DO NOT PUBLISH

Title of Rule: Revision to the Federally Qualified Health Center Rule, Section 8.700
Rule Number: MSB 17-03-23-B
Division / Contact / Phone: Payment Reform / Erin Johnson / 303-866-4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 17-03-23-B, Revision to the Federally Qualified Health Center Rule, Section 8.700
3. This action is an adoption of:	an amendment

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

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

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	7/1/2017
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700 with the proposed text starting beginning at 8.700.1 through the end of 8.700.6. The effective date of this rule is 7/1/2017.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this Rule is to clarify the Department's payment methodology for services outside of the Federally Qualified Health Center (FQHC) encounter rate. Currently, the rules state that FQHCs are reimbursed a 100% cost-based encounter rate for a one-on-one, face-to-face visit between a client and an eligible provider. This Rule revision is necessary to allow for payments to FQHCs separate from the encounter rate for Long Acting Reversible Contraceptives (LARCs), dentures and partial dentures, services provided at an inpatient hospital setting by the FQHC, the Nurse Home Visitor Program, and the Prenatal+ Program. Services provided by a FQHC at an inpatient hospital setting are not FQHC services and therefore should not be reimbursed at the encounter rate. The provision of LARCs, dentures, and partial dentures is costly for FQHCs and therefore an additional payment separate from the encounter rate is necessary to incentivize access and the provision of LARCs. The Prenatal+ Program and Nurse Home Visitor Program currently have payment methodologies that are separate from the encounter rate and are clarified elsewhere in the Rules.

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 revision fulfills the necessary requirements to be an Emergency Rule. The purpose of this rule revision is to clarify the Department's payment methodology for Federally Qualified Health Centers (FQHCs), specifically regarding payments separate from the encounter. Currently, our State Plan and rules for FQHCs state that the Department pays the encounter rate for one-on-one, face-to-face visits between a client and eligible provider. However, it is common practice for FQHCs to bill the Department at the Fee Schedule rate for other types of services – such as inpatient hospital services, the cost of LARC devices, dentures, partial dentures, the Prenatal+ Program, and the Nurse Home Visitor Program. These services should not be reimbursed at the encounter rate and instead should be reimbursed the Fee Schedule rate. However, since our current rules and State Plan do not reference this type of payment there is a large amount of confusion and concern among Department staff and FQHC staff about how to reimburse FQHCs. The Department must

revise its rules to reflect payment for these services outside of the encounter rate. If we stop paying for these services outside of the encounter rate they will no longer be provided.

3. Federal authority for the Rule, if any:

   Section 1902(bb) of the Social Security Act states that State Medicaid Agencies may create an alternative payment methodology for FQHCs as long as the FQHC receives at least their Prospective Payment System (PPS) rate.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   Section 25.5-4-401 (1)(a), C.R.S.

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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 affect the 420,513 Medicaid members that receive medical services at Federally Qualified Health Centers.

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

   Total expenditures for services received at FQHCs during the last fiscal year was $173,425,927.05 or approximately $412.41 per member. This rule change could cause reimbursement to increase for some services delivered at certain FQHCs and to decrease for other services delivered at FQHCs. Many FQHCs are already billing in this manner, and it would have zero budget impact on those FQHCs.

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.

   It is anticipated that the proposed rule will be budget neutral to the Department. This is a change in policy that primarily codifies already existing practices. For those FQHCs that are not billing in line with the proposed rule, there could be a decrease in payment for services that will be determined unallowable under the proposed rule. There could also be an increase in payment for certain services as it clarifies when encounters and fee-for-service claims can be billed in conjunction with each other. The Department assumes that these two impacts will offset each other, resulting in a net budget neutral change.

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

   Since many FQHCs are already billing the Department for these services, and other services, outside of the encounter rate, the costs should be minimal. This rule will eliminate improper billing of services and will give the Department the authority to pay for certain services as fee-for-service claims. Inaction could lead to a disallowance from CMS since these payments were not authorized before they began.

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

   It could potentially be less costly to disallow all payments outside of the encounter rate. However, this would lead to less access to important services such as LARCs, dentures, and partial dentures, or result in an increase in utilization of the services from other provider types.

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 seriously considered disallowing all payments for services outside the encounter rate. However, this idea was rejected as it would be too restrictive to FQHCs and decrease access to imperative health services.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency 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:

Visit means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker providing the services set forth in 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

8.700.2 CLIENT CARE POLICIES

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

8.700.2.B The policies shall include:

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See section 8.700.3.A.3.

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

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

8.700.3 SERVICES

8.700.3.A The following services may be provided by a certified FQHC:

1. General services

   a. Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife visiting nurse, clinical psychologist, podiatrist or clinical social worker as defined in their respective practice acts.

   b. Part-time or intermittent visiting nurse care.

   c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under 8.700.3.A.1.a and b.

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

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

8.700.3.B A certified FQHC may also provide any service authorized for payment outside the per visit encounter rate by 8.700.6.B.

8.700.4 PHYSICIAN RESPONSIBILITIES

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

8.700.5 ALLOWABLE COST

8.700.5.A The following types and items of cost for primary care services are included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist and clinical social worker who owns, is employed by, or furnishes services under contract to an FQHC.

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

3. Costs of services and supplies related to the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist or clinical social worker.

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

5. Costs of services purchased by the clinic or center.

8.700.5.B Unallowable costs include but are not limited to expenses that are incurred by an FQHC and that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per visit encounter rate for Medicaid clients.

Unallowable costs, include, but are not necessarily limited to, the following:

1. Offsite Laboratory/X-Ray;

2. Costs associated with services paid by a contracted Behavioral Health Organization (BHO) are costs for provision of covered services but not allowed in the FQHC costs;

3. Costs associated with clinics or cost centers which do not provide services to Medicaid clients; and,~~.~~

4. Costs of services reimbursed separately from the FQHC encounter rate as described in Section 8.700.6.B.

8.700.6 REIMBURSEMENT

8.700.6.A FQHCs shall be reimbursed a per visit encounter rate based on 100% of reasonable cost. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: medical encounter, dental encounter, or mental health encounter. Duplicate encounters of the same service category occurring on the same day and at the same location are prohibited unless it is a distinct mental health encounter, which is allowable only when rendered services are covered and paid by a contracted BHO.

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

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

a. Submitted charges; or

b. Fee schedule as determined by the Department.

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

a. Submitted charges; or

b. Fee schedule as determined by the Department.

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

a. Submitted charges; or

b. Fee schedule as determined by the Department. The fee schedule payment includes denture alignments, adjustments, and repairs within the first 6 months after placement of the denture. If the fee schedule amount is less than what would have been reimbursed under the per visit PPS rate, the Department will ensure that full payment has been received by the FQHCs.

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

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

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

8.700.6.C~~B~~ A medical encounter, a dental encounter, and a mental health encounter on the same day and at the same location shall count as three separate visits.

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

2. Distinct mental health encounters are allowable only when rendered services are covered and paid by a contracted BHO.

8.700.6.D~~C~~ Encounter rate calculation

a) Effective July 1, 2014, the encounter rate shall be the higher of the Prospective Payment System (PPS) rate or the alternative payment rate.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for a reasonable charge and for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. a) The alternative payment rate shall be the lower of the annual rate or the base rate. The annual rate and the base rate shall be calculated as follows:

   1. Annual rates shall be the FQHCs current year's calculated inflated rate, after audit.

   2. The new base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years.

3. a) New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement base rate for the first year. The base rate shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. This shall be the FQHCs base rate until the next rebasing period.

   b) New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to

rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

4. a) The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

b) Freestanding FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. Freestanding FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

c) The new reimbursement rate for freestanding FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement rate (if less than the new audited rate) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120th day after the freestanding FQHCs fiscal year end.

d) The new reimbursement rate for hospital-based FQHCs shall be effective January 1 of each year.

e) If a hospital-based FQHC fails to provide the requested documentation, the costs associated with those activities shall be presumed to be non-primary care services and shall be settled using the Outpatient Hospital reimbursement rate.

f) All hospital-based FQHCs shall submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities. Non-primary care services shall be reimbursed according to Section 8.300.6.

