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Title of Rule: Revision to the Medical Assistance Rule concerning NCCI, Section 8.041
Rule Number: MSB 06-10-20-A
Division / Contact / Phone: Health Information Office/ Matt Arment/ 303-866-2482

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 06-10-20-A, Revision to the Medical Assistance Rule concerning NCCI, Section 8.041

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) 8.041, 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 8.041 with the proposed text beginning at 8.041 through the end of 8.041. Replace the current text at 8.041.2 with the newly proposed text beginning at 8.041.2.B through the end of 8.041.2.B. This rule is effective June 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning NCCI, Section 8.041
Rule Number: MSB 06-10-20-A
Division / Contact / Phone: Health Information Office/ Matt Arment/ 303-866-2482

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).

   SB 18-266 indicates the Department shall utilize the Medicaid Management Information System to ensure that claims are automatically reviewed prior to payment to identify and correct improper coding that leads to inappropriate payment.

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:

   N/A

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   SB 18-266

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 Rule concerning NCCI, Section 8.041
Rule Number: MSB 06-10-20-A
Division / Contact / Phone: Health Information Office/ Matt Arment/ 303-866-2482

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.

   Organization Health Care Providers

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

   Organization Health Care Providers will see a minimal impact. The new claims editing tool will only deny claims that are billed incorrectly.

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

   It is estimated to cost a total of $4.4 Million to subscribe to commercial technology. An estimated savings of $9.2 million is expected from identifying and rejecting inappropriate claims.

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

   Inaction would not cause an increase in costs; however, it would not provide a potential savings of $9.2 million.

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

   This is the most cost effective and least intrusive method of achieving the purpose of this 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.

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The Department analyzed claims editing solution options. The following options were evaluated and weighed for a final decision of moving forward with Change Healthcare ClaimsXten product:

1. Leveraging existing contract with DXC for the use of the new claims editing tool, ClaimsXten
2. Review other software in marketplace and procure a vendor
3. Custom building a solution through the Colorado interChange system

The cost/benefit of vetting other solutions was weighed, as was the delivery of a custom product engineered by DXC. The cost to procure and/or custom build a solution made these options not viable.

It was determined that the cost of delaying the build to vet other solution would result in missing legislative project milestones, thus losing the funding necessary to procure a product.

The key factors of the ClaimsXten option that outweighed other options included:

- ClaimsXten is a commercially available, off-the-shelf product and therefore qualifies for federal funding;
- DXC and Change Healthcare are willing to work with the Department to deliver the requirements;
- DXC and Change Healthcare have implemented ClaimsXten in other interChange systems, which allows the Department to leverage the interfaces and configurations from those states.

8.041 Claims Editing~~CLAIMS REIMBURSEMENT AND STATUS FOR NATIONAL CORRECT CODING INITIATIVE (NCCI)~~

8.041.1 DEFINITIONS

Current Procedural Terminology (CPT) means the common medical procedure codes used for the purpose of billing medical services as defined by the American Medical Association (AMA).

Fiscal Agent means a vendor who is contracted by the Department to process and maintain the Medicaid Management Information System (MMIS) for purpose of processing claims.

Healthcare Common Procedural Coding System (HCPCS) means an alpha numeric code set as defined by CMS used for the purpose of billing services that are not identified under CPT.

Medically Unlikely Edits (MUE) means units of service edits. This edit restricts the maximum units of services per claim line that may be billed for a procedure code.

National Correct Coding Initiative (NCCI) means a set of claim edits developed by the Centers of Medicare and Medicaid Services (CMS) to promote NCCI methodologies and control improper coding leading to improper Medicaid payments.

Procedure to Procedure edit means the prevention of certain procedure codes from being billed with other procedure codes for the same patient by the same practitioner on the same date of service.

Remittance Statement means the electronic or hard copy statement sent by the Medicaid fiscal agent to advise a provider of claims reimbursement or claims status.

8.041.2 AUTHORITY

8.041.2.A Pursuant to Colorado Revised Statute §25.5-4-300.7 the Department is authorized to implement and maintain a system for reducing medical services coding errors in Medicaid claims submitted to the state department for reimbursement. The system shall include automatic, prepayment review of Medicaid claims through the use of nationally recognized correct coding methods in MMIS.

8.041.2.B The Department will utilize a claims editing program to automatically review claims prior to payment to identify and correct improper coding for professional and outpatient services claims pursuant to Colorado Revised Statute §25.5-4-422(3). The claims editing program will recommend that the Department approve for payment, deny, or modify providers' submitted claims. The claims editing program will utilize a nationally recognized standardized method of processing claims for professional and outpatient services using clinical logic based on the most Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases (ICD), American Medical Association (AMA), Centers for Medicare and Medicaid Services (CMS), and nationally recognized specialty practice guidelines.

Title of Rule: Revision to the Medical Assistance Rule Concerning Provider Screening, Section 8.125
Rule Number: MSB 19-12-06-A
Division / Contact / Phone: Medicaid Operations Office / Matt Arment / 303-866-2482

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 19-12-06-A, Revision to the Medical Assistance Rule concerning Provider Screening, Section 8.125.

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) 8.125, 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 8.125 with the proposed text beginning at 8.125 through the end of 8.125.11.K. This rule is effective June 30, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule Concerning Provider Screening, Section 8.125
Rule Number: MSB 19-12-06-A
Division / Contact / Phone: Medicaid Operations Office / Matt Arment / 303-866-2482

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 federal regulation 42 CFR 455.414 requires that state Medicaid agencies revalidate the enrollment of all providers at least every 5 years.

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:

   N/A

3. Federal authority for the Rule, if any:

   42 CFR 455.414

4. State Authority for the Rule:

   Sections 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 #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Provider Screening, Section 8.125
Rule Number: MSB 19-12-06-A
Division / Contact / Phone: Medicaid Operations Office / Matt Arment / 303-866-2482

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.

   Organization Health Care Providers

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

   Organizational Health Care Providers will be impacted when they have been registered for 5 years and they are due to revalidated.

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 probable cost to the Department is estimated to be around $0.

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

   There are not cost benefits or benefits of inaction for this rule.

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

   This is the most cost effective and least intrusive method for achieving the purpose of this 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 this rule. It is a federal requirement that all Medicaid providers revalidate at least every 5 years.

8.125 PROVIDER SCREENING

8.125.1 DEFINITIONS.

Managed Care Entity is defined at 42 CFR § 455.101.

Ownership interest is defined at 42 CFR § 455.101.

Person with an ownership or control interest is defined at 42 CFR § 455.101.

Enrollment is defined as the process by which an individual or entity not currently enrolled as a Colorado Medicaid provider submits a provider application, undergoes any applicable screening, pays an application fee, as appropriate for the provider type, and is approved by the Department for participation in the Medicaid program. Entities that have never previously enrolled as Medicaid providers or whose enrollment was previously terminated and are not currently enrolled are required to enroll. The date of enrollment shall be considered the date that is communicated to the provider in communication from the Department or its fiscal agent verifying the provider's enrollment in Medicaid.

Revalidation is defined as the process by which an individual or entity actively enrolled as a Colorado Medicaid provider resubmits a provider application, undergoes a state-defined screening process, pays an application fee, as appropriate for the provider type, and is approved by the Department to continue participation in the Medicaid program.

"Disclosing Entity" and "Other Disclosing Entity" are defined at 42 CFR § 455.101.

8.125.2 PROVIDERS DESIGNATED AS LIMITED CATEGORICAL RISK AND NEW PROVIDER TYPES

8.125.2.A. Except as provided for in Section 8.125.2.B, provider types not designated as moderate or high categorical risk at Sections 8.125.3 or 8.125.4 shall be considered limited risk.

8.125.2.B. The risk category for each provider type designated by CMS shall be the risk category for purposes of this rule regardless of whether a provider type may be listed in Sections 8.125.3 or 8.125.4.

8.125.3 PROVIDERS DESIGNATED AS MODERATE CATEGORICAL RISK

8.125.3.A. Emergency Transportation including ambulance service suppliers

8.125.3.B. Non-Emergency Medical Transportation

8.125.3.C. Community Mental Health Center

8.125.3.D. Hospice

8.125.3.E. Independent Laboratory

8.125.3.F. Comprehensive Outpatient Rehabilitation Facility

8.125.3.G. Physical Therapists, both individuals and group practices

8.125.3.H X-Ray Facilities

8.125.3.I. Revalidating Home Health agencies

8.125.3.J. Revalidating Durable Medical equipment suppliers, including revalidating pharmacies that supply Durable Medical Equipment

8.125.3.K. Revalidating Personal Care ~~Agencies under~~Agencies under the state plan

8.125.3.L. Providers of the following services for HCBS waiver members:

1. Alternative Care Facility
2. Adult Day Services
3. Assistive Technology, if the provider is revalidating
4. Behavioral Programing
5. Behavioral Therapies
6. Behavioral Health Supports
7. Behavioral Services
8. Care Giver Education
9. Children's Case Management
10. Children's Habilitation Residential Program (CHRP)
11. Community Connector
12. Community Mental Health Services
13. Community Transition Services
14. Complementary and Integrative Health
15. Day Habilitation
16. Day Treatment

17~~8~~. Expressive Therapy

18~~9~~. Home Delivered Meals

19~~20~~. Home Modifications/Adaptations/Accessibility

20~~1~~. Independent Living Skills Training

21~~2~~. In-Home Support Services, if the provider is revalidating

22~~3~~. Intensive Case Management

2~~3~~4. Massage Therapy

2~~4~~5. Mentorship

2~~5~~6. Non-Medical Transportation

2~~6~~7. Palliative/Supportive Care Skilled

2~~7~~8. Peer Mentorship

2~~8~~9. Personal Care/Homemaker Services, if the provider is revalidating

29~~30~~. Personal Emergency Response System/Medication Reminder/Electronic Monitoring

3~~0~~1. Prevocational Services

3~~1~~2. Professional Services

3~~2~~3. Residential Habilitation Services

3~~3~~4. Respite

3~~4~~5. Specialized Day Rehabilitation Services

3~~5~~6. Specialized Medical Equipment and Supplies, if the provider is revalidating

3~~6~~7. Substance Abuse Counseling

3~~7~~8. Supported Employment

3~~8~~9. Supported Living Program

39~~40~~. Therapy and Counseling

4~~0~~1. Transitional Living Program

41. Youth Day Services

8.125.4 PROVIDERS DESIGNATED AS HIGH CATEGORICAL RISK

8.125.4.A. Enrolling DME Suppliers

8.125.4.B. Enrolling Home Health Agencies

8.125.4.C. Enrolling Personal Care Agencies providing services under the state plan

8.125.4.D. Enrolling providers of the following services for HCBS waiver members:

1. Assistive Technology

2. Personal Care/Homemaker Services

3 Specialized Medical Equipment and Supplies

4 In-Home Support Services

8.125.4.E. Enrolling and revalidating providers for which the Department has suspended payments during an investigation of a credible allegation of fraud, for the duration of the suspension of payments.

