DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning CHCBS Cost Containment Rule Revision, Section 8.506
Rule Number: MSB 21-06-04-A
Division / Contact / Phone: Case Management and Quality Performance / Karli Altman / 303-866-4032

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-06-04-A, Revision to the Medical Assistance Rule concerning CHCBS Cost Containment Rule Revision, Section 8.506

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) 8.506, 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 No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes
   Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.506 with the proposed language beginning at 8.506.3 through the end of 8.506.12.H. This rule is effective April 30, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning CHCBS Cost Containment Rule Revision, Section 8.506
Rule Number: MSB 21-06-04-A
Division / Contact / Phone: Case Management and Quality Performance / Karli Altman / 303-866-4032

STATEMENT OF BASIS AND PURPOSE

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

   The rules implementing the cost containment process, 10 C.C.R. 2505-10, Sections 8.506, are being updated to reflect the removal of the requirement for Case Managers to submit a Cost Containment Form to the Utilization Review Contractor (URC) when the cost of an individual's services increases or decreases by a Department prescribed amount. Additionally, the rules will be updated to add in the requirement for Case Managers to submit a review to the URC not only upon initial enrollment into the HCBS-CHCBS waiver, but also at annual certification to ensure the individual continues to meet targeting criteria for the waiver.

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

   Explain:

2. Federal authority for the Rule, if any:

3. State Authority for the Rule:

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

Initial Review **02/11/22** Final Adoption **03/11/22**
Proposed Effective Date **04/30/22** Emergency Adoption

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning CHCBS Cost Containment Rule Revision, Section 8.506
Rule Number: MSB 21-06-04-A
Division / Contact / Phone: Case Management and Quality Performance / Karli Altman / 303-866-4032

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.

   No costs have been identified. Case managers and members will benefit from no longer having to complete the cost containment review process. The Department will realize cost savings from revising the CHCBS review process.

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 revision of these rules to remove the cost containment process is a result of policy changes will remove duplicative work being done by contracted vendors, creating a savings to the Department. It will also discontinue use of an outdated form and review process that provides little to no value to the department. Members will have a better experience and case managers will have less paperwork.

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 is no anticipated cost/impact; a cost savings will be realized.

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

   Continuing the status quo would result in payment to vendors to complete duplicative work, continuing to have members and case managers complete a form and process that does not result in any meaningful benefit or value to the member or department.

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

   This was the most cost effective and least intrusive method of resolving the duplication in cost containment reviews. This change will be less intrusive;

information the department already has access to will no longer be requested directly from the member and information that is not used in a meaningful way will no longer be obtained from the member.

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 policy decision requiring this rule change was made following consideration of the option to continue the review process. That options were adopted because it would not result in savings to the department; did not decrease administrative burden to the case management agencies or did not improve quality of administration and oversight of the program.

8.506 CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

8.506.1 Legal Basis:

The Children's Home and Community -based Services program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CHCBS program is also authorized under state law at Section 25.5-6-901, et seq. C.R.S.

8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.506.3.B and the additional operations specifically defined for this waiver in Section 8.506.4.B.

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552

8.506.3 General Definitions

A. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved instrument to complete assessments.

B. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs. Additional operations specifically defined for this waiver are described in Section 8.506.4.B.

C. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency.

D. Continued Stay Review means a reassessment by the case manager to determine the Client's continued eligibility and functional level of care.

E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital or skilled nursing facility.

F. County Department means the Department of Human or Social Services in the county where the resident resides.

G. Department means the Department of Health Care Policy and Financing.

H. Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.

I. Functional Eligibility means that the Client meets the criteria for long-term care services as determined by the Department's prescribed instrument.

J. Institutional Placement means residing in an acute care hospital or nursing facility.

K. Intake/Screening/Referral means the initial contact with individuals by the Case Management Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

L. Performance and Quality Review means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by a Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements.

M. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery and utilization of services.

M. Professional Medical Information Page (PMIP)Client means the medical information form signed by a licensed medical professional used to certify Level of Care.

N. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking or receiving services of his or her rights and responsibilities.

O. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1

P. Utilization Review Contractor (URC) means the ~~the~~ agency or agencies contracted with the Department to review the CHCBS waiver application for confirmation that functional eligibility and targeting criteria are met.

8.506.4 Benefits

8.506.4.A Home and Community-based Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at Section 26-1-114, C.R.S.

2. Case Management Agencies will complete all administrative functions of a Client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

   a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of Client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.

b. At the time of making the initial face-to-face contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.

c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

d. Verify that the child meets the eligibility requirements outlined in Client Eligibility, Section 8.506.6.

e. Submit the assessment and documentation ~~of the enrollment application~~ to the URC to ensure the targeting criteria and functional eligibility criteria are met. Minimum documents required:

~~i. Initial Enrollment Form~~

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the approved ~~initial enrollment form~~ certification to the County Department for activation of a Medicaid State Identification Number.

g. Develop the Support Planning document in accordance with Section 8.506.4.B.7.

~~h. Develop a Cost Containment Record in accordance with Section 8.506.12 at the time that the Support Planning is completed.~~

i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with Section 8.506.10.

4. Continued Stay Review

a. Complete a new Assessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved ~~by the URC~~. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

b. Submit the assessment and documentation to the URC to ensure the targeting criteria and functional eligibility criteria are met.

c. Review and revise the Support Planning document in accordance with Section 8.506.4.B.7.

~~c. Calculate expected costs to the Medicaid Program, as set forth in Section 8.506.12, for the redetermination period.~~

d. Notify the county technician of the renewed Long-term Care certification.

5. Discharge/Withdrawal

a. At the time that the Client no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:

i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.

~~ii. Submit a Department designated Discharge form to the URC.~~

iii. Submit PAR termination to the Department's Fiscal Agent.

iv. Notify County Department of termination.

v. Notify agencies providing services to the Client that the child has been discharged from the waiver.

6. Transfers

a. Sending agency responsibilities:

i. Contact the receiving case management agency by telephone and provide notification that:

1) The child is planning to transfer, per the parent(s) or guardian choice.

2) Negotiate an appropriate transfer date.

3) Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.

ii. Using a State designated form, notify the URC of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.

iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual 9 CCR 2503-5 Section 3.560 Case Transfers.