5. a) If a FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

b) A FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:

1. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

2. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

3. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

4. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.

5. The change in scope of service must have existed for at least a full six (6) months.

c) A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.700.6.C.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

1. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

2. The addition or deletion of a covered Medicaid service under the State Plan;

3. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

4. Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;

5. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

6. Changes resulting from a change in the provider mix, including, but not limited to:

i. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;

ii. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);

iii. Indirect medical education adjustments and a direct graduate medical education payment that reflects the

costs of providing teaching services to interns and/or residents; or,

iv. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

d) The following items do not prompt a scope-of-service rate adjustment:

1. An increase or decrease in the cost of supplies or existing services;

2 An increase or decrease in the number of encounters;

3. Changes in office hours or location not directly related to a change in scope of service;

4. Changes in equipment or supplies not directly related to a change in scope of service;

5. Expansion or remodel not directly related to a change in scope of service;

6. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;

7. The addition or removal of administrative staff;

8. The addition or removal of staff members to or from an existing service;

9. Changes in salaries and benefits not directly related to a change in scope of service;

10. Change in patient type and volume without changes in type, duration, or intensity of services;

11. Capital expenditures for losses covered by insurance; or,

12. A change in ownership.

e) A FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

f) Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.C.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid

change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. A FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

g) The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:

1. The Department's application form for a scope-of-service rate adjustment, which includes:

i. The provider number(s) that is/are affected by the change(s) in scope of service;

ii. A date on which the change(s) in scope of service was/were implemented;

iii. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

iv. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

v. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC;

2. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

h) The reimbursement rate for a scope-of-service change applied for January 30, 2017 or afterwards will be calculated as follows:

1. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also

calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

2. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

3. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The "current PPS rate" means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

4. The Department will check that the adjusted PPS rate meets the 3% threshold described above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

5. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.

i) The Department will review the submitted documentation and will notify the FQHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC's fiscal year end.

j) Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified by the Department through an audit or review process.

1. If the Department identifies a change in scope of services, the Department may request the documentation as described in Section 8.700.6.C.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.

2. The rate adjustment methodology will be the same as described in Section 8.700.6.C.5.h.

3. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty

(120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

4. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

k) A FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, a FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If a FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

8.700.6.E~~D~~ The Department shall notify the FQHC of its rate.

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process. This outstationing payment shall be made based upon actual cost with a reasonable cost-per-application limit to be established by the Department. The reasonable cost-per application limit shall be based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall the outstationing payment for FQHCs exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities.

8.700.8.B

1. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

2. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. Effective with the hospital cost report year 2010 and forward, the Department will make an interim payment to Denver Health Medical Center for estimated reasonable costs associated with outstationing activities based on the costs included in the as-filed Medicare cost report. This interim payment will be reconciled to actual costs after the cost report is audited. Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the interim estimated administrative costs and the final audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

8.700.8.C To receive payment, FQHCs shall submit annual logs of applicant information to the Department with their cost report. Applicant logs shall include the applicant's name, date of application, and social security number if available.

8.700.8.D Reimbursement for outstationing administrative costs shall be determined according to the following guidelines:

1. Freestanding FQHCs shall report on a supplementary schedule the administrative and general direct pass-through costs associated with outstationing activities. The Department shall allocate appropriate overhead costs (not separately identified) to calculate the total facility outstationing administrative expenses incurred. Freestanding FQHCs shall receive an annual lump sum retrospective payment based on the audited cost report.

2. Hospitals with hospital-based FQHCs shall submit the administrative and general pass through direct and indirect costs associated with outstationing activities on an extra line on the Medicaid Cost Report and submit all other source documentation to compute allowable outstationing costs. Hospitals with hospital-based FQHCs shall receive payment in accordance with 8.700.8.B. The reimbursement shall be separately identified on the Medicaid Settlement Sheet.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

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 17-04-21-A, Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
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) 8.520, 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:	07/01/2017
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text starting at 8.523 through the end of 8.526.21 with the proposed text. This rule is effective 7/1/2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

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 rule defines the amount, duration, and scope of covered home health services. This revision updates the home health services rule by adding provisions concerning face-to-face visits and place of service limitations, as required under recently issued federal regulations, both of which must be effective by July 1, 2017. Specifically, this revision aligns the Colorado Medicaid home health services rule with federal regulations by adding: (1) a requirement that the physician must document a face-to-face encounter with the Medicaid client for the authorization of home health services within particular timelines; and (2) language clarifying that Medicaid home health services are not limited solely to home settings.

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 recently issued federal home health regulations, concerning documentation of face-to-face encounters and place of service limitations, explicitly require that the Department be in compliance with the new provisions by July 1, 2017.

3. Federal authority for the Rule, if any:

   42 CFR 440.70

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);

Initial Review **06/09/17** Final Adoption
Proposed Effective Date Emergency Adoption **06/09/17**

DOCUMENT #02

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Benefits Rule Concerning Home Health Services, Section 8.520
Rule Number: MSB 17-04-21-A
Division / Contact / Phone: Health Programs Benefits & Operations Division / Amanda Forsythe / 303-866-6459

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 ordering providers by requiring that they must document the occurrence of a face-to-face encounter with any Colorado Medicaid client for whom they order home health services. The proposed rule will also affect home health services clients: First, it will require that the client participates in a face-to-face visit with the ordering provider to receive home health services. Second, by clarifying that home health services may be received in any setting in which normal life activities take place, it will allow many clients to receive home health services out in the community.

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

   The proposed rule will have a positive impact on those clients who will be able to receive necessary home health services while engaged in normal life activities in the community and not just while in the home.

   The proposed rule's face-to-face documentation requirement will likely have a moderate economic impact on the ordering providers, an analysis of which is detailed in the February 2016 Centers for Medicare & Medicaid Services Final Rule concerning Medicaid home health services.

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

   There is no anticipated cost or effect on state revenues of 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 cost of inaction is the Department being out of compliance with federal regulations, which could result a corrective action plan, financial penalties, or other federal enforcement actions.

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

   There are no less costly methods or less intrusive methods for achieving the purpose of the proposed rule, which is the Department's compliance with new federal regulatory requirements.

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

   There are no alternative methods for achieving the purpose of the proposed rule, which is the Department's compliance with new federal regulatory requirements.

8.520 HOME HEALTH SERVICES

8.521 LEGAL BASIS

The Medicaid Home Health Program in Colorado is authorized under 1905(a)(7) of the Social Security Act (P.L. 74-271); and by state law at 26-4-202(1) f, C.R.S. (1994 Supp.) and 26-4-302(l) m, C.R.S. (1994 Supp.).

8.522 COVERED SERVICES

All Home Health providers enrolled in the Medicaid program shall be in compliance with the Colorado Medicaid Home Health Services Benefit Coverage Standard, effective January 1, 2013, incorporated by reference. The incorporation of the Home Health Benefit Policy Statement excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Standards." Pursuant to 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, CO 80203. Certified copies of incorporated materials are provided, at cost, upon request. Any material that has been incorporated by reference may be examined in any Colorado State Publications Depository Library.