8.125.4.F. Enrolling and revalidating providers which have a delinquent debt owed to the State arising out of Medicare, Colorado Medical Assistance or other programs administered by the Department, not including providers which are current under a settlement or repayment agreement with the State.

8.125.4.G. Providers that were excluded by the HHS Office of Inspector General or had their provider agreement terminated for cause by the Department, its contractors or agents or another State's Medicaid program at any time within the previous 10 years.

8.125.4 .H. Providers applying for enrollment within six (6) months from the time that the Department or CMS lifts a temporary enrollment moratorium on the provider's enrollment type.

8.125.5 PROVIDERS WITH MULTIPLE RISK LEVELS

8.125.5.A Providers shall be screened at the highest applicable risk level for which a provider meets the criteria. Providers shall only pay one application fee per location.

8.125.6 PROVIDERS WITH MULTIPLE LOCATIONS

8.125.6.A. Providers must enroll separately each location from which they provide services. Only claims for services provided at locations that are enrolled are eligible for reimbursement.

8.125.6.B. Each provider site will be screened separately and must pay a separate application fee. Providers shall only pay one application fee per location.

8.125.7 ENROLLMENT AND SCREENING OF PROVIDERS

8.125.7.A. All enrolling and revalidating providers must be screened in accordance with requirements appropriate to their categorical risk level.

8.125.7.B. Notwithstanding any other provision of the Colorado Code of Regulations, providers who provide services to Medicaid members as part of a managed care entity's provider network who would have to enroll in order to participate in fee-for-service Medicaid must enroll with the Department and be screened as Medicaid providers.

8.125.7.C. Nothing in Section 8.125.7.B shall require a provider who provides services to Medicaid members as part of a managed care entity's provider network to participate in fee-for-service Medicaid.

8.125.7.D. All physicians or other professionals who order, prescribe, or refer services or items for Medicaid members, whether as part of fee-for-service Medicaid or as part of a managed care entity's provider network under either the state plan, the Children's Health Insurance Program, or a waiver, must be enrolled in order for claims submitted for those ordered, referred, or prescribed services or items to be reimbursed or accepted for the calculation of managed care rates by the Department.

8.125.7.E. The Department may exempt ~~from~~ certain providers from all or part of the screening requirements when certain providers ~~who~~ have been screened ~~by~~, ~~are~~ approved and enrolled or revalidated:

1. By Medicare within the last 5 years, or

2. By another state's Medicaid program within the last 5 years, provided the Department has determined that the state in which the provider was enrolled or revalidated has screening requirements at least as comprehensive and stringent as those for Colorado Medicaid.

8.125.7.F. The Department may deny a Provider's enrollment or terminate a Provider agreement for failure to comply with screening requirements.

8.125.7.G. The Department may terminate a Provider agreement or deny the Provider's enrollment if CMS or the Department determines that the provider has falsified any information provided on the application or cannot verify the identity of any provider applicant.

8.125.8 NATIONAL PROVIDER IDENTIFIER FOR ORDERING, PRESCRIBING, REFERRING

8.125.8.A. As a condition of reimbursement, any claim submitted for a service or item that was ordered, referred, or prescribed for a Medicaid member must contain the National Provider Identifier (NPI) of the ordering, prescribing or referring physician or other professional.

8.125.9 VERIFICATION OF PROVIDER LICENSES

8.125.9.A. If a provider is required to possess a license or certification in order to provide services or supplies in the State of Colorado, then that provider must be so licensed as a condition of enrollment as a Medicaid provider.

8.125.9.B. Required licenses must be kept current and active without any current limitations throughout the term of the agreement.

8.125.10 REVALIDATION

8.125.10.A. Providers actively enrolled in Medicaid must complete all requirements for revalidation at least every 5 years as established by the Department, or upon request from the Department for an off cycle review.

8.125.10.B. The date of revalidation shall be considered the date that the provider's application was initially approved plus 5 years, or by an off-cycle request from the Department.

8.125.10.C.

If a provider fails to comply with any requirement for revalidation by the deadlines established by S~~s~~ections 8.125.10.A. or 8.125.10.B., the provider agreement may be terminated. In the event that the provider agreement is terminated pursuant to this section, any claims for dates of service submitted after deadlines established by S~~s~~ections 8.125.10.A. or 8.125.10.B., are not reimbursable beginning on the day after the date indicated by S~~s~~ection 8.125.10.B.

8.125.11 SITE VISITS

8.125.11.A. All providers designated as "moderate" or "high" categorical risks to the Medicaid program must consent to and pass a site visit before they may be enrolled as Colorado Medicaid

providers. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements.

8.125.11.B. All enrolled providers who are designated as "moderate" or "high" categorical risks must consent to and pass an additional site visit after enrollment or revalidation. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements. Post-enrollment or post-revalidation site visits may occur anytime during the 5 year period after enrollment or revalidation.

8.125.11.C. All providers enrolled in the Colorado Medicaid program must permit CMS, its agents, its designated contractors, the State Attorney General's Medicaid Fraud Control Unit or the Department to conduct unannounced on-site inspections of any and all provider locations.

8.125.11.D. All site visits shall verify the following information:

1. Basic Information including business name, address, phone number, on-site contact person, National Provider Identification number and Employer Identification Number, business license, provider type, owner's name(s), and owner's interest in other medical businesses.

2. Location including appropriate signage, utilities that are turned on, the presence of furniture and applicable equipment, and disability access where applicable and where members are served at the business location.

3. Employees with relevant training, designated employees who are trained to handle Medicaid billing, where applicable, and resources the provider uses to train employees in Medicaid billing where applicable.

4. Appropriate inventory necessary to provide services for specific provider type.

5. Other information as designated by the Department.

8.125.11.E. The Department shall give the provider a report detailing the discrepancies or insufficiencies in the information disclosed by the provider and the criteria the provider failed to meet during the site visit.

8.125.11.F. Providers that are found in full compliance shall be recommended for approval of enrollment or revalidation, subject to other enrollment or revalidation requirements.

8.125.11.G. Providers who meet the vast majority of criteria in Section 8.125.11.D but have small number of minor discrepancies or insufficiencies shall have 60 days from the date of the issuance of the report in Section 8.25.11.E to submit documentation to the Department attesting that the provider has corrected the issues identified during the site visit.

1. If the provider submits attestation within the 60 day timeframe and has met requirements, then the provider shall be recommended for enrollment or revalidation, subject to the verification of other enrollment or revalidation requirements.

2. If the provider fails to submit the attestation in Section 8.125.11.G.1 within the 60 day deadline, the Department may deny the provider's application for enrollment or revalidation.

3. If the provider submits an attestation within 60 days indicating that the provider is not fully compliant with criteria in Section 8.125.11.D, then the Department may,

a. For existing providers, suspend the provider, until the provider demonstrates compliance in subsequent site visit, conducted at the provider's expense; or

b. For new providers, deny the application and require the provider to restart the enrollment process.

8.125.11.H. When site visits reveal major discrepancies or insufficiencies in the information provided in the enrollment application or a majority of the criteria described in Section 8.125.11.D are not met, the Department shall allow for an additional site visit for the provider.

1. Additional site visits shall be conducted at the provider's expense.

2. The provider shall have 14 days from the date of the issuance of the report listed in Section 8.125.11.E above to request an additional site visit.

3. The Department shall deny or terminate enrollment or revalidation of any provider subject to Section 8.125.11.G who does not request an additional site visit within 14 days.

4. If the Department determines that a provider is not in full compliance upon the additional site visit:

a. for a revalidating provider, the Department shall immediately suspend the provider until a subsequent site visit demonstrates provider is in compliance.

b. for an enrolling provider, deny the application and require the provider to restart the enrollment process.

8.125.11.I. The Department shall deny or terminate enrollment or revalidation of any provider who refuses to allow a site visit, unless the Department determines the provider or the provider's staff refused the on-site inspection in error. The provider must provide credible evidence to the Department that it refused the on-site inspection in error within in 7 days of the date of the issuance of the report in Section 8.125.11.E. Any provider who does not provide credible evidence to the Department that it refused the on-site inspection in error shall be denied or terminated from the enrollment or revalidation.

8.125.11.J. The Department shall deny an application or terminate a provider's enrollment when an on-site inspection provides credible evidence that the provider has committed Medicaid fraud.