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, ~~Sectino~~Section 3.560 is available at Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

b. Receiving agency responsibilities

i. Conduct a fact-to-face visit with the child within ten (10) working days of the child's transfer. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.)., and

ii. Review and revise the Support Planning document ~~and the Prior Approval Cost Containment Record~~ and change or coordinate services and providers as necessary.

7. Support Planning

a. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community-based services. A signature from the parent(s) or guardian is required on this state designated form.

b. Documentation that the Client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the Client understands his/her right to change providers

b. On a monthly basis, evaluate the effectiveness of the Support Planning document by monitoring services provided to the child. This monitoring may include:

i. Conducting child, parent(s) or guardian, and provider interviews.

ii. Reviewing ~~cost~~ utilization data.

iii. Reviewing any written reports received.

8. Performance and Quality Review

a. The Department shall conduct a Performance and Quality Review of the Children's Home and Community-based Services program to ensure that the Case Management Agency is in compliance with all statutory and regulatory requirements.

b. A Case Management Agency found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but not limited to:

i. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;

ii. A detailed timeframe for completing the actions to be taken;

iii. The employee(s) responsible for implementing the actions; and

iv. The estimated date of completion.

c. The Case Management Agency shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The Case Management Agency shall explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.

i. Upon receipt of the proposed Corrective Action Plan, the Department will notify the Case Management Agency in writing whether the Corrective Action Plan has been accepted, modified, or rejected.

ii. In the event that the Corrective Action Plan is rejected, the Case Management Agency shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

iii. The Case Management Agency shall begin implementing the Corrective Action Plan upon acceptance by the Department.

iv. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.506.4.C In Home Support Services:

1. IHSS for CHCBS Clients shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.

2. Family members of a Client can only be reimbursed for extraordinary care.

8.506.4.D CHCBS Clients are eligible for all other Medicaid state plan benefits.

8.506.5 Non-Benefit

8.506.5.A Tasks defined as Personal Care or Homemaker in Section 8.552 are not benefits of this waiver.

8.506.6 Client Eligibility

8.506.6.A An eligible Client shall meet the following requirements:

1. Targeting Criteria:

a. Not have reached his/her eighteenth (18th) birthday.

b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Functional Eligibility:

a. The URC certifies, through the Case Management Agency completed assessment, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.

3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.

4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

8.506.6.B Financial Eligibility

1. Parental income and/or resources will result in the child being ineligible for Medicaid benefits.

2. The income and resources of the child do not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance

3. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, Long-Term Care Medical Assistance Eligibility, Consideration of Trusts in Determining Medicaid Eligibility, Section 8.100.7.E.

8.506.6.C Roles of the County Department

1. Processing the Disability Determination Application through the contracted entity determined by the Department.

2. Certify that the child's income and/or resources does not exceed 300% of SSI.

3. Ensure that the parent(s) or guardian is in contact with a case management agency.

4. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility within five (5) workings days of determination.

8.506.7 Waiting List

8.506.7.A The number of Clients who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.

8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

8.506.7.C The waiting list shall be maintained by the URC.

8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the URC will use for the individual's placement on the waiting list.

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the URC will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the URC that an opening for the CHCBS waiver is available the Case Management Agency shall:

1. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

2. Update the existing functional level of care assessment in the official Client record.

3. Reassess for eligibility criteria as set forth at 8.506.6.

4. Notify the URC of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.8 Provider Eligibility

8.506.8.A Providers shall enter into an agreement with the Department to conform to all federal and state established standards for the specific service they provide under the HCBS-CHCBS waiver.

8.506.8.B Providers must comply with the requirements of Section 8.130.

8.506.8.C Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure statute and regulations.

8.506.8.D IHSS providers shall comply with IHSS Rules in Section 8.552.

8.506.9 Provider Responsibilities

8.506.9.A CHCBS providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining, and terminating employees;

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to Section 19-3-307 C.R.S.

8.506.9.B CHCBS Providers shall:

1. Ensure a Client is not discontinued or refused services unless documented reasonable efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure Client records and documentation of services are made available at the request of the case manager, Department, or URC.

3. Ensure that adequate records are maintained.

    a. Client records shall contain:

        i. Name, address, phone number and other identifying information for the Client and the Client's parent(s) and/or legal guardian(s).

        ii. Name, address and phone number of child's Case Manager.

        iii. Name, address and phone number of the Client's primary physician.

        iv. Special health needs or conditions of the Client.

        v. Documentation of the specific services provided, including:

            a. Name of individual provider.

            b. The location for the delivery of services.

            c. Units of service.

            d. The date, month and year of services and, if applicable, the beginning and ending time of day.

        x. Documentation of any changes in the Client's condition or needs, as well as documentation of action taken as a result of the changes.

        xi. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.2.

        xii. Documentation of communication with the Client's case manager.

        xiii. Documentation of communication/coordination with any additional providers.

    b. Personnel records for each employee shall contain:

        i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

        ii. Documentation of training.

        iii. Documentation of supervision and performance evaluation.

        iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.506.

        v. A copy of the employee's job description.

4. Ensure all care provided is coordinated with any other services the Client is receiving.

8.506.9.C Responsibilities specific to IHSS Provider Agencies

1. Eligible IHSS Agencies will conform to all certification standards set forth at 10 C.C.R 2505-10, Section 8.552.5

2. IHSS Agencies will adhere to all responsibilities outlined at 10 C.C.R. 2505.10, Section 8.552.6

3. Ensure that only Health Maintenance Activities are delivered to CHCBS Clients through the IHSS benefit.

8.506.9.D Responsibilities Specific to Case Management Agencies

1. Case Management Agencies will obtain a specific authorization to provide CHCBS case management benefits to Clients as set forth in Provider Enrollment Section 8.487.

2. Verify that the IHSS care plan developed by IHSS providers is in accordance with both Sections 8.506.4.C and 8.552 of this volume.

3. Case Management Agencies must submit all documentation requested by the Department to complete a Performance and Quality Review within the timeframe specified by the Department.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the Support Planning document.

8.506.10.C The first date for which services can be authorized is the latest date of the following:

1. The financial eligibility start date, as determined by the financial eligibility site.

2. The assigned start date on the certification page of the Assessment.

3. The date, on which the Client's parent(s) and/or legal guardian signs the Support Planning document or Intake form, as prescribed by the Department, agreeing to receive services.8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Assessment.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Support Planning document results in a change in services.