8.523 ELIGIBILITY

.10 Home Health services are a benefit available to all Medicaid clients and to all Modified Medical Program clients when all program and services requirements are met. To be eligible for Long Term Home Health services, as set forth at Section 8.523.11.K, Medicaid clients 18 and over shall meet the Level of Care Screening Guidelines for Long Term Care Services at Section 8.401. Medicaid clients under the age of twenty-one may be eligible for special Home Health benefits according to rules at 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES.

.11 Home Health services are eligible for reimbursement under Medicaid only when the services meet all of the following requirements:

A. Services are provided for the treatment of an illness, injury, or disability which may include mental disorders.

B. Services are medically necessary.

C. Services are reasonable in amount, duration, and frequency.

D. Services are provided under a plan of care as defined at Section 8.524 DEFINITIONS.

E. Services are provided on an intermittent basis, as defined at Section 8.524, DEFINITIONS.

F. The only alternative to Home Health services is hospitalization or the emergency room; or the client's medical records accurately justify a medical reason that the services should be provided in the client's home instead of a physician's office, clinic, or other out-patient setting, according to one or more of the following guidelines:

1. The client, due to the client's illness, injury or disability, is not able to go to a physician's office, clinic or other out-patient setting for the needed service, for example, a client with quadriplegia who needs aide services to get in and out of bed.

2. If, because of the client's illness, injury, or disability, going to a physician's office, clinic, or other out-patient setting for the needed service would create a medical hardship for the client. Any statement on the plan of care regarding such medical hardship must be supported by the totality of the client's medical records. Examples of medical hardship would include: a client who would require ambulance transportation, a client in severe pain, or a client who is just out of the hospital after major surgery. Some examples of conditions that would not by themselves be considered creation of a medical hardship would include: a client who is on oxygen, a client who walks with a limp, or a client who uses a cane.

3. Going to a physician's office, clinic, or other out-patient setting for the needed service is contra-indicated by the client's documented medical condition, for example, a client who must be protected from exposure to infections.

4. Going to a physician's office, clinic, or other out-patient setting for the needed service would interfere with the effectiveness of the service. Examples include a young child who would not benefit from out-patient therapy because of extreme fear of the hospital where the out-patient setting is located; clients living in regions where traveling to out-patient therapy would require hours of travel; a client who needs a service repeated at frequencies that would be extremely difficult to accommodate in the physician's office, clinic, or other out-patient setting, such as IV care three times per day, or daily insulin injections; a client who needs regular and prn catheter changes and having Home Health in place will prevent emergency room visits for unscheduled catheter changes due to dislodgement or blockage; a client who, because of the client's illness, injury or disability, including mental disorders, has demonstrated past failure to comply with going to a physician's office, clinic, or other out-patient setting for the needed service, and has suffered adverse health consequences as a result, including use of emergency room and hospital admissions.

5. The client's medical condition requires teaching which is most effectively accomplished in the client's home on a short-term basis.

G. Services are provided in the client's place of residence. The client's place of residence is where the client lives, except that home health services shall not be reimbursed if the client's place of residence is a nursing facility or hospital. Assisted living faculties of any kind are places of residence. If a client is visiting relatives or staying in a hotel during a trip, or similar temporary accommodations, the place where the client is staying will be considered the temporary place of residence for purposes of this rule. Services shall not be reimbursed if provided at the workplace, school, child day care, adult day care, or any other place that is not the client's place of residence, except when the services are prior authorized according to 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES, or Section 8.531 through 8.539, HOME HEALTH AIDE PILOT PROGRAM.

1. Monitoring of health care status may be provided remotely through Home Health Telehealth services.

2. Nothing in this section should be read to prohibit a client from receiving Home Health Services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

H. Services are provided by a Medicaid-certified Home Health agency.

I. The Client is unable to perform the health care tasks for him or herself, and no unpaid family/caregiver able and willing to perform the tasks.

J. When the client has Medicare or other third-party insurance, Medicaid Home Health shall be reimbursed only if the client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.

K. The Client's care falls under one of the following three categories:

1. Acute Home Health, which means Medicaid-reimbursed Home Health services that are:

a. Provided for 60 calendar days; and

b. Provided for the treatment of any of the acute conditions listed below. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

1) Infections.

2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, diabetes.

3) Care related to post-surgical recovery.

4) Post-hospital care provided as follow-up care for the condition that required hospitalization, including neonatal disorders.

5) Exacerbation or severe instability of a chronic condition.

6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.

7) Complications of pregnancy.

2. Long Term Home Health, which means Medicaid-reimbursed Home Health services that are:

a. Provided for 61 calendar days or longer; or

b. Provided for less than 61 calendar days when services are provided solely for the care of chronic conditions.

3. Long Term with Acute Episode Home Health, which means Medicaid-reimbursed Home Health services that are:

a. Provided for care of long-term chronic conditions; and

b. Additionally provided for the treatment of any of the acute episodes listed below. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.

1) Infections.

2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, decubitus.

3) Care related to post-surgical recovery.

4) Post-hospital care provided as follow-up care for the condition that required hospitalization.

5) Exacerbation of a chronic condition.

6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.

7) Complications of pregnancy.

8.524 DEFINITIONS

.10 HOME HEALTH AIDE ASSIGNMENT FORM

Home health aide assignment form means the form which the home health agency uses to list the duties to be performed by the home health aide at each visit.

.11 HOME HEALTH SERVICES

Home Health Services means those services listed at Section 8.522, COVERED SERVICES, and described at Section 8.525, SERVICES REQUIREMENTS.

.12 HOME HEALTH TELEHEALTH

Home Health Telehealth means the remote monitoring of clinical data through electronic information processing technologies.

.13 INTERMITTENT

Intermittent is defined as no more than the combined number of all visits and/or other units of service which will cause the reimbursement per calendar day to equal the maximum reimbursement limits as set forth in the Reimbursement section of these rules. Visits and/or units or combinations thereof may directly follow each other without any break and still be considered intermittent, as long as the maximum reimbursement limit per day is not exceeded.

.14 PLAN OF CARE

A plan of care means a coordinated plan developed by the Home Health agency as ordered by the attending physician for provision of services to a client at his or her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements.

.15 STATE

State means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

8.525 SERVICES REQUIREMENTS

.10 NURSING SERVICES

A. Nursing services include those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards.

B. Nursing services also includes skilled nursing services which are provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws.

C. Nursing services include the remote monitoring of health status through Home Health Telehealth.

.11 HOME HEALTH AIDE SERVICES

A. Home health aide services may be provided when a nurse or therapist determines that an eligible client requires the services of a qualified home health aide, as such services are defined in this section.

B. Home health aide services must be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR 84.36 (d). No later amendments to or editions of 42 CFR 484.36 (d) are included. Copies of 42 CFR 484.36 (d) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

1. If the client receiving home health aide services also requires and receives skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist must make on-site supervisory visits to the client's home no less frequently than every two weeks.

2. If the client receiving home health aide services does not require skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse must make on-site supervisory visits to the client's home no less frequently than every 62 days. Each supervisory visit must occur while the home health aide is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the home health aide services, and shall not be billed to Medicaid as nursing visits.

3. Registered nurses and physical, occupational and speech therapists supervising home health aides must comply with applicable State laws governing their respective professions. In addition, the Nurse Aide Practice Act at § 12-38.1-102(5) C.R.S. (1998), which requires supervision of the practice of nurse aide

services, must be followed. No later amendments to or editions of § 12-38.2-102(5) C.R.S. (1998) are included. Copies of § 12-38.1-102(5) C.R.S. (1998) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street. Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

C. Before providing any services, all home health aides shall be trained and certified according to Federal Medicare regulations at 42 CFR 484.36 and all applicable State and Federal laws and regulations governing nurse aide certification, as amended, except that later amendments to or editions of 42 CFR 484.36 shall not be included in this rule. Copies of 42 CFR 484.36 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. Home, health aide services include skilled personal care, unskilled personal care, and homemaking as defined below:

1. Skilled personal care includes nurse aide tasks performed by a certified nurse aide pursuant to the nurse aide scope of practice defined by the State Board of Nursing, but does not include those tasks that are allowed as unskilled personal care, in HCBS personal care regulations at Section 8.489, PERSONAL CARE.

