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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 15-02-19-A, Revision to the Medical Assistance Long Term Supports and Services Benefit Division Rule Concerning Home and Community Based Services for Persons with Spinal Cord Injury, Section 8.517
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) 8.517, 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)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace all current text beginning at §8.517 through the end of §8.517.11.D.6.d with the new text provided. This revision is effective 06/30/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long-Term Services and Supports Benefit Division Rule Concerning Home and Community Based Services for Persons with Spinal Cord Injury, Section 8.517
Rule Number:	MSB 15-02-19-A
Division / Contact / Phone:	Long Term Services and Supports / Candace Bailey / (303)866-3877

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).

   Section 8.517 outlines all aspects The Home and Community-Based Services for persons with Spinal Cord Injury (HCBS-SCI) waiver pilot program. The current rules have limited complementary and integrative health providers participating in the pilot program. The proposed rule changes will expand provider type and requirements allowing more providers to enroll. Other changes will align the rule with language and changes proposed in the waiver renewal application and in the legislation to extend the waiver. These changes are necessary to meet requirements outlined in legislation and the states application for a waiver renewal to Centers for Medicare & Medicaid Services. Additional benefits of the proposed rule changes are increased client choice and increased client accessibility to receive services.

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:

   Senate Bill 15-011 extends the SCI waiver pilot program for an additional 5-year period and requires that the waiting list be eliminated effective July 1, 2015. As such, an emergency rule is necessary to comply with SB 15-011. Additionally, immediate passage is necessary for the preservation of public health, safety and welfare because the proposed waiver renewal makes changes to the provider model, enrollment cap, and eligibility requirements, which will allow for more individuals to be served under the SCI waiver and will also increase the amount of providers available to serve this population. If this rule is in effect at the time of CMS approval of the waiver, services to those in need can be immediately provided without any further delay

3. Federal authority for the Rule, if any:

42 U.S.C. Section 1915 (c)

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2014);
25.5-6-1301 et seq., C.R.S.
SB15-011

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Title of Rule:	Revision to the Medical Assistance Long-Term Services and Supports Benefit Division Rule Concerning Home and Community Based Services for Persons with Spinal Cord Injury, Section 8.517
Rule Number:	MSB 15-02-19-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.

   This rule will benefit individuals currently enrolled on the SCI Waiver by ultimately increasing the number of complementary and integrative health services providers. An increase in services providers will increase client's choice regarding where they receive their services.

   The rule will benefit the current complementary and integrative health service provider by enabling them to create care plans without having to consult with a physician. The current provider is already at capacity, and the waiver is scheduled to expand its client count in July of 2015; the rule will enable additional providers to enroll and assist in meeting the waivers growing needs.

   The rule will benefit additional providers of complementary and integrative health services in the community who have expressed interest in the SCI waiver but have been unable to meet the requirements outlined in the current rule.

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

   The impact of this rule on SCI waiver clients is positive. The waiver can enroll more providers, giving clients the choice of whom they would like to provide their service. Additionally, many clients have expressed the need and want to receive services in their home. This rule will enable this option and will positively impact the Department's relationship with SCI Waiver clients.

   The rule may impact the current complementary and integrative health service provider financially, however the extent and direction of that impact is dependent on many variables. Currently their facility is running at full capacity and the staff has been working hours beyond their regular operation hours. This rule may allow them to lower the client count, staff hours, and support staff's work load.

   The impact of the rule on complementary and integrative health providers who are currently not enrolled in the SCI Waiver will be positive both financially and in being a part of this

innovative program. There have been multiple providers interested in the waiver and this rule will allow many of those providers to enroll.

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

   The proposed rule changes will have a budget impact, however the additional funds have been forecasted and allocated by the Department's budget division. The updated forecast for the 2015-2016 waiver year has the total expenditure for this program at $3,608,566 with an average cost per client as $33,106. This forecast accounts for an increase to the client count as the legislations states that the SCI waiver shall not have a waiting list.

   The legislation currently has a fiscal note that accounts for all clients utilizing the full amount of services. While the rule aims to increase the number of enrolled clients and qualified providers, the allotted units of services for those client's will remain the same.

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

   Although the annual cost of the program will increase, the increase is a result of the state being able to provide services to more individuals and the funds have already been allocated. The benefit of the proposed rule changes will increase client choice, client enrollment, provider capacity, and allow a contracted, independent evaluator to further evaluate the effectiveness of the program and the complementary and alternative health services.

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

   This is the least costly and intrusive method for adjusting the provider model. This is the only method to aligning the Department with State Statute and our agreement with CMS.

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

   There are no other methods available to establish a new provider model or change the name of the complementary and integrative health services.

8.517 HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY WAIVER

8.517.1 DEFINITIONS OF SERVICES PROVIDED

Adult Day Services means services as defined at Section 8.491.

~~Alternative Therapies~~ Complementary and Integrative Health Services means services as defined at Section 8.517.11.

Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.

Electronic Monitoring means services as defined at Section 8.488.

Home Modification means services as defined at Section 8.493.

Homemaker Services means services as defined at Section 8.490.

In-Home Support Services means services as defined at Section 8.552.

Non-Medical Transportation means services as defined at Section 8.494.

Personal Care Services means services as defined at Section 8.489.

Respite Care means services as defined at Section 8.492.

8.517.2 GENERAL DEFINITIONS

Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about beneficial physiologic and /or psychological changes.

~~Alternative Therapies Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Alternative Therapies Complementary and Integrative Health Services in accordance with Section 8.517.11.D.~~

~~Alternative Therapies Center~~ Complementary and Integrative Health Provider ~~means a location~~ an ~~individual or agency certified annually by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.C.~~

Chiropractic Care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems.

Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.

Complementary and Integrative Health Provider means an individual or agency certified annually by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.

Denver Metro Area means the counties of Adams, Arapahoe, Denver, Douglas, and Jefferson.

Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

Individual Cost Containment Amount means the average ~~costs of institutional services for the nursing facility~~ cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.

Medical Director means an individual that is contracted with the Department of Health Care Policy and Financing to provide oversight of the Complementary and Integrative Health Services and the program evaluation.

Spinal Cord Injury means an injury to the spinal cord and includes the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes 952 through 954.9.

~~Supervising Physician means an individual that is employed or contracted by a certified Alternative Therapies Center to supervise the provision of Alternative Therapies and meets the qualifications required by Section 8.517.11.C.1.f.~~

8.517.3 LEGAL BASIS

The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) ~~program~~ waiver is created upon authorization of a waiver of the state-wideness requirement contained in Section 1902(a)(1) of the Social Security Act (42 U.S.C. § 1396a); and the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act (42 U.S.C. § 1396a). Upon approval by the United States Department of Health and Human Services, this waiver is granted under Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n). 42 U.S.C. § § 1396a and 1396n are incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 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, CO 80203. Additionally, any incorporated material in these rules may be examined at any State depository library. This regulation is adopted pursuant to the authority in Section 25.5-1-301, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Section 24-4-101 et seq., C.R.S. and the Colorado Medical Assistance Act, Sections 25.5-6-1301 et seq., C.R.S.

The addition of “individual” to the Complementary and Integrative Health Provider definition in section 8.517.2, the addition of hospital level of care eligibility criteria in section 8.517.5.C, the elimination of the waitlist at section 8.517.6.1, the addition of the client’s residence as a service location at section 8.517.11.B.3 and all Medical Director responsibilities are contingent and shall not be in effect until the HCBS-SCI Waiver Renewal CO.0961.R01.00 has been approved by the Centers for Medicare and Medicaid Services (CMS).

8.517.4 SCOPE AND PURPOSE

8.517.4.A. The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) ~~program~~ waiver provides assistance to individuals with spinal cord injuries in the Denver Metro Area that require long term supports and services in order to remain in a community setting.

8.517.4.B. The HCBS-SCI ~~program~~ waiver provides an opportunity to study the effectiveness of ~~Alternative Therapies~~ Complementary and Integrative Health Services and the impact the provision of ~~this~~ these service may have on the utilization of other HCBS-SCI ~~program~~ waiver and/or acute care services.

8.517.4.C. An independent evaluation shall be conducted ~~in the third year of program operation~~ no later than January 1, 2020 to determine the effectiveness of the ~~Alternative Therapies~~ Complementary and Integrative Health Services.

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall be offered only to ~~persons~~ individuals who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a diagnosis of Spinal Cord Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) and in the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool.

3. Individuals shall have been determined to have a significant functional impairment as evidenced by a comprehensive functional assessment using the ULTC 100.2 assessment tool that results in at least the minimum scores required per Section 8.401.1.15.

4. Individuals shall reside in the Denver Metro Area as evidenced by residence in one of the following counties:

    a. Adams;

    b. Arapahoe;

    c. Denver;

    d. Douglas; or

    e. Jefferson

8.517.5.B FINANCIAL ELIGIBILITY

Individuals must meet the financial eligibility requirements specified at Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.517.5.C LEVEL OF CARE CRITERIA

Individuals shall require long term support services at a level of care comparable to services typically provided in a nursing facility or hospital.

8.517.5.D NEED FOR HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY (HCBS-SCI) WAIVER SERVICES

1. Only ~~clients~~ individuals that currently receive Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services, or that have agreed to accept HCBS-SCI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-SCI ~~program~~ waiver.

    a. Case management is not an HCBS-SCI service and shall not be used to satisfy this requirement.

b. The desire or need for any Medicaid services other than HCBS-SCI waiver services, as listed at Section 8.517.1, shall not satisfy this eligibility requirement.

2. ~~Clients~~ Individuals that have not received at least one (1) HCBS-SCI waiver service~~s~~ for a period greater than 30 consecutive days shall be discontinued from the waiver.

8.517.5.E EXCLUSIONS

1. ~~Clients~~ Individuals who are residents of nursing facilities or hospitals are not eligible to receive Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services.

2. HCBS-SCI clients that enter a nursing facility or hospital may not receive HCBS-SCI waiver services while admitted to the nursing facility or hospital.

a. HCBS-SCI clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-SCI program.

b. HCBS-SCI clients entering a nursing facility for Respite Care as an HCBS-SCI service shall not be discontinued from the HCBS-SCI program.

8.517.5.F COST CONTAINMENT AND SERVICE ADEQUACY

1. ~~The client~~ Individuals shall not be eligible for the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) ~~program~~ waiver if the case manager determines any of the following during the initial assessment and service planning process:

a. The ~~client's~~ individual's needs cannot be met within the Individual Cost Containment Amount.

b. The ~~client's~~ individual's needs are more extensive than HCBS-SCI ~~program~~ waiver services are able to support and/or that the ~~client's~~ individual's health and safety cannot be assured in a community setting.

2. ~~The client~~ Individuals shall not be eligible for the HCBS-SCI waiver at reassessment if the case manager determines the ~~client's~~ individual's needs are more extensive than HCBS-SCI ~~program~~ waiver services are able to support and/or that the ~~client's~~ individual's health and safety cannot be assured in a community setting.

3. ~~The client~~ Individuals may be eligible for the HCBS-SCI ~~program~~ waiver at reassessment if the case manager determines that HCBS-SCI ~~program~~ waiver services are able to support the ~~client's~~ individual's needs and the ~~client's~~ individual's health and safety can be assured in a community setting.

a. If the case manager expects that the services required to support the ~~client's~~ individual's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the ~~client's~~ individual's request for services is appropriate and justifiable based on the ~~client's~~ individual's condition.

i) ~~The client~~ Individuals may request of the case manager that existing services remain intact during this review process.

ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the ~~client~~ individual with:

1) The client's appeal rights pursuant to Section 8.057; and

2) Alternative options to meet the ~~client's~~ individual's needs that may include, but are not limited to, nursing facility placement.

8.517.6 WAITING LIST

1. The number of clients who may be served through the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver during a fiscal year ~~shall~~ may be limited by the federally approved waiver.

2. Individuals determined eligible for the HCBS-SCI waiver who cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

3. The waiting list shall be maintained by the Department.

4. The ~~Case Manager~~ case manager shall ensure the individual meets all eligibility criteria as set forth at Section 8.517.5 prior to notifying the Department to place the individual on the waiting list.

5. The date the ~~Case Manager~~ case manager determines an individual has met all eligibility requirements as set forth at Section 8.517.5 is the date the Department will use for the individual's placement on the waiting list.

6. When an eligible individual is placed on the waiting list for the HCBS- SCI ~~W~~waiver, the ~~Case Manager~~ case manager shall provide a written notice of the action in accordance with section 8.057 et seq.

7. As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for the HCBS-SCI waiver ~~services~~ in the order of the individual's placement on the waiting list

8. When an opening for the HCBS-SCI ~~W~~waiver becomes available the Department will provide written notice to the Case Management Agency.

9. Within ten business days of notification from the Department that an opening for the HCBS-SCI waiver is available the Case Management Agency shall:

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

   b. Update the existing functional level of care assessment in the official client record if less than six months has elapsed since the date of the previous assessment.

   c. Reassess for eligibility criteria as set forth at 8.517.5.

   d. Notify the Department of the individual's eligibility status.

8.517.7 START DATE FOR SERVICES

8.517.7.A. The start date of eligibility for Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services shall not precede the date that all of the requirements at Section 8.517.5, have been met. The first date for which HCBS-SCI waiver services may be reimbursed shall be the later of the following:

1. The date at which financial eligibility is effective.

2. The date at which the level of care and targeting criteria are certified.

3. The date at which the ~~client~~ individual agrees to accept services and signs all necessary intake and service planning forms.

4. The date of discharge from the hospital or nursing facility.

8.517.8 CASE MANAGEMENT FUNCTIONS

8.517.8.A. The requirements at Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) ~~program.~~waiver.

8.517.9 PRIOR AUTHORIZATION OF SERVICES

8.517.9.A. All Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver services must be prior authorized by the Department or its agent.

8.517.9.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.517.9.C. ~~The Department or its agent shall determine if the~~Claims for services are not reimbursable if~~requested are~~:

1. Services are not c~~C~~onsistent with the client's documented medical condition and functional capacity;

2. Services are not medically necessary or are not r~~R~~easonable in amount, scope, frequency, and duration;

3. Services are ~~Not~~ duplicative of ~~the~~ other services included in the client's Service Plan;

4. ~~Not for services for which t~~The client is receiving funds to purchase services; ~~and~~or

5. Services total ~~Do not total~~ more than 24 hours per day of care.

8.517.9.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

8.517.9.E. ~~Approval of the PAR by the Department or its agent shall authorize providers of HCBS-SCI~~ waiver ~~services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR.~~

~~1.~~ Payment for HCBS-SCI waiver services is also conditional upon:

a. The client's eligibility for HCBS-SCI waiver services;

b. The provider's certification status; and

c. The submission of claims in accordance with proper billing procedures.

8.517.9.F. Prior authorization of services is not a guarantee of payment. ~~The prior authorization of services does not constitute an entitlement to those services.~~ All services ~~provided and~~

~~reimbursed~~ must be ~~delivered~~ provided in accordance with regulation and necessary to meet the client's needs.

8.517.9.G. Services requested on the PAR shall be supported by information on the Long Term Care Service Plan, the ULTC-100.2, and written documentation from the income maintenance technician of the client's current monthly income.

8.517.9.H. The PAR start date shall not precede the start date of HCBS-SCI eligibility in accordance with Section 8.517.7.

8.517.9.I. The PAR end date shall not exceed the end date of the HCBS-SCI eligibility certification period.

8.517.10 PROVIDER AGENCIES

8.517.10.A. HCBS-SCI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

8.517.11 ~~ALTERNATIVE THERAPIES~~ COMPLEMENTARY AND INTEGRATIVE HEALTH SERVICES

~~Alternative Therapies~~ Complementary and Integrative Health Services are limited to Acupuncture, Chiropractic Care, and Massage Therapy as defined at Section 8.517.2.

8.517.11.A. Inclusions

1. Acupuncture used for the treatment of conditions or symptoms related to the client's spinal cord injury.

2. Chiropractic Care used for the treatment of conditions or symptoms related to the client's spinal cord injury.

3. Massage Therapy used for the treatment of conditions or symptoms related to the client's spinal cord injury.

8.517.11.B. Exclusions / Limitations

1. ~~Alternative Therapies~~ Complementary and Integrative Health Services shall be provided only for the treatment of conditions or symptoms related to the client's spinal cord injury.

2. ~~Alternative therapies~~ Complementary and Integrative Health Services shall be limited to the client's assessed need for services as determined by the ~~Supervising Physician~~ Complementary and Integrative Health Provider and documented in the ~~Alternative Therapies~~ Complementary and Integrative Health Care Plan.

3. ~~Alternative Therapies~~ Complementary and Integrative Health Services shall be provided in an approved outpatient setting in accordance with 8.517.11.C.2 or in the client's residence.~~.~~

4. ~~Alternative Therapies~~ Complementary and Integrative Health Services shall be provided only by ~~agencies~~ a Complementary and Integrative Health Provider certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11.~~C.~~

5. Clients receiving ~~Alternative Therapies~~ Complementary and Integrative Health Services shall participate in an independent evaluation to determine the effectiveness of ~~this~~ the services.

6. ~~The utilization of Alternative Therapies may typically begin at a higher frequency and is expected to decrease as the client progresses.~~ ~~Authorization and payment for the Alternative Therapies service~~ The Complementary and Integrative Health Services benefit is limited as follows:

~~a. During the first 90 days of the initial Alternative Therapies Care Plan, the schedule of services recommended by the Supervising Physician shall not exceed 15 visits for any one modality or 30 visits for any combination of modalities.~~

~~b. After the first 90 days of the initial Alternative Therapies Care Plan and in all subsequent Alternative Therapies Care Plans, the schedule of services recommended by the Supervising Physician shall not exceed 12 visits for any one modality or 24 visits for any combination of modalities per 90 day period.~~

a. A client may receive each of the three individual Complementary and Integrative Health Services on a single date of service.

b. A client shall not receive more than four (4) units of each individual Complementary and Integrative Health Service on a single date of service.

c. A client shall not receive more than 204 units of a single Complementary and Integrative Health service during a 365 day certification period.

d. A client shall not receive more than 408 combined units of all Complementary and Integrative Health Services during a 365 day certification period.

8.517.11.C. Certification Standards

1. Organization and Staffing

~~a. Alternative Therapy Centers shall employ or contract with an adequate number of qualified professionals necessary for the provision of Alternative Therapies in accordance with this regulation.~~

a.~~b.~~ ~~Alternative Therapies~~ Complementary and Integrative Health Services must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice ~~and under the direction of a Supervising Physician.~~.

b.~~c.~~ Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (12-29.5-101, C.R.S.) and have at least five years experience practicing Acupuncture at a rate of at least 750 hours per year.

c.~~d.~~ Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (12-33-101, C.R.S.) and have at least five years experience practicing Chiropractic Care at a rate of at least 750 hours per year.

d.~~e.~~ Massage Therapists shall be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (12-35.3-101, C.R.S.) and have at least five years experience practicing Massage Therapy at a rate of at least 750 hours per year.

~~f. Supervising Physicians shall be licensed to practice medicine in the State of Colorado as required by 12-36-107 et seq., C.R.S. Supervising Physicians must~~

~~also be board certified in Physical Medicine and Rehabilitation, Internal Medicine, Neurology, and/or Family Practice and have at least five years experience incorporating Alternative Therapies as part of an overall care plan.~~

2. Environmental Standards for Complementary and Integrative Health Services provided in an outpatient setting.

   a. ~~Alternative Therapy Centers~~ Complementary and Integrative Health Providers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. ~~The facility~~ They shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.

   b. Policies shall be developed and procedures implemented for the effective control of insects, rodents, and other pests.

   c. All wastes shall be disposed in compliance with local, state and federal laws.

   d. A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.

   e. Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.

   f. ~~Alternative Therapy Centers~~ Outpatient settings shall be constructed and maintained to ensure access and safety.

   g. ~~Alternative Therapy Centers~~ Outpatient settings shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.

3. Failure to comply with the requirements of this ~~regulation~~ rule may result in the ~~suspension or recovery of payment for services provided and/or the~~ revocation of the ~~Alternative Therapy Center provider~~ Complementary and Integrative Health Provider certification.

8.517.11.D ~~ALTERNATIVE THERAPIES~~ COMPLEMENTARY AND INTEGRATIVE HEALTH CARE PLAN

1. ~~The Supervising Physician~~ Complementary and Integrative Health Providers shall:

   a. Guide the development of the ~~Alternative Therapies~~ Complementary and Integrative Health Care Plan in coordination with the client and/or client's representative~~, and the Alternative Therapies practitioners as applicable;~~

   b. Recommend the appropriate modality, amount, scope, and duration of the ~~Alternative Therapies~~ Complementary and Integrative Health Services within the established limits as listed at 8.517.11.B;

c. ~~Order~~ Recommend only services ~~and/or modalities~~ that are necessary and appropriate~~;~~ and will be rendered by the ~~authorizing~~recommending Complementary and Integrative Health Provider.

~~d. Supervise the Alternative Therapies practitioners and the services provided.~~

2. The ~~Supervising Physician~~ Complementary and Integrative Health Provider shall reassess the ~~Alternative Therapies~~ Complementary and Integrative Health Care Plan at least ~~every three months~~ annually or more frequently as necessary. The reassessment ~~may~~ shall include a visit with the client.

3. When recommending the use of ~~Alternative Therapies~~Complementary and Integrative Health Services for the treatment of a condition or symptom related to the client's spinal cord injury, the ~~Supervising Physician~~Complementary and Integrative Health Provider should use evidence from published medical literature that demonstrates the effectiveness of ~~Alternative Therapies~~ the services for the treatment of the condition or symptom.

a. Where no evidence exists, ~~the medical judgment of the Supervising Physician and the input of the Alternative Therapies practitioners should guide recommendations.~~ the Complementary and Integrative Health Provider shall use their field expertise to guide service recommendations.

b. If additional expertise is required the Complementary and Integrative Health Provider may; consult the Medical Director and/or consult other Complementary and Integrative Health service providers.

~~4. The Supervising Physician may require consultation or referral to other specialists prior to finalization of the Alternative Therapies Care Plan.~~

4.~~5.~~ The ~~Alternative Therapies Care plan~~ Complementary and Integrative Health Care Plan shall be developed using ~~any~~ Department prescribed form(s) or template(s).

6. The ~~Alternative Therapies~~ Complementary and Integrative Health Care Plan shall include at least the following:

a. A summary of the client's ~~medical~~ treatment history;

b. An assessment of the client's current medical conditions/needs~~, determined by a comprehensive history and physical exam.~~

c. The amount, scope, and duration of each recommended ~~Alternative Therapies modality~~ Complementary and Integrative Health Services and the expected outcomes.

d. The recommended schedule of services.

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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 15-04-23-A, Revision to the Medical Assistance Pharmacy Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.590.7.I, 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)? Yes
   If yes, state effective date: 7/1/2015
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at §8.590.I.2 and .3 with the new text provided. All text indicated in blue is for clarity only and should not be changed. This revision is effective 07/01/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I
Rule Number:	MSB 15-04-23-A
Division / Contact / Phone:	Client and Clinical Care / Carrie Smith / 303-866-3406

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule will increase the DME encounter rate by 0.5% to account for General Assembly funding appropriation.

