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Title of Rule: Revision to the Medical Assistance Act Rule concerning Payment for Inpatient Hospital Services 8.300.1
Rule Number: MSB 23-12-20-A
Division / Contact / Phone: Rates Division / Diana Lambe / 303-866-5526

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 23-12-20-A, **Error! Reference source not found.**

3. This action is an adoption of: an amendment

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

   Sections(s) 8.300.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10), Pages 1-3.

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300 with the proposed text beginning at 8.300.1 through the end of 8.300.1.DD. This rule is effective June 30, 2024.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Payment for Inpatient Hospital Services 8.300.1
Rule Number: MSB 23-12-20-A
Division / Contact / Phone: Rates Division / Diana Lambe / 303-866-5526

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).

   There are two sides to the Health First Colorado's payment methodology for Inpatient Hospital Services Payments. Last year, the Department updated the base rate methodology that was 20+ years old. This year, the Department is updating the other side of the payment equation that assigns an estimate of the resource allocation for the services provided during the inpatient hospital stay. The All Patient Refined Diagnostic Related Groups (APR-DRG) version Colorado is currently using (Version 33) is 8+ years old and needs to be updated on a regular basis going forward to keep up with hospital resource allocation and introduction of new medical technologies/methods of service delivery.

   This rule change is to support the upcoming APR-DRG Version 40 update, which will impact Payment for Hospital Services in 10 CCR 2505-10 8.300. The Department will be making changes to rule regarding certain definitions impacted by its planned implementation of the All Patients Refined Diagnosis Related Groups (APR-DRG) Version 40 update which will use national statistics instead of statistics based upon a hybrid of Colorado and national data. The changes will be focused in two areas: 8.300.1.W. Relative Weight and 8.300.1.AA. Trim Point Day.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 440.10 (2021)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

Initial Review	**04/12/24**	Final Adoption	**05/10/24**
Proposed Effective Date	**06/30/24**	Emergency Adoption	

DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Payment for Inpatient Hospital Services 8.300.1
Rule Number: MSB 23-12-20-A
Division / Contact / Phone: Rates Division / Diana Lambe / 303-866-5526

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 may increase or decrease payments to hospitals for inpatient hospital stays, depending on their case-mix following implementation of the version update. However, the figures were calculated such that Health First Colorado's fee for service payments for hospital services are intended as budget neutral throughout the version transition.

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

   Hospitals may see an increase in reimbursement while others may see a decrease, depending on the case-mix of hospital inpatients following the version transition.

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

   This is a budget neutral change.

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

   The costs of inaction will be a continuation of hospital payments for Medicaid patients which do not align with the expected resources required for inpatient hospital treatments as calculated through modernized statistics. Additionally, new treatments such as CAR-T will continue to be inadequately reimbursed. Further, inaction will continue current administrative complexity which could result in delayed payments for inpatient hospital claims for transgender patients.

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

   There are no other methods to implement this change which are less costly or intrusive.

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

   The Department must regularly update its APR-DRG version in order to maintain alignment in its payments to hospitals for inpatient stays with their expected cost experience. This rule change will establish a pathway for the Department to do so without requiring additional resources through contractor funds or FTE.

8.300 HOSPITAL SERVICES

8.300.1 Definitions

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

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

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

8.300.1.D. Corrective Action is a step-by-step plan approved by the Department to achieve targeted outcomes and address patterns of inappropriate behavior, including, but not limited to, improper billing, unwarranted utilization, or questionable quality of care. Corrective action may include, but is not limited to, Concurrent Review, Continued Stay Review, Prospective Review, Retrospective Review, requirement to self-audit, or any other action as determined appropriate by the Department.

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

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

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

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

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

8.300.1.J. Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

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

8.300.1.L. Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified

for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

1. A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

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

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

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

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

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

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

8. A Medicare Dependent Hospital is defined as set forth at 42 C.F.R § 412.103 (2022). 42 C.F.R. § 412.108(1) (2018) is hereby incorporated by reference into this rule. Such

incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

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

10. A Sole Community Hospital (SCH) is defined by CMS which classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in 412.64) and meets one of the following conditions. No more than 25 percent of residents who become hospital inpatients or no more that 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger within its service area. The hospital has fewer than 50 beds and intermediary certifies that the hospital would have met the criteria in paragraph (a)(I)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specially services at the hospital are inaccessible for at least 30 days in each 2 out of 3 years.

11. For the purposes of Section 8.300: Hospital Services, Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as hospitals which Medicare pays on a prospective basis and which provide data in the Medicare IPPS IMPACT file and supporting data files/tables from which to create their PPS rate. Conversely, non-Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as Pediatric and Critical Access Hospitals for which Medicare does not pay on a prospective basis and which do not have data available on the Medicare IPPS IMPACT file or supporting data files/tables.

12. Rebasing years are every other odd year starting in state fiscal year 2023-24. Non-rebasing years are every other even year starting in state fiscal year 2024-25.

8.300.1.M. Inpatient is a person who has been admitted to a Hospital for purposes of receiving Inpatient Hospital Services.

8.300.1.N. Inpatient Hospital Services means services that are furnished by a Hospital for the care and treatment of an Inpatient and are provided in the Hospital by or under the direction of a physician.

8.300.1.O. Medical Necessity is defined at Section 8.076.1 and, for members ages 20 and under receiving Early and Periodic Screening, Diagnosis, and Treatment services, at Section 8.280.4.E.2.

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

8.300.1.Q. Observation Stay means Outpatient Hospital Services provided in a Hospital for the purposes of evaluating a person for Inpatient admission, stabilization, or extended recovery.

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

8.300.1.S. Outpatient means a person who is receiving professional services at a Hospital or an off-campus location of a Hospital but is not admitted as an Inpatient.

8.300.1.T. Outpatient Hospital Services means services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.

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

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

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

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

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

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

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

8.300.1.BB. Trim Point Day (Outlier Threshold Day) means the day during an inpatient stay after which Outlier Days are counted. ~~The Trim Point Day occurs 2.58 standard deviations above the average length of stay for each DRG. Beginning July 1, 2020, the Trim Point Day for delivery and neonate DRGs is equal to the Trim Point Day as calculated in the applicable Hospital-Specific Relative Value National File for Delivery and Neonate DRGs~~. The Trim Point Day is~~s are~~ based upon the data sources applicable to the DRG version effective during the last date of service of the inpatient hospitalization.

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

8.300.1.DD. Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Rule Concerning the Hospital Expenditure Report Data Collection, 8.4000
Rule Number: MSB 24-01-03-B
Division / Contact / Phone: Special Financing / James Johnston / 3073

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 24-01-03-B, Revisions to the Medical Assistance Rule Concerning the Hospital Expenditure Report Data Collection, 8.4000.

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) 8.4000, 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 8.4000 with the proposed text beginning at 8.4000 through the end of 8.4004.A.2. This rule is effective June 30, 2024.

*to be completed by MSB Board Coordinator

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Title of Rule: Revisions to the Medical Assistance Rule Concerning the Hospital Expenditure Report Data Collection, 8.4000
Rule Number: MSB 24-01-03-B
Division / Contact / Phone: Special Financing / James Johnston / 3073

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).

   HCPF is proposing a new section to the Medical Assistance Rule Concerning Hospital Expenditure Report Data Collection, Section 8.4000. With recently enacted legislation, House Bill 23-1226: Hospital Transparency and Reporting Requirements, hospitals are required to submit annual financial data and certain historic data previously not required to the Colorado Department of Health Care Policy & Financing (HCPF); House Bill 23-1226 also sets up a corrective action process for noncompliance. This rule will outline an expansion of existing processes, requirements and parameters for hospitals to submit the new financial reporting information required by legislation to HCPF, in doing so HCPF will reduce administrative burden for both hospitals and HCPF. For example, hospitals are to annually submit changes to services lines. These rules will define what HCPF will be collecting annually through the reporting template. This rule will also outline the process for corrective action plans for noncompliance.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023); Section 25.5-4-402.8, C.R.S.

Initial Review	**04/12/24**	Final Adoption	**05/10/24**
Proposed Effective Date	**06/30/24**	Emergency Adoption	

DOCUMENT #

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Title of Rule: Revisions to the Medical Assistance Rule Concerning the Hospital Expenditure Report Data Collection, 8.4000
Rule Number: MSB 24-01-03-B
Division / Contact / Phone: Special Financing / James Johnston / 3073

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 requires general, acute care hospitals to submit new financial reports to HCPF on a rolling basis, and certain historic financial data previously not required by law. Citizens of Colorado will benefit from increased financial transparency of Colorado's hospitals, which may result in reduced costs of care for Coloradans and a more financially stable health system.

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

   Multiple studies including the Institute of Medicine (US) Roundtable on Evidence-Based Medicine's The Healthcare Imperative: Lowering Costs and Improving Outcomes (2010), Health care opinion leaders' view on the transparency of health care quality and price information in the United States (2007), and The effects of mandatory transparency in financial market design (2019) have documented that increased financial transparency in economic markets reduces costs for goods and services. Within economic theory, as a market becomes more transparent, more competition is observed, and as competition increases consumers have more buying power. Increased buying power for consumers leads to a reduction in prices from producers. This rule will benefit Coloradans purchasing health care and health care services.

   Institute of Medicine (US) Roundtable on Evidence-Based Medicine; Yong PL, Saunders RS, Olsen LA, editors. The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington (DC): National Academies Press (US); 2010. 10, Transparency of Cost and Performance. Available from: https://www.ncbi.nlm.nih.gov/books/NBK53921/

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Shea K, Shih A, Davis K. Health care opinion leaders' views on the transparency of health care quality and price information in the United States. 2007

Asquith, P., Pathak, P., & Covert, T. (2019). The effects of mandatory transparency in financial market design -NBER. https://www.nber.org/system/files/working_papers/w19417/w19417.pdf

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.

   With the enactment of HB 23-1226, the General Assembly appropriated administrative resources to implement and administer the data collection and analysis. The proposed rule does not create a fiscal impact on the state's general fund.

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

   This proposed rule provides appropriate guidance so hospitals can submit accurate information in compliance with the new law. The proposed rules are needed to implement the legislation, create no additional costs, and there are no benefits of inaction. Costs of inaction include additional administrative burden for both hospitals and HCPF to complete requirements without the additional clarity from rules.

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

   The proposed rule provides necessary guidance for hospitals to comply with the new law. The proposed rule reduces the administrative burden for both HCPF and hospitals.

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.

   Since the legislation requires all Colorado general, acute care hospitals to provide new financial information and certain historic financial data, and this proposed rule standardizes how information is to be provided in the least burdensome manner, there are no alternative methods for implementing the legislation.

8.4000

PURPOSE: To supply data for the Hospital Financial Transparency Report, which is an annually prepared written report detailing uncompensated hospital costs and the different categories of expenditures, by major payoer group, made by hospitals in the state.

8.4001.A DEFINITIONS

1. "Certified Financial Statements" means financial statements, along with accompanying notes, that have been prepared in accordance with Generally Accepted Accounting Principles and that have been audited by an independent certified public accountant(s) in accordance with generally accepted auditing standards.

2. "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and licensed or certified as a critical access hospital by the Colorado Department of Public Health and Environment.

3. "DATABANK Program" means the Colorado Hospital Association program that collects hospital utilization and financial data.

4. "Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described at Section 25.5-4-402.4(7), C.R.S..

5. "General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

6. "Health System" is a larger corporation or an organizational structure that owns, contains, or operates more than one hospital.

7. "Long Term Care Hospital" means a General Hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment.

8. "Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS, and the annual required submission of worksheets and schedules by Medicare certified providers used for Medicare reimbursement.

9. "Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

10. "Quarterly Financial Statements" means internal unaudited financial statements including an income statement and balance sheet prepared in accordance with Generally Accepted Accounting Principles.

11. "Rehabilitation Hospital" means an inpatient rehabilitation facility.

8.4002 RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS FOR ANNUAL REPORTING REQUIREMENTS

8.4002.A ANNUAL STATEMENT SUBMISSION

1. ~~For the purposes of compiling historic data for the Hospital Financial Transparency Report, all General Hospitals and Critical Access Hospitals shall submit Certified Financial Statements and Medicare Cost Reports for all fiscal periods ending after January 1, 2012 through the most recently available fiscal period.~~

~~a. Hospitals shall submit within fifteen (15) days of the effective date of this rule.~~

1. For the purposes of ongoing data compilation for the Hospital Financial Transparency Report, all General Hospitals and Critical Access hospitals shall submit their Certified Financial Statements, ~~and~~ Medicare Cost Reports, and a hospital specific statement of cash flows~~.~~

   a. Hospitals shall submit a Certified Financial Statement within 120 days after the end of its fiscal year, unless the Department grants an extension in writing in advance of that date.

   b. Hospitals shall submit annual Medicare Cost Reports to the Department within thirty (30) days after submitting them to CMS.

   c. Hospitals shall submit a specific statement of cash flows within a time frame specified by HCPF, but not less than 120 days after the hospital's fiscal year end.

2. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from submitting Certified Financial Statements, ~~and~~ Medicare Cost Reports and statements of cash flows.

3. For a hospital that operates within a Health System or other corporate structure, and is normally included in the Health System or other corporate structure's Certified Financial Statements

   a. The hospital may submit the Health System or other corporate structure's Certified Financial Statements if the statements separately identify the financial information for each licensed hospital operating in the state including:

      i. A statement of operations.

      ii. A balance sheet.

      iii. If available, a statement of changes in net assets (or equity).

      iv. If available, a statement of cash flows.

   b. For hospitals in which the consolidated Certified Financial Statements do not separately identify the financial information for each licensed hospital operating in the state, then the hospital shall submit the financial statements that were submitted with its Medicare Cost Report and shall submit a reconciliation of the consolidated financial statement and hospital-specific revenue and expenses reported on the Medicare Cost Report pursuant to the federal centers for Medicare and Medicaid services provider reimbursement manual form 339.

4. If total revenues and total expenses on the submitted financial statements differ from the Medicare Cost Report, the hospital shall submit a reconciliation.

5. A hospital may choose to submit a written explanation of operating, investing, or financing decisions that impact the interpretation of the Certified Financial Statements or Medicare Cost Report.

6. A hospital may choose to submit a written explanation detailing changes in reporting methodology between fiscal periods that would impact the interpretation of the statements and what period may be affected. Examples of reporting methodologies that could change include:

   a. Measurements of financial assets and liabilities.

b. Recording of retirement benefit plans.

c. Recording of income tax expense.

d. Rates of depreciation.

7. The Department is not responsible for the review and authentication of the Certified Financial Statements and the Medicare Cost Report. The authentication of the submitted Certified Financial Statements and the Medicare Cost Report is the responsibility of the hospital or Health System.

8. Submissions shall be certified by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

8.4002.B ANNUAL REPORTING SUBMISSION

1. ~~For the purposes of compiling historic data for the Hospital Financial Transpareny Report, hospitals shall report utilization and financial information for fiscal periods ending after January 1, 2012 through the most recently available fiscal period if such information is available. The Department shall make available or distribute a data reporting template to all hospitals.~~

~~a. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by C.R.S. § 25.5-4-402.8(2)(b)(III).~~

~~b. The Department may allow hospitals to submit data submitted to the DATABANK Program as an alternative to the Department's reporting template. The Department shall instruct hospitals what is an acceptable DATABANK Program submission.~~

~~c. Hospitals shall return the completed reporting template to the Department within fifteen (15) days after receiving the request or on the stated due date, whichever is later.~~

1. For the purposes of ongoing data compilation for the Hospital Transparency~~Expenditure~~ Report, hospitals shall report utilization, ~~and~~ financial, service line, and large project information on the hospital for the requested fiscal year. The Department shall make available or distribute a data reporting template to all hospitals.

a. The Department shall inform hospitals of the fiscal period of the request.

b. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by Section 25.5-4-402.8(2)(b)(III), C.R.S., as well as several required by Section 25.5-4-402.8(2)(b)(II), C.R.S.

c. Hospitals shall return the completed reporting template to the Department within thirty (30) days after receiving the request or on the stated due date, whichever is later.