2. Unskilled personal care means those tasks which are allowed as unskilled personal care at Section 8.489, HOME AND COMMUNITY BASED SERVICES-EBD, PERSONAL CARE. Unskilled care shall be provided only as secondary to required skilled personal care, provided within contiguous units of service.

3. Homemaking includes those tasks that are allowed as homemaking tasks at Section 8.490, HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES. Homemaking services shall be provided only as secondary to required skilled personal care provided within contiguous units of service.

4. Home health aide services solely for the purpose of behavior management are not a benefit under Medicaid Home Health, because behavior management is outside the nurse aide scope of practice.

.12 PHYSICAL THERAPY SERVICES

A. Physical therapy includes any evaluations and treatments allowed under state law at 12-41-101 through 130, C.R.S. (1991, as amended), which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training or the use of the equipment.

C. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation under Medicare, at 42 CFR 484.4; and who meets all requirements under state law. Later

amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care, the physical therapist may open be case and establish the Medicaid plan of care.

E. Effective September 1, 2002, physical therapy services are available for Acute Home Health clients when medically necessary and clients under 18 years of age when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.13 OCCUPATIONAL THERAPY SERVICES

A. Occupational therapy includes any evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training on the use of the equipment.

C. Treatment must be provided by or under the supervision of a certified occupational therapist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or ml be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care or physical or speech therapy, the occupational therapist may open the case and establish the Medicaid plan of care.

E. Effective September 1, 2002, occupational therapy services are available for Acute Home Health clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.14 SPEECH/LANGUAGE PATHOLOGY SERVICES

A. Speech/language pathology services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.

B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through

8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.

C. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

D. For clients who do not require skilled nursing care, the speech therapist may open the case and establish the Medicaid plan of care.

E. Effective September 1, 2002; speech/language pathology services are available for Acute Home Health, clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201A.

.15 HOME HEALTH TELEHEALTH SERVICES

A. The home health telehealth service is the remote monitoring of clinical data through electronic information processing equipment.

B. The information and data collected remotely will be transmitted through electronic information processing equipment from the client to the home health provider. The transmission of the data shall meet HIPAA compliance standards.

C. The home health agency shall create policies and procedures for the use and maintenance of the monitoring equipment and the process of telehealth monitoring. This service shall be used to monitor the client and manage the client's care, and shall include all of the following elements:

1. All data collected must be reviewed by a registered nurse, or licensed practical nurse consistent with state law, within 24 hours of receipt of the ordered transmission,

2. Any planned interventions must be overseen by the client's designated nurse.

3. Collection of clinical data;

4. Transmission of the clinical data from the client to the home health provider;

5. Clinical review and assessment of the clinical data by a registered nurse.

6. Client specific parameters and protocols defined by the agency staff and the client's authorizing physician or podiatrist; and

7. Documentation of the clinical data in the client's chart and a summary of response activities, if needed.

a. Documentation shall be signed and dated by the nurse who assessed the clinical data,

b. Documentation shall include the health care data that was transmitted and the services or activities that are recommended based on the data.

D. Monitoring equipment shall have the capability to measure any changes in the monitored diagnoses, and meet all of the following requirements:

1. Monitoring equipment shall be FDA certified or UL listed, and used according to the manufacturer's instructions;

2. Monitoring equipment shall be maintained in good repair and free from safety hazards; and

3. Monitoring equipment shall be sanitized before it is installed in a client's home.

E. Home health telehealth services are available to clients receiving home health services, when all of the following requirements are met:

1. Client is receiving services from a home health provider for at least one of the following diagnoses:

a. Congestive Heart Failure;

b. Chronic obstructive pulmonary disease;

c. Asthma; or

d. Diabetes.

2. Client requires ongoing and frequent, minimum of 5 times weekly, monitoring to manage their qualifying diagnosis, as defined and ordered by a physician or podiatrist;

3. Client has demonstrated a need for ongoing monitoring as evidenced by having been hospitalized two or more times in the last twelve months for conditions related to the qualifying diagnosis; or, if the client has received home health services for less than six months, the client was hospitalized at least once in the last three months, an acute exacerbation of a qualifying diagnosis that requires telehealth monitoring, or new onset of a qualifying disease that requires ongoing monitoring to manage the client in their residence;

4. Client or caregiver misses no more than 5 transmissions of the provider and agency prescribed monitoring events in a thirty-day period; and

5. Client's home environment has the necessary connections to transmit the telehealth data to the agency and has space to set up and use the equipment as prescribed.

F. The Home Health Agency shall make at least one home health nursing visit every 14 days to a client using Home Health Telehealth services.

G. The Home Health Agency shall develop agency-specific criteria for assessment of the need for home health telehealth services, to include patient selection criteria, home environment compatibility, and patient competency. These assessment forms must be completed prior to the submission of the Enrollment Application and on file at the agency

8.526 PROVIDER AGENCY REQUIREMENTS

.10 A Home Health agency must be a public agency or private organization or part of such an agency or organization which:

A. Is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act; and

B. Has a valid agreement with the State, according to Section 8.130, PROVIDER AGREEMENTS, of this manual, to provide Medicaid Home Health services, as defined above. The Medicaid agreement will cover only those services which are covered by the agency's Medicare certification; and

C. Maintains liability insurance for the minimum amount set annually by the Colorado Department of Health Care Policy and Financing.

.11 Home Health agencies which perform procedures in the client's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 must possess a certificate of waiver from the Health Care Financing Administration or its designated agency.

.12 Home Health agencies must have written policies regarding nurse delegation.

.13 For all clients who are expected to need home health aide services for at least a year, the supervising nurse must, during supervisory visits:

A. Obtain the client's, or the-client's designated representative's, input into the home health aide assignment form, including all home health aide tasks to be performed during each scheduled time period. Details such as, but not limited to, housekeeping duties and standby assistance, must be negotiated and included on the home health aide assignment form so that all obligations and expectations are clear. The home health aide assignment form shall contain information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information that is pertinent to the care that will be given by the aide. The client or the client's designated representative must sign the form, and must be given a copy, at the beginning of services, and at least once per year thereafter. For purposes of complying with this rule, once per year shall be defined as sometime within the certification period which includes the anniversary date of the last signature on a home health aide assignment form.

B. Give each client, and/or the client's designated representative, a new copy of the Patient's Rights form, and explain those rights whenever the home health aide assignment form is renegotiated and rewritten.

.14 Home Health agencies shall obtain the official Medicaid rules, 10 CCR 2505-10 also known as Volume 8, and shall subscribe annually to the official updates. These rules shall be made available to all staff.

.15 Home Health agencies shall have written policies regarding maintenance of clients durable medical equipment, and shall make full disclosure of these policies to all clients with durable medical equipment in the home. The policies shall provide such disclosure to the client at the time of intake.

.16 Home Health agencies shall have written policies regarding procedures for communicating with case managers of clients who are also enrolled in HCBS programs. Such policies shall include, at

a minimum, how agencies will inform case managers that services are being provided or are being changed; and procedures for sending copies of plans of care if requested by case managers. These policies shall be developed with input from case managers.

.17 Any Home Health Agency applying to become a Medicaid participating Home Health Agency shall submit an acceptable compliance plan as a condition of eligibility for entering into a Medicaid provider agreement in Colorado. The plan must demonstrate how the agency will assure compliance with Colorado Medicaid rules, and must demonstrate that the applicant agency knows and understands the rules.