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:

   This rule is being changed to comply with the Long Appropriations Bill, Senate Bill 15-234, which mandates a 0.5% increase for the Durable Medical Equipment encounter rate, effective July 1, 2015.

3. Federal authority for the Rule, if any:

   Two state plan amendments (SPAs) will be submitted to CMS with a requested effective date of July 1, 2015. Reimbursement for the Durable Medical Equipment encounter rate will be made under the current rate until the SPAs are approved. Once approval is received, any such reimbursements made after July 1, 2015 will be adjusted to reflect the new rate contained in the rule.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);
   Senate Bill 15-234

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I
Rule Number:	MSB 15-04-23-A
Division / Contact / Phone:	Client and Clinical Care / Carrie Smith / 303-866-3406

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.

   DME providers will receive increased reimbursement for equipment and supplies provided.

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

   Reimbursement to DME providers is estimated to be increased by $765,579 for FY 2015-16.

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.

   No costs beyond the estimated expenditures due to the rate increase are anticipated.

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

   The rate increase will give providers the ability to continue supplying DME items to clients at their incremental threshold margin. Inaction can result in decreased client services and access to benefits, as well as noncompliance with SB 15-234.

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

   There is not a less costly method for achieving the purpose of the proposed rule which is to comply with SB 15-234.

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.

   An alternative method for achieving a rate increase for the proposed rule was not considered.

8.590.7 REIMBURSEMENT

8.590.7.A. Invoices received from Related Owners or Related Parties shall not be accepted. Only invoices received from unrelated manufacturers or wholesale distributors shall be recognized as allowable invoices.

8.590.7.B. The provider shall not bill the Department for authorized accessory items included by the manufacturer as part of a standard package for an item.

8.590.7.C. The provider shall credit the cost of any accessory or part removed from a standard package to the Department.

8.590.7.D. Clients and providers may negotiate in good faith a trade-in amount for DME items no longer suitable for a client because of growth, development or a change in anatomical and or medical condition. Such trade-in allowances shall be used to reduce the cost incurred by the Department for a replacement item.

8.590.7.E. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacture; wherever the item was returned, and the Department.

8.590.7.F. Reimbursement for allowable modifications, service, and repairs on durable medical equipment is as follows:

1. Labor for modifications, service, and repairs on durable medical equipment shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

2. Parts that are listed on the Department's fee schedule, with a HCPCS code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

3. Manually priced parts are reimbursed according to the same methodology used for purchased equipment, as described in 8.590.7.I.

4. The provider shall not be reimbursed for labor or parts in excess of unit limitations.

5. Reimbursement for a modification that requires the original equipment provider to supply a part from their own inventory or stock is contingent upon the provider submitting supporting documentation that demonstrates the need and actual cost of the parts to be used in the modification.

8.590.7.G. Reimbursement for used equipment shall include:

1. A written, signed and dated agreement from the client accepting the equipment.

2. Billing the Department, the lesser of 60% of the maximum allowable reimbursement indicated in the most recent Medicaid Bulletin or 60% of the provider's usual submitted charges.

8.590.7.H. Reimbursement for purchased or rented equipment shall include, but is not limited to:

1. All elements of the manufacturer's warranties or express warranties.

2. All adjustments and modification needed by the client to make the item useful and functional.

3. Delivery, set-up and installation of equipment in the home, and if appropriate to a specific room in the home.

4. Training and instruction to the client or caregiver in the safe, sanitary, effective and appropriate use of the item and necessary servicing and maintenance to be done by the client or caregiver.

5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides.

8.590.7.I. Reimbursement rate for a purchased item shall be as follows:

1. Fee Schedule items, with a HCPC or CPT code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the Department fee schedule rate.

2. Manually priced items that do not have an assigned Fee Schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less 19.48~~6~~ percent.

3. Manually priced items that do not have an MSRP or Fee Schedule rate shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus 17.85~~26~~ percent.

8.590.7.J. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Medicaid Bulletin.