8.506.10.F The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.

8.506.10.G Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.

8.506.10.H The Long-Term Care Notice of Action Form (LTC-803) shall be completed in the Information Management System (IMS) (as defined at 8.519.1.Z) for all applicable programs at

the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, or at the time of discontinuation.

8.506.11 Reimbursement

8.506.11.A Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

8.506.12 Cost Containment

8.506.12.A The Department is responsible for ensuring that, on average, services delivered to the child are within the Department's cost containment requirements for the respective level of institutional care. Cost Containment includes;

1. Waiver benefit services and units, as defined at 8.506.2.

2. State Plan benefit services and units.

8.506.12.B The case manager must ~~identify costs~~ensure cost effectiveness as part of the Support Planning ~~document~~process. ~~This Cost Containment Record shall be on a Department prescribed form and include all estimated:~~

~~1. Waiver benefit services and units, as defined at 8.506.2.~~

~~2. State Plan benefit services and units.~~

8.506.12.C The costs of the benefit services ~~identified in the Cost Containment Record~~ shall be totaled and divided by the number of days remaining before the end of the child's current enrollment period.

8.506.12.D The cost per day for the child shall be compared against the Department designated cost per day of institutional care to determine cost effectiveness.

~~8.506.12.E The Case Manager will revise the child's Cost Containment Record anytime that a significant change in the Support Planning document results in an increase or change in the services to be provided.~~

~~8.506.12.F The Case Manager will submit the Cost Containment Record to the URC for approval at the time of the child's initial enrollment onto the CHCBS waiver, or any time that a revision to the Cost Containment Record increases by a Department prescribed amount.~~

~~8.506.12.G Approval of the Cost Containment Record by the Department only ensures that the cost of the services does not exceed the equivalent cost of the appropriate institutional care.~~

~~8.506.12.H Approval of the Cost Containment Record form does not constitute approval of Medicaid reimbursement for authorized services identified within the record.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospice Room and Board, Section 8.550.9.C
Rule Number: MSB 22-01-17-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 22-01-17-A, Revision to the Medical Assistance Act Rule concerning Hospice Room and Board

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) 8.550.9.C, 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 8.550.9.C with proposed text beginning at 8.550.9.C through the end of 8.550.9.C. This rule is effective April 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospice Room and Board, Section 8.550.9.C
Rule Number: MSB 22-01-17-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule implements Colorado Senate Bill 21-214, which establishes a state-only room and board payment to qualified hospice providers that render hospice care in a licensed hospice facility to an eligible Medicaid-enrolled member who has a hospice diagnosis, is eligible for nursing facility care and, despite attempts to secure a bed, is unable to secure a Medicaid bed in a nursing facility due to COVID-19 impacts, complexity of medical care, behavioral health issues, or other issues as determined by the Department. Room and board reimbursement is available to qualified hospice providers who provided such services during the period beginning the last quarter of the 2020-21 state fiscal year through the 2021-22 state fiscal year, within existing appropriations.

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:

   Not applicable, this is a state-only payment.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   CRS § 25.5-4-424 (2021)

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 Act Rule concerning Hospice Room and Board, Section 8.550.9.C
Rule Number: MSB 22-01-17-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Eligible patients enrolled in Medicaid who are eligible for nursing facility care, have a hospice diagnosis, and, despite attempts to secure a bed, are unable to secure a Medicaid bed in a nursing facility due to COVID-19 impacts, complexity of medical care, behavioral issues, or other issues as determined by the Department are affected by this rule, as are the qualified hospice providers who provide room and board to such patients where nursing facility beds are unavailable.

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 will improve access to room and board for eligible patients and, within existing appropriations, provide state-only payment to the qualified hospice providers who provide room and board to such patients.

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

   The proposed rule will increase General Fund expenditures for the Department of Health Care Policy and Financing by $684,000 for expenditures beginning in state fiscal year 2020-21 and ending in state fiscal year 2021-22. This assumes an average of 13 patients per day will receive hospice services at an average state per diem rate of $115.38 for 456 days. For state fiscal year 2020-21, the authorizing statute includes a General Fund appropriation of $684,000 to the Department. Funds not expended prior to July 1, 2021, are further appropriated for state fiscal year 2021-22.

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

   The costs of the proposed rule are detailed in question #3. The benefit of the proposed rule is implementing the statutory mandate in CRS § 25.5-4-424 and providing state payment for room and board payment for qualified patients as

detailed in questions #1 and #2. The cost of inaction is failure to implement the statutory mandate in CRS § 25.5-4-424. There are benefits to inaction.

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

   There are no less costly methods or less intrusive methods to implement the state-only hospice room and board payment mandated in CRS § 25.5-4-424

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 implementing the state-only hospice room and board payment mandated in CRS § 25.5-4-424.

8.550 HOSPICE BENEFIT

8.550.9 REIMBURSEMENT

8.550.9.C. State-Only Hospice Room and Board Reimbursement

1. As used in this section, unless context otherwise requires:

   a. "Eligible Patient" means a person who is enrolled in Colorado Medicaid at the time the service is provided and who:

      i) Is eligible under Colorado Medicaid for care in a nursing facility at the time the service is provided;

      ii) Has a hospice diagnosis; and

      iii) Despite attempts to secure a bed, is unable to secure a Medicaid bed in a nursing facility due to COVID-19 impacts, complexity of medical care, behavioral health issues, or other issues as determined by the Department.

   b. "Qualified Hospice Provider" means a hospice provider that:

      i) Has been continuously enrolled with the Department since at least January 1, 2021;

      ii) Provided hospice services to the eligible patient in a licensed hospice facility during the period beginning in the last quarter of the 2020-2021 state fiscal year through the 2021-2022 state fiscal year; and

      iii) Complies with any billing or administrative requests of the Department for purposes of determining eligibility for and administering the state payment.

2. Qualified Hospice Providers who provide hospice care in a licensed hospice facility to an Eligible Patient may receive a room and board payment equal to one-half (1/2) of the statewide average per diem rate, as defined in C.R.S. § 25.5-6-201. The payment is subject to the following limitations:

   a. Payment is limited to not more than twenty-eight (28) days per Eligible Patient.

