DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Medicaid Eligibility Quality Control, Section 8.080
Rule Number: MSB 22-11-03-A
Division / Contact / Phone: Health Policy / 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 22-11-03-A, Revision to the Medical Assistance Act Rule concerning Medicaid Eligibility Quality Control, Section 8.080

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) 8.080, 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*

Delete the text at 8.080 beginning at 8.080 through the end of 8.080. This rule is effective April 30, 2023.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Medicaid Eligibility Quality Control, Section 8.080
Rule Number: MSB 22-11-03-A
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STATEMENT OF BASIS AND PURPOSE

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

   The Medicaid Eligibility Quality Control (MEQC) rule at Section 8.080 is obsolete after the MEQC authority was moved to Section 1.020.10.1 of the Department's Executive Director rules. Section 8.080 is therefore being removed and the authority for MEQC is in Section 1.020.10.1.

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 Part 455, Subpart A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   Title 25.5, Article 4, Part 3, C.R.S. (2022)

Initial Review	**02/10/23**	Final Adoption	**03/10/23**
Proposed Effective Date	**04/30/23**	Emergency Adoption	

DOCUMENT #01

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Rule Number: MSB 22-11-03-A
Division / Contact / Phone: Health Policy / 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.

   No classes of persons are affected by the proposed rule. The Medicaid Eligibility Quality Control (MEQC) is still in effect under the authority of Section 1.020.10.1 of the Executive Director's rules. This rule only removes duplicative language.

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

   There are no probably quantitative or qualitative impacts of the proposed rule.

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

   There are no probable costs to the Department or to any other agency to implement and enforce the proposed rule, as it does not change Department policy or practice. As such, there is no anticipated effect on state revenues.

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

   There are no probable costs of the proposed rule because it does not change Department policy or practice. The benefit of the proposed rule is removing duplicative and obsolete language from Department rule. The cost of inaction is leaving duplicative and obsolete language in Department rule. There are no benefits of inaction.

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

   There are no less costly methods or less intrusive methods to remove obsolete language from Department rule.

DO NOT PUBLISH THIS PAGE

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

   There are no alternative methods for removing obsolete language from Department rule.

8.080 MEDICAID ELIGIBILITY QUALITY CONTROL [moved to 10 CCR 2505-5, Executive Director of Health Care Policy and Financing Rules, Section 1.020.10.1 (2022)]

~~8.080.1 County departments of social/human services and other Department-designated eligibility sites shall maintain, store and preserve electronic and physical individual Medicaid case record(s) and other client-related confidential material to permit the Department to periodically evaluate the accuracy of Medicaid eligibility determinations. Medicaid case records are the property of the Department and shall be restricted to use by the state and county departments of social/human services and other Department-designated eligibility sites.~~

~~8.080.2 County departments of social/human services and other Department-designated eligibility sites shall provide records to the Department within ten (10) working days of request.~~

~~8.080.3 County departments of social/human services and other Department-designated eligibility sites shall respond to the eligibility review findings by completing the Department-prescribed MEQC response form documenting the corrective action taken. The response shall be forwarded to the Department within ten (10) working days from the date of the review finding notification.~~

~~8.080.4 To be considered by the Department, requests from county departments of social/human services and Department-designated eligibility sites for specific program policy interpretation relevant to MEQC pilot projects shall be received by the Department within ten (10) days of the MEQC review findings. All program policy decisions are final.~~

~~8.080.5 County departments of social/human services and Department-designated eligibility sites shall make electronic or physical records available for on-site reviews as requested.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning CHRP Respite and Capacity Limit Rule Change, Section 8.508.100
Rule Number: MSB 22-09-19-A
Division / Contact / Phone: Office of Community Living/ Emily Walsh / 5618

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 22-09-19-A, Revision to the Medical Assistance Rule concerning CHRP Respite and Capacity Limit, Section 8.508.100

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): 10 C.C.R. 2505-10, Sections 8.508.100.A.7 and 10 C.C.R. 2505-10, Sections 8.508.100.F.4

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.508.100 with the proposed text beginning at 8.508.100 through the end of 8.508.100.H.9. This rule is effective April 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning CHRP Respite and Capacity Limit Rule Change, Section 8.508.100
Rule Number: MSB 22-09-19-A
Division / Contact / Phone: Office of Community Living/ Emily Walsh / 5618

STATEMENT OF BASIS AND PURPOSE

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

   The Department is seeking to make two changes to the Children's Habilitation Residential Program (CHRP), a Home and Community Based Service waiver for children and youth with intellectual/developmental disabilities who have complex medical or behavioral support needs that put them at risk of, or in need of, out of home placement. The Department is changing the provider capacity regulations to remove specific capacity limitation and instead reference the Colorado Department of Human Services (CDHS) regulations. Currently, HCPF regulations mirror CDHS regulations on provider capacity. This can cause significant confusion if the rules do not match. By simply referencing the CDHS regulations, HCPF would no longer need to revise regulations each time CDHS modifies the capacity limitations within rule.

   Additionally, the Department is proposing to revise regulations in order to expand access to respite on the CHRP waiver. Expanding the respite unit limits to align with the current respite limits established for the Children's Extensive Support Waiver will allow members to better utilize the benefit and will allow for a potential overage request to be approved by the department when absolutely necessary. The Department obtained budget approval for this change through the FY22-23 budget. This change will align the regulations with the new service 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:

   The waiver was granted under Section 1915(c) of the Social Security Act, 42 U.S.C § 1396n (2022).