8.125.11.K. The Department shall refer providers in Section 8.125.11.J to the State Attorney General.

8.125.12 CRIMINAL BACKGROUND CHECKS AND FINGERPRINTING.

8.125.12.A. As a condition of provider enrollment and revalidation, any individual provider and person with an ownership or control interest in a provider designated as "high" categorical risk to the Medicaid program, must consent to criminal background checks and submit a set of fingerprints, in a form and manner to be determined by the Department.

8.125.12.B. Any provider, and any person with an ownership or control interest in the provider, must consent to criminal background checks and submit a set of fingerprints, in a form and manner designated by the Department, within 30 days upon request from CMS, the Department, the Department's agents, or the Department's designated contractors.

8.125.13 APPLICATION FEE

8.125.13.A. Except when exempted in Sections 8.125.13.C and 8.125.13.D, enrolling and revalidating providers must submit an application fee or a formal request for a hardship exemption with their application.

8.125.13.B. The amount of the application fee is the amount calculated by CMS in accordance with 42 CFR § 424.514(d).

8.125.13.C. Application fees shall apply to all providers except:

1. Individual practitioners

2. Providers who have enrolled or revalidated in Medicare, are approved and paid an application fee within the last 5 years.

3. Providers who have enrolled or revalidated in another State's Medicaid or Children's Health Insurance program, are approved and paid an application fee within the last 5 years provided that the department has determined that the screening procedures in the state in which the provider is enrolled are at least as comprehensive and stringent as the screening procedures required for enrollment in Colorado Medicaid.

8.125.13.D. The Department may exempt a provider, or group of providers, from paying the application fee, through a hardship exemption request or categorical fee waiver, if:

1. The Department determines that requiring a provider to pay an application fee would negatively impact access to care for Medicaid members, and

2. The Department receives approval from the Centers for Medicare and Medicaid Services to exempt the application fee.

8.125.13.E. A provider may not be enrolled or revalidated unless the provider has either paid any applicable application fee or obtained an exemption described at Section 8.125.13.D.

8.125.13.F. The application fee is non-refundable, except if submitted with one of the following:

1. A request for an exemption described at Section 8.125.13.D, that is subsequently approved;

2. An application that is rejected prior to initiation of screening processes;

3. An application that is subsequently denied as a result of the imposition of a temporary moratorium as described at Section 8.125.14.

8.125.14 TEMPORARY MORATORIA

8.125.14.A. In consultation with CMS and HHS, the Department may impose temporary moratoria on the enrollment of new providers or provider types, or impose numerical caps or other limits on providers that the Department and the Secretary of HHS identify as being a significant potential risk for fraud, waste, or abuse, unless the Department determines that such an action would adversely impact Medicaid members' access to medical assistance.

8.125.14.B. Before imposing any moratoria, caps, or other limits on provider enrollment, the Department shall notify the Secretary of HHS in writing and include all details of the moratoria.

8.125.14.C. The Department shall obtain the Secretary of HHS's concurrence with imposition of the moratoria, caps, or other limits on provider enrollment, before such limits shall take effect.

8.125.15 DISCLOSURES BY MEDICAID PROVIDERS, MANAGED CARE ENTITIES, AND FISCAL AGENTS

8.125.15.A. All Medicaid providers, disclosing entities, fiscal agents, and managed care entities must provide the following federally required disclosures to the Department:

1. The name and address of any entity (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity having direct or indirect ownership of 5 percent or more. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.

2. For individuals: Date of birth and Social Security number

3. For business entities: Other tax identification number for any entity with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

4. Whether the entity (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the entity (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

5. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

6. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

7. The identity of any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider who has been convicted of a criminal offense related to that person’s involvement in any program under Medicare, Medicaid, Children’s Health Insurance Program or the Title XX services since the inception of these programs.

8. Full and complete information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12 month period ending on the date of the request; and any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

8.125.15.B. Disclosures from any provider or disclosing entity are due at any of the following times:

1. Upon the provider or disclosing entity submitting the provider application.

2. Upon the provider or disclosing entity executing the provider agreement.

3. Upon request of the Department during revalidation.

4. Within 35 days after any change in ownership of the disclosing entity.

8.125.15.C. Disclosures from fiscal agents are due at any of the following times:

1. Upon the fiscal agent submitting its proposal in accordance with the State's procurement process.

2. Upon the fiscal agent executing a contract with the State.

3. Upon renewal or extension of the contract.

4. Within 35 days after any change in ownership of the fiscal agent.

8.125.15.D. Disclosures from managed care entities are due at any of the following times:

1. Upon the managed care entity submitting its proposal in accordance with the State's procurement process.

2. Upon the managed care entity executing a contract with the State.

3. Upon renewal or extension of the contract.

4. Within 35 days after any change in ownership of the managed care entity.

8.125.15.E. The Department will not reimburse any claim from any provider or entity or make any payment to an entity that fails to disclose ownership or control information as required by 42 CFR § 455.104. The Department will not reimburse any claim from any provider or entity or make any payment to an entity that fails to disclose information related to business transactions as required by 42 CFR § 455.105 beginning on the day following the date the information was due and ending on the day before the date on which the information was supplied. Any payment made to a provider or entity that is not reimbursable in accordance with this section shall be considered an overpayment.

8.125.15.F. The Department may terminate the agreement of any provider or entity or deny enrollment of any provider that fails to disclose information when requested or required by 42 CFR § 455.100-106.

Title of Rule: Revision to the Medical Assistance Eligibility Rule Concerning Adult MAGI and Medicare Eligibility, Section 8.100.4.G
Rule Number: MSB 20-02-03-A
Division / Contact / Phone: Medicaid Operations Office / Janelle Gonzalez / 2608

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 20-02-03-A, Revision to the Medical Assistance Eligibility Rule Concerning Adult MAGI and Medicare Eligibility.

3. This action is an adoption of: new rules

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

   Sections(s) 8.100.4.G, 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 8.100.4.G.4 with the newly proposed text beginning at 8.100.4.G.4.b through the end of 8.100.4.G.b. This rule is effective June 30, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Eligibility Rule Concerning Adult MAGI and Medicare Eligibility, Section 8.100.4.G
Rule Number: MSB 20-02-03-A
Division / Contact / Phone: Medicaid Operations Office / Janelle Gonzalez / 2608

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule will amend 10 CCR 2505-10 8.100.4.G by outlining existing eligibility requirements for the Adult MAGI program. Members cannot receive Adult MAGI benefits if they are entitled to or are enrolled for Medicare benefits and the purpose of this rule is to highlight how Medicare eligibility may potentially impact Adult MAGI eligibility. 42 C.F.R. §435.119(b)(3) outlines eligibility requirements for the Adult MAGI program and states that any person entitled to or enrolled for Medicare benefits under part A or B of title XVII of the Act are no longer eligible for Adult MAGI. Currently, 10 CCR 2505-10 8.100.1 is the only section of rule that outlines Adult MAGI eligibility requirements. This is problematic because 10 CCR 2505-10 8.100.1 is a list of definitions and the Adult MAGI definition does not have a specific citation. By adding the Adult MAGI definition to 8.100.4.G, we will have clearer rules which will improve accessibility.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. §435.119(b)(3) and 1902(a)(10)(A)(i)(VIII) of the Act.

4. State Authority for the Rule:

   Sections 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 Eligibility Rule Concerning Adult MAGI and Medicare Eligibility, Section 8.100.4.G
Rule Number: MSB 20-02-03-A
Division / Contact / Phone: Medicaid Operations Office / Janelle Gonzalez / 2608

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.

   With the proposed rule, members under the Adult MAGI program may be affected if they become eligible for Medicare. There are no costs to the Departments as this rule is intended to enhance current eligibility requirements that are outlined under the existing definition of Adult MAGI in section 10 CCR 2505 – 10 8.100.1. The benefit of implementing the proposed rule is that it will provide clearer understanding of the Adult MAGI eligibility criteria. It will also make the rule legally sufficient for future appeals.

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

   The proposed rule change will allow the department to add the existing definition for Adult MAGI to section 8.100.4.G to provide further clarification for program eligibility requirements. It will provide clarity by emphasizing the fact that Medicare recipients are not eligible for the Adult MAGI program. This update does not change eligibility requirements for the Adult MAGI program however, it will provide members with a clearer explanation of eligibility requirements. The implementation of this rule will reinforce existing practices. This rule may affect members who are under the Adult MAGI program who may become eligible for Medicare in the future. Considering that the rule is only providing clarification for existing rules, there is no anticipated economic impact for the department.

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 that implementation or enforcement of this rule change will result in any costs to the Department or any other agency because this rule change does not make any changes to the eligibility determination process or methods, this rule change will only update members on the rules and the Department will continue with current practice with regard to eligibility determinations.

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

   Inaction will not result in any costs to the Department as there are no changes to eligibility, however, inaction will make relevant eligibility information less clear to members.

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

   There are no alternative methods to transfer the information to members that the proposed rule change would accomplish, therefore there is no less costly method to pursue.

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

   There were no alternative methods considered for the proposed rule.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website.

    a. Children are eligible for Children's MAGI Medical Assistance through the end of the month in which they turn 19 years old. After turning 19, the individual may be eligible for a different Medical Assistance category.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 60% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household.

    a. A dependent child is considered to be living in the home of the parent or caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child even if:

        i) The child is under the jurisdiction of the court (for example, receiving probation services);

        ii) Legal custody is held by an agency that does not have physical possession of the child;

        iii) The child is in regular attendance at a school away from home;

        iv) Either the child or the relative is away from the home to receive medical treatment;

        v) Either the child or the relative is temporarily absent from the home;

        vi) The child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court ordered, the child is no longer considered to be living in the home as of the time the foster care plan is changed.

4. Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.

a. A dependent child living in the household of a parent or caretaker relative shall have minimum essential coverage, in order for the parent or caretaker relative to be eligible for Medical Assistance under this category. Refer to section 8.100.4.G.3.a on who is considered a dependent child.

b. To be eligible for MAGI-Adult Medical Assistance, you cannot be entitled to or enrolled for Medicare benefits under part A or B of Title XVIII of the Social Security Act.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level (MAGI-equivalent) are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage will be provided regardless of changes in the woman's financial circumstances once the income verification requirements are met.

   a. A pregnant women's eligibility period will end effective the earliest possible month, if the following occurs:

      i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90 day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

6. A lawfully admitted non-citizen who is pregnant and who has been in the United States for less than five years is eligible for Medical Assistance if she meets all of the other eligibility requirements specified at 8.100.4.G.5 and fits into one of the immigration categories listed in 8.100.3.G.1.g.iii.1-5 and 8.100.3.G.1.g.vi.1-15. This population is referenced as Legal Immigrant Prenatal.

7. A child whose mother is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as "Eligible Needy Newborn". This coverage also applies in instances where the mother received Medical Assistance to cover the child's birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.

   a. To receive Medical Assistance under this category, the birth must be reported verbally or in writing to the County Department of Human Services or eligibility site. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally-Qualified Health Center Alternative Payment Methodologies
Rule Number: MSB 20-02-04-A
Division / Contact / Phone: Health Programs / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 20-02-04-A, Revision to the Medical Assistance Act Rule concerning Federally-Qualified Health Center Alternative Payment Methodologies

3. This action is an adoption of: an amendment

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

   Sections(s) 8.700.6.D., 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: 06/30/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700.6.D with the proposed text beginning at 8.700.6.D.2.c through the end of 8.700.6.D.2.c. Replace the current text at 8.700.6.D.7 with the proposed text beginning at 8.700.6.D.7 through the end of 8.700.6.D.7. This rule is effective June 30, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally-Qualified Health Center Alternative Payment Methodologies
Rule Number: MSB 20-02-04-A
Division / Contact / Phone: Health Programs / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   The Department identified technical corrections needed to the Federally-Qualified Health Center (FQHC) alternative payment methodologies. The proposed technical changes include (1) removing specialty behavioral health rates from the alternative payment methodology (APM) rates that are at-risk based on the FQHC's quality modifier, and (2) clarifying how clients are attributed to a FQHC for payment under the second Alternative Payment Methodology (APM 2), which utilizes a per member per month (PMPM) payment methodology. The APM 2 rule language currently includes all attributed members, whereas the proposed payment methodology will only apply to clients attributed through claim, family, or case determination. The change removes the clients that are only attributed through geographical criteria. The APM 2 payment methodology is currently pending federal approval and will not be available until such approval is obtained.

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:

   Social Security Act Section 1902(bb)(6) (42 USC 1396a(bb)(6)) (2019)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   Section 25.5-5-102(1)(m), CRS (2019)

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

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally-Qualified Health Center Alternative Payment Methodologies
Rule Number: MSB 20-02-04-A
Division / Contact / Phone: Health Programs / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Removal of specialty behavioral health rates from the alternative payment methodology (APM) rates that are at-risk based on the FQHC's quality modifier will affect FQHC's reimbursed under the APM. The changes accurately describe the payments and attributed populations that are part of the value based Alternative Payment Methodologies. Specialty Behavioral Health services are paid by a managed care entity and the quality evaluation is for medical care. There is no impact to FQHCs or clients from the change.

   The second Alternative Payment Methodology (APM 2) for Federally-Qualified Health Centers is pending federal approval and is therefore not in effect at this time. Upon federal approval, the APM 2 will affect Federally-Qualified Health Centers and the clients they serve. The removal of the geographically attributed ACC members better describes the population that is part of the APM 2 payment. There is no impact to FQHC payment or client services with the 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.

   There is no impact of the proposed changes. They adjust the rules currently in place to achieve the purposes of the APM 1 and APM 2 without confusion.

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 are no costs to the Department or any other agency from the implementation and enforcement of the proposed rule. The rule clarifies how the APM 1 will be applied. The rates that will be paid under APM 2 will remain budget neutral under the revised attribution methodology.

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

Inaction regarding the technical changes will potentially create confusion and require clarification through rulemaking or administrative law decisions. Making the changes now before the active date of the APM 1 and APM 2 payments is the most efficient way to implement the program.

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

   There is no less costly or less intrusive way to make the technical corrections to the existing rules.

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

   The existing rules do not describe APM 1 or APM 2 correctly, there were no alternatives available to consider.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.6.D Encounter rates calculations

Effective July 1, 2018, FQHCs will be paid three separate encounter rates for three separate services: physical health services, dental services, and specialty behavioral health services. Physical health services are covered services reimbursed through the Department's MMIS, except the short-term behavioral health services in the primary care setting policy. Dental services are services provided by a dentist or dental hygienist that are reimbursed by the Department's dental ASO. Specialty behavioral health services are behavioral health services covered and reimbursed by either the RAE or by the MMIS through the short-term behavioral health services in the primary care setting policy. The Department will perform an annual reconciliation to ensure each FQHC has been paid at least their per visit Prospective Payment System (PPS) rate. If an FQHC has been paid below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

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

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

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

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

   c. Beginning July 1, 2020, ~~A~~ a portion of the FQHCs physical health ~~and specialty behavioral health~~ alternative payment methodology rates are at-risk based on the FQHC's quality modifier. An FQHC's quality modifier

is determined by the FQHC's performance on quality indicators in the previous Calendar Year.

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

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

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

    a. Freestanding and hospital-based FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. An extension of up to 75 days may be granted based upon circumstances. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

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

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

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

        i. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

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

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

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

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

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

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

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

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

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

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

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

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

b. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);

c. Indirect medical education adjustments and a direct graduate medical education payment that reflects the

costs of providing teaching services to interns and/or residents; or,

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

c. The following items do not prompt a scope-of-service rate adjustment:

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

ii. An increase or decrease in the number of encounters;

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

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

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

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

vii. The addition or removal of administrative staff;

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

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

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

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

xii. A change in ownership.

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

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid

change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. An FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

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

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

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

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

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

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

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

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

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

    i. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also

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

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

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

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

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

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

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

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

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

iii. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be

implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

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

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

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

7. Pending federal approval, the Department will offer~~, as a pilot program,~~ a second Alternative Payment Methodology (APM 2) that will reimburse FQHCs a Per Member Per Month (PMPM) rate. FQHCs may opt into APM 2 annually. This reimbursement methodology will convert the FQHC's current Physical Health cost per visit rate into an equivalent PMPM rate using historical patient utilization, ~~historical~~ member designated attribution, and the Physical Health cost per visit rate for the specific FQHC. Physical health services rendered to patients not attributed to the FQHC, or attributed based on geographic location, will pay at the appropriate encounter rate. Dental and specialty behavioral health services for all patients will be paid at the appropriate encounter rate. Year 2 rates for FQHCs participating in APM 2 will be set using trended data. Year 3 rates will be set using actual data.

8. The Department will perform an annual reconciliation to ensure the PMPM reimbursement compensates APM 2 providers in an amount that is no less than their PPS per visit rate. The Department shall perform PPS reconciliations should the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC.

9. PMPM and encounter rates for FQHC participating in APM 2 shall be effective on the 1st day of the month that falls at least 120 days after an FQHC's fiscal year end.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Targeted Case Management, Section 8.761
Rule Number: MSB 20-02-05-A
Division / Contact / Phone: Office of Community Living / Heather Fladmark / 303-866-5187

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 20-02-05-A, Revision to the Medical Assistance Rule concerning Targeted Case Management, Section 8.761

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) OP Pages, 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 8.761 with the proposed text beginning at 8.761.2 through the end of 8.761.5. This rule is effective June 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Targeted Case Management, Section 8.761
Rule Number: MSB 20-02-05-A
Division / Contact / Phone: Office of Community Living / Heather Fladmark / 303-866-5187

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).

   8.761.2 and 8.761.4 rules have been revised to reflect the change to how case management activities for the Home and Community Based Services for Persons with Developmental Disabilities waiver (DD), Home and Community Based Services- Supported Living Services waiver (SLS), Home and Community Based Services- Children's Habilitation Residential Program (CHRP) and Home and Community Based Services- Children's Extensive Support waiver (CES) will be reimbursed July 1, 2020. The finalized Targeted Case Management (TCM) moves to a Per Member Per Month (PMPM) reimbursement for ongoing case management services and differs from the current payment methodology which is a 15-Minute unit with a maximum of 240 total units per member per year. This rule change was prompted by an Office of State Auditor (OSA) recommendation that advised the Department to revise the reimbursement methodology for case management services to better incentivize quality over quantity. The Department committed to the General Assembly and to CCBs to pursue this change. Effective July 1, 2020 TCM activities will be reimbursed as a flat PMPM for active members.

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 § 440.169 (b)

4. State Authority for the Rule:

   Sections 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 #

DO NOT PUBLISH THIS PAGE

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 Rule concerning Targeted Case Management, Section 8.761
Rule Number: MSB 20-02-05-A
Division / Contact / Phone: Office of Community Living / Heather Fladmark / 303-866-5187

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 Department reimburses Community Centered Boards (CCB) for case management activities for Persons with Developmental Disabilities via Targeted Case Management (TCM). To receive TCM services individuals must meet specific criteria outlined in regulations and be enrolled in the following programs; Home and Community Based for Persons with Developmental Disabilities Waiver (DD), Home and Community Based Services- Supported Living Services Waiver (SLS), Home and Community Based Services- Children's Habilitation Residential Program Waiver (CHRP) and Home and Community Based Services- Children's Extensive Support Waiver (CES).