   ~~a.~~b. No payments will be made after June 30, 2022 or after appropriations are exhausted, whichever occurs first, in accordance with C.R.S. § 25.5-4-424.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765, Section 8.765
Rule Number: MSB 22-01-17-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 22-01-17-B, Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765, Section 8.765

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) 8.765, 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 8.765 with the proposed text beginning at 8.765 through the end of 8.765.1. Insert the newly proposed text beginning at 8.765.14 through the end of 8.765.14.F. This rule is effective April 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765, Section 8.765
Rule Number: MSB 22-01-17-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).
   Revises the rules for child-serving residential facilities to include the new Qualified Residential Treatment Program (QRTP) license type. The new license type will take effect October 1, 2021 in accordance with the federal Family First Prevention Services Act (FFPSA) and there will be a grace period until June 30, 2022 for all facilities enrolled with Medicaid to be in compliance. The revision will allow the Department to reimburse new QRTP facilities in compliance with the FFPSA and align Department rule with the Colorado Department of Human Services' new QRTP license type. QRTPs will provide a trauma-informed model of care to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

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:

   Pub.L. 115-123, Div. E, Title VII, § 50734, Feb. 9, 2018, 132 Stat. 252

   42 CFR 440.160 (2021)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   CRS § 25.5-5-202(1)(i) (2021)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765, Section 8.765
Rule Number: MSB 22-01-17-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Members currently residing in Residential Child Care Facilities (RCCF), and RCCF providers, will be impacted by 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.

   RCCF providers will have costs associated with changing their model of care and the requirement that QRTPs be 16 beds or less. For our members, services provided in a QRTP will be trauma-informed and designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances, in a setting limited to 16 beds. Members who require this level of care will receive services within the state and better tailored to their needs.

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 the proposed rule to be budget neutral because RCCF services will be phased out and the same funds will be applied QRTP payment.

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

   The probable costs of the proposed rule are RCCF providers being required to obtain the Qualified Residential Treatment Program license. The probable benefit of the proposed rule is aligning with the Federal Family First Prevention Services Act (FFPSA) and aligning with Colorado Department of Human Services license requirements. The probable cost of inaction is non-compliance with the FFPSA. There are no probable benefits to inaction.

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

There are no less costly methods or less intrusive methods to align Department rule with the FFPSA and with Colorado Department of Human Services license requirements.

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 to align Department rule with the FFPSA and with Colorado Department of Human Services license requirements.

8.765 SERVICES FOR CLIENTS IN ~~PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES OR RESIDING IN~~ RESIDENTIAL CHILD CARE FACILITIES AS DEFINED BELOW

8.765.1 DEFINITIONS

Assessment means the process of continuously collecting and evaluating information to develop a client's profile on which to base a Plan of Care, service planning, and referral.

Clinical Staff means medical staff that are at a minimum licensed at the level of registered nurse, performing within the authority of the applicable practice acts.

Colorado Client Assessment Record (CCAR) means a clinical instrument designed to assess the behavior/mental health status of a medically eligible client. The CCAR is used to identify current diagnosis and clinical issues facing the client, to measure progress during treatment and to determine mental health medical necessity. This instrument is used for children in the custody of a county department of human/social services or Division of youth corrections and for those children receiving mental health services in an RCCF through the Child Mental Health Treatment Act.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the Colorado Medicaid program's benefit under Section 8.280 for children and adolescents that provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21.

Emergency Safety Intervention means the use of Restraint and Seclusion as an immediate response to an Emergency Safety Situation.

Emergency Safety Situation means unanticipated behavior of the client that places the client or others at serious threat of violence or injury if no intervention occurs and that calls for Emergency Safety Intervention.

Emergency Services means emergency medical and crisis management services.

Independent Assessment means a process to assess the strengths and needs of the child using an age-appropriate, evidence-based, validated, functional assessment tool. The assessment determines whether treatment in a Qualified Residential Treatment Program (QRTP) provides the most effective and appropriate level of care for the child in the least restrictive environment, in accordance with Colorado Department of Human Services regulations.

Independent Team means a team certifying the need for Psychiatric Residential Treatment Facility (PRTF) services that is independent of the Referral Agency and includes a physician who has competence in the diagnosis and treatment of mental illness and knowledge of the client's condition.

Interdisciplinary Team means staff in a PRTF comprised of a physician, and a Licensed Mental Health Professional, registered nurse or occupational therapist responsible for the treatment of the client.

Licensed Mental Health Professional means a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a psychiatrist licensed pursuant to part 1 of article 36 of title 12, C.R.S., a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S., or a social worker licensed pursuant to part 4 of article 43 or title 12, C.R.S., that is supervised by a licensed clinical social worker. Sections 12-43-301, et seq, 12-36-101, et seq, 12-43-401, et seq, 12-43-501, et seq and 12-43-601, et seq, C.R.S. (2005) are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available 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, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Medication Management Services means review of medication by a physician at intervals consistent with generally accepted medical practice and documentation of informed consent for treatment.

Multidisciplinary Team means staff in a Residential Child Care Facility (RCCF) providing mental health services comprised of at least one Licensed Mental Health Professional and other staff responsible for the treatment of the client and may include a staff member from the Referral Agency.

Plan of Care means a treatment plan designed for each client and family, developed by an Interdisciplinary or Multidisciplinary Team.

Prone Position means a client lying in a face down or front down position.

Psychiatric Residential Treatment Facility (PRTF) means a facility that is not a hospital and provides inpatient psychiatric services for individuals under age 21 under the direction of a physician, licensed pursuant to part 1 of article 36 of title 12, C.R.S.

Qualified Residential Treatment Programs (QRTP) means a facility that provides residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

Referral Agency means the Division of Youth Corrections, County Departments of Human/Social Services who have legal custody of a client, Behavioral Healthcare Organization or Community Mental Health Center that refers the client to a PRTF or RCCF for the purpose of placement through the Child Mental Health Treatment Act.

Restraint includes Drug Used as a Restraint, Mechanical Restraint and Personal Restraint.

Drug Used as a Restraint means any drug that is administered to manage a client's behavior in a way that reduces the safety risk to the client or to others; has the temporary affect of restricting the client's freedom of movement and is not a standard treatment for the client's medical or psychiatric condition.