4. State Authority for the Rule:
   Sections 25.5-1-301 through 25.5-1-303, and 25.5-6-903, C.R.S (2022).

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning CHRP Respite and Capacity Limit Rule Change, Section 8.508.100
Rule Number: MSB 22-09-19-A
Division / Contact / Phone: Office of Community Living/ Emily Walsh / 5618

REGULATORY ANALYSIS

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

   The proposed rule will affect children/youth with intellectual and developmental disabilities and complex medical or behavior support needs, as well as their caregivers. The benefit of the proposed rule changes will expand access to care and support caregivers by eliminating current provider limitations for the respite benefit. Eliminating current limitations adds flexibility in how the service will be used for caregivers. Additionally, cross-referencing to CDHS regulations for capacity limitations in this rule will reduce confusion for stakeholders as the capacity limitations will be codified in a single location.

6. 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 expands access to the respite benefit for members on the CHRP waiver. These changes will improve member outcomes and decrease the use of high-cost crisis services by reducing negative outcomes that may result from caregiver fatigue. This proposed rule will also allow for better and more efficient work between CDHS and HCPF. Currently, because the rules for provider capacity are also set forth in CDHS rules, when CDHS revises capacity limits, there is a period of time during which HCPF is in the process of updating its rule to match the CDHS rule and the limits codified in HCPF rule are inconsistent with the CDHS rule. Moving forward, the HCPF rule will simply cite to the capacity limits codified in CDHS regulations. This rule change will avoid any confusion that occurred when the capacity limits in CDHS rule changed and HCPF's rule was not yet updated.

7. 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 refers to the CDHS Provider capacity limits and makes note of the regulations already in place at CDHS. Because CDHS already regulates provider capacity as it relates to foster care in the CHRP waiver, no effects on state revenue are anticipated. Additionally, for the increased respite benefit, increased unit

limitations have previously received budget approval and additional funding has been appropriated.

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

   Revising the regulations to expand the respite benefit can improve member outcomes and decrease the use of high-cost crisis services by avoiding the potential negative outcomes of caregiver fatigue. This will be of benefit to members currently receiving CHRP services as it will allow for increased access to this critical service. If the Department does not revise the regulations for the respite expansion, Department regulations will not align with the federal waiver agreement.

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

   Because the purpose of the rule is to eliminate the disparity between this rule and the CDHS capacity limits rule that temporarily occurs when the CDHS rule is changed, and the simplest way to eliminate that disparity is to change this rule, there are no less costly or less intrusive methods for achieving the purpose of this rule.

10. 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 achieve the purpose for the proposed rule. The regulations must be updated in order to align with the Federally approved waiver and new appropriations for the respite benefit.

8.508.100 SERVICE DESCRIPTIONS

A. Habilitation

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

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

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

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

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

   b. Self-advocacy training and support which may include assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing Abuse, Neglect, Mistreatment, and/or Exploitation of self, responsibility for one’s own actions, and participation in meetings.

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

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

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

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

and Residential Child Care Facilities to access activities and functions of community life.

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

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

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

6.C Habilitation may be provided for clients age eighteen (18) to twenty (20) in a Host Home. The Host Home must meet all requirements as defined in Section 8.600.

1. Habilitation capacity limits:¶

7. Service Providers and child placement agencies must not exceed habilitation capacity limits at 12 CCR 2509-8; §§ 7.701.2, 7.708.1.A.2, 7.710.48.C. (2022), which are hereby incorporated by reference. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.¶

a. A Foster Care Home or Kinship Foster Care Home may serve a maximum of one (1) Client enrolled in the HCBS-CHRP waiver and two (2) other foster children, or two (2) Clients enrolled in the HCBS-CHRP waiver and no other foster children, unless there has been prior written
approval by the Department. Placements of three (3) Clients approved for the HCBS-CHRP waiver may be made if the Service Provider can
demonstrate to the Department that the Foster Care Home provider has sufficient knowledge, experience, and supports to safely meet the needs of all of the children in the home. In any case, no more than three (3)
Clients enrolled in the HCBS-CHRP waiver will be placed in the same
foster home. Emergency placements will not exceed the maximum established limits. Foster Care Homes that exceed established capacity at the time the rule takes effect will be grandfathered in; however, with
attrition, capacity must comply with the rule.¶
Foster Care Home Maximum Capacity¶
¶

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

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

~~Specialized Group Facility Maximum Capacity¶~~

~~¶~~

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

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

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

10.~~E~~ The Foster Care Home or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all Clients living in the home.

11.~~F~~ The Service Provider shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification before any child or youth can be placed in that home. If emergency placement is needed outside of business hours, the Service Provider or child placement agency shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification the next business day.

B.~~G~~ Hippotherapy

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

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

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

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

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

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

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

8. Equine therapy and therapeutic riding are excluded.

C. ~~H~~ Intensive Support

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

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

3. Intensive support services include:

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

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

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

        ii. Physical and behavioral health factors.

        iii. Education services.

        iv. Family dynamics.

        v. Schedules and routines.

        vi. Current or history of police involvement.

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

        viii. Current services.

        ix. Adaptive equipment needs.

        x. Past interventions and outcomes.

        xi. Immediate need for resources.

        xii. Respite services.

        xiii. Predictive Risk Factors.

        xiv. Increased Risk Factors.

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

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

    b. Environmental modifications.

    c. Support needs in the family home.

    d. Respite services.

    e. Strategies to prevent Crisis triggers.

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

    g. Learning new adaptive or life skills.

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

    i. Medication management and stabilization.

    j. Physical health.

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

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

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

    n. Contingency plan for out of home placement.

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

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

5. Child and Youth Mentorship.

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

    b. Child and Youth Mentorship includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the child or youth with self-care, learning self-advocacy, and protective oversight.

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

6. Follow-up services.

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

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

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

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

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

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

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

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

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

DI.D. Massage Therapy

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

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

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

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

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

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

E.~~J~~ Movement Therapy

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

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

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

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

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

F.~~K~~ Respite

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

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

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

4. ~~Respite care is authorized for short-term temporary relief of the Caretaker for not more than seven (7) consecutive days per month, not to exceed twenty-eight (28) days in a calendar year.~~ The total amount of respite provided in one Service Plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units, where one unit is equal to 15 minutes. The Department may approve a higher amount ~~based on a need~~when needed due to the client's age, disability or unique family circumstances.