8.590.7.K. Reimbursement for clients eligible for both Medicare and Medicaid shall be made in the following manner:

1. The provider shall bill Medicare first unless otherwise authorized by the Department.

2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments.

3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions:

a. A copy of the Explanation of Medicare Benefits' shall be maintained in the provider's files when billing electronically or attached to the claim if it is billed manually; or

b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error.

8.590.7.L. Reimbursement for Complex Rehabilitation Technology provided to clients shall be made when the following conditions are met:

1. The billing provider is a Complex Rehabilitation Technology Supplier;

2. The client has been evaluated or assessed, for selected Complex Rehabilitation Technology identified in the Medicaid Bulletin, by:

a. A Qualified Health Care Professional; and

b. A Complex Rehabilitation Technology Professional employed by the billing provider.

3. The Complex Rehabilitation Technology is provided in compliance with all applicable federal and state laws, rules, and regulations, including those rules governing the Medical Assistance Program.

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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 15-05-04-A, Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.300.6.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)? Yes
   If yes, state effective date: 7/1/2015
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert a new eighth unnumbered paragraph at §8.300.6.A.1 immediately following the seventh unnumbered paragraph and immediately preceding §8.300.6.A.2. All text indicated in blue is for context only and should not be changed. This revision is effective 07/01/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 15-05-04-A
Division / Contact / Phone:	Payment Reform / Andrew Abalos / 2130

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).

   On April 24, 2015, Governor Hickenlooper signed Senate Bill 15-234, which set the Colorado state budget for FY 2015-16. After much debate by the General Assembly, the signed budget includes reimbursement increases for Medicaid providers, including hospitals. As a result, Medicaid hospitals are receiving a 0.5% increase in their reimbursement rate for outpatient services. This outpatient reimbursement rate change requires a new rule since the rate history is included in the regulation for cost settlement purposes. Currently, hospitals are reimbursed at 71.6% of cost for outpatient services (excluding those services reimbursed based upon the fee schedule such as lab, physical therapy, and occupational therapy). Effective July 1, 2015, the proposed rule will change the reimbursement to 72% of cost, which represents a payment increase of 0.5% as required by Senate Bill 15-234.

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:

   The purpose of this rule is to comply with state law, specifically the mandates of Senate Bill 15-234.

3. Federal authority for the Rule, if any:

42 U.S.C. 1396a(a)(30)(A);
42 C.F.R. 447.321

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2014);
   24-4-103(6), C.R.S., (2014), 25.5-4-402.3(4)(B)(I) C.R.S (2014); 10 CCR 2505-10 8.300.6; SB 15-234

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 15-05-04-A
Division / Contact / Phone:	Payment Reform / Andrew Abalos / 2130

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.

   Hospitals will receive increased reimbursement for outpatient services provided to Medicaid clients. These costs have already been accounted for in the state budget for FY 2015-16 through Senate Bill 15-234.

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

   Reimbursement to hospitals for outpatient services is estimated to increase by $2,554,824 for FY 2015-16 as a result of the 0.5% rate increase. The increase contained in this rule will allow hospitals who underwent several years of rate cuts to recuperate more of their costs of providing services to Medicaid clients and potentially provide improved services to more recipients.

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 would cost the Department approximately $2,554,824 in FY 2015-16 for the increased reimbursement to hospitals. These costs have already been accounted for in the state budget for FY 2015-16 through Senate Bill 15-234. There are no additional costs to the Department or any other agency due to the implementation and enforcement of the proposed rule.

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

   The proposed rule will allow the Department to increase reimbursement to hospitals for outpatient services provided to Medicaid clients as required in Senate Bill 15-234. Hospitals will receive a 0.5% rate increase, which will be funded by both state and federal dollars. Inaction would leave the Department out of compliance with state legislation, and Hospitals would continue to receive reimbursement at current levels.

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

Senate Bill 15-234 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2015. There are no methods for achieving the purpose of the proposed rule that are less costly or less intrusive.

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.

Senate Bill 15-234 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2015. There are no methods for achieving the purpose of the proposed rule that are less costly or less intrusive.

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.