DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Federally Qualified Health Center Reimbursement, Section 8.700.6
Rule Number: MSB 21-05-10-A
Division / Contact / Phone: Rates Division / Erin Johnson / 4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-05-10-A, Revision to the Medical Assistance Rule Concerning Federally Qualified Health Center Reimbursement, Section 8.700.6

3. This action is an adoption of: an amendment

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

   Sections(s) 8.700.6, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700.6.D.4.d with the proposed text beginning at 8.700.6.D.4.d through the end of 8.700.6.D.4.d. This rule is effective October 10,2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Federally Qualified Health Center Reimbursement, Section 8.700.6
Rule Number: MSB 21-05-10-A
Division / Contact / Phone: Rates Division / Erin Johnson / 4370

STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this rule revision is to adjust the FQHC rate setting process to consider the changes in utilization and cost due to Covid-19. The pandemic has caused utilization to drop at FQHCs and costs have changed as well. To avoid setting unreasonable rates, this rule revision will set rates for FQHC cost reports with fiscal year ends between May 31, 2021 and March 31, 2022 using the previous year's rates multiplied 2.7%. The previous year's rates set using cost reports with fiscal year ends between May 31, 2020 and March 31, 2021 were set using the previous year's rates multiplied by the Medicare Economic Index (MEI).

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C.A § 1396a(bb).

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Sections 25.5-5-408(1)(d), C.R.S. (2021)

Initial Review Final Adoption
Proposed Effective Date Emergency Adoption

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Federally Qualified Health Center Reimbursement, Section 8.700.6
Rule Number: MSB 21-05-10-A
Division / Contact / Phone: Rates Division / Erin Johnson / 4370

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.

   Federally Qualified Health Centers will be impacted by this rule. This rule revision will set reasonable FQHC rates for time periods where costs and visits were dramatically impacted by the Covid-19 pandemic. FQHCs will benefit from this rule because their rates will neither skyrocket nor drop due to the extreme changes caused by the pandemic.

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

   FQHC rates will increase by 2.7%. FQHC rates usually increase annually by an overall average of 2.3% per year. However, due to Covid-19 related changes to cost and utilization, the Department believes 2.7% is a more reasonable increase.

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

   This rule revision will impact the Department and State revenues. Instead of having unpredictable and potentially very high FQHC rates, we will have predictable and reasonable FQHC rates for the near future. The Department will be better able to budget FQHC payments and not see an alarming increase in FQHC payments.

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

   If the Department does not adopt this rule change, FQHC rates will be more unstable and less predictable. It is likely FQHC rates will increase greatly, causing the Department to spend more on FQHCs than expected.

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

DO NOT PUBLISH THIS PAGE

There are no other methods that are less costly or less intrusive to achieve 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.

   The Department has considered other ways to set FQHC rates such as using estimates for pandemic months or another inflationary factor, such as the MEI. The inflationary factor of 2.7% was chosen based on historical FQHC data and information from FQHC's experience during the pandemic.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.6 REIMBURSEMENT

8.700.6.A FQHCs shall be reimbursed separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: physical health encounter, dental encounter, or specialty behavioral health encounter. Distinct dental encounters are allowable only when rendered services are covered and paid by the Department's dental Administrative Service Organization (ASO). Distinct specialty behavioral health encounters are allowable only when rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy.

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

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

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

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

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

8. Antagonist injections for substance use disorders provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

9. COVID-19 vaccine administration provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department

10. Monoclonal Antibody COVID-19 infusion administration provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

8.700.6.C A physical health encounter, a dental encounter, and a specialty behavioral health encounter on the same day and at the same location shall count as three separate visits.

1. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.700.6.D Encounter rates calculations

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 portion of the FQHCs physical 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.

c. Effective December 11, 2020, FQHC cost reports with fiscal year ends between May 31, 2020 and March 31, 2021 will be set using the previous year's rates multiplied by the Medicare Economic Index (MEI).

d. Effective September 28, 2021, FQHC cost reports with fiscal year ends between May 31, 2021 and March 31, 2022 will be set using the previous year's rates multiplied by 2.7%.

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 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, 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.

8.700.6.E The Department shall notify the FQHC of its rates.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the RHC Rule Concerning Adding Provider Types to RHC Visit, Section 8.740
Rule Number: MSB 21-05-24-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-05-24-A, Revision to the RHC Rule Concerning Adding Provider Types to RHC Visit, Section 8.740

3. This action is an adoption of: an amendment

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

   Sections(s) 8.700, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? 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 8.740.4.A.1.a with the proposed text beginning at 8.740.4.A.1.a through the end of 8.740.4.A.1.a. Replace the current text at 8.740.6.A.3 with the proposed text beginning at 8.740.6.A.3 through the end of 8.740.6.A.3. This rule is effective October 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the RHC Rule Concerning Adding Provider Types to RHC Visit, Section 8.740
Rule Number: MSB 21-05-24-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this rule is to change the definition of a payable encounter at Rural Health Clinics. The amended rule adds licensed professional counselors, licensed marriage and family therapists, and licensed addiction counselors to the provider types that can generate a billable encounter.