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

   Overall, this regulation will result in similar revenue for CCBs for identical services statewide. The appropriation and expenditures for TCM will remain equivalent, the Department projects there may be some variance (both positive and negative) across individual CCBs depending on their specific business practices. The new per member per month reimbursement methodology will simplify billing for CCB case managers, who must currently track their time in 15-minute intervals. The new methodology is expected allow case managers to spend more time coordinating services for members and less time documenting their work.

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 that implementation or enforcement of this rule change will result in any costs to the Department or any other agency. This rule change does not make any changes to the TCM rules or regulation and it is just an adjustment, calculated as a budget-neutral change to the payment methodology within the existing appropriation. It will not affect state revenues.

The Department is able to implement all billing changes associated with the unit conversion within existing funding and staffing.

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

   The Department does not incur a cost of implementing the rule since the change is to the reimbursement methodology for targeted case management is budget neutral. However, Inaction will not allow the Department to comply with audit findings from the November 2018 CCB OSA performance audit which required the Department to make changes to its payment methodology for the CCBs. The current methodology allows for potential accidental waste and abuse and puts the Department at risk.

   Implementation of this rule reduces audit risks that exist with the current methodology. The new methodology also will benefit CCBs who will no longer be tasked with tracking and billing TCM in 15-minute units. Implementation of this change will simplify CCBs administrative tasks associated with TCM and allow a greater focus on providing members with quality case management.

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

   The reimbursement methodology is believed to be the least intrusive method to simplify billing for CCB case managers who currently must track their time in 15-minute intervals. The new methodology is expected to greatly decrease the amount of time case managers spend recording, billing and reconciling the provision of TCM. Eliminating the annual 240-unit TCM cap will also insure that members receive the TCM services they need and reduce risk of less than sufficient case management after exceeding the limit.

   Inaction will not allow the Department to comply with audit findings from the November 2018 CCB OSA performance audit which required the Department to make changes to its payment methodology for the CCBs. The current methodology allows for potential accidental waste and abuse and puts the Department at risk. The new reimbursement methodology will improve the billng effeciencies and accuricites for all CCBs which is the least costly reimbursement methodology.

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

   There were no other alternative methods explored by the Department. The Department believes that implementation of this rule, implementing a PMPM

reimbursement methodology, eliminates the audit risks associated with the current methodology for the Department. The new methodology also will benefit CCBs who do not have to track and bill in 15-minute units. The benefit of implementation greatly outweighs the costs associated with inaction.

8.761 TARGETED CASE MANAGEMENT (TCM) SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITITES

.14 Targeted Case Management services for Persons with Developmental Disabilities consists of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources. Targeted case management services includes the following activities:

a. Comprehensive assessment and 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. These assessment activities include:

1. Taking Client history; and

2. Identifying the Client's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators as necessary, to form a complete assessment of the Client.

b. Development and periodic revision of a specific care plan that:

1. Is based on the information collected through the assessment;

2. Specifies the goals and actions to address the medical, social, educational, and other services needed by the Client;

3. Includes activities such as ensuring the active participation of the Client, and working with the Client (or the Client representative as defined in Section 8.500.1) and others to develop those goals; and

4. Identifies a course of action to respond to the assessed needs of the Client.

c. Referral and related activities to help a Client obtain needed services including activities that help link a Client with:

1. Medical, social, educational providers; or

2. Other programs and services including making referrals to providers for needed services and scheduling appointments, as needed.

d. Monitoring and follow-up includes activities that are necessary to ensure the care plan is implemented and adequately addresses the Client’s needs. Monitoring and follow up actions shall:

1. Be performed when necessary to address health and safety and services in the care plan;

2. Include activities to ensure:

A. Services are being furnished in accordance with the Client’s care plan;

B. Services in the care plan are adequate; and

C. Necessary adjustments in the care plan and service arrangements with providers are made if the needs of the Client have changed;

3. Include direct contact and observation with the Client in a place where services are delivered to a Client in accordance with the following frequency:

A. Face to face monitoring shall be completed for a Client enrolled in HCBS-DD at least once per quarter;

B. Face to face monitoring shall be completed for a Client enrolled in HCBS-SLS at least once per quarter;

C. Face to face monitoring shall be completed for a Client in HCBS-CES at least once per quarter; and

D. Face to face monitoring shall be completed at least once every six months for children in Early Intervention Services.

.15 All case documentation must be entered into the Department's IMS within five (5) business days from the date of activity.

8.761.2 DETERMINATION OF CLIENT ELIGIBLITY

.21 To receive targeted case management services individuals must meet the following criteria:

a. Be determined eligible for Medicaid by the County Department of Social/Human Services in the county in which the person resides;

b. Be determined by the designated Community Centered Board to have a developmental disability or developmental delay; and

c. Be actively enrolled in one of the following programs~~-~~:

1. Home and Community Based Services for Persons with Developmental Disabilities waiver (HCBS-DD);

2. Home and Community Based Services - Supported Living Services waiver (HCBS-SLS);

3. Home and Community Based Services- Children's Habilitation Residential Program (HCBS-CHRP)

3. Home and Community Based Services - Children's Extensive Support waiver (HCBS-CES); or

4. Early Intervention Services (EI) .

.22 The specific programs listed in Section ~~8.761.21 (c)(1)~~8.761.21.c.1 through ~~(~~4~~)~~ are the only programs which are eligible for targeted case management services.

8.761.3 PROVIDER ELIGIBILITY

.31 Only certified Early Intervention Services may be reimbursed for targeted case management services for persons enrolled in Early Intervention Services pursuant to 12 CCR 2509-10, Section 7.913.

.32 Only case management agencies certified by the Department pursuant to Sections 8.519 through 8.519.23 may provide case management for persons enrolled in the Home and Community Based Services outlined in Sections 8.503 Home and Community Based Services for Children's Extensive Support (HCBS-CES) Waiver, 8.508 Home and Community Based Services for Children's Residential Habilitation Program (HCBS-CRHP), 8.500 Home and Community Based Services for the Developmentally Disabled (HCBS-DD) Waiver, and 8.500.90 Home and Community Based Services for Supported Living Services (HCBS-SLS) Waiver *et seq.*

8.761.4 REIMBURSEMENT

.41 Claims are reimbursable only when supported by the following documentation:

a. The name of the Client;

b. The date of the activity;

c. The nature of the activity including whether it is direct or indirect contact with the Client;

d. The content of the activity including the relevant observations, assessments, findings;

e. Outcomes achieved, and as appropriate, follow up action;

f. For EI services, ~~T~~the total number of units associated with the activity; and

g. For HCBS waiver programs, documentation required under Sections 8.519 and 8.760.

.42 TCM providers shall record what documentation exists in the log notes and enter it into the state data system as required by the Department.

.43 Claims related to EI for travel time to and from a TCM activity are reimbursable at the same unit rate as TCM services. The time claimed for travel shall be documented separately from the time claimed for the TCM activity.

.44 Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at 42 C.F.R. § 447.205 and shall be based upon a market-based. EI shall continue to utilize the rate with a unit of service equal to fifteen (15) minutes according to the State's approved fee schedule. EI TCM, which is limited to 240 units per Client per state fiscal year.

.45 TCM services may not be claimed prior to the first day of enrollment into an eligible program nor prior to the actual date of eligibility for Medicaid benefits.

.46 TCM ~~is limited to 60 units per Client for State Fiscal Year 2011-12 (April 1 to June 30, 2012). Thereafter, TCM is limited to 240 units per Client per state fiscal year~~ for HCBS-DD, HCBS-CES, HCBS-CHRP and HCBS-SLS are to be reimbursed based on the Departments TCM Fee Schedule. ~~.~~

8.761.5 EXCLUSIONS

.51 Case management services provided to any individuals enrolled in the following programs are not billable as Tt~~t~~argeted Cc~~c~~ase Mm~~m~~anagement services for persons with developmental disabilities as specified in Ss~~s~~ection 8.760:

a. Persons enrolled in a Home and Community Based Services waiver not included as an eligible HCBS service as described in ~~10 CCR 2505-10~~ Section 8.761.21.c.

b. Persons residing in a Class I nursing facility.

c. Persons residing in an Intermediate Care Facility for the Intellectually Disabled (ICF-ID).

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Prescription Tracking Requirements, Section 8.800.11.E.1
Rule Number: MSB 20-03-16-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

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 20-03-16-A, Revision to the Medical Assistance Rule Concerning Prescription Tracking Requirements, Section 8.800.11.E.1

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) 8.800.11.E.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.800.11.E.1 with the proposed text beginning at 8.800.11.E.1.c through the end of 8.800.11.E.1.c. This rule is effective June 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Prescription Tracking Requirements, Section 8.800.11.E.1
Rule Number: MSB 20-03-16-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

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 must ensure that member's access to critical medication is not thwarted. Therefore, the Department is waiving the prescription signature requirements in Sections 8.800.11.E.1.a and 8.800.11.E.1.b only when a public health emergency is declared by the Governor. This will serve as a safety precaution by eliminating the need to touch pens and electronic screens; in addition to eliminating a potential barrier for a member to receive medication when they can not physically come into the pharmacy to obtain it if they have contracted COVID19.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

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

Initial Review — Final Adoption **05/08/2020**
Proposed Effective Date **06/30/2020** — Emergency Adoption

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Pharmaceutical Rule Concerning Prescription Tracking Requirements, Section 8.800.11.E.1
Rule Number: MSB 20-03-16-A
Division / Contact / Phone: Pharmacy Office / Kristina Gould / 303-866-6715

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.