5. During the time when Respite care is occurring, the Foster Care Home or Kinship Care Home may not exceed six (6) foster children or a maximum of eight (8) total children, with no more than two (2) children under the age of (two) 2. The respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.

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

G.~~L~~ Community Connector

1. Community Connector services are provided one-on-one to deliver instruction for documented Complex Behavior that are exhibited by the Client while in the community,

such as physically or sexually aggressive behavior towards others and/or exposing themselves.

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

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

4. This service is limited to 260 hours or 1040 units per year.

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

H. ~~M~~ Transition Support

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

2. Services include:

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

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

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

      ii. Physical and behavioral health factors.

      iii. Education services.

      iv. Family dynamics.

      v. Schedules and routines.

      vi. Current or history of police involvement.

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

      viii. Current services.

      ix. Adaptive equipment needs.

      x. Past interventions and outcomes.

      xi. Immediate need for resources.

      xii. Respite services.

      xiii. Predictive Risk Factors.

      xiv. Increased Risk Factors.

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

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

    b. Environmental modifications.

    c. Strategies for transition risk factors.

    d. Strategies for avoiding Crisis triggers.

    e. Support needs in the Family home.

    f. Respite services.

    g. Learning new adaptive or life skills.

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

    i. Medication management and stabilization.

    j. Physical health.

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

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

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

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

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

4. Child and Youth Mentorship

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

    b. Child and Youth Mentorship includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the Client with self-care, learning self-advocacy, and protective oversight.

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

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

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

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

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

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

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

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

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

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Medicare-Only Provider Types, Section 8.125 & 8.126
Rule Number: MSB 22-12-28-B
Division / Contact / Phone: Operations Section / Alex Lyons / 303-866-2865

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 22-12-28-B, Rule Concerning Medicare-Only Provider Types

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): 8.125, 8.126

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

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.125 with the proposed text beginning at 8.125.3.M through the end of 8.125.3.M. Replace the current text at 8.125 with the proposed text beginning at 8.125.4.E through the end of 8.125.4.I. Replace the current text at 8.125 with the proposed text beginning at 8.125.10.A through the end of 8.125.10.A. Replace the current text at 8.125 with the proposed text beginning at 8.125.15 through the end of 8.125.15.A. Replace the current text at 8.126 with the proposed text beginning at 8.126.1 through the end of 8.126.1.N. This rule is effective April 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Medicare-Only Provider Types, Section 8.125 & 8.126
Rule Number: MSB 22-12-28-B
Division / Contact / Phone: Operations Section / Alex Lyons / 303-866-2865

STATEMENT OF BASIS AND PURPOSE

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

   This rule clarifies that Medicare-Only Providers means a provider enrolled in the Medical Assistance Program for purposes of Medicare cost-sharing only, pursuant to 42 CFR §455.410(d).

2. An emergency rule-making is imperatively necessary

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

3. Federal authority for the Rule, if any:

   42 CFR Parts 412, 413, 425, 455, and 495.

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022)

Initial Review		Final Adoption	**03/10/23**
Proposed Effective Date	**4/30/23**	Emergency Adoption	

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Medicare-Only Provider Types, Section 8.125 & 8.126
Rule Number: MSB 22-12-28-B
Division / Contact / Phone: Operations Section / Alex Lyons / 303-866-2865

REGULATORY ANALYSIS

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

   This rule does not create any new benefit or cost. Its purpose is to clarify that "Medicare-Only Providers" means a provider enrolled in the Medical Assistance Program for purposes of Medicare cost-sharing only, pursuant to 42 CFR §455.410(d).

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

   There will be minimal quantitative or qualitative impact upon affected classes of persons because this proposed rule merely clarifies existing provider regulations and does not create or eliminate any benefit or tangible cost.

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 costs of both implementation and enforcement of the proposed rule are likely to be negligible.

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 would be the costs associated with updating our regulatory language and making affected parties aware of the change. The benefit of taking action would be complying with federal law, and the cost of inaction would be violating federal law, potentially exposing the Department to legal liability.

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

DO NOT PUBLISH THIS PAGE

There is likely no less-costly way to change the Department's rules to align with federal regulatory requirements other than to adopt the language that specifies the regulatory clarification required by federal statute.

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.

   No alternatives were seriously considered because this rule implements federal law in the manner prescribed by 42 CFR §455.410(d) and to do otherwise would risk legal exposure for the Department.

8.125 PROVIDER SCREENING

8.125.1 DEFINITIONS.

Managed Care Entity is defined at 42 CFR § 455.101.

Ownership interest is defined at 42 CFR § 455.101.

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

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

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

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

8.125.2 PROVIDERS DESIGNATED AS LIMITED CATEGORICAL RISK AND NEW PROVIDER TYPES

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

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

8.125.3 PROVIDERS DESIGNATED AS MODERATE CATEGORICAL RISK

8.125.3.A. Emergency Transportation including ambulance service suppliers

8.125.3.B. Non-Emergency Medical Transportation

8.125.3.C. Community Mental Health Center

8.125.3.D. Hospice

8.125.3.E. Independent Laboratory

8.125.3.F. Comprehensive Outpatient Rehabilitation Facility

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

8.125.3.H X-Ray Facilities

8.125.3.I. Revalidating Home Health agencies

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

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

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

1. Alternative Care Facility
2. Adult Day Services
3. Assistive Technology, if the provider is revalidating
4. Behavioral Programing
5. Behavioral Therapies
6. Behavioral Health Supports
7. Behavioral Services
8. Care Giver Education
9. Children's Case Management
10. Children's Habilitation Residential Program (CHRP)
11. Community Connector
12. Community Mental Health Services
13. Community Transition Services
14. Complementary and Integrative Health
15. Day Habilitation
16. Day Treatment
17. Expressive Therapy
18. Home Delivered Meals
19. Home Modifications/Adaptations/Accessibility
20. Independent Living Skills Training
21. In-Home Support Services, if the provider is revalidating
22. Intensive Case Management
23. Massage Therapy
24. Mentorship