Mechanical Restraint means any device attached or adjacent to the client's body that the client cannot easily remove that restricts freedom of movement or normal access to the client's body.

Personal Restraint means personal application of physical force without the use of any device, for the purpose of restraining the free movement of the client's body. This does not include briefly holding a client without undue force in order to calm or comfort, or holding a client's hand to safely escort the client from one area to another. This does not include the act of getting the client under control and into the required position for Restraint.

Residential Child Care Facility (RCCF) means any facility that provides out-of-home, 24-hour care, protection and supervision for children in accordance with 12 C.C.R. 2509-8, Section 7.705.91.A.

Seclusion means the involuntary confinement of a client alone in a room or an area from which the client is physically prohibited from leaving.

[SECTIONS 8.765.2-13 ARE UNAFFECTED BY THIS RULE CHANGE]

8.765.14 QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP)

8.765.14.A CLIENT ELIGIBILITY

1. Children up to age eighteen (18) years old and for those persons up to twenty-one (21) years old who consent to the placement or are placed by court order, for whom an Independent Assessment determines that the child's needs cannot be met in a less restrictive, family-based setting because of their serious emotional or behavioral disorders or disturbances.

2. Managed Care Entities must use the Independent Assessment to inform medical necessity determinations.

3. For children in the custody of a county department of human/social services or Division of ~~youth corrections~~Youth Services and for those children receiving mental health services in a Qualified Residential Treatment Program (QRTP) through the Child and Youth Mental Health Treatment Act, the Independent Assessment will determine mental health medical necessity.

8.765.14.B QRTP AND PROVIDER ELIGIBILITY

1. Beginning October 1, 2021, to be eligible for Colorado Medicaid reimbursement, a QRTP must:

   a. Be enrolled with Colorado Medicaid;

   b. Be licensed by the Colorado Department of Human Services (CDHS), Provider Services Unit (PSU), as a Child Care Facility with QRTP indicated~~s~~ as the Service Type in accordance with CDHS regulations;

   c. Be accredited by:

      i. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO),

      ii. The Commission on Accreditation of Rehabilitation Facilities (CARF),

      iii. The Council on Accreditation of Services for Families and Children, or

      iv. Any other independent, not-for-profit accrediting organization approved by the Secretary of Health and Human Services.

   d. Submit an attestation form to the Department with the facility's Colorado Medicaid enrollment application with Colorado Medicaid that attests:

      i. The facility has no more than sixteen (16) beds, including all beds at a single address or on adjoining properties regardless of program or facility type;

      ii. The facility does not share a campus with a Psychiatric Residential Treatment Facility (PRTF);

      iii. For facilities more than one (1) mile but less than ten (10) miles apart by road from another overnight facility controlled by the same ownership or governing body, the other overnight facility meets the following criteria:

         1. The facility maintains its own license;

2. The facility has dedicated staff that ensures a stable treatment environment;

3. Residents do not move between the facility and another during the episode of care

iv. For facilities less than one (1) mile apart, but not on the same campus or adjoining properties, the QRTP is in a home-like structure (cottage, house, apartment) located farther than 750 feet from another overnight facility within a community setting that includes publicly used infrastructure (roads, parks, shared spaces, etc.).

2. Provider Qualifications.

a. The rendering provider for the following services must be an enrolled Licensed Mental Health Professional in a QRTP:

i. Individual therapy,

ii. Group therapy, and

iii. Family therapy.

8.765.14.C COVERED SERVICES

1. Medically necessary services pursuant to Section 8.076.1.8 that are not excluded in Section 8.765.14.D and are:

a. Included in the member's stabilization plan created by the QRTP in accordance Colorado Department of Human Services (CDHS) regulations.

b. Included in the member's individual child and family plan created by the QRTP in accordance with CDHS regulations.

c. Included in the member's discharge and aftercare plan created by the QRTP in accordance with CDHS regulations.

2. All EPSDT services not specified in Sections 8.765.14.C.1-3 are covered under Section 8.280.

8.765.14.D NON-COVERED SERVICES

1. The following services are not covered for members in a QRTP:

a. Room and board;

b. Educational, vocational, and job training services;

c. Recreational or social activities; and

d. Services provided to inmates of public institutions or residents of Institutions of Mental Disease (IMD).

8.765.14.E PRIOR AUTHORIZATION REQUIREMENTS

1. Prior authorization may be required for this benefit.

8.765.14.F REIMBURSEMENT.

1. QRTPs are reimbursed a per diem rate, as determined by the Department, if the following conditions are fulfilled:

   a. Rendered services are documented in the treatment record at the frequencies specified in the member's care plan(s);

   b. A care plan(s) is on record for the time period reported in the reimbursement claim; and

   c. The care meets professionally recognized standards for care in a QRTP.

2. QRTPs must enroll as a Colorado Medicaid provider to act as a billing entity for Licensed Mental Health Professionals rendering mental health services in the QRTP.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the DMEPOS Rule Concerning Pharmacists Prescribing COVID-19 at-home over-the-counter tests, Section 8.590
Rule Number: MSB 22-01-30-A
Division / Contact / Phone: Health Programs Office / Haylee Rodgers / 9467

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 22-01-30-A, Revision to the DMEPOS Rule Concerning Pharmacists Prescribing COVID-19 at-home over-the-counter tests, Section 8.590

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) 8.590.2.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 8.590.2.A with the proposed text beginning at 8.590.2.A through the end of 8.590.2.A. This rule is effective April 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the DMEPOS Rule Concerning Pharmacists Prescribing COVID-19 at-home over-the-counter tests, Section 8.590
Rule Number: MSB 22-01-30-A
Division / Contact / Phone: Health Programs Office / Haylee Rodgers / 9467

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 allows pharmacists to prescribe at-home over-the-counter COVID-19 tests for reimbursement under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) benefit. The basis of this rule is that CMS has mandated coverage of these tests which are available at pharmacies. Pharmacies are enrolled as DMEPOS providers and can bill for the tests, however a prescription is required.