2. Hospitals shall submit the following items required by Section 25.5-4-402.8(2)(b)(II), C.R.S.

a. Hospitals shall submit an annual summary of the hospital's transfer of cash, equity, investments, or other assets to and from related parties, including but not limited to the hospital's parent organization along with the report pursuant to Section 25.5-4-402.8(2)(b)(III), C.R.S.. Hospitals shall submit this summary within 120 days after the end of its fiscal year, unless the Department grants an extension in writing in advance of that

date. A hospital may aggregate the transfers for each entity receiving or making the transfer. The summary shall include:

i. The purpose of the transfer, and

ii. Whether the transfer was made within or outside of Colorado.

b. Hospitals shall submit changes to no more than twenty-five categories of specific major service lines along with the report pursuant to Section 25.5-4-402.8(2)(b)(III), C.R.S..

i. HCPF shall determine up to twenty-five service line categories and inform hospitals of them before the submission period begins.

c. Hospitals shall submit a narrative report of major planned and completed projects and capital investments greater than twenty-five million dollars along with the report pursuant to Section 25.5-4-402.8(2)(b)(III), C.R.S.. Hospitals shall submit this summary within 120 days after the end of its fiscal year, unless the Department grants an extension in writing in advance of that date. Except the information HCPF receives from hospitals regarding planned activities is confidential, proprietary, contains trade secrets, and is not a public record pursuant to Part 2 of Article 72 of Title 24.

3. Hospitals shall submit a roll-forward schedule detailing the changes in property, plant, and equipment balances from the beginning to the end of the reporting period.

a. Changes shall be appropriately categorized as either purchases, other acquisitions, sales, disposals, depreciation expense or other changes. Significant amounts categorized as other changes should be separately described. The roll-forward schedule should provide details of changes by property, plant, and equipment category including, but not limited to land, buildings, buildings – accumulated depreciation, building improvements, building improvements – accumulated depreciation, leasehold improvements – leasehold improvements – accumulated depreciation, equipment, equipment – accumulated depreciation, other and other – accumulated depreciation. The beginning and ending balances on the roll-forward schedule should agree to the respective balance sheet.

4. For the purposes of compiling historic data for the Hospital Financial Transparency Report, hospitals shall report no later than July 1, 2024.

a. The Department shall make available or distribute a data reporting template to all hospitals

b. For each fiscal year 2014-15 through 2019-20, a summary of the hospital's transfer of cash, equity, investments, or other assets to and from related parties, including but not limited to the hospital's parent organization. A hospital may aggregate the transfer of each entity receiving or making the transfer. The summary shall include:

i. The purpose of the transfer, and

ii. Whether the transfer was made within or outside of Colorado.

b. For each fiscal year from 2014-15 through 2019-20, information on affiliations and a report of physician practice acquisitions including but not limited to:

i. The names and transaction price of acquired hospitals, affiliated hospitals, newly constructed hospitals, and rehabilitation hospitals,

ii. The names and transaction price of acquired or affiliated physician group practices, and

iii. The number and transaction price of individual physician practices acquired or affiliated..

c. For each fiscal year from 2019-20 through 2022-23, details of significant other revenue that would otherwise be reported in the Medicare Cost Report.

d. HCPF shall include instructions for completing the one-time data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by. Section 25.5-4-402.8(2)(b.5), C.R.S.

e. Hospitals shall return the completed reporting template to the Department within thirty (30) days after receiving the request or on the stated due date, whichever is later.

5. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the reporting submission.

6. The Department shall determine the reasonableness of the data submitted by comparing it to the submitted Certified Financial Statement.

7. Submissions shall be certified by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

8.4002.C DEPARTMENT REPORTING & TRANSPARENCY

1. The Department is responsible for the compilation of the hospital submissions.

2. The Department shall consult with the Enterprise Board on the structure and format of the Hospital Expenditure Report at the Enterprise Board meetings.

3. The Department shall share the hospital's data in the Hospital Financial Transparency Report and a copy of the report with the hospital a minimum of fifteen (15) days before the report is publicly available or issued to the Enterprise Board.

4. After the collection and review of the data submission, a machine-readable format of the hospital data shall be made available to the statewide hospital association at no cost to the association.

5. HCPF shall report on the annual Hospital Transparency Report during HCPF's State Measurement for Accountable, Responsive, and Transparent Government Act hearing.

8.4003 RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS FOR QUARTERLY REPORTING REQUIREMENTS

8.4003.A QUARTERLY STATEMENT SUBMISSIONS

1. All General Hospitals and Critical Access Hospitals shall submit Quarterly Financial Statements within ninety (90) days of the end of the calendar quarter.

2. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from submitting Quarterly Financial Statements.

3. For a hospital that operates within a Health System or other corporate structure, and is normally included in the Health System or other corporate structure's Quarterly Financial Statements, the hospital may submit the Health System or other corporate structure's Quarterly Financial Statements.

4. A hospital may choose to submit a written explanation detailing changes in reporting methodology between fiscal periods that would impact the interpretation of the statements and what period may be affected. Examples of reporting methodologies that could change include:

    a. Measurements of financial assets and liabilities.

    b. Recording of retirement benefit plans.

    c. Recording of income tax expense.

    d. Rates of depreciation.

5. The Department is not responsible for the review and authentication of the Quarterly Financial Statements. The authentication of the submitted Quarterly Financial Statements is the responsibility of the hospital or Health System.

6. Submissions shall be certified by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer.

8.4003.B QUARTERLY REPORTING SUBMISSION

1. For the purposes of ongoing quarterly data compilation for the Hospital Financial Transparency Report, hospitals shall report Quarterly Financial Statements for the requested quarter. The Department shall make available or distribute a data reporting template to all hospitals.

    a. The Department shall inform hospitals of the time period of the request.

    b. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by Section 25.5-4-402.8(2)(b)(IV)(A), C.R.S.

    c. Hospitals shall return the completed reporting template to the Department within ninety (90) days after receiving the request or on the stated due date, whichever is later.

8.4003.C DEPARTMENT QUARTERLY REPORTING & TRANSPARENCY

1. The Department is responsible for the compilation of the hospital Quarterly Financial Statement submissions.

2. The Department shall provide any analysis, report, or presentation based on the Quarterly Financial Statements to each hospital at least fifteen (15) days prior to the public release of any analysis, report, or presentation. The Department shall clearly state any analysis, report, or presentation based on Quarterly Financial Statements is unaudited when applicable.

3. After the collection and review of the Quarterly Financial Statement submissions, a machine-readable format of the hospital data shall be made available to the statewide hospital association at no cost to the association.

8.4004.A HOSPITAL FINANCIAL TRANSPARENCY COMPLIANCE AND CORRECTIVE ACTION PROCESS

1. If a hospital does not provide all the of the information required pursuant to subsection (2)(b) of section 25.5-4-402.8, C.R.S., HCPF shall inform the hospital of its noncompliance within sixty (60) days and identify the information the hospital needs to provide.

    a. If a hospital does not comply, HCPF shall issue a corrective action plan with a timeline of sixty (60) days required for compliance.

    b. If a hospital continues not to comply, HCPF may create a mandatory pay-for-reporting compliance measure within the Hospital Transformation Program that is tied to the Healthcare Affordability and Sustainability Fee Supplemental Payment.

2. If HCPF determines a hospital's noncompliance with reporting requirements is knowing or willful or there is a repeated pattern of noncompliance, HCPF shall consider the size of the hospital and the seriousness of the violation in setting a fine amount, not to exceed the amounts specified in Section 25.5-4-402.8(2)(g)(II), C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Electronic Visit Verification (EVV) Provider Types, Section 8.001.A.2
Rule Number: MSB 23-10-25-B
Division / Contact / Phone: Policy Development and Implementation Section / Erica Schaler / 303-866-3195

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 23-10-25-B, Electronic Visit Verification (EVV) 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): 8.001.2.A

   Sections(s) 8.001.2.A, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.001.2.A with the proposed text beginning at 8.001.2.A through the end of 8.001.2.A.15. This rule is effective June 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Electronic Visit Verification (EVV) Provider Types, Section 8.001.A.2
Rule Number: MSB 23-10-25-B
Division / Contact / Phone: Policy Development and Implementation Section / Erica Schaler / 303-866-3195

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 removes Hospice Services from the provider types required to utilize Electronic Visit Verification (EVV). The current rule includes Hospice Services as a provider type required to utilize EVV. In order to align the rule with current practices, Hospice Services must be removed as a provider type from EVV requirements. Additionally, there are technical changes to the numbering as a result of removing hospice throughout the rule.

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:

1. Federal authority for the Rule, if any:

   Section 12006(A) of the 21st Century Cures Act, P.L. No. 114-255

2. State Authority for the Rule:

   Sections 25.5-1-301-303 (2023).

Initial Review **04/12/24** Final Adoption **05/10/24**
Proposed Effective Date **06/30/24** Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Electronic Visit Verification (EVV) Provider Types, Section 8.001.A.2
Rule Number: MSB 23-10-25-B
Division / Contact / Phone: Policy Development and Implementation Section / Erica Schaler / 303-866-3195

REGULATORY ANALYSIS

3. 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 nature of hospice service delivery is much different than the other services where EVV is required. EVV is not a practical program integrity tool for hospice services and creates burden for the providers.

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

   Because this rule change aligns the rule with current practices, the fiscal impact will be neutral.

5. 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.

   Budget reviewed the proposed rule and has determined it is budget neutral.

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

   The probable cost of the proposed rule is provided in the response to question #3 above. The benefit of the proposed rule is aligning the rule with current practices to reduce audit risk and provider administrative burden.

7. 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 than aligning the rule with current practices. This rule is budget neutral.

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

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There are no alternative methods for aligning the rule with current practices and reducing future audit risk.

8.001 ELECTRONIC VISIT VERIFICATION (EVV)

8.001.2 Provider Applicability

8.001.2.A. When providing services in the home or community, Providers of the following services reimbursed by the Department as fee-for-service must utilize EVV:

1. Behavioral Services ~~when provided in the home or community~~, as defined in Sections 8.212, and 8.500.94.B.~~2~~3.~~, when provided in the home or community~~;

2. Consumer Directed Attendant Support Services as defined in Sections 8.510 and 8.500.90.I;

3. Home Health Services as defined in Section 8.520.1.K;

4. Homemaker Services as defined in Sections 8.490.1 and 8.500.94.B.~~8~~9;

~~5. Hospice Services when provided in the home as defined in Section 8.550.1;~~

5~~6~~. Independent Living Skills Training as defined in Section 8.516.10.A.1;

6~~7~~. In-Home Support Services as defined in Sections 8.506.4.C and 8.552.1.M;

7~~8~~. Life Skills Training as defined in Section 8.553.1.~~H~~I;

8~~10~~. ~~.~~Pediatric Behavioral Therapies provided under Early, Periodic Screening, Diagnosis and Treatment (EPSDT) Services as defined in Section 8.280.1~~, when provided in the home or community.~~;

9~~1110~~. Pediatric Personal Care ~~when provided in the home or community,~~ as ~~defined~~ described in ~~Section 8.535.1~~ Appendix A to Sections 8.500-8.599;

10~~21~~. Personal Care Services provided as defined in Sections 8.489.10.11 and 8.500.94.B.~~13~~14;

a. Personal Care Services provided in a Provider-owned residential type setting and paid via per diem are excluded from the EVV requirements outlined in this rule.

11~~32~~. Physical Therapy and Occupational Therapy ~~when provided in the home or community~~ as ~~defined~~ described in Section 8.200.3.A.6;

12~~43~~. Private Duty Nursing as defined in Section 8.540.1;

13~~54~~. Respite ~~when provided in the home or community,~~ as defined in Sections 8.492.10.11 and 8.508.100.~~J~~F;

14~~65~~. Speech Therapy ~~when provided in the home or community~~, as ~~defined~~ described in Section 8.200.3.D.2; and

15~~76~~. Youth Day Services when provided in the home or community as defined in Sectio~~n~~n 8.503.40.A.13.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Nursing Facility Reimbursement Rule concerning Pay for Performance and Medicare costs Sections 8.440.2.A, 8.441.5.H, 8.441.5.L, and 8.443.12.
Rule Number: MSB 24-03-01-A
Division / Contact / Phone: Office of Community Living / Christine Bates / 303-866-5419

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 24-03-01-A, Revision to the Medical Assistance Nursing Facility Reimbursement Rule concerning Pay for Performance and Medicare costs Sections 8.440.2.A, 8.441.5.H, 8.441.5.L, and 8.443.12.

3. This action is an adoption of: 4 rule section amendments

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

   Sections(s) 8.440.2.A, 8.441.5.H, 8.441.5.L, 8.443.12, 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 8.400 with the proposed text beginning at 8.400.2.A.18 through the end of 8.400.2.A.18. Replace the current text at 8.400 with the proposed text beginning at 8.441.5.H.2.c.3 through the end of 8.441.5.H.2.c.3. Replace the current text at 8.400 with the proposed text beginning at 8.441.5.L through the end of 8.441.5.L.4. Replace the current text at 8.400 with the proposed text beginning at 8.443.12 through the end of 8.443.12.9. This rule is effective June 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Nursing Facility Reimbursement Rule concerning Pay for Performance and Medicare costs Sections 8.440.2.A, 8.441.5.H, 8.441.5.L, and 8.443.12.
Rule Number: MSB 24-03-01-A
Division / Contact / Phone: Office of Community Living / Christine Bates / 303-866-5419

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).

   These changes are required per HB 23-1228. Medicare costs are being removed from nursing facility cost reports (8.440.2.A, 8.441.5.H. and 8.441.5.L). The Pay for Performance supplemental payment for nursing facilities is being increased.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301-303, C.R.S. (2023);
   Sections 25.5-6-202, 203, 208, and 210, C.R.S., as revised pursuant to HB23-1228.

Initial Review	**04/12/24**	Final Adoption	**05/10/24**
Proposed Effective Date	**06/30/24**	Emergency Adoption	

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Nursing Facility Reimbursement Rule concerning Pay for Performance and Medicare costs Sections 8.440.2.A, 8.441.5.H, 8.441.5.L, and 8.443.12.
Rule Number: MSB 24-03-01-A
Division / Contact / Phone: Office of Community Living / Christine Bates / 303-866-5419

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.

   Nursing facility residents will ultimately benefit from the increased Pay for Performance (P4P) supplemental payment to nursing facilities which provide an incentive for facilities to provide higher quality services. This increase in supplemental payments to nursing facilities will approximately double the payment by SFY 2026-27 to those facilities that apply. The removal of Medicare costs from the nursing facility cost reports will redirect funds from nursing facilities with higher Medicare utilization to nursing facilities with higher Medicaid utilization.

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

   Nursing facility residents of facilities that receive P4P supplemental payments will benefit from the increased quality of services provided by the facility. The change in the per diem rate incurred by the Medicare cost removal from nursing facilities is net zero across all facilities. Each individual nursing facility will be affected differently based on the amount of Medicare costs being removed from their cost reports but the effect is negligible for most facilities.