25. Non-Medical Transportation

26. Palliative/Supportive Care Skilled

27. Peer Mentorship

28. Personal Care/Homemaker Services, if the provider is revalidating

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

30. Prevocational Services

31. Professional Services

32. Residential Habilitation Services

33. Respite

34. Specialized Day Rehabilitation Services

35. Specialized Medical Equipment and Supplies, if the provider is revalidating

36. Substance Abuse Counseling

37. Supported Employment

38. Supported Living Program

39. Therapy and Counseling

40. Transitional Living Program

41. Youth Day Services

8.125.3.M. Medicare Only Providers

1. Independent Diagnostic Testing Facility

2. Revalidating Medicare Diabetes Prevention Program Supplier

3. Newly enrolling Opioid Treatment Program that has been fully and continuously certified by Substance Abuse and Mental Health Services Administration (SAMHSA) since October 24, 2018.

4. Revalidating Opioid Treatment Program

8.125.4 PROVIDERS DESIGNATED AS HIGH CATEGORICAL RISK

8.125.4.A. Enrolling DME Suppliers

8.125.4.B. Enrolling Home Health Agencies

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

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

1. Assistive Technology

2. Personal Care/Homemaker Services

3 Specialized Medical Equipment and Supplies

4 In-Home Support Services

8.125.4.E. Medicare Only Providers

1. Enrolling Medicare Diabetes Prevention Program Supplier

2. Enrolling Opioid Treatment Program that has not been fully and continuously certified by SAMHSA since October 24, 2018.

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

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

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

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

8.125.5 PROVIDERS WITH MULTIPLE RISK LEVELS

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

8.125.6 PROVIDERS WITH MULTIPLE LOCATIONS

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

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

8.125.7 ENROLLMENT AND SCREENING OF PROVIDERS

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

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

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

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

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

1. By Medicare within the last 5 years, or

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

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

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

8.125.8 NATIONAL PROVIDER IDENTIFIER FOR ORDERING, PRESCRIBING, REFERRING

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

8.125.9 VERIFICATION OF PROVIDER LICENSES

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

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

8.125.10 REVALIDATION

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

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

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

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

8.125.11 - 8.125.13 Repealed [Emergency rules eff. 07/08/2022]

8.125.14 TEMPORARY MORATORIA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Upon request of the Department during revalidation.

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

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

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

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

3. Upon renewal or extension of the contract.

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

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

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

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

3. Upon renewal or extension of the contract.

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

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

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

8.126 COLORADO NPI RULE

8.126.1 Definitions

A. Billing Provider Field means the data field on a Claim that reflects the Health Care Provider to which the payer issues payment.

B. Campus means the physical area immediately adjacent to the Hospital’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Centers of Medicare and Medicaid Services to be part of the provider's campus.

C. Claim means a request for payment for the delivery of medical care, services, or goods authorized under the Medical Assistance Program, submitted to the Department through its fiscal agent by a Health Care Provider. Claim includes the transmission of encounter information for the purpose of reporting the delivery of medical care, services, or goods.

D. Health Care Provider means any person or organization that furnishes, bills for, or is paid for medical care, services, or goods to one or more Medical Assistance Program members.

1. A Health Care Provider includes an Organization Health Care Provider, Subpart of an Organization Health Care Provider, Off Campus Location, and a Site of an Organization Health Care Provider.

2. Unless specified otherwise in Subsection 8.126.1, a Health Care Provider may include a Health Care Provider located outside the state of Colorado (out-of-state provider) that is licensed and/or certified pursuant to their state laws.

E. Hospital means an Organization Health Care Provider that is enrolled in the Medical Assistance Program under the Provider Type of “Hospital - General” as defined in this Subsection 8.126.1.

F. Medical Assistance Program means the programs authorized under Articles 4, 5, 6, 8, and 10 of Title 25.5.

G. National Provider Identifier (NPI) means the standard, unique health identifier for Health Care Providers or Organization Health Care Providers that is used by the National Plan and Provider Enumeration System (NPPES) in accordance with 45 C.F.R. pt. 162.

H. Off-Campus Location means a facility that:

1. Has operations that are directly or indirectly owned or controlled by, in whole or in part, or affiliated with, a Hospital, regardless of whether the operations are under the same governing body as the Hospital;

2. Is not on the Hospital’s Campus;

3. Provides services that are organizationally and functionally integrated with the Hospital;

4. Is an outpatient facility providing preventive, diagnostic, treatment, or emergency services; and

5. Is identified on the Hospital’s State License Addendum issued by the Colorado Department of Public Health and Environment or, for Hospitals licensed outside of Colorado, documentation demonstrating direct or indirect ownership or control of the Off-Campus Location.

I. Organization Health Care Provider means a Health Care Provider that is not an individual.

J. Provider Type means a classification of Health Care Provider or Organization Health Care Provider to which the payer issues payment for services provided to individuals enrolled in the Medical Assistance Program, according to the Provider Type license, accreditation, certification, and/or service provided. The Provider Types recognized by the Department are as follows:

1. Administrative Services Organization (ASO) is an entity that has entered into a valid, active contract to provide ASO services with the Colorado Department of Health Care Policy and Financing.

2. Ambulatory Surgical Center (ASC) means a health care entity that is:

a. Licensed by the Colorado Department of Public Health and Environment as an Ambulatory Surgical Center; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as an Ambulatory Surgical Center.