18. A home health provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

19. A Home Health Agency may be denied or terminated from participation in Colorado Medicaid <u>independently of participation in Medicare,</u> according to procedures found at Section 8.050 through Section 8.051.44, based on good cause, as defined at 8.051.01. Good cause for denial or termination of a Home Health Agency shall include, but not be limited to, the following:

A. <u>Medicare Conditions Out of Compliance.</u> For purposes of this section, the applicable Medicare Conditions of Participation are found in 42 CFR 484, at 484.10,484.12,484.14, 484.16,484.18,484.30, 484.32,484.36,484.48, and 484.52. No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on the first re-certification survey after initial certification, or on a complaint investigation prior to the first re-certification survey.

2. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on two consecutive surveys and/or complaint investigations.

3. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on three non-consecutive surveys and/or complaint investigations.

B. <u>Medicare Standards Out of Compliance.</u> For purposes of this section, the applicable Medicare Standards are the Standards under each of the above-referenced Medicare Conditions of Participation, with special emphasis on standards found at 484.10 (b)(4), (b)(5),and (c); 484.12 (a) and (c); 484.14 (c)(d) and (g); 484.18 (b) and (c); 484.30 (a); 484.36 (c); and 484.52 (b). No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that receives repeated deficiency citations on the same standard, or standards, more man twice, or less often if the scope and severity is high.

2. Number of, as well as severity and scope of deficiency citations against standards shall be considered as factors in decisions to deny or terminate provider agreements.

C. Improper Billing Practices: Any Home Health Agency that is found by .the State or its agent(s) to have engaged in the following practices may he denied or terminated from participation in Colorado Medicaid:

1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home. Providers shall submit or produce requested documentation in accordance with rules at 8.079.62.

a. Required documentation includes evidence of a face-to-face visit with the client's referring provider, or other appropriate provider, as required at 42 CFR 440.70. Title 42 of the Code of Federal Regulations, Part 440.70 (2016) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency 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.

2. Billing for unnecessary visits, or visits that are unreasonable in amount, frequency and duration; especially nursing visits solely for the purpose of assessment and teaching.

3. Billing for home health aide visits on which no skilled tasks were performed and documented, or the skilled tasks performed were not medically necessary.

4. Billing for home health services provided at locations other than the client's, place of residence. This rule shall not apply for out-of-home Services provided with prior authorization as EPSDT extra-ordinary Home Health.

5. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any Home Health Agency that is also certified as a personal care/homemaker provider, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.

b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total tune spent on the visit does not equal at least 2 ½ hours plus the number of hours billed for personal care and homemaker.

c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 ½ hours.

d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

g. If any of the above practices occur, the Home Health Agency shall not be absolved from liability by failure or refusal to include personal care and/or homemaking needs on the Home Health plan of care.

1. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 5 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

2. Billing for excessive units of home health aide services for all time periods during which regulations are in effect defining the unit for home health aide as hour and/or half hour increments.

8. Billing for any services that are found to be out of compliance with any of the rules in this section, including but not limited to, those found in post-payment review rules at 8.529.

D. Prior Termination From Medicaid Participation, A Home Health Agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a Home Health Agency or any other type of service provider.

E. Abrupt Prior Closure. A Home Health Agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

20. Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation

shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal agent.

21. When a Home Health Agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.527 PRIOR AUTHORIZATION

.10 ACUTE HOME HEALTH

Acute Home Health services, as defined at Section 8.523, ELIGIBILITY, do not require prior authorization. This includes episodes of Acute Home Health for Long Term Home Health clients.

.11 LONG TERM HOME HEALTH

Long Term Home Health services, as defined at Section 8.523, ELIGIBILITY, shall be prior authorized according to the requirements below.

A. PRIOR AUTHORIZATION PROCESS

Long Term Home Health services provided to Medicaid clients shall be prior authorized by the Department or its designated review entity.

1. When an agency accepts an HCBS waiver client 18 years of age and older to Long Term Home Health services, the Home Health Agency shall contact the client’s case management agency to inform the case manager of the client's need for Home Health services.

2. The Home Health Agency shall submit the formal written prior authorization request to the Department or its designated review entity within 10 working days of the “from” date on the Home Health plan of care or within 10 working days of the end of the client’s Acute Home Health period or current Long Term Home Health PAR. Physician signature on the plan of care is not needed for prior authorization purposes. The Department or its designated review entity shall not send the prior authorization to the fiscal agent until the Home Health Agency submits the formal, complete, written prior authorization request (PAR).

3. The complete formal written PAR shall include:

a. A completed Department-prescribed Prior Authorization Request Form;

b. A Home Health plan of care which shall include all clinical assessments and current clinical summaries or updates of the client. The plan of care shall be on the HCFA-485 form, or a form that is identical in content to the HCFA-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the plan of care or addendum, which shall list the specific

procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.528.11.B and C, are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the plan of care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services.

c. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a home health aide visit;

d. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, the record shall document that the client's pharmacy was contacted and advised/the Home Health Agency that the pharmacy will not provide medication set-ups.

e. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, the record shall provide documentation supporting the current need for two person transfers and the reason adaptive equipment cannot be used instead.

4. Authorization time frames:

a. Prior authorization requests shall be submitted and may be approved for up to a one year period.

b. Home Health Agencies shall not be required to change dates on the Home Health plans of care to match the client’s waiver program certification dates, if a client is in an HCBS waiver program.

c. Home Health Agencies shall send new plans of care and other documentation as requested by the Department or its designated review entity.

d. The Department or its designated review entity may initiate PAR revisions if the plans of care indicate significantly decreased services.

e. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the HCFA-485.

5. The prior authorization request shall be reviewed by the Department or its designated review entity to determine compliance with Medicaid rules, and shall be approved, denied, or returned for additional information within 10 working days of receipt. The PAR shall not be backdated to a date prior to the 'from' date of the HCFA-485.

6. The Department or its designated review entity shall approve or deny according to the following guidelines for safeguarding clients:

a. PAR Approval: If services requested are in compliance with Medicaid rules, and are medically necessary and appropriate for the diagnosis and treatment plan, the services shall be approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

1. The Department or its designated review entity shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.

2. The Department or its designated review entity, through the Medicaid fiscal agent, shall notify clients of Long Term Home Health denials, including partial denials, and appeal rights in accordance with Section 8.393.28 and Section 8.057, RECIPIENT APPEALS.

3. If any services have already been provided, but are subsequently denied on the prior authorization request, the Department or its designated review entity shall notify the Home Health Agency of the denial. Services already provided may be approved for payment, retroactive to the start date on the PAR form, or up to 30 working days whichever is shorter. If denied, services shall be approved for 15 additional days after the date on which the notice of denial is mailed to the client, so that the client's right to advance notice is preserved. An informal case conference may be arranged to discuss disagreements. If the disagreement is not satisfactorily resolved, the Home Health Agency may file a provider appeal in accordance with Section 8.050, PROVIDER APPEALS.

7. Neither the presence nor the absence of a preliminary authorization or a formal written PAR approval from the authorizing agent shall exempt a Home Health Agency at any time from:

a. Following all applicable Medicaid rules;

b. Providing only services that are medically necessary to the needs of the client; or

c. Ensuring the accuracy of preliminary and formal written PAR information provided to the Department or its designated review entity.