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 total of P4P supplemental payments available for all nursing facilities will be 12% of the total of all annual Provider Fee supplemental payments for SFY 2024-25 and 2025-26. The total estimated payments will be approximately $6.8 million in SFY 2024-25 and $7.2 million in SFY 2025-26. Total available P4P supplemental payments will be increased to 15% of the total of all annual Provider Fee supplemental payments for SFY 2026-27 and all subsequent years. Thus the total available for P4P supplemental payments will be approximately $9.4 million in SFY 2026-27. This will approximately double the amount of payments nursing facilities that apply for P4P supplemental payments will receive. Removing the Medicare costs

from the nursing facility cost reports is a permanent change that will redirect Medicaid reimbursement away from facilities in which Medicare utilization is higher than Medicaid utilization to those facilities that have a proportionally higher Medicaid utilization.

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

   Because P4P supplemental payments are drawn from funds collected as provider fees, this rule revision is budget neutral. The benefit of P4P incentives is the higher quality services facilities are incentivized to provide to receive the supplemental payments. The cost of inaction would be that HCPF would be out of compliance with the revised statutory requirements set forth in HB23-1228. 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 for achieving the intent of HB23-1228.

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 to rule-making were considered as the statutory changes made by HB23-1228 required amendments to bring existing rules into alignment.

8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT

8.440.2.A. The following general categories and examples of items and services are not included in the facility's per diem rate. Items 1 – 11 may be charged to the resident's personal needs account if requested~~,~~ in writing by a resident and/or the responsible party. (~~r~~Refer to Section 8.482 for policy guidance on resident personal needs accounts):

18. Non-Medicaid ancillary services such as laboratory, radiology, physical therapy, occupational therapy, speech therapy and respiratory therapy.

8.441.5 COMPLETION OF NON-REIMBURSABLE EXPENSES AND EXPENSE LIMITATIONS AND ADDITIONS SCHEDULE

8.441.5.H. MANAGEMENT SERVICES

2. In addition to the requirements of ~~10 CCR 2505-10 s~~Section 8.441.5.H.1, the following requirements shall apply to owner-related management companies:

c. When management services are provided to a nursing facility by an owner-related management company, the nursing facility shall compile and present for inspection supporting documentation of actual costs incurred in providing the management company services. This shall include, at a minimum, the following:

i) Documentation supporting the reasonableness of salaries paid to owners and owner-related employees of the management company, as specified in ~~10 CCR 2505-10 s~~Section 8.441.5.B;

ii) Allocation schedules;

iii) ~~Medicare Home Office cost reports~~Home Office Cost Statement, Form CMS-287-22;

8.441.5.L. LIMITATION ON MEDICARE PART A AND PART B COSTS

1. Effective July 1, 2024, Medicare and other third party (non-Medicaid) ancillary costs shall be excluded from the allowable Medicaid reimbursement for Class I nursing facilities.~~Only those Medicare costs that are reasonable, necessary and patient-related shall be included in calculating the allowable Medicaid reimbursement for class I nursing facilities.~~

~~2. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for a class I facility shall be: The level of Part A costs allowed in the facility's latest Medicare cost report submitted by the facility to the Department prior to July 1, 1997.~~

~~3. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for newly certified Medicaid nursing facilities shall be: The level of Part A costs allowed in the facility's first full year Medicaid cost report submitted by the facility to the Department.~~

~~4. Part B direct costs for Medicare shall be excluded from the allowable Medicaid reimbursement for class I nursing facilities.~~

8.443.12 PAY-FOR-PERFORMANCE SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to those Class I nursing ~~facility~~ facilities ~~providers~~ that provide services resulting in better care and higher quality of life for their residents.

1. Annually, the Department shall calculate the payment by multiplying a Pay-for-Performance (P4P) per diem rate by Medicaid patient days.

2. ~~The P4P per diem rate shall be calculated according to the following table:~~The P4P per diem rate for a Class I nursing facility is determined using their P4P points. The per diem rates are tiered such that Class I nursing facilities with greater points receive a ~~greater~~higher per diem rate than facilities with lesser points. There are five tiers delineating the per diem rates with each tier assigned a certain points range. For each tier, the per diem rate increases by a multiplier.

The multiplier and point range for each tier are:

P4P Points	Per Diem Rate
0 – 20 points	~~No add on~~0(x)
21 – 45 points	~~$1.00~~1(x)
46 – 60 points	~~$2.00~~2(x)
61 – 79 points	~~$3.00~~3(x)
80 – 100 points	~~$4.00~~4(x)

For SFY 2024-25 and 2025-26, the P4P per diem rates shall equal an amount such that total ~~supplemental~~P4P payments made to all Class I nursing facilities shall be no less than twelve percent (12%) of the total of all annual P~~p~~Provider F~~f~~Fee supplemental payments. For SFY 2026-27 and all subsequent years, the P4P per diem rates shall equal an amount such that total ~~provider fee~~ P4P supplemental payments made to all Class I nursing facilities shall be no less than fifteen percent (15%) of the total of all annual Provider Fee supplemental payments.

3. The P4P points ~~will~~shall be based on a completed and verified/audited application including performance measures in the domains~~:~~ of quality of life, quality of care, and nursing facility management.

   The application includes the following:

   a. The number of points associated with each performance measure;

   b. The criteria the nursing facility must meet or exceed to qualify for the points associated with each performance measure.

4. The prerequisites for participating in the program are as follows:

   a. ~~No~~ A nursing facility with substandard deficiencies on a regular annual, complaint, or any other CDPHE survey that qualifies for the P4P supplemental payment ~~will~~shall ~~be considered~~receive one half the calculated payment ~~for pay for performance~~. Substandard quality of care means one or more deficiencies related to participation requirements ~~under~~ set forth at 42 C.F.R. § 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 C.F.R. § 483.24, Quality of Life ~~quality of life~~, or 42 C.F.R. § 483.25, ~~q~~Quality of ~~c~~Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual

harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

b. ~~The facility must perform a resident/family satisfaction survey. The survey must (a) be developed, recognized, and standardized by an entity external to the facility; and, (b) be administered on an annual basis with results tabulated by an agency external to the facility. The facility must report their response rate, and a summary report must be made publicly available along with the facility's State's survey results.~~ The facility must perform a resident/family satisfaction survey in the manner determined by the department and published annually on the pay for performance application published to the department~~"~~s website.

5. To apply for a P4P supplemental payment, the nursing facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The nursing facility must maintain documentation supporting its representations for each performance measure for which the facility represents it meets or exceeds the specified criteria. Additionally, the nursing facility must submit with its application ~~T~~the required documentation for each performance measure ~~i~~as identified on the application. ~~and must be submitted with the its application. In addition, the facility must include a written narrative for each sub-category to be considered that describes the process used to achieve and sustain each measure.~~

6. ~~The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions.~~ Applications and supporting documentation ~~as received will~~shall be considered complete as received. No post receipt or additional information ~~will~~shall be accepted ~~for that~~after submission of the application. Facilities ~~will~~ shall be selected for onsite verification of performance measures representations based on risk.

7. ~~Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.~~A nursing facility ~~will~~may accumulate a maximum of 100 points by meeting all performance measures indicated on the application.

8. ~~The Department shall perform these calculations annually to coincide with the July 1st rate setting process.~~Medicaid patient days shall be determined ~~from the~~based on claims data from the MMIS and/or information provided by the nursing facility for the most recently completed calendar year ending prior to the calculation of the supplemental payment ~~ending prior to the state fiscal year~~.

9. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthly to Class I nursing facilities. For state administered Class I nursing facilities the amount shall be divided by four and reimbursed quarterly.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Colorado Indigent Care Program Rule concerning CICP Social Security Number and Other Minor Updates.
Rule Number: MSB 24-01-25-A
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

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 24-01-25-A, Revision to the Colorado Indigent Care Program Rule concerning CICP Social Security Number and Other Minor Updates.

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) 8.900, 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 8.900 with the proposed text beginning at 8.900 through the end of 8.900 Appendix A. This rule is effective June 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Colorado Indigent Care Program Rule concerning CICP Social Security Number and Other Minor Updates.
Rule Number: MSB 24-01-25-A
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

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 changes to this rule are intended to bring the CICP and Hospital Discounted Care into closer alignment, and to clean up the rule as a whole, including removing language referencing lawful presence and adding clarifications to existing language.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

25.5-3-101 through 25.5-3-111 C.R.S. (2023)

Initial Review **04/12/24** Final Adoption **05/10/24**
Proposed Effective Date **06/30/24** Emergency Adoption

DOCUMENT #

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Title of Rule: Revision to the Colorado Indigent Care Program Rule concerning CICP Social Security Number and Other Minor Updates.
Rule Number: MSB 24-01-25-A
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REGULATORY ANALYSIS

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

   The proposed rule will affect all applicants for the CICP but will most positively benefit applicants without Social Security Numbers. These patients will no longer have to sign an affidavit stating they meet an exception to the requirement or be denied if they do not meet one of the exceptions. The change will reduce the administrative burden for CICP providers, as they will no longer have to request the Social Security Number or signed affidavit for any applicant or their household members. The program covers Coloradans up to 250% of the Federal Poverty Guideline who are not eligible for Health First Colorado or CHP+.

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

   Quantitatively, it is not possible to estimate the total number of patients that this rule change would impact, as the number of patients who currently do not have or do not wish to provide their Social Security Number or who are concerned about signing the affidavit is unknown. It is expected that the number of patients who complete the application with the removal of this requirement would increase overall.

   Qualitatively, this rule change will lessen the administrative burden for providers as they would no longer be required to obtain either a Social Security Number or affidavit from each adult household member included in the application applying for discounted care.

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 of Health Care Policy and Financing sees no fiscal impact of this rule change for the Department. Funding for hospitals will continue in accordance with rule 8.2000. The CICP Clinics currently do not receive funding from the program after the elimination of the funding line during the 2021 legislative session.

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

   The benefit of action is a reduced amount of information needed to complete CICP applications. There are no costs of action.

   The cost of inaction is that patients will continue to be denied CICP due solely to not having or not wanting to provide a Social Security Number. There is no benefit of inaction.

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

   Since the Department of Health Care Policy and Financing does not foresee any fiscal impact of this rule change, there are not any less costly methods that were considered.

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 other alternative methods were considered.

8.900 COLORADO INDIGENT CARE PROGRAM (CICP)

PROGRAM OVERVIEW AND LEGAL BASIS

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate Qualified Health Care Providers for uncompensated costs associated with services rendered to uninsured or underinsured patients. Qualified Health Care Providers who receive this funding render discounted health care services to Colorado residents and ~~,~~ migrant workers ~~and lawfully present immigrants~~ with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to Qualified Health Care Providers who serve eligible persons. The CICP issues procedures to ensure the funding is used to serve the uninsured and underinsured population in a uniform method. Any significant departure from these procedures will result in termination of the approval of, and the funding to, a health care provider. The CICP is authorized by state law at Title 25.5, Article 3, Part 1.

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in section 10-16-102(34), C.R.S. Eligible persons receiving discounted health care services from Qualified Health Care Providers are subject to the limitations and requirements imposed by Title 25.5, Article 3, Part 1, C.R.S.

8.901 DEFINITIONS

A. Applicant means an individual who has applied at a Qualified Health Care Provider to receive discounted health care services.

B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.

C. Client means an individual whose application to receive discounted health care services has been approved by a Qualified Health Care Provider.

D. Clinic Provider means any Qualified Health Care Provider that is a community health clinic licensed or certified by the Department of Public Health and Environment pursuant to C.R.S §25-1.5-103, a federally qualified health center as defined in 42 U.S.C. sec. 1395x (aa)(4), or a rural health clinic, as defined in 42 U.S.C. sec. 1395x (aa)(2).

E. Colorado Indigent Care Program or CICP or Program means the Colorado Indigent Care Program as authorized by state law at Title 25.5, Article 3, Part 1, C.R.S.

F. Denver Metropolitan Area means the Denver-Aurora-Lakewood, CO metropolitan area as defined by the Bureau of Labor Statistics.

G. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.

H. Doubled-up means a person who has no permanent housing of their own and who is temporarily living with a person who has no legal obligation to financially support them.

I. Emergency Care means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

J. General Provider means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. sec. 1395x(aa)(4), a rural health clinic, as defined in 42 U.S.C. sec. 1395x(aa)(2), a health maintenance organization issued a certificate authority pursuant to Section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to Section 25.5-3-108(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the Program, General Provider includes associated physicians.

~~42 U.S.C. sec. 1395x(aa)(2) (2021)is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203.~~

K. Homeless means a person who lacks a fixed, regular, and adequate night-time residence, or is in a doubled-up situation, or is in imminent danger of losing their primary night-time residence, and who lacks resources or support networks to remain in housing, or has a primary night-time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

L. Hospital Discounted Care means Health Care Billing for Indigent Patients as defined in Title 25.5, Article 3, Part 5, C.R.S.

M. Hospital Provider means any Qualified Health Care Provider that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103, C.R.S. and which operates inpatient facilities.

N. ~~Liquid Resources means resources that can be readily converted to cash, including but not limited to checking and savings accounts, health savings accounts, prepaid bank cards, certificates of deposit less the penalty for early withdrawal.~~

~~O.~~ Medicaid means the Colorado medical assistance program as defined in Title 25.5, Article 4, C.R.S.

~~P~~O. Qualified Health Care Provider means any General Provider who is approved by the Department to provide, and receive funding for, discounted health care services under the CICP.

~~Q~~P. ~~Spend Down means when an Applicant uses his or her available Liquid Resources to pay off part or all of a medical bill to lower his or her financial determination to a level that will allow him or her to qualify for the Program.~~

~~R.~~ Transitional housing means housing designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing.

~~S~~Q. Uniform Application means the application for discounted care created pursuant to Section 8.922.

~~T~~R. Urgent Care means treatment needed because of an injury or serious illness that requires treatment within 48 hours.

8.902 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Requirements for Qualified Health Care Providers

1. Agreements will be made annually between the Department and Qualified Health Care Providers through an application process.

2. Agreements may be executed with Hospital Providers throughout Colorado that meet the following requirements:

a. Licensed or certified as a general hospital or birth center by the Department of Public Health and Environment.

b. Hospital Providers shall provide Emergency Care to all Clients throughout the Program year at discounted rates.

c. Hospital Providers shall have at least two obstetricians with staff privileges at the Hospital Provider who agree to provide obstetric services to individuals under Medicaid. In the case where a Hospital Provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the Hospital Provider to perform non-emergency obstetric procedures.

This requirement does not apply to a Hospital Provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

d. Using the information submitted by an Applicant and the Uniform Application developed and distributed by the Department, the Qualified Health Care Provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within ~~three business~~14 calendar days of receipt of the missing documents. Hospital Providers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age 18 and older;

II. Household size, where all non-spouse or civil union partner, non-student adults ages 18 to 64 included on the application must have financial support demonstrated or attested to.

i. An applicant must include their spouse or civil union partner in their household for purposes of the application.

ii. Any additional person living at the same address as the applicant may also be included in the household.

iii. An applicant may include household members who live in other states or countries if the applicant attests that they provide at least 50% of the household member's support~~; and~~.

~~III. Liquid Resources. Including Liquid Resources in the financial eligibility determination is optional for Hospital Providers. If a Hospital Provider~~

~~chooses to include Liquid Resources in the financial eligibility determination, at least $2,500 must be excluded for each family member counted in household size, and the Hospital Provider must include a Spend Down opportunity. Effective June 1, Liquid Resources may no longer be counted for applicants.~~

e. Hospital Providers shall use the Sliding Fee Scale developed by the Department or submit for Department approval with their annual application a Sliding Fee Scale that shows copayments for different service categories divided into at least three income tiers covering 0 to 250% of the federal poverty ~~level~~guideline. Copayments shall be expressed in dollar amounts and shall not exceed the copayments in the Standard Client Copayment Table found in Appendix A. Hospital Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

f. Hospital Providers shall submit Program utilization and charge data in a format and timeline determined by the Department.