3. Audiologist means an individual licensed as an audiologist by the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

4. Behavioral Therapy Clinic means any group practice that has at least one affiliated Behavioral Therapy Individual. The affiliated Behavioral Therapy Individual must be enrolled in the Colorado Medical Assistance Program.

5. Behavioral Therapy Individual means an individual that:

a. Is nationally certified as a Board-Certified Behavioral Analyst (BCBA); or

b. Meets one of the following:

(1) Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology and is actively licensed by the State Board of Examiners; and has completed 400 hours of training; and/or has direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(2) Has a doctoral degree in one of the behavioral or health sciences; and has completed 800 hours of specific training; and/or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(3) Is nationally certified as a BCBA; or

(4) Has a master’s degree or higher in behavioral or health sciences; and is a licensed teacher with an endorsement of school psychologist; or is a licensed teacher with an endorsement of special education or early

childhood special education; or is credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist); and has completed 1,000 hours of direct supervised training or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

6. Birthing Center means a health care entity licensed as a Birth Center by the Colorado Department of Public Health and Environment. Out-of-state providers are not eligible for enrollment.

7. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers.

8. Certified Registered Nurse Anesthetist (CRNA) means an individual who is:

   a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

   b. Included within the advanced practice registry as a CRNA.

9. Clinic – Dental means any group practice that has at least one affiliated, licensed dentist or dental hygienist.

   a. The affiliated dentist or dental hygienist must be enrolled in the Colorado Medical Assistance Program; and

   b. A dental practice or clinic must be owned by a licensed dentist except if the dental practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.); and

   c. A dental hygiene practice or clinic must be owned by a licensed dentist or licensed dental hygienist except if the dental hygiene practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.)

10. Clinic – Practitioner means any group practice that has at least one affiliated, licensed physician, osteopath, or podiatrist. The affiliated practitioner must be enrolled in the Colorado Medical Assistance Program.

11. Community Clinic means a health care entity that is:

   a. Licensed as a Community Clinic or Freestanding Emergency Department (FSED) by the Colorado Department of Public Health and Environment;

   b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program; and

   c. Owned by a Medicare participating hospital.

12. Community Mental Health Center (CMHC) means a health care entity that:

    a. Is licensed as a Community Mental Health Center by the Colorado Department of Public Health and Environment;

    b. Has program approval to operate as a CMHC from the Colorado Department of Human Services; and

    c. If the CMHC delivers substance use disorder services, shall have Substance Use Disorder program approval from Colorado Department of Human Services.

13. Dental Hygienist means an individual who is licensed as a Dental Hygienist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

14. Dentist means an individual who is licensed as a Dentist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

15. Dialysis Treatment Clinic [Formerly Known as Dialysis Center] means a health care entity that is:

    a. Licensed as a Dialysis Treatment Clinic by the Colorado Department of Public Health and Environment; and

    b. Certified by Centers for Medicare and Medicaid Services to participate in the Medicare program as an End-Stage Renal Dialysis Facility (ESRD).

16. Federally Qualified Health Center (FQHC) means a health care entity that has been awarded a Section 330 Grant from the Health Resources and Services Administration. A health care entity that has been designated as a “look-alike” is also eligible to be enrolled as an FQHC.

17. Foreign Teaching Physician means an individual who is licensed as a distinguished foreign teaching physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

18. Home and Community Based Services (HCBS) means Health First Colorado (Colorado’s Medicaid Program)’s community-based care alternatives to institutional, Long-Term care. Providers enrolling as an HCBS provider shall meet all applicable state and federal requirements to provide HCBS by waiver and specialty type.

19. Home Health Agency means a health care entity that:

    a. Has a Class A Home Care Agency license from the Colorado Department of Public Health and Environment; and

    b. Is certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as Home Health Agency.

20. Hospice means a health care entity that is:

    a. Licensed as a Hospice by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospice.

21. Hospital – General means a health care entity that is:

    a. Licensed as a General Hospital by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospital.

22. Hospital – Psychiatric [Formerly Known as Hospital - Mental] means a health care entity that is:

    a. Licensed as a Psychiatric Hospital by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Psychiatric Hospital.

23. Independent Laboratory means a laboratory that:

    a. Has a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification; and

    b. Is certified through the Centers for Medicare and Medicaid Services as a laboratory.

24. Indian Health Service – Federally Qualified Health Center (FQHC) means a health care entity that:

    a. Is treated by the Centers for Medicare and Medicaid Services as a comprehensive Federally funded health center; and

    b. Includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

25. Indian Health Service – Pharmacy means a health care entity that has evidence of participation in the Indian Health Service.

26. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) [Formerly Known as Nursing Facility – ICF/IID] means a health care entity that is:

    a. Licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities through the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as an ICF/IID.

27. Licensed Behavioral Health Clinician means an individual that is licensed by the Colorado Department of Regulatory Agencies as either:

    a. A Licensed Clinical Social Worker;

b. A Licensed Professional Counselor;

c. A Licensed Marriage and Family Therapist; or

d. A Licensed Addiction Counselor.

28. Licensed Psychologist means an individual who is licensed as a psychologist by the State Board of Psychologist Examiners within the Colorado Department of Regulatory Agencies.

29. Managed Care Entity [Formerly Known as Health Maintenance Organization (HMO)] means an entity that has a valid and comprehensive or all-inclusive risk contract with the Colorado Department of Health Care Policy and Financing.

30. Medicare Only Providers means a provider enrolled in the Medical Assistance Program for purposes of Medicare cost-sharing only, pursuant to 42 CFR §455.410(d).