   Waiving the signature requirements poses an auditing concern as it is more difficult to confirm delivery of medications. However, amid this pandemic an auditing concern is less worrisome than members potentially spreading the virus to other people and/or not being able to obtain their medications in the event that they cannot physically come into the pharmacy to sign for their medications if they have contracted COVID19 and are placed in quarantine.

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 quantitative impact is the potential for pharmacies to bill Medicaid for medications that have not been dispensed to members; i.e. it is more difficult for the Department to audit pharmacies on whether or not a member actually received their medications without the signature requirement in place. However, qualitatively this potential rule change can assist in mitigating the spread of COVID19 which is far more cost effective quantitatively and qualitatively than preventing potential billing mistakes by pharmacies given the declaration of a public health emergency by the Governor.

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 probable cost to the Department is that while the governor has declared a state of public health emergency, pharmacies can bill the Department for claims without the signature requirement meaning that some pharmacies could bill the Department for claims that were never actually given to a member.

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

   The probable cost of the proposed rule is that the Department will not be able to effectively audit pharmacy claims for this period of time. The probable benefit is

mitigating the spread of COVID19 and ensuring patients can access the medications they need if they have contracted COVID19 without having to physically come into the pharmacy and sign for their medication. The probable cost of inaction is spreading COVID19 through pharmacy touchpads and pens. The probable benefit of inaction is that the Department will still be able to more effectively audit pharmacy claims.

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

   N/A

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

   N/A

8.800 PHARMACEUTICALS

8.800.11 PRESCRIPTION RECORD REQUIREMENTS

8.800.11.A. The original prescription shall be a hard copy written, faxed or electronically mailed or otherwise transmitted by the prescriber or reduced to writing by pharmacy staff when received by telephone. All information required by the Colorado State Board of Pharmacy shall appear on each prescription including any information required if a substitution for a drug is made. All refill information shall be recorded in accordance with the Colorado State Board of Pharmacy requirements.

8.800.11.B. All records for new prescriptions and refills for which payment from the Medical Assistance Program is requested shall be maintained in accordance with Colorado State Board of Pharmacy requirements except that such records must be retained for the length of time set forth in 10 C.C.R. 2505-10, Section 8.040.2.

8.800.11.C. The pharmacist shall be responsible for assuring that reasonable efforts have been made to obtain, record, and maintain the following member information from the member or his/her apparent agent for each new prescription:

1. Name, address, telephone number, date of birth or age, and gender;

2. Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive, chronological list of medications and prescribed relevant devices; and

3. Additional comments relevant to the member's pharmaceutical care as described in the Prospective Drug Review and Member Counseling sections set forth in 10 C.C.R. 2505-10, Section 8.800.9.

8.800.11.D. TAMPER-RESISTANT PRESCRIPTION DRUG PADS OR PAPER

1. The use of tamper-resistant prescription drug pads or paper is required for all written or electronically printed prescriptions for all Medical Assistance Program members when:

   a. Prescriptions are issued for outpatient drugs, including controlled and uncontrolled substances, or OTC drugs that are reimbursable through the Medical Assistance Program and dispensed by a pharmacy; and

   b. The Medical Assistance Program is the primary or secondary payer of the prescription being filled.

2. To be considered tamper-resistant, the pad/paper used for a written or electronically printed prescription shall integrate three distinct characteristics. The three characteristics and the specific features required are as follows:

   a. Characteristic #1: One or more industry-recognized features designed to prevent unauthorized copying of completed or blank prescription form. A prescription shall contain at least one of the following features:

i) Void/Illegal/Copy Pantograph with or with the Reverse Rx feature. The word “Void”, “Illegal”, or “Copy” appears when the prescription is photocopied. If the paper has the Reverse Rx feature, the Rx symbol must disappear when photocopied at light setting. The Reverse Rx feature is not allowed as a feature by itself.

ii) Micro-fine printed security message generated by a computer, electronic medical records system or other electronic means. The message may serve as a signature line or border. This must be printed in 0.5 font or smaller and readable when viewed at 5x magnification or greater and illegible when copied.

iii) Coin-reactive ink or security mark. The pad or paper identifies an area on the pad/paper where the ink changes color or reveals wording or a picture when that area is rubbed by a coin. This must be accompanied by a message describing what is necessary to demonstrate authenticity.

iv) Security print watermark. Specific wording is printed on the front or back of the prescription paper and can only be seen when viewed at an angle.

v) Paper with a watermark. This is paper that contains a watermark that can be seen when backlit.

b. Characteristic #2: One or more industry recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. A prescription shall contain at least one of the following features:

i) An erasure-revealing background. This is a background that consists of a non-white solid color or consistent pattern that has been printed onto the paper. If an erasure or modification is attempted, the background will show marks or the color of the underlying paper where the alterations were made.

ii) Toner fusing technology for laser-printed prescriptions. This is a treatment that is added to the surface of the paper to create a strong bond between the laser-printed text and the paper. The computer-printed information cannot be lifted from the surface of the paper without damaging the paper.

iii) Chemical-reactive paper. This is paper that contains features that show discoloration or reveals a hidden message if solvents are used to attempt to wash the ink from its surface.

iv) Plain bond paper combined with inkjet-printing. The inkjet printing is absorbed into the high grade paper stock. Erasures and modifications cannot be made without damaging the paper.

v) Pre-printed quantity check-off boxes indicated in ranges of no more than 25 per range combined with a written quantity. The range box corresponding to the quantity prescribed must be checked by the prescriber for the prescription to be valid.

vi) Pre-printed refill indicator where the number of refills allowed is marked or no refills or “NR” is marked when no refills are authorized. Refill

information must be completed by the prescriber for the prescription to be valid.

vii) Characters surrounding the authorized dispensing quantity and the number of refills. Special characters such as a series of asterisks must be repeated on both sides of the numbers indicating the quantity and the number of refills authorized (e.g., Quantity ***50*** Refill ***3***). This is acceptable only for prescriptions that are generated by a computer, electronic medical records system or other electronic means.

c. Characteristic #3: One or more industry recognized features designed to prevent the use of counterfeit forms. A prescription must contain at least one of the following features:

i) Security features listed visibly in a box, band or border on the prescription. This must be a complete listing of all of the security features incorporated into the prescription pad/paper in order to minimize tampering.

ii) Security threads. Metal, fluorescent or plastic security threads are embedded into the prescription pad/paper.

iii) Thermochromic ink. All or some of the pad or paper is pre-printed with ink that changes color when exposed to heat and then changes back to its original color when cooled. This must be accompanied by a message describing what is necessary to demonstrate authenticity.

3. The use of tamper-resistant prescription pads or paper is not required when:

a. Prescriptions are transmitted by telephone, fax or E-prescription directly to the pharmacy by the prescriber or prescriber's staff that is authorized to act on the prescriber's behalf; or

b. A prescriber administers or provides the drug directly to the member; or

c. A prescriber in an institutional setting writes the order into the medical record and then the order is given by medical staff directly to the pharmacy; or

d. A Medical Assistance Program managed care entity pays for or dispenses the prescription; or

e. A prescription is written for any medical item, service or equipment that is not considered an outpatient drug; or

f. A drug that is provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made as part of payment for the following and not as direct reimbursement for the drug):

i) Inpatient hospital services;

ii) Hospice services;

iii) Dental services (except when a State Plan authorizes direct reimbursement to the dispensing dentist);

iv) Physician services;

v) Outpatient hospital services;

vi) Nursing facilities and intermediate care facilities for the mentally retarded;

vii) Other laboratory and x-ray services; or

viii) Renal dialysis.

4. The pharmacy may dispense up to a 72-hour supply of a covered outpatient prescription drug in an emergency situation, provided that the pharmacy obtains a compliant prescription in writing, or by telephone, facsimile, or E-prescription, within 72 hours of filling the prescription.

5. When a Medical Assistance Program member is determined retroactively eligible after a pharmacy has filled the recipient's prescription, the prescription shall be deemed to comply with the tamper-resistant pad/paper requirements. This presumption applies only to prescriptions that were filled before the member was determined eligible. Prescriptions that are filled or refilled after the member is determined eligible require a new, tamper-resistant prescription or the pharmacy may obtain verbal confirmation of the prescription from the prescriber or may obtain the prescription from the prescriber by facsimile or E-prescription.

8.800.11.E. Prescription tracking and claim reversals

1. The pharmacy shall keep:

a. A chronological log that contains the member's name, his or her signature or agent's signature and date of the receipt of the prescription; or

b. An electronic prescription tracking system that records the status of prescriptions through the fill process including the date and time that the prescription was transferred to a person whom pharmacy personnel verified was the member or agent of the member.

c. The requirements in subsections (a) and (b) are waived for the duration of a public health emergency as declared by the Governor.

2. Pharmacies using a chronological log shall review all Medical Assistance Program prescriptions in shall-call status (filled but not released to the member or the member's agent) at least weekly and enter a reversal of prescriptions not picked up within 14 days of billing. In no case shall prescriptions be kept in shall-call status for more than 21 days. The pharmacy shall maintain a record of each reversal for audit purposes.

3. Pharmacies using an electronic prescription tracking system shall review all Medical Assistance Program prescriptions in shall-call status on a daily basis and enter a reversal of prescriptions not picked up within 10 days of billing. In no case shall prescriptions be kept in shall-call status for more than 14 days. The pharmacy shall maintain a record of each reversal for audit purposes.