   This rule is necessary to maintain access to mental health services at RHCs. Without the rule, RHCs would be unable to provide services with the provider types that had been providing the services in the past. The change maintains care practices that have been present since prior to July 1, 2018.

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:

   1902(bb) SSA

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

Initial Review | Final Adoption
Proposed Effective Date | Emergency Adoption

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the RHC Rule Concerning Adding Provider Types to RHC Visit, Section 8.740
Rule Number: MSB 21-05-24-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

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.

   Medicaid clients that receive care at Rural Health Clinics will be impacted by this rule. The emergency rule will support access to care and continuity of care at RHCs. No class of persons will bear any costs of the proposed rule. Medicaid clients will benefit from the proposed rule.

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

   The proposed impact is neutral to Medicaid clients. The services were available at RHCs previously through the behavioral health managed care program. Medicaid policy changed to allow these services through fee for service coverage.

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 probable with this rule change. It continues coverage of the services with no change to the payment mechanism. Overall, this policy change is expected to save funds when implemented by all providers including RHCs.

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

   There are no probable costs associated with the proposed rule. Probable benefits of action will align coverage between RHCs and FQHCs and other behavioral health providers. With inaction, there may be some probable cost savings due to RHC providers being unable to be paid for a subset of behavioral health services. There are no foreseen probable benefits of inaction. Probable detriments are that many Medicaid clients in rural areas will have their behavioral health treatment fragmented. RHCs will not be able to provide these services and be paid.

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

DO NOT PUBLISH THIS PAGE

There are no other methods that are less costly or less intrusive to achieve 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.

   The Department has considered not changing the rule as an alternative method to achieve the integration of physical and mental health. That method would have been detrimental to the integration of the short term behavioral health policy. There is no other way to pay for the RHC services except through the Prospective Payment System methodology under the Social Security Act (Title XIX, Section 1902(bb)). The short-term behavioral health policy fosters integration of physical and behavioral health from a single health care entity. To facilitate integration without this rule for RHCs would be to abandon the short-term behavioral health policy for a large number of clients living in rural areas because there would be no way to pay for these services. The alternative methods would not achieve the purpose of this rule.

8.740 RURAL HEALTH CLINICS

8.740.1 DEFINITIONS

Rural Health Clinic means a clinic or center that:

1. Has been certified as a Rural Health Clinic under Medicare.

2. Is located in a rural area, which is an area that is not delineated as an urbanized area by the Bureau of the Census.

3. Has been designated by the Secretary of Health and Human Services as a Health Professional Shortage Area (HPSA) through the Colorado Department of Public Health and Environment.

4. Is not a rehabilitation facility or a facility primarily for the care and treatment of mental diseases.

Visit means a face-to-face encounter, or an interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounter between a clinic client and any health professional providing the services set forth in 8.740.4. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care

8.740.2 REQUIREMENTS FOR PARTICIPATION

8.740.2.A. A Rural Health Clinic shall be certified under Medicare.

8.740.2.B. A Rural Health Clinic providing laboratory services shall be certified as a clinical laboratory in accordance with 10 C.C.R 2505-10, Section 8.660.

8.740.3 CLIENT CARE POLICIES

8.740.3.A. The Rural Health Clinic’s health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the Rural Health Clinic staff.

8.740.3.B. The policies shall include:

1. A description of the services the Rural Health Clinic furnishes directly and those furnished through agreement or arrangement. See section 8.740.4.A.4.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the Rural Health Clinic.

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

8.740.4 SERVICES

8.740.4.A. The following services may be provided by a certified Rural Health Clinic:

1. General services

    a. Outpatient primary care services that are furnished by a physician assistant, clinical psychologist, clinical social worker, nurse practitioner, ~~or~~ nurse midwife, licensed professional counselor, licensed marriage and family therapist, or licensed addiction counselor as defined in their respective practice acts.

    b. Part-time or intermittent visiting nurse care.

    c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.740.4.A.1.a and b.

2. Laboratory services. Rural Health Clinics furnish basic laboratory services essential to the immediate diagnosis and treatment of the client.

3. Emergency services. Rural Health Clinics furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

4. Services provided through agreements or arrangements. The Rural Health Clinic has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including inpatient hospital care; physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the Rural Health Clinic.