31. Non-Physician Practitioner Group means any group practice consisting of any of the following:

a. Licensed Nurse Practitioners;

b. Licensed Audiologists;

c. Licensed Occupational Therapists;

d. Licensed Behavioral Health Clinicians;

e. Licensed Psychologists;

f. Licensed Speech Therapists; and/or

g. Licensed Physical Therapists.

h. Beginning on the effective date of this amended rule, and for the remainder of the COVID-19 Public Health Emergency (PHE), providers that have enrolled as a Mass Immunizer Roster Biller (provider specialty type 73) with Medicare may temporarily enroll in the medical assistance program as a Non-Physician Practitioner Group for the purpose of billing for the administration of COVID-19 vaccinations for medical assistance clients.

32. Non-Physician Practitioner Individual means a registered nurse, which means an individual licensed as a Registered Nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies.

33. Nurse Midwife means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Midwife.

34. Nurse Practitioner means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Practitioner.

35. Nursing Facility means a health care entity that is:

a. Licensed as a Nursing Care Facility through the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as a Skilled Nursing Care Facility.

36. Occupational Therapist means an individual who is licensed as an Occupational Therapist by the Director of the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

37. Optical Outlet means a health care supplier that is qualified to make and supply eyeglasses and contact lenses for the correction of vision. If, in the performance of its duties, the Optical Outlet requires laboratory services, the laboratory is required to have a current and valid CLIA certification.

38. Optometrist means an individual who is licensed as an Optometrist by the State Board of Optometry within the Colorado Department of Regulatory Agencies.

39. Osteopath means an individual who holds a degree of “doctor of osteopathy,” and who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

40. Personal Care Agency means a health care entity that has a Class A or Class B Home Care Agency license from the Colorado Department of Public Health and Environment.

41. Pharmacist means an individual who is licensed as a Pharmacist by the State Board of Pharmacy within the Colorado Department of Regulatory Agencies.

42. Pharmacy means a pharmacy, pharmacy outlet, or prescription drug outlet registered by the Board of Pharmacy within the Colorado Department of Regulatory Agencies.

43. Physical Therapist means an individual who is licensed as a Physical Therapist by the Physical Therapy Board within the Colorado Department of Regulatory Agencies.

44. Physician means an individual who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

45. Physician Assistant means an individual who is licensed as a physician assistant by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

46. Podiatrist means an individual licensed as a podiatrist by the Colorado Podiatry Board within the Colorado Department of Regulatory Agencies.

47. Psychiatric Residential Treatment Facility (PRTF) means a health care entity that:

a. Is licensed by the Colorado Department of Human Services as a Residential Child Care Facility and a PRTF; and

b. Is certified as a qualified residential provider by the Department of Public Health and Environment; and

c. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children; and

d. Has provided an attestation to the Department that the PRTF is in compliance with the conditions of participation as required by Colorado Department of Human Services and the Centers for Medicare and Medicaid Services.

48. Qualified Medicare Beneficiary (QMB) Benefits Only means the provider type designation used for Chiropractors who participate under the QMB Program. Chiropractor means an individual licensed as a chiropractor by the Board of Chiropractic Examiners within the Colorado Department of Regulatory Agencies. QMB Benefits Only providers must also be certified as QMB Benefits Only providers through the Centers for Medicare and Medicaid Services.

49. Regional Accountable Entity (RAE) means an entity that has entered into a valid, existing contract with the Colorado Department of Health Care Policy and Financing to be a Regional Accountable Entity.

50. Rehabilitation Agency means a group practice that requires at least one affiliated and licensed professional enrolled in the Colorado Medical Assistance Program.

51. Residential Child Care Facility (RCCF) means a health care entity that is:

a. Designated by the Colorado Department of Human Services to provide Medicaid-reimbursable mental health services as an RCCF; and

b. Licensed by Colorado Department of Human Services as an RCCF.

52. Rural Health Clinic (RHC) means a clinic that is certified by the Centers for Medicare and Medicaid Services as a Rural Health Clinic.

53. School Health Services means a school district or Board of Cooperative Educational Services that has a valid, active contract with the Colorado Department of Health Care Policy and Financing to participate in the Colorado School Health Services Program.

a. The Site at which an Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program enrolled under the Provider Type of School Health Services is a school district.

54. Speech Therapist is an individual certified as a Speech Language Pathologist by the Director of the Divisions of Professions and Occupations within the Colorado Department of Regulatory Agencies.

55. Substance Use Disorder (SUD) – Clinic means a health care entity that:

a. Is licensed as a SUD Provider by the Colorado Department of Human Services;

b. Has program approval to operate as a SUD – Clinic from Colorado Department of Human Services; and

c. Has at least one affiliated advanced practice nurse, physician/psychiatrist, physician assistant, or behavioral health clinician who is certified in addiction medicine.

56. Supply means a Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) provider that meets one or both of the following definitions:

a. Complex Rehabilitation Technology (CRT) Supplier means a health care supplier that meets all the requirements of Section 8.590.5.D, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate;

(2) Has CRT Professional Certification; and

(3) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS and CRT.

b. Durable Medical Equipment (DME) means a health care supplier that meets the requirements of Sections 8.590.5.A and B, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate; and

(2) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS.

57. Transportation means a provider that meets one or both of the following definitions:

a. Emergency Medical Transportation (EMT) [Formerly Known as Emergency Medical Transportation and Air Ambulance] means providers that:

(1) Meet all provider screening requirements in Section 8.125.

(2) Comply with commercial liability insurance requirements.

(3) Maintain the appropriate licensure for:

(a) Ground ambulance license as required by Colorado Department of Public Health and Environment; and

(b) Air ambulance license as required by Colorado Department of Public Health and Environment.

(4) License, operate, and equip ground and air ambulances in accordance with federal and state regulations.

b. Non-Emergent Medical Transportation (NEMT) means a provider that:

(1) Has a Public Utilities Commission (PUC) common carrier certificate as a taxicab; or

(2) Has a PUC Medicaid Client Transport (MCT) Permit as required by the PUC; or

(3) Has a ground ambulance license as required by Department of Public Health and Environment; or

(4) Has an Air Ambulance license as required by Colorado Department of Public Health and Environment; or

(5) Is exempt from licensure requirements in accordance with the PUC.

58. X-Ray Facility means an imaging center that:

a. Has an X-Ray Facility and Machine Registration Report certified by the Colorado Department of Public Health and Environment; and

b. Is certified by the Centers for Medicare and Medicaid Services to participate in Medicare as an X-Ray facility.

K. Service Facility Location Field means the physical location specifically where services were rendered as identified on the Claim.

L. Site means the physical location by street address, including suite number, where goods and/or services are provided. The term Site when involving a Health Care Provider that voluntarily contracts with a RAE as a Primary Care Medical Provider (PCMP) to participate in the Department's Accountable Care Collaborative (ACC) as a medical home, also includes the following requirements:

1. PCMP services must be identifiable from other goods and/or services, including services provided by specialists provided by the Health Care Provider in the same physical location through a separate and unique NPI.

2. PCMP services provided at a Campus or Off-Campus Location must be identifiable from other goods and/or services, including services provided by specialists, provided by the Health Care Provider on the same Campus or Off-Campus Location through a separate and unique NPI.

M. Subpart means a component or separate physical location of an Organization Health Care Provider that may be separately licensed or certified. This definition is intended to be consistent with the use of the term "Subpart" as defined in 45 C.F.R. pt. 162.

N. The definitions in Subsection 8.126.1 apply only to Section 8.126.

8.126.2 Enrollment of Health Care Providers

A. Health Care Providers must enroll in the Medical Assistance Program through the Department's Fiscal Agent, if they:

1. deliver medical care, services, or goods authorized under the Medical Assistance Program; and

2. are required to submit a Claim.

8.126.3 Health Care Provider Requirements to Obtain and Use an NPI

A. A Health Care Provider that is required or eligible to obtain an NPI pursuant to 45 C.F.R. § 162.410 must:

1. Enroll with a unique NPI that identifies the Health Care Provider that delivers medical care, services, or goods authorized under the Medical Assistance Program; and

2. Utilize the Health Care Provider's unique NPI for all Claims.

   a. A Health Care Provider that is not enrolled as of January 1, 2020, must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2020.

   b. All Off Campus Locations must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2020.

   c. All Health Care Providers must submit every Claim using the unique NPI used for enrollment that identifies both the Provider Type and Site effective for date-of-services on or after January 1, 2021.

   d. On every Claim, including Coordination of Benefits Agreement (COBA) automatic crossover Claims, the Organization Health Care Provider shall use the Service Facility Location Field to represent the most specific Site with an NPI where the services are rendered unless the Billing Provider Field represents the most specific Site with an NPI where the services are rendered.

8.126.4 Organization Health Care Provider Requirements to Obtain and Use an NPI

A. Each Organization Health Care Provider and each Subpart of an Organization Health Care Provider that is required or eligible to obtain an NPI pursuant to 45 C.F.R. § 162.410 must enroll using a unique NPI.

1. Each Organization Health Care Provider must enroll using its unique NPI for each Site at which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program.

   a. A Hospital must enroll in the Medical Assistance Program with a unique NPI for:

      (1) Its Campus; and

      (2) Each Off-Campus Location.

2. Each Organization Health Care Provider must enroll in the Medical Assistance Program using a unique NPI for each Provider Type at each Site from which the Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program.

   a. A Hospital must enroll with a unique NPI for each Provider Type at each Site at its Campus and at each Off-Campus Location at which it delivers medical care, services, or goods authorized under the Medical Assistance Program.

3. An Organization Health Care Provider that is a School Health Services provider type must enroll once per School District and not each individual Site.

8.126.5 Health Care Provider Requirements Not Eligible to Receive an NPI

A. A Health Care Provider that is not eligible pursuant to 45 C.F.R. § 162.410 to receive an NPI shall:

1. Enroll without submitting an NPI. The Health Care Provider must obtain a unique identification number assigned by the Department through its Fiscal Agent, that identifies

both the unique Provider Type at each Site at which the Health Care Provider delivers medical care, services or goods authorized under the Medical Assistance Program; and

2. Use the unique identification number assigned by the Department through its Fiscal Agent on every Claim.

    a. A Health Care Provider that is not eligible to obtain an NPI that is not enrolled as of January 1, 2020, must submit every Claim using the unique identification number used for enrollment that identifies both the Provider Type and Site, effective January 1, 2020.

    b. All Health Care Providers that are not eligible to obtain an NPI must submit every Claim using the unique identification number used for enrollment that identifies both the Provider Type and Site, effective January 1, 2021.

8.126.6 New Providers as of January 1, 2020

A. A Health Care Provider that is not enrolled as of January 1, 2020, shall not apply to be enrolled to deliver medical care, services, or goods authorized under the Medical Assistance Program unless the Health Care Provider complies with Section 8.126.

8.126.7 Existing Providers as of January 1, 2021

A. A Health Care Provider that is enrolled as of January 1, 2021, shall not apply to have their enrollment revalidated to deliver medical care, services, or goods authorized under the Medical Assistance Program, as required under 42 C.F.R. § 455.414, unless the Health Care Provider complies with Section 8.126.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Verified Information at Renewal, Section 8.100.3.P
Rule Number: MSB 23-01-31-A
Division / Contact / Phone: Eligibility Policy Section/ Ana Bordallo / 303-866-3558

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 22-12-08-A, Revision to the Medical Assistance Rule concerning Verified Information at Renewal, Section 8.100.3.P

3. This action is an adoption of: an amendment

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

   Sections(s)8.100.3.P, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.3.P with the proposed text beginning at 8.100.3.P.3 through the end of 8.100.3.P.3. This rule is effective April 30, 2023.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Verified Information at Renewal, Section 8.100.3.P
Rule Number: MSB 23-01-31-A
Division / Contact / Phone: Eligibility Policy Section/ Ana Bordallo / 303-866-3558

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 change will amend 10 CCR 2505-10 section 8.100.3.P to update the lookback period of three months to six months when determining if a case has up-to-date information as part of the ex-parte review at renewal. Policy received guidance from CMS that allows states the flexibility to determine whether verified information is considered up-to date and states can consider information verified within the last 6 months. The lookback period determines if a member's case has up-to-date information, if not, this information is requested at renewal. System updates have been made to implement this change.