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:

   1905(7) SSA

4. State Authority for the Rule:

   State Plan: Attachment 3.1-A 7.g. and Attachment 4.19-B
   Colorado Statute: CRS 25.5-4-416

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021)

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the DMEPOS Rule Concerning Pharmacists Prescribing COVID-19 at-home over-the-counter tests, Section 8.590
Rule Number: MSB 22-01-30-A
Division / Contact / Phone: Health Programs Office / Haylee Rodgers / 9467

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.

   All members will be affected by, and benefit from, this rule as it will allow them to receive these tests from pharmacies without a prescription from their physician. Pharmacies enrolled as DMEPOS providers will benefit from this rule as it will allow them to be reimbursed for these tests.

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

   DMEPOS Pharmacy providers will receive reimbursement when they submit claims for at-home over-the-counter COVID-19 tests. Members will not have to pay out of pocket for these tests as they will be covered benefits. This rule serves the larger public health objective of ensuring testing is available to everyone.

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 incur new costs associated with the mandated coverage of these tests.

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

   There are no other methods that are less costly or less intrusive to achieve the purpose of the proposed rule.

5. 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 is no alternative method for achieving the goal of having these tests covered at a pharmacy which does not involve allowing pharmacists to prescribe the test.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.590.2 BENEFITS

8.590.2.A. All covered DME and Supplies shall, at a minimum, be:

1. A Medical Necessity; and

2. Prescribed by a physician and, when applicable, recommended by an appropriately licensed practitioner.

3. At-home over-the-counter COVID-19 tests may be prescribed by a licensed pharmacist.

8.590.2.B. DME and Supplies for Members Residing in Facilities

1. DME and Supplies for members residing in a hospital, nursing facility or other facility, are provided by those facilities and reimbursed as part of the per diem rate. DME and Supplies shall not be separately billed, except under the following circumstances:

   a. The member is within fourteen days of discharge, and

   b. Prior authorization or training are needed to assist the member with equipment usage, and

   c. The equipment is needed immediately upon discharge from the facility.

2. Repairs and modifications to member owned DME, not required as part of the per diem reimbursement, shall be provided to members residing in a hospital, nursing facility or other facility receiving per diem Medicaid reimbursement.

3. Prosthetic or Orthotic Devices may be provided to members residing in a hospital, nursing facility or other facility receiving per diem Medicaid reimbursement if Prosthetic or Orthotic benefits are not included in the facility's per diem rate.

8.590.2.C. DME and Supplies shall not be duplicative or serve the same purpose as items already utilized by the member unless it is medically required for emergency or backup support. Backup equipment shall be limited to one.

8.590.2.D. All DME and Supplies reimbursed for by the Department shall become the property of the member unless the member and provider are notified otherwise by the Department at the time of purchase.

8.590.2.E. Rental equipment shall be provided if the Department determines it to be cost effective and Medically Necessary.

8.590.2.F. Supplies shall be for a specific purpose, not incidental or general purpose usage.

8.590.2.G. The following DME and Supplies categories are benefits for members regardless of age, and include but are not limited to:

1. Ambulation devices and accessories including but not limited to canes, crutches or walkers.

2. Bath and bedroom safety equipment.

3. Bath and bedroom equipment and accessories including, but not limited to, specialized beds and mattress overlays.

4. Manual or power Wheelchairs and accessories.

5. Diabetic monitoring equipment and related disposable supplies.

6. Elastic supports/stockings.

7. Blood pressure, apnea, blood oxygen, pacemaker and uterine monitoring equipment and supplies.

8. Oxygen and oxygen equipment in the member's home, a nursing facility or other institution. The institutional oxygen benefit is fully described in 10 C.C.R. 2505-10, Sections 8.580, and 8.585.

9. Transcutaneous and/or neuromuscular electrical nerve stimulators (TENS/NMES) and related supplies.

10. Trapeze, traction and fracture frames.

11. Lymphedema pumps and compressors.

12. Specialized use rehabilitation equipment.

13. Oral and enteral formulas and supplies.

14. Parenteral equipment and supplies.

15. Environmental controls for a member living unattended if the controls are needed to assure medical safety.

16. Facilitative Devices.

    a. Telephone communication devices for the hearing impaired and other facilitative listening devices, except hearing aids, and Cochlear Implants.

    b. Computer equipment and reading devices with voice input or output, optical scanners, talking software, Braille printers and other devices that provide access to text.

    c. Computer equipment with voice output, artificial larynges, voice amplification devices and other alternative and augmentative communication devices.

    d. Voice recognition computer equipment software and hardware and other forms of computers for persons with disabilities.

    e. Any other device that enables a person with a disability to communicate, see, hear or maneuver including artificial limbs and orthopedic footwear.

17. Complex Rehabilitation Technology.

8.590.2.H. The following DME are benefits to members under the age of 21:

1. Hearing aids and accessories.

2. Phonic ear.

3. Therapy balls for use in physical or occupational therapy treatment.

4. Selective therapeutic toys.

5. Computers and computer software when utilization is intended to meet medical rather than educational needs.

6. Vision correction unrelated to eye surgery.

8.590.2.I. The following Prosthetic or Orthotic Devices are benefits for members regardless of age:

1. Artificial limbs.

2. Facial Prosthetics.

3. Ankle-foot/knee-ankle-foot orthotics.

4. Recumbent ankle positioning splints.

5. Thoracic-lumbar-sacral orthoses.

6. Lumbar-sacral orthoses.

7. Rigid and semi-rigid braces.

8. Therapeutic shoes.

9. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements.

10. Specialized eating utensils and other medically necessary activities of daily living aids.

11. Augmentative communication devices and communication boards.

8.590.2.J. Repairs and replacement parts are covered under the following conditions:

1. The item was purchased by Medicaid; or

2. The item is owned by the member, member’s family or guardian; and

3. The item is used exclusively by the member; and

4. The item’s need for repair was not caused by member Misuse or Abuse; and

5. The item is no longer under the manufacturer warranty.

8.590.2.K. The minimum replacement timeline for a Speech Generating Device is five years.

1. Stolen devices may be replaced within the five-year timeline; however, the client is limited to one-time replacement due to theft, and a police report must be provided for verification of the incident.

2. Replacement will not be granted within the five-year timeline for devices that are damaged, lost, misused, abused or neglected.