4. Upon receipt of a written request from the Department or the Medicaid Fraud Unit for a record of Medical Assistance Program claims and reversals, the pharmacy has up to 72

hours or three working days to provide the requested information or to enter into an agreement with the Department or Unit stating the specific time within which the data shall be produced.

8.800.11.F. Any information, documents or records required to be retained under 10 C.C.R. 2505-10, Section 8.800.11 shall be made available for inspection to authorized personnel of the Department, U.S. Department of Health and Human Services or the Medicaid Fraud Control Unit.

Title of Rule: Revision to Medical Assistance Rule Concerning Disability Trusts, Section 8.100.7.E.6.b.
Rule Number: MSB 19-09-04-A
Division / Contact / Phone: Legal Division / Tiffany Walker / 3798

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 19-09-04-A, Revision to Medical Assistance Rule Concerning Disability Trusts, Section 8.100.7.E.6.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) 8.100.7.E.6.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).

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.7.E.6.b with the proposed text beginning at 8.100.7.E.6.b.i through the end of 8.100.7.E.6.b.i. This rule is effective June 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule Concerning Disability Trusts, Section 8.100.7.E.6.b.
Rule Number: MSB 19-09-04-A
Division / Contact / Phone: Legal Division / Tiffany Walker / 3798

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 proposing several changes to the rule concerning disability trusts. Pursuant to federal and state law, disability trusts are exempt from being considered a countable resource in determining medical assistance eligibility. Under Colorado law, no disability trust shall be valid unless the department of health care policy and financing has reviewed the trust and determined that the trust conforms to the requirements of section 15-14-412.8, C.R.S. and any rules adopted by the medical services board. The proposed rule change: (1) creates an exception to the early termination requirement for individuals who change their residency; (2) clarifies that the Department may only be entitled to a pro-rata share of the remaining trust balance upon termination if such balance is insufficient to fully reimburse all states that provided medical assistance benefits to the Medicaid client; (3) allows an annuity funding the disability trust to name the trust as remainder beneficiary; (4) adds provisions that will aide in the oversight of disability trusts; and (5) removes references to a funding requirement that no longer exists under Colorado law. These rule revisions will supplement the existing requirements for disability trusts under 15-14-412.8, C.R.S. The proposed changes will impact all Medicaid clients who have established a disability trust; however, there should be no impact on the medical assistance benefits received by such clients unless they establish a trust that is not in compliance with any adopted changes to the rules and regulations.

   Currently, a disability trust is required to terminate when an individual is no longer receiving medical assistance benefits in the State of Colorado. This is often referred to as the early termination rule. The main purpose of the proposed rule revision is to create an exception to the early termination rule that allows a disability trust to continue if the trustee provides proof that the beneficiary is receiving medical assistance in another state and that the trust is required to receive such assistance. The Department has successfully defended the early termination provision in court but agrees with stakeholders that it is unfair to require termination of a disability trust solely based on the fact that an individual no longer resides in Colorado. If the proposed rule revision is approved, the early termination provision will be retained in part, allowing a trust to continue for the benefit of the individual if they leave the State of Colorado but only if certain requirements are met. Although some stakeholders contend that the provision should be deleted in its entirety based on the fact that the federal rule only mentions termination on death and is silent on early terminations, the early

termination rule has been longstanding under Colorado law and has been upheld by courts on several occasions. Further, there is legal authority to support the position that Colorado may impose additional requirements on the administration of trusts, even if such requirements are not included under the federal law. Retaining the early termination provision, in part, is necessary to ensure the purpose of these disability trusts is maintained.

Another purpose of the proposed changes is to codify the Department's recognition that other states may be entitled to reimbursement from disability trusts, and to the extent that the remaining trust assets are insufficient to reimburse each state in full, the reimbursement shall be pro-rata among the states. The language in our current regulation has been misinterpreted to require that the State of Colorado will receive repayment prior to other states, which has resulted in practitioners drafting disability trusts that do not qualify as exempt for social security's purposes since the inclusion of other states and pro-rata payback is a requirement under the social security rules. The proposed changes also include a revision to allow an annuity to name the trust as a remainder beneficiary, rather than the Department individually, which is similarly directed at clarifying these multistate reimbursement issues.

In addition, the proposed rule adds a new notification requirement for large trust distributions and clarifies when a trust accounting is due to the Department, both of which are necessary to aide in the Department's oversight of these trusts. Pursuant to the rules and regulations concerning disability trusts, any trust distribution must be for the "sole benefit" of the trust beneficiary. However, the Department has become increasingly aware that disability trusts, including those that are administered within the State of Colorado, are often used inappropriately to make distributions that are not for the "sole benefit" of the beneficiary. The improper use of a disability trust diminishes the Department's potential remainder interest, and as a result, ensuring that disability trusts are being properly administered is one of the primary functions of the trust unit. These proposed oversight changes are even more necessary if the revision to the early termination provision proposed herein is approved. If approved, it would be more common for a trust to be outside the jurisdiction of Colorado courts, which could further impede the Department's ability to ensure that such trusts are being used solely for the benefit of the beneficiary. Further, other states have similar, but more restrictive, oversight requirements.

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:

Not Applicable

3. Federal authority for the Rule, if any:

Keith v. Rizzuto, 212 F.3d 1190 (10th Cir. 2000) – The holding of this case supports the proposition that states are free to decide whether and under what conditions to recognize exempt trusts, which would include disability trusts, as long as it is possible to comply with both federal law and the separate conditions under state law. It is the Department's position that it is possible to comply with both federal law and any state law changes proposed herein, and therefore, retaining the early termination provision, as revised, and adding in the oversight provisions is permissible.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S.;
   25.5-6-103, C.R.S.;
   15-14-412.8, C.R.S.

   The Medical Services Board is granted the authority to adopt such rules as are necessary with respect to disability trusts established pursuant to section 15-14-412.8, C.R.S. No disability trust shall be valid unless the trust conforms to the requirements of section 15-14-412.8, C.R.S., and any rules adopted by the medical services board pursuant to section 25.5-6-103, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule Concerning Disability Trusts, Section 8.100.7.E.6.b.
Rule Number: MSB 19-09-04-A
Division / Contact / Phone: Legal Division / Tiffany Walker / 3798

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 benefit individuals who created a disability trust but no longer receive medical assistance benefits in Colorado due to a change in residency. The current rule provides that a disability trust shall terminate if an individual is no longer receiving medical assistance benefits in Colorado, and at such time the State of Colorado is required to be reimbursed from the balance of the disability trust up to the amount of medical assistance benefits paid. The proposed rule will create an exception to this early termination provision to allow a disability trust to continue if an individual changes residency but is receiving medical assistance benefits under another state Medicaid program. This will allow the individual to continue to retain the entire balance of the disability trust for their benefit as long as they are receiving medical assistance benefits in any state, delaying the required reimbursement to the state(s).

   There is potential harm to the Department as result of the rule change, since it would delay the Department's recovery from the disability trust should the individual change their residency and remain on benefits. Instead of reimbursing the Department, the disability trust assets will continue to be used for the benefit of the individual, which will likely reduce or eliminate the Department's recovery from the trust. However, the decrease in litigation due to this issue will benefit the Department, as will the ability to focus employee resources on other types of trust recoveries.

   In addition, there would be an increase in the amount of trusts that would require yearly monitoring by the Department, which may require the allocation of additional staff time. The Department monitors disability trusts to ensure compliance with the Department's rules and regulations on an annual basis. When a disability trust terminates, the Department is reimbursed and there is no longer a need to monitor the trust. This increase in disability trusts that will require annual monitoring is attributable to the out of state trusts that would have terminated early under our current rule but will now continue until the individual no longer receives medical assistance benefits in any state by reason of death or otherwise. To aide with the difficulty in monitoring trusts leaving the State of Colorado, the Department is

proposing changes to the rule to ensure annual accountings are sent to the Department by the Trustee. Further, the trustee will be required to provide separate notice of larger distributions prior to the annual accounting. These additional oversight provisions have been added to ensure that the distributions made from disability trusts are for the sole benefit of the individual as required by law and will reduce the amount of time currently spent requesting and reviewing trust accountings. Ensuring compliance is important because any noncompliant distributions harm the Department's potential recovery.

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

   Through the rule change, the affected classes of persons will be able to retain the funds in their disability trust if they change residency as long as they are receiving medical assistance benefits in another state and require the trust to do so. This will be an overall positive impact to this class. The additional oversight requirements will also have a positive impact on the class, protecting the trust balance for both the class, as primary beneficiaries of these trusts, and the Department, as remainder beneficiary.

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 rule change will not result in any expansion of program benefits, and therefore, there is no expected cost to the Department or any other agency. The only potential financial impact of the rule change will result from the Department no longer being able to require the early termination of a disability trust for the sole reason that the individual changed their residency. This may result in a decrease in the remaining trust balance that is available to repay the Department upon the later termination of the trust; however, the other proposed rule changes give the Department the increased ability to ensure that all disability trusts remain in compliance with the trust rules and regulations and will decrease the improper depletion of remaining trust funds which are eventually used to repay the Department. Decreased funds spent litigating this issue and the ability to focus employee resources on other types of trust recoveries will also offset this potential decrease in disability trust recoveries.

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

   The cost of inaction with regard to the early termination change is that the Department will continue to require termination of these trusts upon a change of residency, which has been the subject of ongoing litigation that has depleted Department funds and employee resources due to the time spent on these matters.