3. Agreements may be executed with Clinic Providers throughout Colorado that meet the following minimum criteria:

a. Licensed or certified as a community health clinic by the Department of Public Health and Environment or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.

b. Using the information submitted by an Applicant, the provider shall use the ~~Uniform A~~application developed and distributed by the Department to determine whether the Applicant meets all requirements to receive discounted health care services under the Program. Clinic Providers may develop their own application and submit it to the Department for approval. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the Applicant will be notified of the missing documentation within three business days. An eligibility determination shall be made within ~~three business~~14 calendar days of receipt of the missing documents. Clinic Providers who are federally qualified health centers shall determine Client financial eligibility as required under federal regulations and guidelines. Clinic Providers who are not federally qualified health centers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age 18 and older, and

II. Household size.

c. Clinic Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories. Copayments for Clients between 0 and 100% of the federal poverty ~~level~~ guideline shall be nominal or $0. Sliding Fee Scales shall have at least three tiers between 101 and 250% of the federal poverty ~~level~~guideline.

I. Sliding fee scales used by federally qualified health centers approved by the federal government meet all requirements of the Program.

II. Copayments for Clients between 101 and 250% of the federal poverty ~~level~~ guideline may not be less than the copayments for Clients between 0 and 100% of the federal poverty ~~level~~guideline.

III. The same sliding fee scale shall be used for all Clients eligible for the Program.

IV. Sliding fee scales shall be reviewed by the Qualified Health Care Provider on a regular basis to ensure there are no barriers to care.

d. Clinic Providers shall inform Applicants and Clients of their copayment responsibilities at the time their application is approved.

~~e. Clinic Providers shall submit Program data and quality metrics with their annual application. Specific quality metrics are listed in Section 8.905.B. The data and quality metrics shall be submitted in a format determined by the Department and provided as part of the annual application.~~

~~4. Determination of Lawful Presence~~

~~a. Effective July 1, 2022, Applicants are no longer required to provide proof of lawful presence in order to be eligible for the CICP.~~

~~b. Qualified Health Care Providers shall develop procedures for handling original lawful presence documents to ensure that the documents are not lost, damaged or destroyed. Qualified Health Care Providers shall develop and follow procedures for returning or mailing original documents to Applicants within five business days of receipt.~~

~~c. Qualified Health Care Providers shall accept copies of an Applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter.~~

~~d. Qualified Health Care Providers shall retain photocopies of the Applicant's affidavit and lawful presence documentation.~~

~~e. Qualified Health Care Providers shall assist applicants who have a disability, are homeless, or who lack proficiency in English with obtaining documentation to establish citizenship or lawful presence.~~

~~I. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the Applicant may provide the required documentation; or referring the Applicant to other agencies or organizations which may be able to provide assistance.~~

~~II. Examples of additional assistance that shall be provided to Applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the Applicant.~~

III. The Qualified Health Care Provider shall not be required to pay for the cost of obtaining required documentation.

IV. The Qualified Health Care Provider shall document its efforts of providing additional assistance to the Applicant and retain such documentation.

54. Qualified Health Care Providers shall provide the Applicant and/or representative a written notice in the Applicant's preferred language of the provider's determination as to the Applicant's eligibility to receive discounted services under the Program. If eligibility to receive discounted health care services is granted by the Qualified Health Care Provider, the notice shall include the dates of eligibility and the Applicant's copay responsibilities. If eligibility to receive discounted health care services is denied, the notice shall include a brief, plain language explanation of the reason(s) for the denial. Every notice of the Qualified Health Care Provider's decision, whether an approval or a denial, shall include an explanation of the Applicant's appeal rights found at Section 8.902.B in these regulations.

65. Qualified Health Care Providers shall screen all Applicants for eligibility for Medicaid and the Children's Basic Health Plan and refer Applicants to those programs if they appear eligible. The Qualified Health Care Provider shall refer Applicants to Colorado's health insurance marketplace for information about private health insurance.

76. Qualified Health Care Providers shall not discriminate against Applicants or Clients based on race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

B. Client Appeals

1. If an Applicant or Client feels that a financial determination or denial is in error, he or she shall only challenge the financial determination or denial by filing an appeal with the Qualified Health Care Provider who determined eligibility to receive discounted health care services under the CICP pursuant to this Section 8.902. There is no appeal process available through the Office of Administrative Courts.

2. Instructions for Filing an Appeal

The Qualified Health Care Provider shall inform the Applicant or Client that he or she has the right to appeal the financial determination or denial if he or she is not satisfied with the Qualified Health Care Provider's decision.

An Applicant or Client who wishes to appeal a denial must:

a. Submit a letter requesting appeal within 30 calendar days of the date of the denial notice. Appeals submitted after the deadline may be denied for being submitted untimely;

b. Enclose any supporting documentation;

If no denial notice is received earlier, an appeal letter may be submitted within 45 calendar days of the date the application was completed. The deadline for an appeal letter may be extended for good cause.

3. Appeals

a. An Applicant or Client may file an appeal if he or she wishes to challenge the accuracy of his or her initial financial determination.

b. Each Qualified Health Care Provider must designate a manager to review appeals and supporting documentation.

c. If the initial financial determination is found to be inaccurate,

~~I.~~ the financial determination will be corrected, with eligibility effective retroactive to the initial effective date of application~~, and~~

~~II. services provided during the applicable backdating period must be discounted~~.

d. A decision shall be issued to the Applicant or Client and the Department in writing within 15 calendar days following receipt of the appeal request.

4. Provider Management Exception

a. An Applicant or Client may request a provider management exception simultaneously with an appeal, or within 15 calendar days of the date of the Qualified Health Care Provider's decision regarding an appeal.

b. A provider management exception may be granted at the Qualified Health Care Provider's discretion if the Applicant or Client can demonstrate that there are circumstances that should be taken into consideration when establishing the household financial status.

c. Each Qualified Health Care Provider must designate a manager to review provider management exceptions and supporting documents.

I. The facility shall notify the Client in writing of the Qualified Health Care Provider's findings within 15 calendar days of receipt of the Client's written request.

II. The Qualified Health Care Provider must note provider management exceptions on the application.

d. A financial determination from a provider management exception is effective as of the initial effective date of application.

e. Qualified Health Care Providers are not required to honor provider management exceptions granted by other Qualified Health Care Providers.

C. Financial Eligibility

General Rule: An Applicant shall be financially eligible for discounted health care services under the CICP if their household income is no more than 250% of the current ~~F~~federal ~~P~~poverty ~~G~~guidelines ~~(FPG)~~for a household of that size.

1. Qualified Health Care Providers determine eligibility for the CICP and shall maintain auditable files of applications for discounted health care services under the CICP until June 30 of the seventh state fiscal year following the eligibility determination.

2. The determination of financial eligibility process looks at the financial circumstances of a household as of the date that an application is started. ~~In the event that an applicant is~~

~~applying to cover a past individual visit or admission, or a string of visits, admissions, or both that occurred in a short amount of time and is either not going to be applying for CICP going forward or the date(s) of service are outside of the standard 90 day backdating window, the household financial status is considered as of the date of service instead of the date of the application.~~

3. All Qualified Health Care Providers must accept each other's CICP financial determinations unless the Qualified Health Care Provider believes that the financial determination was determined incorrectly, the Qualified Health Care Provider's financial determination process is materially different from the process used by the issuing Qualified Health Care Provider, or that the financial determination was a result of a provider management exception.

4. CICP eligibility is retroactive for services received from a Qualified Health Care Provider up to ~~90~~ 181 days prior to application.

5. Documentation concerning the Applicant's financial status shall be maintained by the provider until June 30 of the seventh state fiscal year following the eligibility determination.

6. Beyond the distribution of available funds made by the CICP, allowable Client copayments, and other third-party sources, a provider shall not seek payment from a Client for the provider's CICP discounted health care services to the Client.

7. Emergency Application for Providers

   a. In emergency circumstances, an Applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the Qualified Health Care Provider shall follow these steps in processing the application:

      I. Use the regular application to receive discounted health care services under the CICP but indicate emergency application on the application.

      II. Ask the Applicant to give spoken answers to all questions and ~~determine a~~apply the federal poverty ~~level~~ guideline based on the spoken information provided. If the Applicant appears eligible for Medicaid or CHP+, the Applicant will need to apply for the applicable program prior to being placed on CICP.

      III. ~~.~~Ask the Applicant to sign the application indicating their understanding of their ~~federal poverty level and~~\ eligibility determination in relationship to the federal poverty guideline made using their spoken information.

   b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the Client receives any care other than the emergency room visit, the Hospital Provider must request the Client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the Client does not support the earlier, spoken information, the Hospital Provider must obtain a new application from the Client. If the Client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.

c. ~~In emergency circumstances, an Applicant is not required to provide identification or execute an affidavit as specified at Section 8.904.D.~~

D. Audit Requirements

The Department will conduct audits of Qualified Health Care Providers. Qualified Health Care Providers shall comply with requests for data and other information from the Department. Qualified Health Care Providers shall complete corrective actions when required by the Department. The Department's intention is to audit one-third of the participating Qualified Health Care Providers each year. After any Qualified Health Care Provider discontinues participation in the program, the provider must maintain compliance with audit requirements for the records created during the period during which the Qualified Health Care Provider was participating.

E. HIPAA

The CICP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 at 45 C.F.R. sec. 160.103. The CICP is not a part of the Colorado Medical Assistance Program, nor of Health First Colorado, Colorado's Medicaid program. CICP's principal activity is the making of grants to providers who serve eligible persons who are uninsured or underinsured. The state personnel administering the CICP will provide oversight in the form of procedures and conditions to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a Qualified Health Care Provider or Client.

8.903 DISCOUNTED HEALTH CARE SERVICES

A. Funding provided under the CICP shall be used to provide Clients with discounted health care services determined to be medically necessary by the Qualified Health Care Provider.

B. All health care services normally provided at the Qualified Health Care Provider should be available at a discount to Clients. If health care services normally provided at the Qualified Health Care Provider are not available to Clients at a discount, Clients must be informed that the services can be offered without a discount prior to the rendering of such services. Service availability is to be applied uniformly for all Clients.

C. Qualified Health Care Providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:

1. Emergency Care;

2. Urgent Care; and

3. Any other medical care.

D. Additional discounted health care services may include:

1. Emergency mental health services if the Qualified Health Care Provider renders these services to a Client at the same time that the Client receives other medically necessary services.

2. Qualified Health Care Providers may provide discounted pharmaceutical services. The Qualified Health Care Provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the Qualified Health Care Provider. Qualified Health Care Providers shall exclude prescription drugs

included in the definition of Medicare Part-D from eligible Clients who are also eligible for Medicare.

3. Qualified Health Care Providers may provide packages of services to patients with modified copayment requirements.

   a. Packages of services benefit Clients who need to utilize services more often than average Clients. Things that would be beneficial to the client include but are not limited to charging a lower copay, charging the copay on an alternative schedule (i.e. once a week, or ever other time), or setting a cap on the amount or number of copayments made towards the packaged services. Examples of packages may include but are not limited to oncology treatments, physical therapy, and dialysis.

   b. Qualified Health Care Providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for uninsured or underinsured women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The Qualified Health Care Provider is responsible for providing a description of the services included in the prenatal benefit to the Client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.

2. Nursing home care.

3. Chiropractic services.

4. Cosmetic surgery.

5. Experimental and non-United States Federal Drug Administration approved treatments.

6. Elective surgeries that are not medically necessary.

7. Court ordered procedures, such as drug testing.

8. Abortions - Except as specified in section 25.5-3-106, C.R.S.

9. Mental health services in clinic settings pursuant to section 25.5-3-110, C.R.S., Title 27, Article 66, Part 1, any provisions of Title 23, Article 22, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an Applicant shall satisfy the following requirements:

1. ~~Execute an affidavit regarding citizenship status;~~

~~a. Beginning on July 1, 2022, applicants are no longer required to execute an affidavit regarding citizenship status.~~

~~2. Be lawfully present in the United States;~~

~~a. Beginning on July 1, 2022, applicants are no longer required to be lawfully present in the United States.~~

~~3.~~ Be a resident of Colorado; and

~~4~~2. Meet all CICP eligibility requirements as defined ~~by state law and procedures~~in Section 8.902.C, 25.5-3-104, C.R.S., and this Section 8.904~~; and~~.

~~5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, or meet one of the following exceptions:~~

~~a. individual is an unborn child;~~

~~b. individual is homeless and unable to provide a SSN;~~

~~c. individual is ineligible for a SSN:~~

~~d. individual may only be issued a SSN for a valid non-work reason in accordance with 20 C.F.R. sec. 422.104;~~

~~e. individual refuses to obtain a SSN because of well-established religious objections.~~

B. Applicants

1. Any adult age 18 and older may apply to receive discounted health care services on behalf of themselves and members of the Applicant's family household.

2. If an Applicant is deceased, the personal representative of the estate or a family member may complete the application on behalf of the Applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.

3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the Applicant's family household. All non-spouse or civil union partner, non-student adults ages 18-64 must have financial support demonstrated or attested to in order to be included in household size. All minors and those 65 or older do not need documentation of financial support to be counted in household size. Income from spouses or civil union partners and all non-student adults must be included in the application.

4. A minor shall not be rated separately from his or her parents or guardians unless he or she is emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Signing the Application

The Applicant or an authorized representative of the Applicant must sign the application to receive discounted health care services submitted to the Qualified Health Care Provider within ~~90~~ 181 calendar days of the date of health care services. If an Applicant is unable to sign the application or has died, a spouse, civil union partner, relative, or guardian may sign the

application. Until it is signed, the application is not complete, the Applicant cannot receive discounted health care services under the CICP, and the Applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

~~D. Affidavit~~

~~1. Each first-time Applicant, or Applicant seeking to reapply, 18 years of age or older shall execute an affidavit stating:~~

~~a. That he or she is a United States citizen, or~~

~~b. That he or she is a legal permanent resident or is otherwise lawfully present in the United States pursuant to 1 CCR 204-30; Rule 5.~~

~~2. For an Applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall verify lawful presence through the Federal Systematic Alien Verification for Entitlements (SAVE) Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security within three business days of receipt of the lawful presence documentation. A SAVE verification is not needed for Applicants who provide an ID issued by a REAL ID Act compliant state that bears the REAL ID Act indicator.~~

~~3. Effective July 1, 2022, Applicants are no longer required to execute an affidavit of lawful presence.~~

~~E. Establishing Lawful Presence~~

~~1. Each first-time Applicant, or Applicant seeking to reapply, eighteen years of age or older shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30; Rule 5 (effective September 17, 2020), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30; Rule 5 excludes later amendments to, or editions of, the referenced material. 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: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.~~

~~2. Submission of Documentation~~

~~Lawful presence documentation may be accepted from the Applicant, the Applicant's spouse, civil union partner, parent, guardian, or authorized representative in person, by mail, by email, or facsimile.~~

~~3. Expired or absent documentation for non-U.S. citizens~~

~~a. If an Applicant is unable to present any documentation evidencing his or her immigration status, refer the Applicant to the local Department of Homeland Security office to obtain documentation of status.~~

~~b. In unusual circumstances involving Applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the Applicant can provide an alien registration number, the~~

~~provider may file U.S.C.I.S. Form G-845 and Supplement, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status.~~

~~c. If an Applicant does not present documentation proving their lawful presence but instead presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.~~

~~4. Effective July 1, 2022, Applicants are no longer required to provide proof of lawful presence.~~

~~F~~D. Residence in Colorado

An Applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons; and

~~2. Meet the lawful presence criteria, as defined in paragraph E of this Section; and~~

~~3~~2. Employed in Colorado.