8.590.2.L. Repairs, replacement, and maintenance shall be:

1. Based on the manufacturer's recommendations, and

2. Performed by a qualified rehabilitation professional, and

3. Allowed on the member's primary equipment or one piece of backup equipment.

4. Multiple backup equipment will not be repaired, replaced or maintained.

8.590.2.M. If repairs are frequent and repair costs approach the purchase price of new equipment, the provider shall make a request for the purchase of new equipment. The prior authorization request shall include supporting documentation explaining the need for the replacement equipment and the cost estimates for repairs on both the old equipment and the new equipment purchase.

8.590.2.N. Supplies are a covered benefit when related to the following:

1. Surgical, wound or burn care.

2. Syringes or needles.

3. Bowel or bladder care.

4. Incontinence.

5. Antiseptics or solutions.

6. Gastric feeding sets and supplies.

7. Tracheostomy and endotracheal care supplies.

8. Diabetic monitoring.

8.590.2.O. Quantities of Supplies shall not exceed one month's supply unless they are only available in larger quantities as packaged by the manufacturer.

8.590.2.P. Medicaid members for whom Wheelchairs, Wheelchair component parts and other specialized equipment were authorized and ordered prior to enrollment in a Managed Care Organization, but delivered after the Managed Care Organization enrollment shall be the responsibility of the Department. All other DME and Supplies for members enrolled in a Managed Care Organization shall be the responsibility of the Managed Care Organization.

8.590.2.Q. Items, for the purposes of Rule 8.590, that are used for the following are not a benefit to a member of any age:

1. Routine personal hygiene.

2. Education.

3. Exercise.

4. Participation in sports.

5. Cosmetic purposes.

8.590.2.R. For members age 21 and over, the following items are not a benefit:

1. Hearing aids and accessories.

2. Phonic ears.

3. Therapeutic toys.

4. Vision correction unrelated to eye surgery.

8.590.2.S. Rental Policy.

1. The Department may set a financial cap on certain rental items. The monetary price for those items shall be determined by the Department and noted in the fee schedule. The provider is responsible for all maintenance and repairs as described at 8.590.4.N-P, until the cap is reached.

2. Upon reaching the capped amount, the equipment shall be considered purchased and shall become the property of the member. The provider shall give the member or caregiver all applicable information regarding the equipment. The equipment shall not be under warranty after the rental period ends.

3. The rental period may be interrupted, for a maximum of sixty consecutive days.

    a. If the rental period is interrupted for a period greater than sixty consecutive days, the rental period must begin again. The interruption must be justified, documented by a physician, and maintained by the provider as described at 10 CCR 2505-10, Section 8.590.4.E.

4. If the member changes providers, the current rental cap remains in force.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule Concerning HB21-1275 Pharmacy Implementation, Section 8.800.5
Rule Number: MSB 22-01-30-B
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 22-01-30-B, Revision to the Medical Assistance Act Rule Concerning HB21-1275 Pharmacy Implementation, Section 8.800.5

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

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.800.5 with the proposed text beginning at 8.800.5.A through the end of 8.800.5.A. this rule is effective April 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule Concerning HB21-1275 Pharmacy Implementation, Section 8.800.5
Rule Number: MSB 22-01-30-B
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 pharmacy office is implementing HB21-1275 which requires the Department to A) reimburse pharmacists for all services that are allowed in Part 6 of Article 280 of Title 12 and B) to allow pharmacists to dispense, administer and be reimbursed for long acting injectables for both mental illness and substance use disorders through the pharmacy or medical benefit.

   In order to implement part B of HB21-1275, the Department must modify Section 8.800.5 to allow pharmacists and pharmacies to bill for long acting injectables for both mental illness and substance use disorders for reimbursement through the pharmacy or medical benefit even if the product is administered in a physician's office or clinic.

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. (2021);
   Section 25.5-5-511, C.R.S. (2020)
   Section 25.5-5-512, C.R.S. (2020)

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 Act Rule Concerning HB21-1275 Pharmacy Implementation, Section 8.800.5
Rule Number: MSB 22-01-30-B
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.

   Pharmacists and pharmacies will benefit from the proposed rule because they will have greater flexibility to bill for long acting injectables for both mental illness and substance use disorders. The Department will bear the costs from the proposed rule because the medical claims system and pharmacy claims systems are not configured to inhibit duplicate billing, therefore creating more administrative work to continuously analyze claims for duplicate billing.

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

   Qualitatively, this rule will create greater ease for pharmacists and pharmacies when billing for long acting injectables for both mental illness and substance use disorders because they can bill through either the pharmacy or medical benefit. Qualitatively, this rule will create more work for the Department as it relates to duplicate billing claims analysis.

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 the medical and pharmacy claims systems are not configured to inhibit duplicate billing as it relates to long acting injectables for both mental illness and substance use disorders.

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 medical and pharmacy claims systems are not configured to inhibit duplicate billing as it relates to long acting injectables for both mental illness and substance use disorders; whereas the benefit of action is compliance with the passage of HB21-1275.

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

   Not applicable.

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.

   Not applicable.

8.800 PHARMACEUTICALS

8.800.5 DRUGS ADMINISTERED OR PROVIDED IN PHYSICIAN OFFICES OR CLINICS

8.800.5.A. Extended-release injectable drugs which treat mental health or substance use disorders, and are administered in a pharmacy, physician's office, or clinic, may be considered part of the physician services benefit and billed on the physician claim form; such drugs may also be considered a pharmacy benefit and billed by a pharmacy. Any other drugs administered in a physician's office or clinic are considered part of the physician's services benefit only and are not a pharmacy benefit. ~~Such drugs shall be billed on the physician claim form with the exception of drugs previously billed under 8.800.5.B. Pharmacies shall not bill for any products that are administered in a physician's office or clinic.~~

8.800.5.B. Dispensing Prescribers whose offices or sites of practice are located within 25 miles from the nearest participating pharmacy shall not be reimbursed for drugs or services that are dispensed from their offices.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Pharmacy Reimbursement, Section 8.200.2.B and C
Rule Number: MSB 22-01-30-C
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 22-01-30-C, Revision to the Medical Assistance Rule concerning Pharmacy Reimbursement, Section 8.200.2.B and C

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) Sections 8.200.2.B-C, 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 8.200.2 with the proposed text beginning at 8.200.2.B through the end of 8.200.2.C. This rule is effective April 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Pharmacy Reimbursement, Section 8.200.2.B and C
Rule Number: MSB 22-01-30-C
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 proposed rule implements requirements of Colorado House Bill 21-1275, under which pharmacists may provide covered Health First Colorado (Colorado Medicaid) services, in accordance with the scope of practice for pharmacists as described by the Colorado Department of Regulatory Agencies rules, without a physician order.

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 440.120(a) (2021)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   CRS § 25.5-5-511(2)(a) (2021)

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Pharmacy Reimbursement, Section 8.200.2.B and C
Rule Number: MSB 22-01-30-C
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.

   Pharmacists and members receiving pharmaceutical services will be affected by the proposed rule, both of which benefit from the increased access to pharmaceutical services and corresponding reimbursement.

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 ability of pharmacists to generate revenue for the same services provided by other health-care providers is equitable, helps fund staff and services in medical homes, and alleviates barriers to access of care in community settings.

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 Colorado House Bill 21-1275 fiscal note estimates additional expenditures of $1,762,820 ($372,554 state share) in state fiscal year 2021-22 and $4,193,853 ($1,363,884 state share) in state fiscal year 2022-23 ongoing. This includes system costs, benefit costs and operating costs.

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 the additional Health First Colorado expenditures outlined in question #3. The probable benefit of the proposed rule is complying with state statute. The cost of inaction is misalignment between state statute and Department rule. 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.

   There are no less costly methods or less intrusive methods to align Department rule with state statute.

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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 aligning Department rule with state statute.

8.200 PHYSICIAN SERVICES

8.200.2 Providers

8.200.2.B. Physician services that may be provided by non-physician providers without a physician order.

1. Advanced Practice Nurses may provide and order covered goods and services in accordance with the scope of practice as described in the Colorado Department of Regulatory Agencies rules without a physician order.

2. Licensed Psychologists may provide and order covered mental health goods and services in accordance with the scope of practice as described in the Colorado Department of Regulatory Agencies rules without a physician order.

    a. Services ordered by a Licensed Psychologist but rendered by a non-licensed mental health provider must be signed and dated by the Licensed Psychologist contemporaneously with the rendering of the service by a non-licensed mental health provider.

3. Optometrists may provide covered optometric goods and services within their scope of practice as described by the Colorado Department of Regulatory Agencies rules without a physician order.

4. Podiatrists may provide covered foot care services within their scope of practice as described by the Colorado Department of Regulatory Agencies rules without a physician order.

5. Licensed dental hygienists may provide unsupervised covered dental hygiene services in accordance with the scope of practice for dental hygienists as described in the Colorado Department of Regulatory Agencies rules without a physician order.

6. Licensed pharmacists may provide covered services, in accordance with the scope of practice for pharmacists as described by the Colorado Department of Regulatory Agencies rules, without a physician order.

8.200.2.C. Physician services that may be provided by a non-physician provider when ordered by a provider acting under the authority described in Sections 8.200.2.A. and 8.200.2.B.

1. Registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed physician assistants may provide services ordered by a physician.

a. Services must be rendered and supervised in accordance with the scope of practice for the non-physician provider described in the Colorado Department of Regulatory Agencies rules.

~~2. Licensed pharmacists, in accordance with the scope of practice for pharmacists as described in the Colorado Department of Regulatory Agencies rules 3 CCR 719-1 and C.R.S. 12-42.5-101 et. seq., may provide covered services.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the FQHC Rule Concerning Reimbursement for Antiviral Medication for COVID-19, Section 8.700.6.B
Rule Number: MSB 22-01-30-D
Division / Contact / Phone: Health Programs Office / Morgan Anderson / 2362

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 22-01-30-D, Revision to the FQHC Rule Concerning Reimbursement for Antiviral Medication for COVID-19, Section 8.700.6.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) 8.700.6.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). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700.6.B with the proposed text beginning at 8.700.6.B.11 through the end of 8.700.6.B.11. This rule is effective April 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the FQHC Rule Concerning Reimbursement for Antiviral Medication for COVID-19, Section 8.700.6.B
Rule Number: MSB 22-01-30-D
Division / Contact / Phone: Health Programs Office / Morgan Anderson / 2362

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 Federally Qualified Health Center (FQHC) reimbursement for the antiviral medication, remdesivir, when administered in an outpatient setting. Remdesivir is an antiviral medication for COVID-19 that stops the virus from spreading in the body and reduces time to recovery. Remdesivir treatments are expensive, and the current FQHC encounter rate does not cover the cost of providing the drug. This rule will revise reimbursement to reimburse FQHCs at the fee schedule amount for the cost of the remdesivir antiviral medication.

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:

   State Plan: Attachment 3.1-A 2.c. and Attachment 4.19-B
   Colorado Statute: CRS 25.5-5-102(1)(m)
   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021)

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the FQHC Rule Concerning Reimbursement for Antiviral Medication for COVID-19, Section 8.700.6.B
Rule Number: MSB 22-01-30-D
Division / Contact / Phone: Health Programs Office / Morgan Anderson / 2362

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 increase FQHC reimbursement for the COVID-19 antiviral medication, remdesivir, when administered in an outpatient setting. Therefore, FQHCs will not incur budgetary concerns to provide these services. This rule will also improve access to Medicaid members that receive services at FQHCs.

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

   FQHCs will be directly reimbursed at the fee schedule rate for the COVID-19 antiviral medication, remdesivir. This rule will reimburse FQHCs for this service directly instead of an indirect reimbursement through their encounter rates in the future.

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. The Department will directly reimburse FQHCs for administering the COVID-19 antiviral medication, remdesivir, in the outpatient setting. Without this rule, the costs of these services would be included in future rates. Therefore, there should be no significant budgetary impact as FQHC rates will not increase in the future due to their direct reimbursement due to this rule revision.

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 FQHCs will likely suffer budgetary concerns due to not having direct reimbursement for administering COVID-19 antiviral medications. FQHCs will also be less incentivized to provide this service due to lack of direct reimbursement.

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

   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 considered not reimbursing FQHCs the fee schedule amount for the COVID-19 antiviral medication, remdesivir, but decided it was better to reimburse at the fee schedule amount to improve access.

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.

11. COVID-19 antiviral medication, remdesivir, provided at the FQHC shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.