With regard to the other changes, the cost of inaction is that the Department will continue to spend an excessive amount of time on pursuing remedies for the improper administration of these trusts which harms the Department as a remainder beneficiary. Often, if a large improper distribution is made, there is no remedy because the funds have been spent over a year ago and are unrecoverable. The additional notice requirement for larger distributions will increase the likelihood that a non-compliant distribution is recoverable, since notice will be provided more contemporaneously with the distribution. Also, the rule change clarifies that an annual accounting is required without the Department making a formal request each year. The changes will decrease the amount of employee time required for the oversight of these trusts as well as adding extra measures to ensure compliance or easily remedy non-compliance.

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 rule.

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

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

8.100.7.E Consideration of Trusts in Determining Medical Assistance Eligibility

b. Disability Trusts

i) A trust that is established solely for the benefit of a disabled individual under the age of 65, which consists of the assets of the individual, and is established for the purpose or with the effect of establishing or maintaining the individual's resource eligibility for Medical Assistance and which meets the following criteria:

a) The individual for whom the trust is established must meet the disability criteria of Social Security.

b) ~~The only assets used to fund the trust are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under Sullivan v. Zebley. (This provision is applicable to disability trusts established from July 1, 1994 to December 31, 2000.)~~[Removed and Reserved]

c) The trust is established solely for the benefit of the disabled individual by the individual, the individual's parent, the individual's grandparent, the individual's legal guardian, or by the court.

d) The sole lifetime beneficiaries of the trust are the individual for whose benefit the trust is established, ~~and~~ the Colorado Department of Health Care Policy and Financing, and any other state that provides medical assistance to the individual under such state's Medicaid program.

e) The trust terminates upon the death of the individual or if the trust is no longer required for Medical Assistance eligibility ~~in Colorado~~.

i) If the individual becomes ineligible for Medical Assistance in Colorado or any other state due to a change in residency, then the trust shall terminate unless the Department receives proof that: (1) the individual is receiving medical assistance under another state's Medicaid program; and (2) the trust is required for the individual to receive those medical assistance benefits. The trustee must submit the required proof no later than sixty (60) calendar days from the date the trustee acquires knowledge of the change in residency. An extension of time may be granted upon submission of a written request to the Department by the trustee.

ii) The trustee must provide the Department with notice of the individual's death, loss of Medicaid eligibility, or change in residency no later than sixty (60) calendar days from the date the trustee acquires knowledge of such event.

f) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the trust and approval of the trust.

g) If the trust is funded with an annuity or other periodic payments, the ~~Department~~ trust shall be named on the contract or settlement as the remainder beneficiary or the Department and any other state that provided medical assistance to the individual under such state's Medicaid program may be named as remainder beneficiary up to the amount of Medical Assistance paid on behalf of the individual.

h) The trust shall provide that, upon the death of the beneficiary or termination of the trust, the Department and any other state that provided medical assistance to the individual under such state's Medicaid program shall receive all amounts remaining in the trust up to the amount of total ~~Medical~~ medical ~~Assistance~~ assistance paid on behalf of the individual. If the trust does not have sufficient funds to reimburse each state in full, the amount remaining in the trust shall be distributed based on each state's proportionate share of the total amount of medical assistance benefits paid by all of the states on the individual's behalf.

i) No expenditures may be made after the death of the beneficiary, except for federal and state taxes. However, prior to the death of the individual beneficiary, trust funds may be used to purchase a burial fund for the beneficiary.

j) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.

k) The trust fund shall not be considered as a countable resource in determining eligibility for Medical Assistance.

l) [Rule 8.110.52 B 5. b. 1) l), adopted or amended on or after November 1, 2000 and before November 1, 2001 was not extended by HB 02-1203, and therefore expired May 15, 2002.]

m) Distributions from the trust may be made only to or for the benefit of the individual beneficiary. Cash distributions from the trust shall be considered income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.

n) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward eligibility.

o) The trust must include the name and mailing address of the trustee. The Department must be notified of any trustee address changes or change of trustee(s) within 30 calendar days.

p) The trust must provide that an ~~annual~~ accounting of trust income and expenditures and ~~an annual~~ statement of trust assets shall be submitted to the eligibility site ~~or~~ and to the Department on an annual basis and upon reasonable request or ~~upon~~ any change of trustee. Further, the

trust must provide that the trustee is required to give the Department notice of any distribution in excess of $5,000 no later than thirty (30) days after such distribution. The Department shall acknowledge receipt within thirty (30) days of receiving the notice.

q) Prior to the establishment or funding of a disability trust, the trust shall be submitted for review to the Department, along with proof that the individual beneficiary is disabled according to Social Security criteria. No disability trust shall be valid unless the Department has reviewed the trust and determined that the trust conforms to the requirements of 15-14-412.8,C.R.S., as amended, and any rules adopted by the Medical Services Board.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Services, Sections 8.300.1 and 8.300.3.A.
Rule Number: MSB 20-03-02-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / / Raine Henry/303-866-4493

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 20-03-02-A, Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Services, Sections 8.300.1 and 8.300.3.A.

3. This action is an adoption of: an amendment

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

   Sections(s) 8.300.1.AA. and 8.300.3.A., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). 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.CC. Replace the current text at 8.300.3.A.3 through the end of 8.300.3.A.3. This rule is effective June 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 Inpatient Hospital Services, Sections 8.300.1 and 8.300.3.A.
Rule Number: MSB 20-03-02-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / / Raine Henry/303-866-4493

STATEMENT OF BASIS AND PURPOSE

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

   This rule revision will change the reimbursement structure for deliveries at 8.300.3.A.3. Specifically, it will separate reimbursement for a mother's hospitalization during and after delivery from reimbursement for a newborn's hospitalization after delivery. A corresponding change is being made to the definition of Trim Point Day (Outlier Threshold Day) at what would now be 8.300.1.AA. These claims are currently combined because historically it took too long for the Department to provide hospitals with new member IDs for neonates. Hospital stakeholders have informed the Department that this is no longer the case. Additionally, the change is necessary in order to institute updates to the All Patient Refined Diagnosis Related Groups (APR-DRG).

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 25.5-5-325, C.R.S (2019)

Initial Review	**04/10/2020**	Final Adoption	**05/08/2020**
Proposed Effective Date	**06/30/2020**	Emergency Adoption	

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Services, Sections 8.300.1 and 8.300.3.A.
Rule Number: MSB 20-03-02-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / / Raine Henry/303-866-4493

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 Department expects this to result in decreased payments to some hospitals, increased payments to others and to have an overall budget neutral impact.

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 expects this change to add clarity and efficiency to claims processing for providers and the Department.

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

   The Department does not expect there to be a cost associated with this change to delivery services reimbursement.

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

   The benefit of this change is increased clarity and efficiency of claim reimbursement for providers and the Department. There are no anticipated costs associated with this rulemaking.

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 intrusive methods for achieving the purpose of the proposed rule revisions.

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

   There are no alternative methods for making the proposed change to delivery services reimbursement.

8.300 HOSPITAL SERVICES

8.300.1 Definitions

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

8.300.1.B. 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.

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

8.300.1.D. Department means the Department of Health Care Policy and Financing.

8.300.1.E. 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.

8.300.1.F. 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.

8.300.1.G. 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.

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

8.300.1.I. 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.

8.300.1.J. 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.

8.300.1.K.

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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

7. 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.

8. A Medicare Dependent Hospital is defined as set forth at 42 C.F.R § 412.103. 42 C.F.R. § 412.108(1) (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 § 24-4-410(12.5)(V)(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.

9. 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.

8.300.1.L. 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.

8.300.1.M. 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.

8.300.1.N. Medical Necessity is defined at Section 8.076.1.~~.~~

8.300.1.O. 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.

8.300.1.P. 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.

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

8.300.1.R. 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.

8.300.1.S. 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.

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

8.300.1.U. 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.

8.300.1.V. 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.

8.300.1.W. 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.

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

8.300.1.Y. 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.

8.300.1.Z. 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."

8.300.1.AA. Trim Point Day (Outlier Threshold Day) means the day during an inpatient stay after which Outlier Days are counted. The Trim Point Day occurs 2.58 standard deviations above the average length of stay for each DRG. Beginning July 1, 2020, the Trim Point Day for delivery and neonate DRGs is equal to the Trim Point Day as calculated in the applicable Hospital-Specific Relative Value National File for Delivery and Neonate DRGs~~which would occur 2.58 standard deviations above the mean (average) length of stay (ALOS) for each DRG~~.

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

8.300.1.CC. 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.

[SECTION 8.300.2 IS UNAFFECTED BY THIS RULE CHANGE, PLEASE LEAVE IT AS IS]

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. Inpatient Hospital services include:

   a. bed and board, including special dietary service, in a semi-private room to the extent available;

   b. professional services of hospital staff;

c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;

d. emergency room services;

e. drugs, blood products;

f. medical supplies, equipment and appliances as related to care and treatment; and

g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.

2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

3. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

~~Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.~~

4. Psychiatric Hospital Services

Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-network Hospital.

a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.

b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:

i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and

ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

5. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-network DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or

b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or

c. placement or repair of the dialysis route (“shunt”, “cannula”).

8.300.3.B Covered Hospital Services – Outpatient

[SECTIONS 8.300.3.B THROUGH 8.300.3.C UNAFFECTED BY THIS RULE CHANGE, PLEASE LEAVE THOSE SECTIONS AS THEY ARE]

8.300.4 Non-Covered Services

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.

2. Inpatient Hospital Services which are not a covered Medicare benefit.

3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department’s utilization review vendor or other Department representative.

4. Days awaiting placement or appropriate transfer to a lower level of care are not a covered benefit unless otherwise Medically Necessary.

5. Substance abuse rehabilitation treatment is not covered unless individuals are aged 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement.