.057 when:

1. The Applicant is determined not to have a developmental delay or developmental disability,

2. The Applicant is determined eligible or ineligible for Long-Term Services and Supports (LTSS),

3. The Applicant is determined eligible or ineligible for placement on a waiting list for LTSS services,

4. An Adverse Action occurs that affects the Client's waiver enrollment status.

B. The CCB shall appear and defend its decision at the Office of Administrative Courts.

C. The CCB shall notify the Case Management Agency in the Client's Service Plan within one (1) business day of the Adverse Action.

D. The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business days of an Adverse Action that affects Medicaid financial eligibility.

E. The CCB shall notify the applicant's parent or Guardian of an Adverse Action if the applicant or Client is determined ineligible for any reason including if:

1. The Client is detained or resides in a correctional facility for at least one day, and

2. The Client enters an institute for mental health for a duration greater than thirty (30) days.

F. The CMA shall provide the Long-Term Care notice of action form to Clients in accordance with section 8.507 when:

1. An Adverse Action occurs that affects the Client's waiver services, or

G. The CMA shall notify all providers in the Client's Service Plan within one (1) business days of the Adverse Action.

1. The CMA shall notify the county Department of Human/Social Services income maintenance technician within ten (10) business days of an Adverse Action that may affect financial eligibility for HCBS waiver services.

H. The applicant or Client shall be informed of an Adverse Action if the applicant or client is determined to be ineligible as set forth in the waiver- specific Client eligibility criteria and the following:

1. The Client cannot be served safely within the Cost Containment identified in the HCBS waiver,

2. The Client is placed in an Institution for treatment for more than thirty (30) consecutive days,

3. The Client is detained or resides in a correctional facility for at least one day, or

4. The Client enters an institute for mental health for more than thirty (30) consecutive days.

I. The Client shall be notified, pursuant to section 8.057.2. when the following results in an Adverse Action that does not relate to waiver client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the Level of Care Evaluation and Determination

2. A Service Plan or waiver service exceeds the limits set forth in the federally approved waiver.

3. The Client is being terminated from HCBS due to a failure to attend a Level of Care assessment appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

4. The Client is being terminated from HCBS due to a failure to attend a Service Plan appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

5. The Client enrolls in a different LTSS program.

6. The Client moves out of state. The Client shall be discontinued effective the day after the date of the move.

    a. A Client who leaves the state on a temporary basis, with intent to return to Colorado, pursuant to Section 8.100.3.B.4, shall not be terminated unless one or more of the Client eligibility criteria are no longer met.

J. If a Client voluntarily withdraws from the waiver, the termination shall be effective the day after the date the s the request was made by the Client

    1. The case manager shall review with the Client their decision to voluntarily withdraw from the waiver. The Case Manager shall not send a notice of action, upon confirmation of withdraw.

K. The CMA shall not send a Long-Term Care notice of action form when the basis for termination is death of the Client~~,~~ but shall document the event in the Client record. The date of action shall be the day after the date of death.

L. The CMA shall appear and defend its decision at the Office of Administrative Courts when the CMA has issued an Adverse Action.

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to Medical Assistance Rule Concerning Service Plan Authorization Limit (SPAL) Section 8.500.102.B
Rule Number: MSB 19-12-16-A
Division / Contact / Phone: Benefits and Services Management Division Kara Masteller / x5605

# 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 19-12-16-A Revision to Medical Assistance Rule Concerning Service Plan Authorization Limit (SPAL) Section 8.500.102.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) 8.500.102.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 8.500.102 with the proposed text beginning at 8.500.102.B through the end of 8.500.102.G. This rule is effective May 30, 2020.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to Medical Assistance Rule Concerning Service Plan Authorization Limit (SPAL) Section 8.500.102.B
Rule Number: MSB 19-12-16-A
Division / Contact / Phone: Benefits and Services Management Division Kara Masteller / x5605