8. EXPEDITED AUTHORIZATION PROCESS

If requested by a Home Health Agency, for extreme emergencies or complicated cases, following the initial assessment by the Home Health Agency, and after receipt of HCFA-485 or care notes in writing, the Department or its designated review entity may use the information provided by the Home Health Agency to take one of the following actions:

a. Provide preliminary authorization of the services until the formal written PAR procedure delineated at 8.527.11.A.1-8 above is completed, for up to a maximum of 15 calendar days. If an expedited authorization was provided by the Department or its designated review entity the date of service effective under the expedited authorization (never dated back prior to "from" date on HCFA-485) shall be indicated on the prior authorization form that is forwarded to the fiscal agent;

b. Postpone/deny preliminary authorization until the Home Health Agency provides full documentation as delineated at 8.527.11.A. 3. The Home Health Agency shall submit a formal written PAR in order for due process to occur as delineated at 8.527.11.A.6.

9. If the client has an acute episode, the Home Health Agency shall bill for Acute Home Health, in accordance with billing manual instructions, without obtaining prior authorization approval from the Department or its designated review entity. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within ten (10) working days of the beginning and within ten (10) working days of the end of the acute care episode.

Note: The Section numbered 8.527.10 A was deleted effective August 30, 2012.

Note: The Section numbered 8.527.11 B was deleted effective July 1, 2002.

.12 EPSDT SERVICES

Home Health services may be provided when identified as medically necessary for pediatric clients 20 years of age or younger through Early Periodic Screening Diagnosis and Treatment (EPSDT), and prior authorized according to the requirements below.

A. Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530 shall be reviewed for medical necessity under the EPSDT Federal requirement.

B. Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530 shall not include services that are available under other Colorado Medicaid benefits, and for which the client is eligible, including but not limited to, Private Duty Nursing, Section 8.540; HCBS personal care, Section 8.489; School Health and Related Services, Section 8.290, or out-patient therapies, Section 8.330. Exceptions may be made if EPSDT Home Health services will be more cost-effective, provided that client safety is assured. Such exceptions shall in no way be construed as mandating the delegation of nursing tasks.

C. Prior authorization requests for EPSDT Home Health shall be submitted and reviewed as outlined in SECTION 8.527.11 A.

1. The complete prior authorization request shall include all documentation outlined in SECTION 8.527.11.3 and shall include any other medical information which will document the medical necessity for the EPSDT Home Health services. The plan of care shall include the place of service for each Home Health visit.

.13 HOME HEALTH TELEHEALTH SERVICES

A. Home Health Telehealth services are available to clients only after the Home Health Agency has received prior authorization.

B. The Home Health Agency shall request prior authorization every 60 days that continuing telehealth services are needed.

C. The PAR shall include all of the following:

1. A completed Home Health Telehealth enrollment form;

2. An order for Telehealth monitoring signed and dated by the ordering physician or podiatrist;

3. A home health plan of care, which shall include nursing and/or therapy assessments for clients. Telehealth monitoring shall be included on the HCFA-485 form, or a form that contains similar information to the HCFA-485, and all applicable forms shall be completed; and

4. For on-going telehealth, the agency shall include documentation on how Telehealth data has been used to manage the client's care, if the client has been using Telehealth services.

.14 The complete prior authorization request must include:

A. A State-prescribed Prior Authorization Request Form;

B. A physician-signed plan of care on the HCFA-485 or a form that is identical in content to the HCFA-485, which shall include nursing and therapy assessments, current clinical summaries and updates of the client, and all therapy services requested, including the specific procedures and modalities to be used and the amount, duration and frequency;

C. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and

D. Any other medical information which will document the medical necessity for the Home Health services.

8.528 REIMBURSEMENT

.10 CLAIMS

Claims shall be submitted to the fiscal agent according to Section 8.040, RULES GOVERNING SUBMISSION OF CLAMS, and Section 8.043, TIMELY FILING REQUIREMENTS.

Home Health providers shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.2, RULES GOVERNING SUBMISSION OF CLAIMS, and Section 8.130, PROVIDER AGREEMENTS.

.11 UNIT OF REIMBURSEMENT

A. The unit of reimbursement for the Home Health services of nursing, physical therapy, occupational therapy, and speech therapy shall be one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

B. The Basic Unit of reimbursement for home health aide services shall be up to one hour. A unit of time that is less than fifteen minutes shall not be reimbursable as a basic unit.

C. For home health aide visits that last longer than one hour, Extended Units may be billed in addition to the Basic Unit. Extended Units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes shall not be reimbursable as an extended unit.]

D. Reimbursement for supplies used by Home Health agency staff is included in the reimbursement for nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services, to the following extent:

1. Supplies used during provision of any Home Health services by Home Health agency staff for the practice of universal precautions shall be the financial responsibility of the Home Health agency. This excludes gloves used for bowel programs and catheter care but includes all other supplies required for the practice of universal precautions by Home Health agency staff. If a Home Health agency asks a client to provide such supplies, this will constitute a failure to accept Medicaid payment in full, in violation of Section 8.012, PROHIBITION OF CHARGES TO RECIPIENTS.

2. Supplies other than those required for practice of universal precautions which are used by the Home Health agency staff to provide Home Health care services shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

3. Supplies used for the practice of universal precautions by the client's family or other informal caregivers shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

E. The unit of reimbursement for home health telehealth is one calendar day.

1. The Home Health Agency may bill one initial visit per client each time the monitoring equipment is installed in the home.

2. The Home Health Agency may bill the daily rate for each day the telehealth monitoring equipment is used to monitor and manage the client’s care.

.12 The following restrictions shall be placed on Home Health services for purposes of reimbursement:

A. Nursing visits shall not be reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Mental Health Assessment and Services Agencies. Nursing visits for mentally ill clients shall be reimbursed under Medicaid Home Health for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

B. The state shall not authorize nor reimburse home health aide services for the purpose of providing only unskilled personal care and/or homemaking services. Units during which unskilled personal care and/or homemaking services are provided and billed under the home health aide benefit must be contiguous with units during which services defined as skilled personal care are provided. For clients who are also eligible for HCBS personal care and homemaker services, the units spent on unskilled personal care and homemaker services and billed as aide services shall be reasonable in relation to the

skilled care provided on the contiguous units. For example, if the transfer and bath are skilled, it would be reasonable for the aide to also dress the client, and to wipe up any water spills on the bathroom floor, and to prepare a meal if the aide is there at mealtime. It would not be reasonable for the aide to stay four more hours to do all the weekly cleaning and laundry, unless the client is not eligible for homemaker services under HCBS.

C. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed $270, effective July 1, 2002, for Acute Home Health Services or Long Term with Acute Episode Home Health Services; and shall not exceed $211, effective My 1, 2002, for Long Term Home Health Services.

Effective September 1, 2002, the maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed S291 for Acute Home Health Services or Long Term with Acute Episode Home Health Services, and shall not exceed $227 for Long Term Home Health Services.

Criteria for the three different categories of care are found at 8.523.11, K in this section. The maximum daily reimbursement includes reimbursement for nursing visits, home health aide units, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.

D. Medicaid will not reimburse for two nurses during one visit, two home health aides at the same time, two physical therapists during one visit, two occupational therapists during one visit, or two speech therapists during one visit. An exception to this rule is for two home health aides, when two are required for transfers, and there are no other, persons available to assist, and when there is a justifiable reason why adaptive equipment cannot be used instead. Another exception is for two nurses when two are required to perform a procedure. For these exceptions, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

E. If a client is seen simultaneously by two persons to provide a single service, for which one person supervises or instructs the other, the Home Health agency shall only bill and be reimbursed for one employee's visit or units. For example, if two nurses visit the client, and the first nurse provides care and also orients and trains the second nurse in the client's care, only the first nurse's time counts as a reimbursable visit.