8.740.5 PHYSICIAN RESPONSIBILITIES

8.740.5.A. A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on client referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.740.6 ALLOWABLE COSTS

8.740.6.A. The following types and items of cost shall be included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician who owns, is employed by, or furnishes services under contract to a Rural Health Clinic.

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

3. Costs of services and supplies incident to the services of a physician, physician assistant, clinical psychologist, clinical social worker, nurse practitioner, ~~or~~ nurse-midwife, licensed professional counselor, licensed marriage and family therapist, or licensed addiction counselor.

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

5. Costs of services purchased by the Rural Health Clinic.

8.740.7 REIMBURSEMENT

8.740.7.A. The Department shall reimburse Rural Health Clinics a per visit encounter rate. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.740.7.B. The encounter rate shall be the higher of:

1. The Prospective Payment System (PPS), as 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, BIPA is incorporated herein by reference. No amendments or later editions are incorporated. The Acute Care Benefits Section Manager at the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of BIPA, or the materials may be examined at any publications depository library.

2. The Medicare rate.

   a. The Medicare rate for hospital based Rural Health Clinics with fewer than 50 beds shall be based on actual costs.

   b. The Medicare rate for all other Rural Health Clinics is the Medicare upper payment limit for Rural Health Clinics.

8.740.7.C. The Department will reimburse Long-Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices separate from the Rural Health Clinic per visit encounter rate. Reimbursement will be the lower of:

1. 340B acquisition costs;

2. Submitted charges; or

3. Fee schedule as determined by the Department.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital High Acuity Rate Negotiation, Section 8.300.5
Rule Number: MSB 21-05-26-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 21-05-26-A, Revision to the Medical Assistance Act Rule concerning Inpatient Hospital High Acuity Rate Negotiation, Section 8.300.5

3. This action is an adoption of: an amendment

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

   Sections(s) 8.300.5, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Revise the current text at 8.300.5 with the newly proposed text beginning at 8.300.5.G through the end of 8.300.5.G. This rule is effective October 10, 2021.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule adds inpatient hospital reimbursement rate negotiation for in-state services where the payment methodology insufficiently accounts for the level of acuity, all other placement options have been exhausted, and the service has been reviewed and authorized by the Department's Medical Director. The change will allow the Department to reimburse inpatient hospitals at a rate which more closely aligns with the hospital cost experiences in such circumstances. This rate negotiation authority is needed to maintain access to care for high-needs members. Rates paid to certain managed care organizations may include corresponding changes, as the Department pays these rates based on fee-for-service expenditures.

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.

3. Federal authority for the Rule, if any:

   42 CFR 440.10 (2021)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Section 25.5-5-102(1)(a), C.R.S. (2021)

Initial Review

Proposed Effective Date

Final Adoption

Emergency Adoption

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REGULATORY ANALYSIS

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

   High acuity members, for which the in-state hospital payment methodology is insufficient and all other placement options have been exhausted—as determined by the Department's Medical Director, and inpatient hospitals rendering such high acuity services are affected by the proposed rule. The Department bears the cost of the proposed rule. High acuity members benefit from the proposed rule by facilitating access to inpatient hospital services where all other placement options have been exhausted.

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

   High acuity members are impacted by this proposed rule by providing a reimbursement mechanism that facilitates in-state inpatient hospital services where all other placement options have been exhausted.

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 anticipates that this proposed rule will have a budget impact of $500,768, including $219,336 General fund in FFY 2020-21 and $909,354, including $440,582 General Fund in FFY 2021-22.

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

   The cost of the proposed rule is higher negotiated reimbursement rates for in-state inpatient hospital services that fit the criteria. The benefit of the proposed rule is providing a reimbursement mechanism that facilitates in-state inpatient hospital services where the inpatient hospital methodology is insufficient for the level of acuity and all other placement options have been exhausted. The cost of inaction is inability to secure in-state inpatient hospital services for high acuity members where the inpatient hospital payment methodologies are insufficient to account for the

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level of acuity and all other placement options have been exhausted. There are no benefits to inaction.

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

   The proposed rate negotiation would apply only where all other placement options have been exhausted and the in-state inpatient payment methodology insufficiently accounts for the level of acuity. By necessity, other placement options must be considered before negotiating a higher rate.

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

   The Department exhausted all traditional placement options for high acuity cases but was unable to secure appropriate placement under the standard reimbursement.

8.300 HOSPITAL SERVICES

8.300.5 Payment for Inpatient Hospital Services

8.300.5.G Payment for High Acuity In-State Services

1. The Department may negotiate a higher reimbursement rate for in-state inpatient hospital services where:

   a. The in-state inpatient payment methodology insufficiently accounts for the level of acuity;

   b. All other placement options have been exhausted; and

   c. The services have been reviewed and authorized by the Medical Director for the Department.