## STATEMENT OF BASIS AND PURPOSE

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

   The Department is revising this section of the rule, 10 CCR 2505-10 8.500.102, to allow for the addition of Waiver Transition Services to the existing list of services which are exempt from the service plan authorization limit (SPAL) for Supported Living Services. The Department sought and ultimately received legislative approval through House Bill 18-1326 to include four transition services in six Home and Community Based Service (HCBS) waiver programs, with the necessary funds appropriated, starting January 1, 2019. These services are excluded from the SPAL and therefore the rules implementing the program 10 CCR 2505-10 8.500.102 must be revised.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   Section 25.5-6-1501, C.R.S. (2019)

| | | | |
|---|---|---|---|
| Initial Review | **03/13/2020** | Final Adoption | **04/10/2020** |
| Proposed Effective Date | **05/08/2020** | Emergency Adoption | |

**DOCUMENT #09**

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to Medical Assistance Rule Concerning Service Plan Authorization Limit (SPAL) Section 8.500.102.B
Rule Number: MSB 19-12-16-A
Division / Contact / Phone: Benefits and Services Management Division Kara Masteller / x5605

## REGULATORY ANALYSIS

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

   Individuals who will be affected by this rule are individuals who use Waiver Transition services in the Supported Living Services (SLS) waiver. They will benefit from this rule change, but they will not bear any cost from this rule change.

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

   Clients on the SLS waiver who utilize Waiver Transition services will benefit from having reduced impact on their SPAL. If the services were counted against the SPAL, it would mean that they would have less funds to pay for services critical to their ability to live in the community. By excluding the waiver transition services from the SPAL, individuals will not be forced to chose between critical services and services that will aid them in successfully transitioning into the community.

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 additional cost to the Department outside of the appropriation for these services. The legislation that allowed the waiver transition services to be sustained within the HCBS waivers had additional funds appropriated to cover the costs of the services.

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

   Costs will be minimal to exclude these services from the SPAL, as funds were appropriated through the legislation for these services. If these services are left within the SPAL it could mean an individual could be forced to choose between services critical to meeting their needs and being able to successfully transition into the community.

**DO NOT PUBLISH THIS PAGE**

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

   These services were never intended to be counted within the SPAL.

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.

## 8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

8.500.102.A The service plan authorization limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a client's ongoing service needs within one (1) service plan year.

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations, ~~and~~ vehicle modifications, health maintenance activities available under the Consumer Directed Attendant Support Services (CDASS), home delivered meals, life skills training, peer mentorship, and transition setup.

8.500.102.C The total of all HCBS-SLS services in one service plan shall not exceed the overall authorization limitation as set forth in the federally approved HCBS-SLS waiver.

8.500.102.D Each SPAL is assigned a specific dollar amount determined through an analysis of historical utilization of authorized waiver services, total reimbursement for services, and the spending authority for the HCBS-SLS waiver. Adjustments to the SPAL amount may be determined by the Department and Operating Agency as necessary to manage waiver costs.

8.500.102.E Each SPAL is associated with six support levels determined by an algorithm which analyzes a client's level of service need as determined by the SIS assessment and additional factors including exceptional medical and behavioral support needs and identification as a community safety risk.

8.500.102.F The SPAL determination shall be implemented in a uniform manner statewide and the SPAL amount is not subject to appeal.

~~8.500.102.G HEALTH MAINTENANCE ACTIVITIES AVAILABLE UNDER CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) IS NOT SUBJECT TO THE SERVICE PLAN AUTHORIZATION LIMIT~~

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# SECRETARY OF STATE

## RULES ACTION SUMMARY AND FILING INSTRUCTIONS

### SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-01-14-A, Revision to the Medical Assistance Payments for Outpatient Hospital Services Rule Concerning Drug Payment Reweighting, Section 8.300.6.

3. This action is an adoption of: an amendment

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

   Sections(s) 8.300.6, 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 with the proposed text beginning at 8.300.1 through the end of 8.300.1. Replace the current text at 8.300.6 with the text proposed beginning at 8.300.6.A through the end of 8.300.6.A. This rule is effective May 30, 2020.

*to be completed by MSB Board Coordinator

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Payments for Outpatient Hospital Services Rule Concerning Drug Payment Reweighting, Section 8.300.6.
Rule Number: MSB 20-01-14-A
Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

## STATEMENT OF BASIS AND PURPOSE

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

   The rule describes the outpatient hospital payment methodology currently in use. The additional language will modify the methodology such that the allowed payment to Critical Access Hospitals and Medicare Dependent Hospitals for outpatient drugs is increased with a corresponding decrease in allowed payment for outpatient drugs for urban non-independent hospitals. This rule change is necessary for the adequate reimbursement of drugs for Critical Access and Medicare Dependent Hospitals, given the variation in cost profiles between this group and their urban non-independent counterparts.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.321

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   C.R.S. § 25.5-4-401

| | | | |
|---|---|---|---|
| Initial Review | **[date]** | Final Adoption | **[date]** |
| Proposed Effective Date | **[date]** | Emergency Adoption | **[date]** |

**DOCUMENT #**

**DO NOT PUBLISH THIS PAGE**

Title of Rule: Revision to the Medical Assistance Payments for Outpatient Hospital Services Rule Concerning Drug Payment Reweighting, Section 8.300.6.
Rule Number: MSB 20-01-14-A
Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

## 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.

   Critical Access Hospitals and Medicare Dependent Hospitals will benefit by receiving an increase in their allowed payments for outpatient drugs. Urban non-independent hospitals will bear the costs with a decrease in their allowed payments for outpatient drugs.

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

   Using Calendar Year 2018 data, a 3.47% decrease in outpatient hospital drug payments for urban non-independent hospitals will fund a 42.93% increase in outpatient hospital drug payments for Critical Access and Medicare Dependent Hospitals.

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

   Increasing the allowed payments to one set of hospitals with a corresponding decrease to another allows the Department to implement this change with budget neutrality.

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

   Access to outpatient drugs in the communities served by Critical Access Hospitals and Medicare Dependent Hospitals will become increasingly more limited.

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

   A less intrusive method of achieving this rule's purpose would be to maintain current levels of allowed payment to urban non-independent hospitals while still increasing allowed payment to Critical Access and Medical Dependent Hospitals. However, this

would require a budget action, as there would be a net increase in the expenditures for outpatient hospital services. The length of time required to implement a budget action would be met by a sustained or increasing barrier to access for Medicaid members requiring outpatient drugs.

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

   Alternative methods of achieving this rule's purpose were the carving out of drug payments from the outpatient hospital setting – however, this did not uniformly increase payment for the hospitals the proposed rule intends to assist. Additionally, this would have required a budget action. The length of time required to implement a budget action would be met by a sustained or increasing barrier to access for Medicaid members requiring outpatient drugs.

## 8.300 HOSPITAL SERVICES

### 8.300.1 Definitions

Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.

Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.

Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.

Department means the Department of Health Care Policy and Financing.

Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.

DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals.

Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.

Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably be expected to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

Enhanced Ambulatory Patient Group (EAPG) means a cluster of similar procedures within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of services performed during Outpatient visits that utilize similar amounts of Hospital resources.

Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous

nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.

A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.

A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.

A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital which primarily serves an inpatient population requiring long-term care services including but not limited to respiratory therapy, head trauma treatment, complex wound care, IV antibiotic treatment and pain management.

A Spine/Brain Injury Treatment Specialty Hospital licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital OR CMS-certified as a Rehabilitation Hospital is a Not-for Profit Hospital as determined by the CMS Cost Report for the most recent fiscal year. A Spine/Brain Injury Treatment Specialty Hospital primarily serves an inpatient population requiring long term acute care and extensive rehabilitation for recent spine/brain injuries. To qualify as a Spine/Brain Injury Treatment Specialty Hospital, for at least 50% of Medicaid members discharged in the preceding calendar year the hospital must have submitted Medicaid claims including spine/brain injury treatment codes (previously grouped to APR-DRG 40, 44, 55, 56, and 57). The Department shall revoke the designation if the percentage of Medicaid members discharged falls below the 50% requirement for a calendar year. Designation is removed the calendar year following the disqualifying year.

A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.

A Medicare Dependent Hospital is defined as set forth at 42 C.F.R § 412.108(a). 42 C.F.R. § 412.108(a) (2019) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S § 24-4-103(12.5)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

A Non-independent Urban Hospital is a hospital which reports a name of the home office of the chain with which they are affiliated on the CMS-2552-10 Cost Report in Worksheet S-2 Part 1, Line 141, Column 1, with the exception of individual hospitals reporting an affiliation not reported amongst other hospitals located in Colorado.

Inpatient means a person who is receiving professional services at a Hospital; the services include a room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will remain at least overnight and occupy a bed even though it later develops that the client can be discharged or transferred to another Hospital and does not actually use a bed overnight.

Inpatient Hospital Services means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the Hospital by or under the direction of a physician.