F. Any visit made solely for the purpose of supervising the home health aide shall not be reimbursed.

G. Any visit made by a nurse or therapist to simultaneously serve two or more clients residing in the same household shall be reimbursed as one visit only, unless services to each client are separate and distinct. If two or more clients residing in the same household receive Medicaid home health aide services, the personal care for each client shall be documented and billed separately for each client. Any homemaker services provided during units contiguous to skilled personal care units shall be billed to any one of the clients in the household, but the homemaker services shall not be duplicated and/or billed for more than one client. For example, if more than one client in the household needs meal preparation, it is expected that one aide prepare the meal for all of them. If the clients in the same household use different agencies, the agencies shall coordinate with each other to prevent duplication of homemaking.

H. No more than one Home Health agency shall be reimbursed for providing Home Health services during a specific plan period to the same client, unless the second agency is

providing a Home Health service that is not available from the first agency. The first agency must take responsibility for the coordination of all Home Health services. Home and Community Based Services, including personal care, are not Home Health services.

I. Physical, occupational, or speech therapy visits shall be reimbursed only when:

1. Improvement of functioning is expected or continuing;

2. The therapy assists in overcoming developmental problems;

3. Therapy visits are necessary to prevent deterioration;

4. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration; and to teach home health aides or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; and/or

5. Therapy visits are indicated to assess the safety or optimal functioning of the client in the home, or to train in the use of equipment used in implementation of the therapy plan of care.

J. Nursing visits provided solely for the purpose of assessing and/or teaching shall be reimbursed by Medicaid only under the following guidelines:

1. For an initial assessment visit ordered by a physician when there is a reasonable expectation that ongoing nursing or home health aide care may be needed. Initial nursing assessment visits shall not be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

2. If a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the client or the client's unpaid family/caregiver how to perform the task, that visit shall not be considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the client or unpaid family/caregiver performing the task to verify that the task is being performed correctly shall be considered a visit that is solely for the purpose of assessing and teaching.

3. Nursing visits solely for the purpose of assessing the client and/or teaching the client or the client's unpaid family/caregiver shall not be reimbursed unless the care is Acute Home Health or Long Term Home Health With Acute Episode, as defined in Section 8.523, ELIGIBILITY, or the care is for extreme instability of a chronic condition under Long Term Home Health, as defined in Section 3.523, ELIGIBILITY.

4. Nursing visits provided solely for the purpose of assessment and/or teaching shall not exceed the frequency that is justified by the client's documented medical condition and symptoms, up to the maximum reimbursement limits. Assessment visits shall continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific conditions and/or symptoms which are not stable and/or not resolved. Teaching visits shall be as frequent as necessary, up to the maximum reimbursement limits, to teach the client or the client's unpaid family/caregiver, and shall continue only as long as needed for the client or the client's unpaid family/caregiver to demonstrate

understanding or to perform care, or until it is determined that the client or unpaid family/caregiver is unable to learn or to perform the skill being taught. The visit on which the nurse determines that there is no longer a need for assessment and/or teaching shall be reimbursed if it is the last visit provided solely for assessment and/or teaching.

5. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if the client is capable of self-assessment and of contacting the physician as needed; and if the client's medical records do not justify a need for client teaching beyond that already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment

6. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if there is an available and willing unpaid family/caregiver who is capable of assessing the client's condition and needs and contacting the physician as needed; and if the client's medical records do not justify a need for teaching of the client's unpaid family/caregiver beyond the teaching already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment.

K. Nursing visits provided solely for the purpose of assessment and/or teaching and foot care shall not be reimbursed unless the visit meets the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, and/or the guidelines to be reimbursed as a foot care visit.

Nursing visits provided solely for the purpose of providing foot care shall be reimbursed by Medicaid only if the client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the client and/or unpaid family/caregiver is not able or willing to provide the foot care. This will include documented and supported diagnoses that involve severe peripheral involvement, anti-coagulation therapy, or other conditions such as, but not limited to, spasticity and compromised immune system which could lead to a high risk of medical complications from injuries to the feet.

Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit the clinical record must indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for foot care to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

1. absent (not palpable) posterior tibial pulse;

2. absent (not palpable) dorsalis pedis pulse;

3. three of the advanced trophic changes such as:

    a. hair growth (decrease or absence),

    b. nail changes (thickening),

    c. pigmentary changes (discoloration),

d. skin texture (thin, shiny),

e. skin color (rubor or redness);

4. claudication (limping, lameness);

4. temperature changes (cold feet);

5. edema;

6. parasthesia;

7. burning.

L. Nursing visits provided solely for the purpose of assessment and/or teaching and pre-pouring of medications shall not be reimbursed unless the visit meets either the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, or the guidelines for reimbursement as a visit solely for the purpose of pre-pouring medications. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers shall be reimbursed by Medicaid under the following guidelines:

1. The client is not living in a licensed personal care boarding home, including Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at 25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015. No later amendments to or editions of 25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015 are included. Copies of 25-1-107 (ee) (L5), C.R.S., as amended by House Bill 98-1015 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714 or the material may be examined at any State Publications Depository Library; and

2. The client is not physically or mentally capable of pre-pouring his/her own medications or has a medical history of non- compliance with taking medications if they are not pre-poured; and

3. The client has no unpaid family/caregiver who is willing or able to pre-pour the medications for the client; and

4. There is documentation in the client's chart that the client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular client.

M. Nursing visits solely for the purpose of performing venipuncture, or for venipuncture and assessment and/or teaching, shall be reimbursed only if all the regulations in Section 8.520 through Section 8.530.10, B, HOME HEALTH SERVICES, are met.

.13 RATES OF REIMBURSEMENT

A. Payment for Home Health services, other than nursing visits, shall be the lower of the billed charges or the maximum unit rate of reimbursement.

For nursing visits the payment shall be the lower of the billed charges, the maximum unit rate of reimbursement or prior authorized charges.

Prior authorized charges for stable clients requiring uncomplicated daily visits shall not exceed $50.00 for the first brief nursing visit of the day and $35.00 for the second or subsequent brief nursing visit of the day.

B. Maximum interim payment unit rates are:

Effective July 1, 2002:

1. Nursing visits: $67.85

2. Acute Home Health Aide Basic unit: $22.37

3. Long Term Home Health Aide Basic unit: $30.08

4. Home Health Aide Extended unit: $8.99

5. Physical Therapy visits: $58.36

6. Occupational Therapy visits: $61.98

7. Speech Therapy visits: $63.60

Effective September 1, 2002:

1. Nursing visits: $71.42

2. Any Home Health Aide Basic unit $31.66

3. Home Health Aide Extended unit: $9.46

4. Physical Therapy visits: $61.43

5. Occupational Therapy visits: $65.24

6. Speech Therapy visits: $66.95

Effective February 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 99-00. The interim rates shall not be reduced, if total Medicaid home health expenditures in State FY 99-00 do not exceed $73,571,787. If total expenditures for the Home Health budget do exceed $73,571,787, the Department shall determine which Home Health Agencies received average per unduplicated client payments for State FY 99-00 Home Health services which were more than 16.5% over State FY 98-99 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each agency's unit rates, retro-active to February 1, 2000, by a percentage that will bring each agency's average payment per unduplicated client for State FY 99-00 to no more than a 16.5% increase over its State FY 98-99 average per unduplicated client payment. Agencies that became newly certified as Medicare/Medicaid providers in State FY 99-00 and have no Medicaid Home Health payment history for State FY 98-99 shall be exempt.

D. Effective September 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 00-01 with the following exemptions:

1. Exempt Agencies

a) Agencies that became newly certified as Medicare/Medicaid providers in State FY 00-01 and have no Medicaid Home Health payment history for State FY 99-00 shall be exempt.

b) Agencies that had total Medicaid Home Health payments of less than $125,000 in FY 99-00 shall be exempt.