~~G~~E. Applicants Not Eligible

1. The following individuals are not eligible to receive discounted services under the CICP:

~~a. Individuals for whom lawful presence cannot be verified.~~

~~I. Effective July 1, 2022, lawful presence is no longer a requirement for CICP, and these individuals are no longer ineligible for discounted services.~~

~~b~~a. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

~~c~~b. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

~~d~~c. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

~~e~~d. Persons who qualify for Medicaid. However, Applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:

I. QMB benefits described at Section 8.100.6.L of these regulations;

II. SLMB benefits described at Section 8.1006.M, or

III. The QI1 benefits described at Section 8.100.6.N.

~~f~~e. Individuals who are eligible for the Children's Basic Health Plan.

~~H~~F. Health Insurance Information

The Applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

~~I~~G. Subsequent Insurance Payments

If a Client receives discounted health care services under the CICP, and their insurance subsequently pays for services, or if the Client is awarded a settlement, the insurance company or patient shall reimburse the Qualified Health Care Provider for discounted health care services rendered to the Client.

8.905 DEPARTMENT RESPONSIBILITIES

A. Provider Application

1. The Department shall produce and publish a provider application annually~~.~~

~~a. The application will be updated annually to~~ using updated Program information and ~~incorporate~~ incorporating any necessary changes ~~and update any Program information~~.

~~b. The application will include data and quality metric submission templates.~~

2. The Department shall determine Qualified Health Care Providers annually through the application process.

3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108(5)(a)(I), C.R.S.

4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108(5)(a)(II), C.R.S.

5. The Department shall produce and publish a provider directory annually.

B. Payments to Providers

1. Funding for hospitals shall be distributed in accordance with Sections 8.300 and 8.905.B.~~3~~2.

~~2. Clinics~~

~~a. Funding for Clinic Providers is appropriated through the Colorado General Assembly under the Children's Hospital, Clinic Based Indigent Care line item.~~

~~Effective July 1, 2018, funding for clinics shall be separated into two different groups, as follows:~~

~~I. 75 percent of the funding will be distributed based on Clinic Providers' write-off costs relative to the total write-off costs for all Clinic Providers.~~

~~II. 25 percent of the funding will be distributed based on a points system granted to Clinic Providers based on their quality metric scores multiplied by the Clinic Provider's total visits from their submitted Program data.~~

~~b. The quality metric scores will be calculated based on the following four metrics. The metrics are defined by the Health Resources & Services Administration (HRSA):~~

~~I. Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up~~

~~II. Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan~~

~~III. Diabetes: Hemoglobin A1c Poor Control~~

~~IV. Controlling High Blood Pressure~~

~~c. Write-off costs will be calculated as follows:~~

~~I. Distribution of available funds for CICP care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate CICP charges.~~

~~II. Clinic Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department.~~

~~III. Clinic Providers shall deduct the full patient liability amount from total charges, which is the amount due from the Client as identified in the CICP Standard Client Copayment Table, as defined under Appendix A in these rules, or an alternative sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department. The summary information submitted to the Department by the provider shall include the full CICP patient liability amount even if the Clinic Provider receives the full payment at a later date or through several smaller installments or no payment from the Client.~~

~~IV. CICP charges will be converted to CICP costs using the most recently available cost-to-charge ratio from the Clinic Provider's cost report or other financial documentation accepted by the Department.~~

~~d. The Department shall notify Clinic Providers of their expected payment no later than August 31 of each year. The notification shall include the total expected payment and a description of the methodology used to calculate the payment.~~

~~3~~2. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with CICP care days (days of care

provided under the CICP) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.s;

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.s per licensed bed;

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations;

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

e. Participates in the CICP.

The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

C. Provider Appeals

1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.

2. The provider's first level appeal must be filed within five business days of the receipt of the denial letter. The Department's Special Financing Division Director will respond to any first level appeals within ten business days of receipt of the appeal.

3. If a provider disagrees with the Department's Special Financing Division Director's first level appeal determination, they may file a second level appeal within five business days of the receipt of the first level appeal determination. The Department's Executive Director will respond to the second level appeal within ten business days of the receipt of the second level appeal.

D. Advisory Council

The Department shall create a CICP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICP Stakeholder Advisory Council. Members shall include:

1. A member representing the Department;

2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;

3. A representative from a federally qualified health center as defined at 42 U.S.C. sec. 1395x (aa)(4);

4. A representative from a rural health clinic as defined at 42 U.S.C. sec. 1395x (aa)(2), or a representative from a clinic licensed or certified as a community health clinic by the Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;

5. A representative from either Denver Health or University Hospital;

6. A representative from an urban hospital;

7. A representative from a rural or critical access hospital;

8. A representative of an organization of Colorado community health centers, as defined in the federal “Public Health Service Act”, 42 U.S.C. sec. 254b;

9. A representative from an organization of Colorado hospitals.

Members shall serve without compensation or reimbursement of expenses. The Executive Director shall ~~at least annually~~ select a chair for the council ~~to serve for a maximum period of twelve months~~and the appointment will be valid until the seat is vacated, the Chair steps down, or a new chair is selected by the Executive Director. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

The council shall

1. Advise the Department of operation and policies for the Program

2. Make recommendations to the Medical Services Board regarding rules for the Program

E. Annual Report

1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.

2. The report shall at minimum include charges for each ~~Qualified Health Care~~Hospital Provider, numbers of Clients served, and total payments made to each ~~Qualified Health Care~~Hospital Provider.

10 CCR 2505-10 § 8.900 APPENDIX A: STANDARD CICP CLIENT COPAYMENT

A. Client Copayments - General Policies

A Client is responsible for paying a portion of his or her medical bills. The Client's portion is called the Client Copayment. Qualified Health Care Providers are responsible for charging the Client a copayment. Qualified Health Care Providers may require Clients to pay their copayment prior to receiving care (except for Emergency Care). Qualified Health Care Providers may charge copayments in accordance with the Standard Client Copayment Table or an alternate sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department.

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%
Ambulatory Surgery	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Inpatient Facility	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Hospital Physician	$0	$7	$35	$55	$80	$110	$150	$195	$270	$300	$315
Emergency Room	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Emergency Transportation	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Outpatient Hospital Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Clinic Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Specialty Outpatient	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Prescription	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Laboratory	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Basic Radiology & Imaging	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
High-Level Radiology & Imaging	$0	$30	$90	$130	$185	$250	$335	$425	$580	$645	$680

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related Client Copayments under the Standard Client Copayment Table.

1. Inpatient facility charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.

2. Ambulatory Surgery charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.

3. Hospital Physician charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.

4. Clinic Services charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Outpatient charges include primary and preventive medical care. This charge does not include radiology or laboratory services performed at the clinic.

5. Emergency Room charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).

6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Specialty Outpatient charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

7. Emergency Transportation charges are for transportation provided by an ambulance.

8. Laboratory Service charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

9. Basic Radiology and Imaging Service charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

10. Prescription charges are for prescription drugs received by a Client at a Qualified Health Care Provider’s pharmacy as an outpatient service. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.

11. High-Level Radiology and Imaging Service charges are for Clients receiving a Magnetic Resonance Imaging, Computed Tomography, Positron Emission Tomography or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory in the outpatient hospital, emergency room, or clinic setting.

12. Outpatient Hospital Service charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Outpatient Hospital Services charges include primary and preventive medical care. This charge does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

13. Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

B. Homeless Clients, Clients living in transitional housing, "doubled-up" Clients, or recipients of Colorado's Aid to the Needy Disabled financial assistance program, who are at or below 40% of the fFederal Ppoverty Level guideline are exempt from Client Copayments.

1. Homeless Clients are exempt from Client Copayments, the income verification requirement, and providing proof of residency when completing the CICP application.

2. Transitional housing is designed to assist individuals in becoming self-supporting. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. Transitional housing Clients are exempt from the income verification requirement when completing the CICP application.

3. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the Client are considered doubled-up. The individual allowing the Client to reside with him or her may be asked to provide a written statement confirming that the Client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.

4. Recipients of Colorado's Aid to the Needy Disabled financial assistance program are exempt from Client Copayments, and the income verification requirement when completing the CICP application.

C. Client Annual Copayment Cap

1. Homeless Clients whose financial determination is between 0 and 40% of the federal poverty level guideline are exempt from copayments, so their copayment cap is $0. Clients whose financial determination is between 0 and 40% of the federal poverty level guideline who are not homeless have a copayment cap that is the lesser of 10% of the family's net income or $120. Clients who are also Old Age Pension Health and Medical Care Program clients have a copayment cap of $300 as mandated by Section 8.941.10. For all other CICP Clients, annual copayments shall not exceed 10% of the family's financial determination.

2. Clients who are also Old Age Pension Health and Medical Care Program clients have annual copayment caps based on a calendar year. All other Client annual copayment caps (annual caps) are based on the Client's date of eligibility.

3. Clients are responsible for any charges incurred prior to the determination of the Client's financial eligibility.

4. Clients are responsible for tracking their CICP copayments and informing the provider in writing, including documentation, within 90 days after meeting or exceeding their annual cap. If a Client overpays the annual cap and informs the Qualified Health Care Provider

of that fact in writing, the Qualified Health Care Provider shall reimburse the Client for the overpayment.

5. A CICP Client is eligible to receive a new determination if his or her financial or family situation has changed since the initial financial determination. CICP copayments made under the prior financial determination will not count toward a new CICP copayment cap and the Client's annual copayment cap resets when the Client completes a new application.

6. An annual cap applies only to charges incurred after a Client is eligible to receive discounted health care services and applies only to discounted services incurred at a CICP Qualified Health Care Provider, including services discounted under Hospital Discounted Care.

D. The Client must pay the lower of the copayment listed, the patient responsibility portion if the Client is insured, or actual charges. Payment plans must be offered to Clients and must follow the requirements set forth in Section 8.923 of the Hospital Discounted Care rule.

E. Clients shall be notified at or before time of services rendered of their copayment responsibility and available payment plan option.

F. Grants from foundations to Clients from non-profit, tax exempt, charitable foundations specifically for Client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

DO NOT PUBLISH THIS PAGE

Title of Rule: Rule Concerning Safety Net Providers Language Update, Section 8.750
Rule Number: MSB 24-02-13-A
Division / Contact / Phone: Health Policy Office / Alex Lyons / alex.lyons@state.co.us

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 24-02-13-A, Rule Concerning Safety Net Providers Language Update, Section 8.750

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) 8.750, Colorado Department of Health Care Policy and Financing

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 8.750 with the proposed text beginning at 8.750 through the end of 8.750.4.A. This rule is effective June 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Rule Concerning Safety Net Providers Language Update, Section 8.750
Rule Number: MSB 24-02-13-A
Division / Contact / Phone: Health Policy Office / Alex Lyons / alex.lyons@state.co.us

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 change is part of the Department's work to align our regulations with House Bill 22-1278. Specifically, this proposed rule will implement terminology changes mandated by HB 22-1278 by shifting Community Mental Health Clinics (CMHCs) to the new Comprehensive Community Behavioral Health and Essential Behavioral Health Safety Net provider designations, and by describing the requirements and covered services for providers participating in the new provider types.

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:

2. Federal authority for the Rule, if any:

3. State Authority for the Rule:

   Sections 25.5-1-301-303, C.R.S. (2023);
   Section 27-50-101(7), (11), (13), C.R.S.

Initial Review	**04/12/24**	Final Adoption	**05/10/24**
Proposed Effective Date	**06/30/24**	Emergency Adoption	

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Rule Concerning Safety Net Providers Language Update, Section 8.750
Rule Number: MSB 24-02-13-A
Division / Contact / Phone: Health Policy Office / Alex Lyons / alex.lyons@state.co.us

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.

   Health First Colorado members will benefit from this rule because the organization of their benefits will reflect the state's new behavioral health system. There is likely no class that will bear costs as a result of this proposed rule because it does not alter the scope or amount of benefits available to members.

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

   Quantitively, there will likely not be a significant economic impact or other cost as a result of this proposed rule because it implements terminology changes but does not alter the scope or amount or benefits available to Health First Colorado members. Qualitatively, the rule will benefit members by aligning the organization of the benefit with the state's new behavioral health system.

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 cost to the Department from the implementation of this rule is likely to be minimal, as are its effect on state revenues. No other agencies will incur costs as a result of implementation of this rule.

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

   The benefit of this proposed rule is that will align the Department's regulations with terminology mandated by state law, while there are no costs associated with implementation of these rule changes. The cost of inaction will be that the Department's rules do not reflect the state's current organization of its behavioral health system. There are no perceived benefits to inaction.

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

There are likely no less costly or intrusive way to achieve the purpose of the proposed rule because this rule implements terminology changes mandated by HB 22-1278.

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

   The Department did not consider any alternative methods because this rulemaking fulfills the direct legislative mandate in HB 22-1278 to align the Department's regulations with the state's new behavioral health system.

8.750 ~~COMMUNITY MENTAL HEALTH CENTERS/CLINICS~~COMPREHENSIVE COMMUNITY BEHAVIORAL HEALTH PROVIDERS AND ESSENTIAL BEHAVIORAL HEALTH SAFETY NET PROVIDERS

8.750.1 DEFINITIONS

"Comprehensive community behavioral health provider" means a licensed behavioral health entity or behavioral health provider approved by the Behavioral Health Administration (BHA) to provide care coordination and behavioral health safety net services, either directly or through formal agreements with behavioral health providers in the community or region.

"Essential Behavioral Health Safety Net Providers" means a licensed behavioral health entity or behavioral health provider approved by BHA to provide care coordination and at least one of the behavioral health safety net services listed in 27-50-101(11) C.R.S.

~~Community Mental Health Center/Clinic means either a physical plant or health institution planned, organized, operated, and maintained to provide basic community services or a group of services under unified administration or affiliated with one another.~~

~~Outpatient means a program of care in which the client receives services in a hospital or other health care facility, but does not remain in the facility twenty four hours a day.~~

~~Rehabilitative services means activities and/or services recommended by a physician or other licensed practitioner, for maximum reduction or restoration of a physical or mental disability to the best possible functional level.~~

8.750.2 REQUIREMENTS FOR PARTICIPATION

8.750.2.A. The ~~center/clinic~~provider must be ~~licensed~~ approved by the ~~Colorado Department of Public Health and Environment (CDPHE)~~Behavioral Health Administration (BHA).

8.750.3 COVERED SERVICES

~~8.750.3.A. Services shall include but are not limited to prevention, diagnosis and treatment of emotional or mental disorders. Such services shall be rendered primarily on an outpatient and consultative basis for clients residing in a particular community in or near the facility so situated.~~

8.750.3.~~B~~A. ~~Community Mental Health Centers/Clinics~~Comprehensive Community Behavioral Health providers shall provide ~~medically necessary~~the covered ~~rehabilitation~~ behavioral health safety net services ~~in an outpatient setting. Covered services shall include~~listed in 27-50-101(11) C.R.S.

8.750.3.B Essential Behavioral Health Safety Net providers shall provide at least one of the covered behavioral health services ~~in an outpatient setting. Covered services shall include those~~ listed in 27-50-101(13) C.R.S.

2. ~~Group psychotherapy services shall be face-to-face, or interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) in accordance with Section 8.095, services that are insight-oriented, behavior modifying, and that involve emotional interactions of the group members. Group psychotherapy services shall assist in providing relief from distress and behavior issues with other clients who have similar problems and who meet regularly with a practitioner. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care~~

3. ~~Individual psychotherapy services shall be face-to-face, or interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) in accordance with Section 8.095, services that are tailored to address the individual needs of the client. Services shall be insight-oriented, behavior modifying and/or supportive with the client in an office or outpatient facility setting. Individual psychotherapy services are limited to thirty-five visits per State fiscal year. Any health benefits provided through interactive audio, interactive video, or interactive data communication must meet the same standard of care as in-person care~~

8.750.4 REIMBURSEMENT

8.750.4.A. ~~For the purpose of reimbursing Community Mental Health Center and Clinic~~Comprehensive Community Behavioral Health providers and Essential Behavioral Health Safety Net providers ~~providers, the Department shall establish a price schedule annually with the Department of Human Services in order to reimburse each provider for its actual or reasonable cost of services.~~ must be reimbursed in accordance with 25.5-4-403 C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act concerning Private Duty Nursing Benefit Rule, Section 8.540
Rule Number: MSB 24-02-29-B
Division / Contact / Phone: Benefits and Services Management / Christine Merriman / x 5349

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 24-02-29-B, Revision to the Medical Assistance Act concerning Private Duty Nursing Benefit Rule, Section 8.540

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):

   Section 8.540, Private Duty Nursing, 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 8.540 with the propose text beginning at 8.540.1 through the end of 8.540.8.G. This rule is effective June 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act concerning Private Duty Nursing Benefit Rule, Section 8.540
Rule Number: MSB 24-02-29-B
Division / Contact / Phone: Benefits and Services Management / Christine Merriman / x 5349

STATEMENT OF BASIS AND PURPOSE

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

   The Department is revising the regulations regarding Private Duty Nursing Benefit to update and modernize program rules. The rule governs the state plan benefit for Private Duty Nursing for adults and children requiring continuous nursing services in their home and community. This revision was drafted with extensive stakeholder engagement and input.

   The revision of the Private Duty Nursing rule will provide clarity and simplification of the rule language as well as a structured reorganization of requirements under this benefit. These changes are necessary to improve the benefit for members and providers.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR § 440.80

4. State Authority for the Rule:

   Section § 25.5-5-303 (2023); Sections 25.5-1-301-303 (2023).

Initial Review **04/12/24** Final Adoption **05/10/24**
Proposed Effective Date **06/30/24** Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act concerning Private Duty Nursing Benefit Rule, Section 8.540
Rule Number: MSB 24-02-29-B
Division / Contact / Phone: Benefits and Services Management / Christine Merriman / x 5349

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.

   Class A licensed skilled home health agencies certified to provide services for Health First members, and adult and pediatric state plan members who require individual and continuous nursing care in the home at the level of care routinely provided in hospitals or nursing facilities will benefit from this rule revision These providers and members will bear no costs from the proposed rule amendments.

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

   Members and providers will benefit from clearer regulations and the removal of outdated and redundant language. This clarity will improve the quality of services provided and the efficiency of service delivery. The revised regulations will make it easier for members and providers to understand who qualifies for services and how they should be delivered.

   There is a qualitative impact to revising the Private Duty Nursing (PDN) rules. Clearer language and processes will result in better access to the benefit for members and will be less burdensome to providers. By introducing a process to transfer Prior Authorization Requests (PAR), there will be fewer requirements for members and families to provide supporting documentation, resulting in a faster and less burdensome transition period. By utilizing the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) definition of medical necessity for children ages 20 and younger, it is possible that the benefit will be easier to access for some pediatric members. Specifically, the proposed rule will make explicitly clear that technology dependence is not a primary qualifier for PDN. Lastly, the Department has conducted a comprehensive policy and budgetary analysis to identify the primary areas of clarification needed to best support members requiring PDN and the agencies providing those services. The results of the analysis found that there was a need to fully revise the existing benefit regulations, including establishing reimbursement requirements to align with member safety, revise definitions to

ensure consistency across programs, and better describe the utilization management process.

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 financial impacts associated with this revision. The Department of Public Health and Environment will have a slight impact to their workload upon implementation of the new regulations, as the adoption of the rule will require that they update their survey citations.

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

   There are no costs to the Department as a result of the proposed regulations. The proposed changes will help close identified gaps in the regulations for the approximately 900 members utilizing this benefit. The revision of the Private Duty Nursing regulations will provide clarity and simplification of the rule language as well as a structured reorganization of requirements under this benefit. Inaction would cause continued confusion from stakeholders regarding obsolete language and outdated requirements. Inaction would likely cause an increase in appeals, and costs related to those cases would rise.

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

   There are no less costly or intrusive methods for achieving the purpose of this rule. This revision is the most cost-effective and least intrusive method for achieving simplification of the Private Duty Nursing regulations.

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.

   Because the rules had not been substantially reviewed and amended since 2016,this revision process was the most effective way to achieve the necessary goals.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.1 DEFINITIONS

A. ~~A~~ Designated Representative means a person appointed by the member to act on their behalf for healthcare and treatment decisions as documented in the member's advanced healthcare directive or other comparable documentation.

~~A.~~B. Family/In-Home Caregiver means an ~~unpaid~~ individual who assumes a portion of the~~client's~~ member's ~~Private Duty Nursing~~ care in the home~~, when Home Health Agency staff is not present~~ in the absence of agency staff. A Family/In-Home Caregiver may either live in the~~client's~~ member's home or ~~go~~ travel to the ~~client's~~ member's home to provide care.

C. Group Nursing means the provision of Private Duty Nursing services by a Registered Nurse or Licensed Practical Nurse to more than one member at the same time in the same home or community-based setting.

~~B.~~D. Home Health Agency (HHA) means an ~~public~~ agency or ~~private~~ organization ~~or part of such an agency or organization which~~ that is certified for participation as a Medicare Home Health provider ~~under Title XVIII of the Social Security Act~~pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider ~~through the Colorado Department of Public Health and Environment~~as required by § 25-27.5-103(1), C.R.S.

E. Medical Necessity ~~means a Medical Assistance program good or service~~is as defined in Program Integrity rules ~~(10 CCR 2505-10~~at Section 8.076.1.8~~)~~. For children 20 and younger, this is further defined to include the requirements ~~outlined~~set forth in the Early and Periodic Screening, Diagnosis, and Treatment rules ~~(10 CCR 2505-10~~at Section 8.280.1~~)~~.

F. PDN Nursing Assessment means an individualized comprehensive assessment completed by the ~~Home Health Agency~~HHA case coordinator that accurately reflects the member's current health status and includes information that may be used to demonstrate the member's progress toward achievement of the desired outcomes. The comprehensive assessment shall identify the member's need for home care and meet the member's medical, nursing, rehabilitative, social, and discharge planning needs.

G. Physician or Allowed Practitioners means an enrolled physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) who oversees the delivery of skilled care to a member within their scope of practice~~, in accordance with State law~~as set forth at Colorado Revised Statutes, Title 25, Articles 240 or 255, as applicable. ~~who is actively enrolled with Health First Colorado.~~

~~C.~~ Plan of Care (POC) means a completed Centers for Medicare and Medicaid Services (CMS) Form 485~~care plan~~, also referred to as a~~the~~ care plan, ~~Form CMS-485,~~ developed by the ~~Home Health Agency~~HHA in consultation with the ~~client~~ member, that has been ordered by the ~~attending~~ physician or allowed practitioner for the provision of services to a ~~client~~ member at his/her residence or community setting, and is periodically reviewed and signed by the physician or allowed practitioner in accordance with Medicare requirements at 42 CFR § 484.~~18~~60.

~~D.~~H. Private Duty Nursing (PDN) means ~~face-to-face Skilled Nursing that is more individualized and continuous than the nursing care that is available under the home health benefit or routinely provided in a hospital or nursing facility.~~medically necessary nursing services ~~for members who require~~that are more individual and continuous care than is available under the Home Health

benefit, or routinely provided by the nursing staff of ~~the~~a hospital or skilled nursing facility, that allow a member to remain in their home or community-based setting.

~~E.~~I. Private Duty Nursing (PDN) means ~~face-to-face Skilled Nursing that is more individualized and continuous than the nursing care that is available under the home health benefit or routinely provided in a hospital or nursing facility.~~medically necessary nursing services ~~for members who require~~that are more individual and continuous care than is available under the Home Health benefit, or routinely provided by the nursing staff of ~~the~~a hospital or skilled nursing facility, that allow a member to remain in their home or community-based setting.

~~F.~~J. Re-Hospitalization means any hospital admission that occurs after the initial hospitalization for the same condition.

~~G.~~K. Skilled Nursing/~~s~~Skilled N~~n~~ursing S~~s~~ervice means services provided under the licensure, scope, and standards of the Colorado Nurse and Nurse Aide Practice Act, § 12-255-101, C.R.S.~~Title 12 Article 38 of the Colorado Revised Statutes~~, performed by a registered nurse (RN) under the direction of a physician or allowed practitioner, or a licensed practical nurse (LPN) under the supervision of a RN and the direction of a physician or allowed practitioner, for care that cannot be delegated by the judgment of the ~~nurse~~RN or LPN.

~~H.~~ Technology Dependent means ~~a client who~~the daily use of medical devices or procedures to maintain a bodily function without which adverse health consequences~~,~~ creating further disability, hospitalization or death could likely follow.~~:~~

~~I. Is dependent at least part of each day on a mechanical ventilator; or~~

~~J.~~

~~K. Requires prolonged intravenous administration of nutritional substances or drugs; or~~

~~L.~~

L. ~~Is dependent daily on other respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support or tube feedings when they are not intermittent.~~

M. Utilization Review Contractor (URC) means a third-party vendor contracted by the Department to perform utilization management functions for specific services.

8.540.2 ~~ELIGIBILITY~~CRITERIA FOR SERVICES

8.540.2.A To receive PDN services, a member must receive an approved PAR as set forth in Section 8.540.6 and satisfy the following criteria~~A client member shall be eligible for PDN services when the client is~~:

~~Technology Dependent.~~

~~Medically stable, except for acute episodes that can be safely managed under PDN, as determined by the attending physician.~~

1. The member is a~~A~~ble to be safely served in their home or community setting by a ~~home health agency~~HHA under the agency requirements and limitations of the PDN benefit and with the staff services available.

2. The member is n~~N~~ot residing in a nursing facility or hospital at the time PDN services are delivered.

3. The member has previously been determined to be eligible for the medical assistance program pursuant to Section 8.100. ~~is an e~~Eligible ~~member of Health First Colorado for Medicaid in a non-institutional setting.~~

4. The member ~~Able to~~ meets ~~one~~ of the following ~~medical~~ criteria:

   ~~a.~~ Members aged 21 years or older who demonstrate medical necessity for ~~s~~Skilled ~~n~~Nursing ~~s~~Services in accordance with ~~10 CCR 2505-10 §~~Section 8.076.1.8, are ~~dependent on technology~~technology dependent, ~~daily. The client needs PDN services while on a mechanical ventilator~~ and for whom a delay~~ed~~ in skilled nurse-level interventions would result in deterioration of a chronic condition, loss of function, imminent risk to health status due to medical fragility~~,~~ or risk of death.

   ~~Skilled nursing includes but is not limited to:.~~

   ~~SystemsSystematic body system assessments, including multistep approaches of systemsrequiring the skills of a licensed skilled provider. (e.g., respiratory assessment, airway assessment, vital signs, nutritional and hydration assessment, complex gastrointestinal assessment and management, seizure management requiring intervention, or level of consciousness e.g. respiratory, gastrointestinal, cognitive, skin, genitourinary, musculoskeletal, cardiovascular, cardiac,)~~

   ~~Administration of treatment for complex respiratory issues related to technological dependence requiring multistep approaches on a day-to-day basis (e.g., ventilator tracheostomy).~~

   ~~Assessment of complex respiratory issues and interventions with use of oximetry, titration of oxygen, ventilator settings, humidification systems, fluid balance, or any other cardiopulmonary critical indicators based on medical necessity.~~

   ~~Skilled nursing interventions of intravenous/parenteral administration of multiple medications and nutritional substances on a continuing or intermittent basis with frequent interventions.~~

   ~~b. Skilled nursing interventions of enteral nutrition and medications requiring multi-step approaches daily.~~

   ~~c.~~

   ~~d.~~

a.

~~e. The client needs PDN services for ventilator weaning during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions from tracheostomy, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%~~Members aged 20 years or younger ~~that~~who demonstrate medical necessity in accordance with Early and Periodic Screening, Diagnostic, and Treatment benefits requirements at ~~10 CCR 2505-10 §~~Section 8.280.4.E.~~The pediatric client needs PDN services after tracheostomy decannulation during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions, not using auxiliary muscles for breathing, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%.~~

b.

i. Member's age 20 years or younger ~~must~~shall require skilled nursing assessment, intervention, and evaluation of both equipment (if applicable) and member.

The services provided ~~are~~shall be medical in nature, safe, effective, generally recognized as an accepted method of treatment, not experimental/investigational, cost-effective, necessary for care of a member's condition, and ~~are~~ within accepted standards of nursing practice.

~~PDN services are medically necessary services that allow a member to remain in their home or community-based setting. is considered supplemental to the care provided by a member's family or designated caregivers and allows the member to remain in their residence rather than an institution.~~

ii.

8.540.3

~~The Utilization Review Contractor (URC) shall consider combinations of technologies and co-morbidities when making medical determinations with exceptions per EPSDT. The medical judgment of the attending physician or allowed practitioner and the URC shall be used for an individual determination wherever the medical criteria are not defined by specific measurements. .The pediatric client needs PDN services during the hours spent on continuous positive airway pressure (C-PAP), until the client is medically stable.~~

~~1. The pediatric client needs PDN services for oxygen administration only if there is documentation of rapid desaturation without the oxygen as evidenced by a drop in pulse oximeter readings below 85% within 15-20 minutes, and/or respiratory rate increases, and/or heart rate increases and/or skin color changes. If oxygen is the only technology present, the URC shall review for an individual determination of medical necessity for PDN.~~

2. The pediatric client needs PDN services during the hours required for prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids.

3. The URC shall consider combinations of technologies and co-morbidities when making medical determinations for the following medical conditions:

4. A pediatric client with tube feedings, including nasogastric tube, gastric tube, gastric button and jejunostomy tube, whether intermittent or not, who is not on mechanical ventilation.

5. An adult client with a tracheostomy, who is not on mechanical ventilation or being weaned from mechanical ventilation.

6. An adult client with a tracheostomy decannulation, who is not on mechanical ventilation or being weaned from mechanical ventilation.

7. An adult client who has Continuous Positive Airway Pressure (C-PAP), but is not on mechanical ventilation or being weaned from mechanical ventilation.

8. An adult client with oxygen supplementation, who is not on mechanical ventilation or being weaned from mechanical ventilation.

9. An adult client receiving prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids who is not on mechanical ventilation or being weaned from mechanical ventilation.

10. An adult client with tube feedings that are continuous, including nasogastric tube, gastric tube, gastric button and jejunostomy tube who is not on mechanical ventilation nor being weaned from mechanical ventilation.

11. The medical judgment of the attending physician and the URC shall be used to determine if the criteria are met wherever the medical criteria are not defined by specific measurements.

The criteria for approval of PDN services areis based upon the submission of records that demonstrate the skilled nature of the nursing care provided, including physician and/or allowed practitioner records, specialty notes, and nursing notes.

A member's need for skilled nursing care is based solely on their unique condition and individual needs at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

BENEFITS~~**Beginning November 1, 2021, providers must submit a prior authorization request for all new PDN services. For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request in accordance with the schedule provided in Section 8.540.7.G.**~~

8.540.3.A All ~~private duty nursing (~~PDN~~)~~ services require prior authorization as ~~outlined~~ set forth in S~~s~~ection 8.540.6-7.~~ 8.540.7~~

1. The ongoing need for PDN care ~~is~~shall be ~~periodically~~ re-evaluated annually, at a minimum, or when necessary due to a change in the member's condition~~ with a minimum of an annual review~~. ~~HCPF~~The Department, in coordination with the URC, determines the number of PDN hours~~,~~ based on documented medical necessity. PDN hours may be increased or reduced when necessitated by a change in the member's condition as documented in the member's medical record~~ based on medical necessity accompanied by a change in condition as documented in the medical records~~.

2. Authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. ~~Payment~~Reimbursement for PDN claims requires that~~ is based on~~ the member hav~~inge~~ active coverage on the date of service. ~~and c~~Submitted claims shall ~~meet~~comply with current billing policies effective ~~at the time of services~~on the date of service as ~~outlined~~set forth in the Home Health Billing Information Manual.

3. A member's need for skilled nursing care is determined based solely on their unique condition and individual needs at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

4. Authorized PDN hours ~~that have been authorized are~~shall be used only to meet the medically necessary needs as ~~outlined~~described in the POC and approved prior authorization request (PAR).

8.540.3.B A pediatric ~~client~~ member aged 20 or younger may be approved for up to 24 hours per day of PDN services if the ~~client~~ member meets the URC medical necessity criteria defined at Section 8.540.1.E. ~~identified by HCPF and used by the URC. PDN for pediatric clients is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable.~~

~~The URC shall determine the number of appropriate pediatric PDN hours by considering age, stability, need for frequent suctioning and the ability to manage the tracheostomyThe URC shall consult with the Home Health Agency and the attending physician or primary care physician, to provide medical case management with the goal of resolving the problem that precipitated the need for extended PDN care of more than 16 hours.~~

~~The URC shall consider combinations of technologies and co-morbidities when making medical criteria determinations.~~

~~Twenty-four hour care may be approved for pediatric clients during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year.~~

8.540.3.C Adult ~~clients~~ members aged 21 or older may be approved up to 23 hours per day of PDN services if the member meets medical necessity criteria defined at Section 8.540.1.E. ~~identified by HCPF and used by the URC.~~when determined medically necessary.

8.540.3.D A member may be eligible for a short-term increase in PDN services for a change of condition. The ~~Home Health Agency~~HHA ~~must~~shall apply for additional hours through a revision to the original PAR~~prior authorization request~~.

8.540.3.E A ~~client~~ member who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the ~~client's~~ member's activities of daily living take him or her away from the home. The total hours authorized shall not exceed ~~the hours~~those that would have been authorized if the ~~client~~ member received all care in the home.

8.540.4 BENEFIT LIMITATIONS

8.540.A A ~~client~~ member who meets both the eligibility requirements for PDN and home health shall be allowed to choose whether to receive care ~~under~~ as either a PDN or ~~under h~~Home ~~H~~health benefit. The ~~client~~ member may choose a combination of the two benefits if the care is not ~~duplicative~~duplicative and the resulting combined care does not exceed the medical needs of the ~~client~~member.

8.540.4.B Total ~~H~~hours of PDN services shall ~~never~~ not exceed what has been ~~the hours per day that the URC~~ determine~~ds are~~ medically necessary by the URC and ordered by the physician or allowed practitioner.

~~Only services that require the~~ When a service can be safely and effectively performed (or self-administered) without the direct intervention or delegation of a registered nurse or licensed practical nurse are considered, the service is not considered a nursing service per Colorado Revised Statutes 12-255-131.

8.540.4.C ~~The following limitations apply to the PDN benefit and will not be approved~~PDN services shall not be authorized under the following circumstances:

1. The ~~S~~service~~s~~ consist~~ing~~ ~~only~~ of assistance with activities of daily living or other non-skilled services.

2. The physician's or allowed practitioner's treatment plan does not identify the need for skilled nursing.

3. The services consist of ~~O~~observation or monitoring for medical conditions not requiring skilled nursing assessment and intervention, as documented in the physician's or allowed practitioner's treatment plan and/or nursing notes.

4. The PDN services ~~when~~are used solely for the convenience of the member or other caregiver.

5. ~~C~~The services are custodial or ~~sitter~~stand-by care to ensure compliance with treatment.

6. The ~~care~~services are ~~is~~ intended for other members of the household who are not receiving approved, group PDN services ~~under a group rate~~.

~~1.~~7. The ~~care is a duplication~~services are duplicative of care covered ~~under~~by another ~~service~~benefit or funding source.

8.540.4.D ~~APPLICATION~~ HOSPITAL DISCHARGE PROCEDURES

~~1.~~

The hospital discharge planner shall plan for the member's hospital discharge by coordinating with the ~~Home Health Agency~~HHA to:

a. ~~The hospital discharge planner shall coordinate with the Home Health Agency~~ Arrange services with the ~~Home Health Agency~~HHA, medical equipment suppliers, counselors and other healthcare service providers as needed.~~Refer the client or the client's authorized representative to appropriate agencies for Medicaid eligibility determination in the non-institutional setting, as needed.~~

~~a.~~b. Coordinate a safe home care plan in conjunction with the physician or allowed practitioner and the HHA that meets program requirements ~~in conjunction with the physician or allowed practitioner and the Home Health Agency~~.

~~Plan for the client's hospital discharge by:~~

~~Arrange services with the Home Health Agency, medical equipment suppliers, counselors and other health care service providers as needed.~~

~~Coordinate, in conjunction with the physician and the Home Health Agency, a home care plan that is safe and meets program requirements.~~

~~Advise the Home Health Agency of any changes in medical condition and care needs.~~

~~Ensure that the client, family and caregivers are educated about the client's medical condition and trained to perform the home care.~~

c. Advise the ~~Home Health Agency~~HHA of any changes in medical condition and care needs.

~~b. Submit an application to determine PDN eligibility to the URC if the client is hospitalized when services are first requested or ordered.~~

~~—~~Ensure that the ~~client~~ member, family and caregivers are educated about the ~~client's~~ member's medical condition and trained to perform the home care in the absence of ~~Home Health Agency~~HHA staff.

~~c. The Home Health Agency case coordinator shall submit the application for PDN services to the URC if the client is not in the hospital.~~

~~d.~~

~~e. An application may be submitted up to six months prior to the anticipated need for PDN services. Updated medical information shall be sent to the URC as soon as the service start date is known.~~

~~f.~~

~~g. The application shall be submitted on a Department PDN application form. Any medical information necessary to determine the client's medical need shall be included with the application form.~~

~~h.~~

~~i. If the client has other insurance that has denied PDN coverage, a copy of the denial letter, explanation of benefits or the insurance policy shall be included with the application.~~

~~j.~~

~~k. If services are being requested beyond the 16 hour per day benefit as a result of an EPSDT medical screening, written documentation of those screening results shall be included with the application. The EPSDT claim form shall not meet this requirement.~~

~~l.~~

~~m. The URC nurse reviewer shall review applications for PDN according to the following procedures:~~

~~n.~~

~~o. Review the information provided and apply the medical criteria.~~

~~p.~~

~~q. Return the application to the submitting party for more information within seven working days of receipt of an incomplete application if the application is not complete.~~

~~r.~~

~~s. Approve the application, or refer the application to the URC physician reviewer within 10 working days of receipt of the complete application. The physician reviewer shall have 10 working days to determine approval or denial of the application for PDN.Notify the client or the client's designated representative and the submitting party of application approval.~~

~~t.~~

~~u. Notify the client, the client's designated representative and the submitting party of the client's appeal rights by placing written notification in the mail within one working day of a denial decision.~~

~~v.~~

~~w. Clients who are approved and who subsequently discontinue PDN for any reason do not need an application to request resumption of PDN services within six months of discontinuing PDN services. Services may be resumed upon approval of a Prior Authorization Request (PAR).~~

~~x.~~d.

8.540.5 PROVIDER AND FAMILY REQUIREMENTS

8.540.5.A. Provider Eligibility

1. HHA Sservices mustshall be provided by an Medicare and Medicaid-certified Home Health AgencyHHA certified for participation pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider pursuant to § 25-27.5-103(1), C.R.S..

2. All Home Health Agency providers shall comply with theapplicable rules and regulations set forthpromulgated by the Colorado Department of Public Health and EnvironmentBoard of Health, Medical Services Boardthe Colorado Department of Health Care Policy and Financing, Medical Board, Nursing Boardthe Colorado Department of Regulatory Agencies, Department of Labor and Employment, and the the Centers for Medicare and and Medicaid Services, and the Colorado Department of Labor and Employment.

8.540.5.B Provider Agency Requirements

1. An Home Health AgencyHHA mustshall:

   a. Be certified for participation as a Medicare Home Health provider pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider as required by § 25-27.5-103(1), C.R.S.under Title XVIII of the Social Security Act;

   b. Be a Colorado Medicaid enrolled provider;

   c. Maintain liability insurance for the minimum amount set annually as outlined inset forth at 6 CCR 1011-1, Chapter 26, Section 4.2; and

   d. Be licensedHold a State of Colorado Class A Home Care Agency license in good standing by the State of Colorado as a Class A Home Care Agency in good standing.

2. Home Health Agencies whichthat perform proceduresteststs in the member's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988identified as eligible for a Clinical Laboratory Improvement Amendments (CLIA) waiver pursuant to 42 C.F.R. § 493.15 shall possess a certificate of waiver from the Centers for Medicare and Medicaid Services (CMS) or its Designee.

3. A Home Health AgencyHHA cannotshall not discontinue or refuse services to a member unless documented efforts have been made per agency policies to resolve the situation that triggers the discontinuation or refusal. The Home Health AgencyHHA must shall provide at least 30 calendar days advance notice to the member or the member's designated representativeof at least thirty (30) calendar days to the member, or the member's designated representative.

4. In the event an Home Health AgencyHHA is ceasesing operations, provider agenciesit mustshall notify the Department within thirty (30) calendar days. The notification mustshall be submitted through the Provider Portal as a maintenance application for the disenrollment request. The provider mustshall also email the notice to the Department the notice at the designated Home Health email inbox.

8.540.5.C Provider Responsibilities

1. A certified HHA Home Health Agency may be authorized tothat provides PDN services shall if the agency meets all of the following:

   a. Employs nursing staff nursing staff licensed to practice in Colorado pursuant to the Nurse and Nurse Aide Practice Act, § 12-255-101, C.R.S.currently licensed in Colorado with that possess the education and experience in providing PDN or

care to ~~Technology-Dependent persons~~ individuals who require skilled nursing care in a home or community~~-~~ based setting in accordance with ~~Home Health Agency~~HHA policy, state practice acts, and professional standards of practice~~.~~

b. Employ~~s~~ nursing personnel with documented skills, training and/or experience appropriate for the ~~client's~~ member's individualized needs and care requirements, including cultural and disability competency.

c. ~~Employs staff with experience or training, in providing services to the client's particular demographic or cultural group.~~Provide~~s~~ appropriate nursing skills orientation and ongoing in-service education to nursing staff to meet the member's specific nursing care needs.

d. ~~Coordinates services with a supplemental certified Home Health Agency, if necessary, to meet the staffing needs of the client.~~Require~~s~~ nursing staff to complete cardiopulmonary resuscitation (CPR) instruction and certification at least every two years.

~~Requires the primary nurse and other personnel to spend time in the hospital prior to the initial hospital discharge or after Re-Hospitalization, to refine skills and learn individualized care requirements.~~Provide~~s~~ adequate supervision and training for all nursing staff as required by the agencies listed in Section 8.540.5.A.2. To be reimbursed for time billed, nursing

e. staff shall be engaged in an activity that directly benefits the member receiving services. Staff shall be physically able and mentally alert to carry out the duties of the job.

~~Requires nursing staff to complete cardio pulmonary resuscitation (CPR) instruction and certification at least every two years~~~~The maximum number of hours provided by an individual nurse will be restricted to a level that can safely and reasonably be provided. No individual nurse will be authorized to work more than a sixteen (16) hour shift per day except in an emergency situation.~~

~~e.~~f. ~~Provides adequate supervision and training for all nursing staff.~~Coordinate~~s~~ services with a supplemental certified ~~Home Health Agency~~HHA, if necessary, to meet the staffing needs of the member.

~~f.~~g. Designate~~s~~ a case coordinator who is responsible for the management of private duty nursing services~~home care, which includes the following:~~

~~Assists with the hospital discharge planning process by providing input and information to, and by obtaining information from, the hospital discharge planner and attending physician regarding the home care plan.~~ Develop~~ings~~ the individualized care plan by completing the PDN nursing assessment and obtaining information from the attending physician or allowed practitioner and the primary caregiver

h. .

~~g.~~i. For ~~If the~~ members ~~is~~ discharging from ~~the~~a hospital, include information from the discharge planner ~~must be included~~ in the care planning process.

~~h.~~ Assess~~es~~ the home prior to the initial start of services or hospital discharge and on an ongoing basis for safety compliance.

~~i. Submits an application for PDN to the URC if the client is not in the hospital at the time services are requested.~~

~~j.~~

~~k. Refers the client or the client's designated representative to the appropriate agency for Medicaid eligibility determination, if needed.~~

~~l. Ensures that a completed PAR is submitted to the URC prior to the start of care and before the previous PAR expires.~~

~~m.~~

~~n. Provides overall coordination of home services and service providers.~~

~~o.~~j.

~~p.~~k. Involve~~s~~ the ~~client~~ member and Family/~~In~~ In-Home Caregiver in the plan for home care and the provision of home care.

~~q.~~l. Assist~~s~~ the ~~client~~ member to reach maximum independence.

~~r.~~m. Communicate~~s~~ changes in the ~~case~~ member's status with the ~~attending~~ physician or allowed practitioner and the URC on a timely basis, including changes in medical conditions and/or psychological/social situations that may affect safety and home care needs, and revise~~. A revision to~~ the PAR ~~prior authorization request may be warranted~~if a change in services is required to meet the member's changed needs.

~~s.~~n. Assist~~s~~ with communication and coordination between the service providers supplementing the primary ~~Home Health Agency~~HHA, the primary care physician or allowed practitioner, specialist(s) and the primary ~~Home Health Agency~~HHA as needed.

~~t.~~o. Make~~s~~ regular on-site visits according to ~~Home Health Agency~~HHA policies and procedures and professional standards of practice to monitor the safety and quality of home care~~,~~ and make~~s~~ appropriate referrals to other agencies for care as necessary.

~~u.~~p. Ensure~~s~~ that a complete and current care plan~~s~~ prepared within the prior ~~, no older than sixty (~~60~~)~~ days~~,~~ and nursing chart~~s~~ are in the ~~client's~~ member's home at all times. The nursing ~~Charts~~ chart shall include interim physician or allowed practitioner orders, current medication orders and nursing notes. Records of treatments and interventions shall clearly show compliance with the ~~times indicated on the~~ care plan~~s~~.

~~v.~~q. Communicate~~s~~ with the ~~Single Entry Point or other case managers~~ Case Management Agency and/or Regional Accountability Entity as needed regarding service planning and coordination.

~~w.~~r. Make~~s~~ and document~~s~~ the efforts made to resolve any situation that triggers a discontinuation of or refusal to provide services prior to discontinuation or refusal to provide services.

8.540.5.D ~~Documents that the~~ Family/In-Home Caregiver Responsibilities~~:~~

1. The ~~Home Health Agency~~HHA ~~must~~shall inform the member and their ~~f~~Family/~~i~~In-~~h~~Home ~~c~~Caregiver of the following responsibilities for PDN services and ensure that the caregiver:

    a. Is able to assume some portion of the ~~client's~~ member's care when agency staff is not available~~-~~.

b. Has the specific skills necessary to care for the ~~client.~~member.

c. Has completed CPR instruction or certification and/or training specific to the ~~client's~~ member's emergency needs prior to providing PDN services.

d. Is able to maintain a home environment that allows for safe home care, including a plan for emergency situations.

e. Participates in the planning, ~~implementation~~implementation, and evaluation of PDN services.

f. Communicates changes in care needs and any problems to health care providers and physicians or allowed practitioners as needed.

g. Works toward the ~~client's~~ member's maximum independence, including finding and using alternative resources as appropriate.

~~g.~~h. Has notified power companies, fire departments and other pertinent agencies~~,~~ of the presence of a ~~special needs~~person relying on skilled nursing ~~person~~ in the household.

8.540.5.E
Environmental Requirements

1. Prior to providing PDN services, ~~T~~the ~~Home Health Agency~~HHA shall p~~P~~erform~~s~~ an in-home assessment and document~~s~~ that the home meets the following safety requirements:

   a. Adequate electrical power, including a back-up power system.

   b. Adequate space and ventilation for equipment and supplies.

   c. Adequate fire safety and adequate exits for medical and other emergencies.

   d. A clean environment to the extent that the ~~client's~~ member's life or health is not at risk.

   e. A working ~~tele~~phone available 24 hours a day.

8.540.5.F Physician or Allowed Practitioner Role

1. The ~~Home Health Agency~~HHA shall coordinate with the ~~client's~~ member's attending physician or allowed practitioner to:

   a. Determine that the ~~client~~ member is medically stable, except for acute episodes that ~~can~~may be managed ~~under~~ by PDN services, and that the ~~client~~ member ~~can~~may be safely served ~~under~~ within the requirements and limitations of the PDN benefit.

   b. Cooperate with the URC in establishing medical eligibility.

   c. Prescribe a plan of care at least every 60 days.

d. Coordinate with any other physician(s) or allowed practitioner(s) ~~who are~~ treating the ~~client~~member.

e. Communicate ~~with the Home Health Agency about~~ changes in the ~~client's~~ member's medical condition and care, ~~especially upon~~including discharge from the hospital.

f. Empower the ~~client~~ member and the Family/In-Home Caregiver by working with them ~~and the Home Health Agency~~ to maximize the ~~client's~~ member's independence.

8.540.6 PRIOR AUTHORIZATION PROCEDURES

8.540.6.A A ~~prior authorization request (~~PAR~~)~~ is required for all PDN services. ~~to review the utilization of services and assess the medical necessity of skilled nursing services.~~ Prior authorization is a request for medically necessary services, ~~performed for a single member and~~ based on the needs of the member. The presence of ~~A~~additional members in the home ~~do~~shall not impact the individual member's ~~needs~~medical necessity determination. ~~The Home Health Agency shall submit the initial PAR to the URC prior to the start of PDN.~~

8.540.6.B The PAR ~~shall~~ may be approved for up to six months for a new ~~client~~ member and up to one year for ongoing care~~, based on medical necessity~~. ~~depending upon prognosis for improvement or recovery, according to the medical criteria.~~

8.540.6.C ~~The PAR information shall:~~~~Prior authorization requests~~The PAR ~~must~~shall include the following:

1. A ~~C~~current ~~plan of care (~~POC~~)~~ on CMS Form 485 ~~form~~, or form of similar format, that summarizes health conditions, specific care needs, and current treatments, signed by the physician or allowed practitioner or ~~has~~ a documented verbal order. The POC shall ~~should~~ include:~~Be submitted on a Department PAR form. A copy of the current plan of care shall be included. For new clients admitted to PDN directly from the hospital, a copy of the transcribed verbal physician orders may be substituted for the plan of care if the client has been approved for admission to PDN.~~

    a. A signed PDN Nursing Assessment, a current clinical summary or 60-day summary of care, ~~the physician or allowed practitioner's signed plan of care~~POC including orders for all disciplines and treatments signed by the physician or allowed practitioner, and goals of care/rehabilitation potential, if applicable.

    b. A ~~C~~current diagnosis list and medication list including PRN medications.

    c. A documented process by which the member receiving services and support may continue to receive necessary care, which may include backup care, if the member's ~~f~~Family or In-Home ~~c~~Caregiver is unavailable due to an emergency situation or unforeseen circumstances. The ~~f~~Family or ~~the~~ In-Home ~~c~~Caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.

    d. A hospital discharge summary~~,~~ if there has been a hospitalization since last PAR.

~~A hospital discharge summary, if there has been a hospitalization since last PAR.Be submitted with the plan of care that:~~

~~Is on the CMS-485 form, or a form that is identical in format to the CMS-485. All sections of the form relating to nursing needs shall be completed.~~

~~Includes a signed nursing assessment, a current clinical summary or update of the client's condition and a physician's plan of treatment. A hospital discharge summary shall be included if there was a hospitalization since the last PAR.~~

~~Indicates the frequency and the number of times per day that all technology-related care is to be administered. Ranges and a typical number of hours needed per day are required. The top of the range is the number of hours ordered by the physician as medically necessary. The lower number is the amount of care that may occur due to family availability or choice, holidays or vacations or absence from the home.~~

~~Includes a process by which the client receiving services and support may continue to receive necessary care, which may include respite care, if the client's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or the caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.~~

~~Completion of PDN Tool to reflect an assessment of the member within the certification period encompassing the PAR start date. Documentation submitted should support the score on the Tool.Include an explanation for the decision to use an LPN. This decision shall be at the discretion of the attending physician, the Home Health Agency and the RN responsible for supervising the LPN.~~

2. Identification of professional disciplines supporting the medical needs of the member in the home and responsible for the delivery of care. If care overlaps, ~~D~~documentation ~~should~~shall identify overlapping care and the rationale for the overlap.~~Cover a period of up to one year depending upon medical necessity determination.~~

~~3.~~ For new members ~~admitted~~approved for ~~to~~ PDN directly upon discharge from the hospital, a copy of the transcribed verbal physician or allowed practitioner orders may be substituted for the ~~plan of care~~POC ~~if the member has been approved for admission to PDN services.~~Include only the services of PDN-RN and/or PDN-LPN. If any other ~~services are included on the PAR, the URC shall return the PAR without processing it.Be submitted within five working days of the change as a revision when a change in the plan~~

of care results in an increase in hours. A revised plan of care or a copy of the physician's verbal orders for the increased hours including the effective date shall be included with the PAR form.

4.3.

5.4. Documentation submitted shouldshall include sufficient information to demonstrate the medical necessity of sSkilled nNursing sServices. The number of hours authorized may differ from the number of hours requested based on the clinical review of the request and supporting documentation. TheAn Home Health Agency (HHA) mustshall not misrepresent or omit facts in a treatment plan.Be submitted to decrease the number of hours for which the client may be eligible when a change in the client's condition occurs which could affect the client's eligibility for PDN, or decrease the number of hours for which the client may be eligible. The agency shall notify the URC within one working day of the change. Failure to notify the URC may result in recovery of inappropriate payments, if any, from the Home Health Agency.

5. If a member's condition necessitates a change in PDN hours, the HHA mustshall submit a PAR revision request within ten (10) workingbusiness days of a change. The revision canmay be an increase or a decrease in hours. Discharge notification is also required within ten (10) workingbusiness days via a PAR revision request.Be submitted within five working days of the discharge or death, as a revised PAR when a client is discharged or dies prior to the end date of the PAR. The revision is to the end date and the number of service units.

6. In the event a member changes provider agencies, the receiving HHA mustshall submit a Change of Provider Form and 485/Plan of Care (POC) to the URC within ten (10) business days of starting PDN services.

7. In the event of limited nursing resources for a HHA, two HHAs may coordinate care and provide services to the same member as long as there is no duplication of services on the same date(s) of service and requires the followingthe HHAs comply with the following:

    a. The HHAs mustshall document the need and reason for two HHAs to render services to a member.

    b. The two HHAs mustshall coordinate the member's Plan of Care (POC and) maintain the POC and documentation on all services rendered by each PDN Provider in the member's records.

    c. Each HHA shall obtains prior authorization, and identifiesy to the URC the coordinated POC and revises the PAR as needed to ensure coverage.

8.540.7 UTILIZATION REVIEW

8.540.7.A Providers mustshall submit requests for prior authorization of private duty nursing (PDN) services directly to the Utilization Review Contractor (URC) within ten (10) business days of starting PDN services.

Incomplete requests willshall be pended backheld in pending status to the HHA for up to ten (10) business days for the provider to submit to acquire additional, required information.

~~HHAs should only request services for care outlined in the POC.~~

8.540.7.B The criteria for approval of PDN services are based upon the submission of records that demonstrate the skilled nature of the nursing care needed, including physician and/or allowed practitioner records, specialty notes, and nursing notes. The URC ~~will~~shall review requests for prior authorization according to the information ~~provided~~submitted and the application of the medical criteria as described herein.

1. The URC shall consider combinations of technologies and co-morbidities when making medical determinations that would qualify the member for care pursuant to EPSDT exceptions to benefit limits and coverage standards. The medical judgment of the attending physician or allowed practitioner and the URC shall be used for an individual determination whenever the medical criteria are not defined by specific measurements.

2. Within 10 business days of receipt of the complete PAR, ~~T~~the URC ~~will~~shall approve or deny the PAR, or refer the PAR to the URC physician reviewer~~, within ten (10) workingbusiness days of receipt of the complete PAR~~.

3. The URC ~~will~~shall process the physician review referrals and approve, partially approve, or deny the PAR within 10 ~~working~~ business days of ~~receipt from~~referral to the physician ~~the nurse~~ reviewer.

8.540.7.C The URC shall issue ~~W~~written notification of all PAR denials, including a member's appeal rights, ~~will be issued~~ to the member or member's designated representative and the submitting provider within one business day of the determination.

1. The ~~Home Health Agency~~HHA may request ~~a~~ reconsideration ~~from~~by the URC if the PAR is only partially approved or is denied. The HHA also may request a Peer ~~-~~ to ~~-~~ Peer review if the ordering physician or allowed practitioner ~~is in agreement~~agrees.

2. Services provided during the period between the provider's submission of the PAR to the URC ~~to~~through the final approval or denial by HCPF may be approved for ~~p~~payment. ~~-~~Payment may be made retroactive to the start date on the PAR form~~,~~ or for up to 30 calendar days prior to PAR approval, whichever is shorter.

~~1.~~ When a PAR determination results in the reduction or termination of services~~is denied or reduced~~, services shall be approved for ~~thirty (~~30~~)~~ additional calendar days after the date on the member's notice of denial letter. If the ~~denial~~termination or reduction of PDN services is appealed by the member in accordance with Section 8.057, services ~~will~~shall be maintained at the ~~currently~~previously approved level for the duration of the appeal until the final agency action is rendered.

3.

4. For appeals of an initial PAR denial, continuation of benefits is not applicable.

8.540.7.D

~~The URC shall review PARs according to the following procedures:~~

~~Review information provided and apply the medical criteria as described herein.~~

~~Return an incomplete PAR to the Home Health Agency for correction within ten working days of receipt.~~

~~Approve the PAR, or refer the PAR to the URC physician reviewer, within 10 working days of receipt of the complete PAR.~~

~~Process physician review referrals and approve, partially approve, or deny the PAR within 10 working days of receipt from the nurse reviewer. The URC physician reviewer shall attempt to contact the attending physician or the primary care physician for more information prior to a denial or reduction in services.~~

~~Provide written notification to the client or client's designated representative and submitting party of all PAR denials and the client's appeal rights, within one working day of the decision.~~

~~Approve subsequent continued stay PARs that have been to physician review without referral, if the client's condition and the requested hours have not changed.~~

~~Notify the Department of all extraordinary PDN services approved as a result of an EPSDT screen.~~

~~Notify the submitting party of all PAR approvals.~~

~~Expedite PAR reviews in situations where adhering to the time frames above would seriously jeopardize the client's life or health.~~

Expedited PAR reviews may be requested in situations where adhering to the time frames above would seriously jeopardize the ~~client's~~member's life or health.~~No services shall be approved for dates of service prior to the date the URC receives a complete PAR. PAR revisions for medically necessary increased services may be approved back to the day prior to receipt by the URC if the revised PAR was received within five working days of the increase in services. Facsimiles may be accepted.~~

~~The URC nurse reviewer may attend hospital discharge planning conferences, and may conduct on site visits to each client at admission and every six months thereafter.~~

~~For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request (PAR) in accordance with the schedule in Sections 8.540.7.G.1-10. When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client.~~

~~Ten percent (10%) of PARs must be submitted by November 30, 2021;~~

~~An additional 10% of PARs must be submitted by December 31, 2021;~~

~~An additional 10% of PARs must be submitted by January 31, 2022;~~

~~An additional 10% of PARs must be submitted by February 28, 2022;~~

~~An additional 10% of PARs must be submitted by March 31, 2022;~~

~~An additional 10% of PARs must be submitted by April 30, 2022;~~

~~An additional 10% of PARs must be submitted by May 31, 2022;~~

~~An additional 10% of PARs must be submitted by June 30, 2022;~~

~~An additional 10% of PARs must be submitted by July 31, 2022;~~

~~The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.~~

8.540.8 REIMBURSEMENT

8.540.8.A No skilled services shall be authorized or reimbursed if the skilled hours of service, regardless of funding source, total more than 24 hours per day for members aged 20 or younger and no more than 23 hours per day for members aged 21 or older.

8.540.8.B No services shall be reimbursed if the care is duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health or other insurance.

8.540.8.C Approval of the PAR by the URC shall authorize the ~~Home Health Agency~~HHA to submit claims to the Medicaid fiscal agent for authorized PDN services provided during the authorized period. Payment of claims is ~~conditional~~ conditioned upon the ~~client's~~ member's ~~financial~~ benefit eligibility on the date~~s~~ of service and the provider's use of correct billing procedures.

8.540.8.D No services shall be reimbursed for dates of service prior to the PAR start date as authorized by the URC, except as provided in Section 8.540.7.C.2.

8.540.8.E Skilled Nursing services ~~under~~ provided as a~~the~~ PDN benefit shall be reimbursed in units of one hour~~,~~ at the lesser of the provider's usual and customary charge or the maximum Medicaid allowable rates established by ~~the Department~~HCPF~~, whichever is less~~.

1. Units of one hour may be billed for RN or ~~,~~ LPN ~~based on the personnel rendering the care.,~~

2. The RN group rate shall~~ould~~ be utilized when a registered nurse is providing PDN services to more than one member at the same time in the same setting.

~~The LPN group rate shall be utilized when a licensed practical nurse is providing PDN services to more than one member at the same time in the same setting. (registered nurse providing PDN to more than one client at the same time in the same setting),~~

~~The LPN group rate shallhould be utilized when a licensed practical nurse is providing PDN services to more than one member at the same time in the same setting. (licensed practical nurse providing PDN to more than one client at the same time in the same setting) or~~

3.

4. The ~~B~~blended RN/LPN rate ~~is~~shall be requested by the ~~Home Health Agency~~HHA when utilizing an RN or LPN as the assigned staff for more than one member at the same time in the same setting. ~~used as a (group rate by request of the Home Health Agency only).~~

5. PDN services may be provided by a single nurse to an individual or to multiple individuals in a non-institutional group setting as described above. The nurse-member ratio ~~will~~shall not exceed what ~~can~~is required for one licensed nurse to ~~be~~ safely care~~d~~ for each member simultaneously, ~~simultaneously by one licensed nurse depending~~based on member acuity and the availability of additional support in the home.

8.540.8.F Reimbursement ~~will~~shall not be allowed at any time when nursing staff is sleeping during the provision of PDN services.

8.540.8.G No individual nurse ~~will~~shall be reimbursed for over ~~sixteen (~~16~~)~~ hours of care per day, except in a documented emergency situation.