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:

   CMS provided guidance that states have the flexibility to determine if verified information is considered reliable information available to the state agency verified within the last 6 months. The Department has made updates from 3 to 6 months in December within the Colorado Benefits Management system. This rule aligns our regulations with both Federal and system changes.

3. Federal authority for the Rule, if any:

   42 CRF § 435.916, § 435.948, and § 435.949

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

Initial Review		Final Adoption	**03/10/23**
Proposed Effective Date	**04/30/23**	Emergency Adoption	

DOCUMENT #05

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REGULATORY ANALYSIS

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

   The proposed rule will impact members who have a renewal coming due and enrolled in a MAGI/Non-MAG Medical Assistance program. This rule update benefits a member who continues to meet all criteria eligible by helping them remain eligible without having to provide verifications at renewal.

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 help determine if a case needs up-to-date information at renewal during the ex-parte review for MAGI/Non-MAG Medical Assistance program.

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 expects that updating the look back period for renewals during the ex parte reviews from 3 months to 6 months will have a no impact to the Department due to previous systems updates that allow for electronic verification of income in real time.

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

   There is no cost to the Department associated with this policy. The probable benefit of this policy is to ease the burden on members during the renewal process as they will have more chances to provide the relevant documents. The cost of inaction is the current renewal process can be more burdensome on individual members. There are no obvious benefits to inaction.

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

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There are no less costly methods of increasing the look back period during renewals from 3 months to 6 months.

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

   There were no alternative methods considered for the proposed rule

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.P. Redetermination of Eligibility

1. "Redetermination of eligibility" means a case review and necessary verification to determine whether the Medical Assistance Program member continues to be eligible to receive Medical Assistance.

   "Reconsideration period" means the 90-day period following termination of eligibility.

   Beginning on the case approval date, a redetermination shall be accomplished at least every 12 months for Title XIX Medical Assistance only cases. An eligibility site may redetermine eligibility through telephone, mail, or online electronically means.

2. The eligibility site shall promptly redetermine eligibility when:

   a. it receives and verifies information which indicates a change in a member's circumstances which may affect continued eligibility for Medical Assistance; or

   b. it receives direction to do so from the Department.

   The eligibility site shall redetermine eligibility according to timelines defined by the Department.

3. Ex Parte Review: A redetermination form will not be sent to the member if all current eligibility requirements can be verified by reviewing information from another assistance program or if this information can be verified though an electronic verification system – this process is referenced as Ex Parte Review. The use of telephonic or electronic redeterminations shall be noted in the case record. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the six~~three~~ months prior to the redetermination month, and all other eligibility requirements are met, then an approval notice will be sent for all eligible members of the household who are requesting assistance. This approval notice shall include directions on how to view the information used to determine eligibility.

4. If all required information is not available and/or the information received does not support a finding of eligibility, a redetermination form will be issued to the household at least 30 days prior to the end of the eligibility period. The redetermination form shall be prepopulated with the current information on file and sent to the household at least 30 days prior to the redetermination period ending. As part of the ex parte review, the member will be informed of any verification needed to determine eligibility.

   The redetermination form shall direct members to verify that the information provided is accurate or to report any changes to the information. Members must complete and the return the redetermination with necessary verifications and the signature form. If a member fails to sign the signature form or comply with any of these requirements, the member will be terminated from the program for failure to complete the redetermination process.

The following procedures relate to mail-out redetermination:

a. A Redetermination Form shall be mailed to the member together with any other forms to be completed;

b. Members shall provide requested forms, verifications and information to the eligibility site within 10 working days;

c. When the member is unable to complete the forms due to physical, mental or emotional disabilities, or other good cause, and has no one to help him/her, the eligibility site shall either assist the member or refer him/her to a legal or other resource. When initial arrangements or a change in arrangements are being made, an extension of up to thirty days shall be allowed. The action of the eligibility site in assistance or referral shall be recorded in the case record and CBMS case comments.

d. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE or institutional services disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of Medical Assistance provided to the individual.

e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the individual. This notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.

f. Members who return properly completed redetermination forms and requested information during the reconsideration period shall not be required to submit a new application for eligibility. If redetermination forms and requested information are not returned within 90 days after termination, the member must submit a new application to obtain enrollment in the program.

g. For individuals who are determined to be eligible for Medical Assistance within the reconsideration period, the effective date of coverage will be the first day of the month in which the redetermination form was returned. If the member has a gap in coverage due to submitting the redetermination within the reconsideration period, the member can request up to three months in retroactive coverage.

5. When the redetermination verification information is received by the eligibility site, it shall be date stamped. Within fifteen working days, the verification information shall be thoroughly reviewed for completeness, accuracy, and consistency. All factors shall be evaluated as to their effect on eligibility at that time. Verifications shall be documented in the case file and CBMS case comments. The case file shall be used as a checklist in the redetermination process, and shall be used to keep track of matters requiring further action. When additional information is needed:

   a. due to incomplete information, the request form shall be mailed to the member with a letter specifying the items that require completion. The member shall return the completed request form to the eligibility site no later than ten working days.;

   b. due to incomplete, inaccurate or inconsistent data, the Medical Assistance member shall be contacted by telephone or in writing so that the worker may secure the proper information according to timelines defined by the Department.

6. Due to the federal Coronavirus COVID-19 Public Health Emergency, the Department will continue eligibility for all Medical Assistance categories, regardless of a redetermination and/or reported change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.