Medical Necessity is defined at Section 8.076.1..

Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals, Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital are considered Non-DRG Hospitals since their reimbursement is based on a per diem rate.

Observation Stay means a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length.

Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

Outpatient means a client who is receiving professional services at a Hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-a-day basis.

Outpatient Hospital Services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.

Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.

Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his/her best possible functional level.

Relative Weight (DRG weight or EAPG weight) means a numerical value which reflects the relative resource consumption for the DRG or EAPG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost for each DRG or EAPG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.

Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.

State University Teaching Hospital means a Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education; and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called "swing beds."

Trim Point Day (Outlier Threshold Day) means the day which would occur 2.58 standard deviations above the mean (average) length of stay (ALOS) for each DRG.

Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.

Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

## 8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

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

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

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

adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

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

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

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

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital Services shall be referred to as the EAPG Payment.

a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10, Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific

Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.

b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.

c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:

(1) Per Diem

(2) Significant Procedure. Subtypes of Significant Procedures Are:

(a) General Significant Procedures

(b) Physical Therapy and Rehabilitation

(c) Mental Health and Counseling

(d) Dental Procedure

(e) Radiologic Procedure

(f) Diagnostic Significant Procedure

(3) Medical Visit

(4) Ancillary

(5) Incidental

(6) Drug

(7) Durable Medical Equipment

(8) Unassigned

d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.

e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are of subtypes Physical Therapy and Rehabilitation and Radiologic Significant Procedure do not

cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.

f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.

g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.

i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

j. Details describing 340B Drugs will have an EAPG Payment calculated using 80 percent (80%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

k. The Hospital-specific Medicaid Outpatient base rate for the year of the methodology implementation for each hospital is calculated using the following method.

(1) Assign each hospital to one of the following peer groups based on hospital type and location:

(a) Pediatric Hospitals

(b) Urban Hospitals

(c) Rural Hospitals

(2) Process Medicaid outpatient hospital claims from state fiscal year 2015, known as the Base Year, through the methodology described in 8.300.6.A.1.a-j using Colorado's EAPG Relative Weights. For lines with incomplete data, estimations of EAPG Adjusted Weights will be used.

(3) Calculate costs from hospital charge data using the computation of the ratio of costs to charges from the CMS-2552-10 Cost Report. After the application of inflation factors to account for the difference in cost and caseload from state fiscal year 2015 to the implementation period, costs and EAPG Adjusted Weights are aggregated by peer group and are used to form peer group base rates. Each hospital is assigned the peer group base rate depending on their respective peer group assigned in 8.300.6.A.1.k.(1).

(4) For each hospital, calculate the projected EAPG payment by multiplying its peer group base rate by its hospital-specific EAPG Adjusted Weights as calculated in 8.300.6.A.1.k.(2). If the projected payment exceeds a +/- 10% difference in payment from the prior outpatient hospital reimbursement methodology, the hospital will receive an adjustment to their base rate to cap its resulting gains or losses in projected EAPG payments to 10%.

(5) For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(4), shall be adjusted by an equal percentage, when required due to changes in the available funds appropriated by the General Assembly. The application of this change to the Medicaid Outpatient base rate shall be determined by the Department.

l. Effective June 1, 2020, by the modification of the EAPG Weights, the allowed reimbursement of outpatient hospital drugs shall be increased by 42.93% for drugs provided at Critical Access Hospitals and Medicare Dependent Hospitals, and decreased by 3.47% for drugs provided at non-independent urban hospitals.

2. Payments to Out-of-Network DRG Hospitals

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

Effective October 31, 2016, Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based the system of Enhanced Ambulatory Patient Grouping described in 10 CCR 2505-10 Section 8.300.6.A.1. Such hospitals will be assigned to a Rural or Urban peer group depending on hospital location and will receive a base rate of 90% of the respective peer group base rate as calculated in 8.300.6.A.1.k.(3). Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in 8.300.6.A.k.(5).

3. Payments for Outpatient Hospital Specialty Drugs

Effective August 11, 2018, for services meeting the criteria of an Outpatient Hospital Specialty Drug that would have otherwise been compensated through the EAPG methodology, a hospital must submit a request for authorization to the Department prior

to administration of the drug. If the request is approved, then the payment will be negotiated between the Department and the hospital on a case-by-case basis.