2. Exempt Clients

a) Clients who are newly enrolled in Medicaid shall be exempt if they receive Medicaid Home Health services within thirty days of their very first Medicaid enrollment. Clients with prior spans of Medicaid eligibility shall not be considered newly enrolled even if there was a period of non-enrollment between eligibility spans.

b) Clients who are deinstitutionalized from nursing facilities shall be exempt if the nursing facility care was billed to Medicaid and was not billed as respite care; if they begin receiving Home Health services no later than thirty days after discharge, from the nursing facility; and if they do not return to nursing facility placement after an interim period of Home Health care.

E. The FT 00-01 interim rates shall not be reduced if total Medicaid community long term care expenditures in State FY 00-01 do not exceed $198,862,688. If total expenditures for the community long term care budget do exceed $198,862,688, the Department shall determine which non-exempt Home Health Agencies received average per non-exempt unduplicated client payments for State FY 00-01 Home Health services which were more than 16.5% over State FY 99-00 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each non-exempt agency's unit rates, retroactive to September 1, 2000, by a percentage that will bring each agency's average payment per non-exempt unduplicated client for State FY 00-01 to no more than 16.5% increase over its State FY 99-00 average per unduplicated client payment.

F. Services shall be billed according to category of service upon publication of instructions in the provider-billing manual.

1. For Acute Home Health Services, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health.

2. For Long Term Home Health Services provided to a minor, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy as Long Term Home Health. For Long Term Home

Health Services provided to an adult, Home Health Agencies shall bill nursing, and home health aide services as Long Term Home Health. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

3. For Long Term with Acute Episode Home Health Services, Home Health Agencies shall bill all nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health, until the client's care becomes Long Term Home Health again.

4. For all nursing visits provided solely for the purpose of assessment and teaching, not including initial assessment visits at the start of care, Home Health Agencies shall bill a revenue code assigned for nursing assessment and teaching visits.

G. Maximum unit rates may be adjusted by the State as funding becomes available.

.14 SPECIAL REIMBURSEMENT CONDITIONS

A. Reimbursement for third party resource and Medicare crossover claims shall not exceed Medicaid costs.

B. When Home Health agencies provide Home Health services, in accordance with these regulations, to clients who receive Home and Community Based Services for the Developmentally Disabled (HCBS-DD), the Home Health agency shall be reimbursed:

1. Under normal procedures for Home Health reimbursement, if the client resides in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or Individual Residential Services & Supports (IRSS) Host Homes and Settings; or

2. By the group home provider, if the client resides in Group Residential Services & Supports (GRSS), because the provider has already received Medicaid funding for the home health services and is responsible for payment to the Home Health agency.

C. Acute Home Health services provided to Medicaid HMO clients, including Medicaid HMO clients who are also HCBS recipients, shall not be reimbursed under the Medicaid Home Health program, but shall be reimbursed under Medicaid HMO rules. If a client's Home Health service need exceeds 60 days, the Home Health Agency shall submit a Prior Authorization for Long Term: Home Health to the designated review entity.

D. All Medicare requirements shall be met and exhausted prior to any dual eligible client’s claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except in the specific cases listed at 8.528.14.D.1 and 8.525.14.D.2.

1. A Home Health Agency may bill Medicaid without billing Medicare if the services below are the only services on the claim:

a. Pre-pouring of medications;

b. Certified Home Health Aide services;

c. Occupational Therapy services when provided as the sole skilled service; or

d. Routine Laboratory Draw services.

2. A Home Health Agency may bill Medicaid at the time of services, if the conditions below apply. The claim must also be submitted to Medicare so that the denial, when received, is part of the client's file.

   a. The client is stable;

   b. The client is not experiencing an acute episode; and

   c. The client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

3. The Home Health Agency shall maintain clear documentation in the client's record of the conditions and services that are billed to Medicaid without billing Medicare.

4. A Home Health Advance Beneficiary Notice (HHABN) shall be filled out as prescribed by Medicare.

E. A dual eligible Long Term Home Health Care client who has an Acute Episode shall be switched from Medicaid to Medicare reimbursement. Medicaid resumes as the payer of record when Medicare denies payment as a non-covered benefit and the service is a Medicaid benefit, or when the service consists of those listed in 8.528.14.D.2.

F. If both Medicare and Medicaid reimburse for the same visit or service provided to a client in the same episode, the reimbursement shall be considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

1. Upon receiving a duplicate payment, Home Health agencies shall return the payment to Medicaid within sixty (60) calendar days of final Medicare payment.

2. Failure to return the Medicaid payment to the Department shall be deemed a false claim and subject to the provisions set forth in 25.5-4-303.5, C.R.S., et seq. and referred to the Medicaid Fraud Control Unit in the Colorado Department of Law for criminal investigation.

8.529 POST-PAYMENT REVIEW

.10 The Medicaid Quality Assurance Unit shall periodically conduct post-payment reviews of selected Home Health services.

.11 Home Health agencies shall submit or produce requested documentation of services to the Medicaid Quality Assurance Unit in accordance with rules at 8.079.62. Such documentation shall include, at a minimum:

A. Physician-signed plans of care, which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client. The plan of care must be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services provided must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.

B. Records documenting the nature and extent of the care actually provided such as, but not limited to, nursing notes.

.12 The Medicaid Quality Assurance Unit shall review all information available from any source, shall contact clients, and may conduct on-site visits to Home Health agencies and/or clients.

.13 The Medicaid Quality Assurance Unit shall initiate appropriate administrative, civil, or criminal investigations and/or sanctions for all services which:

A. Are found to be out of compliance with all applicable regulations;

B. Are not consistent with the client's documented medical needs and functional capacity,

C. Are not reasonable in amount, frequency, and duration;

D. Are duplicative of any other services that the client received or that the client received funds to purchase;

E. Total more than twenty-four hours per day of paid care, regardless of funding source (An example of care totaling more than 24 hours per day would be 5 home health visits plus 12 hours of personal care);

F. Consist of visits or contiguous units which are shorter or longer than the length of time required to perform all the tasks prescribed on the care plan.

.14 Clients and families of clients shall not be billed by home health agencies for any services for which Medicaid reimbursement is recovered as a result of post-payment review.

.15 Providers may appeal post-pay sanctions in accordance with Section 8.050, PROVIDER APPEALS AND HEARINGS.

8.530 DENIAL, TERMINATION, OR REDUCTION IN SERVICES

.10 When services are denied, terminated, or reduced by action of the Home Health agency, the Home Health agency shall notify the client.

A. Termination of Services to Clients Still Medically Eligible for Coverage of Medicaid Home. Health Services

When a Home Health agency decides to terminate services to a client who needs and wants continued Home Health services, and who remains eligible for coverage of services under the Medicaid Home Health rules, the agency shall give the client, and/or the client's designated representative, written advance, notice of at least fifteen business days, and the attending physician shall also be notified. Notice shall be provided in person or by certified mail, and shall be considered given when it is documented that the recipient has received the notice. The notice shall provide the reason for the change in services. The agency shall make a good faith effort to assist the client in securing the services of another agency. If there is indication that ongoing services from another source can not be arranged by the end of the advance notice period, the terminating agency shall ensure client safety by making referrals to appropriate case management agencies and/or County Departments of Social Services; and the attending physician shall be informed about the situation. Exceptions will be made to the requirement for 15 days advance notice when the provider has documented that there is danger to the client, Home Health agency, staff, or when the client has begun to receive Home Health services through a Medicaid HMO. Clients who believe that a Home Health agency has

not acted properly, in terminating services may call me Home Health Hotline, at 1-800-842-8826 to request an investigation.