DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospice Room and Board
Rule Number: MSB 21-08-18-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-08-18-A, Revision to the Medical Assistance Act Rule concerning Hospice Room and Board

3. This action is an adoption of: new rules

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

   Sections(s) 8.550.9.C, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/10/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text beginning at 8.550.9.C through the end of 8.550.9.C.
This rule is effective September 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospice Room and Board
Rule Number: MSB 21-08-18-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

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

2. An emergency rule-making is imperatively necessary

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

   Explain:

   This rule is imperatively necessary to comply with state law at CRS § 25.5-4-424 to implement the hospice state-only room and board payment mandated by statute.

3. Federal authority for the Rule, if any:

   Not applicable, this is a state-only payment.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   CRS § 25.5-4-424 (2021)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Hospice Room and Board
Rule Number: MSB 21-08-18-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

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

   There are no alternative methods for implementing the state-only hospice room and board payment mandated in CRS § 25.5-4-424.

8.550 HOSPICE BENEFIT

8.550.9 REIMBURSEMENT

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

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

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

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

      ii) Has a hospice diagnosis; and

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

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

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

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

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

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

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 21-08-30-A
Division / Contact / Phone:Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-08-30-A, Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300

3. This action is an adoption of: an amendment

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

   Sections(s) Sections 8.300.3 and 8.300.5, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: September 10, 2021

   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

*to be completed by MSB Board Coordinator

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Replace the current text at 8.300 with the proposed text beginning at 8.300.3.A.6 through the end of 8.300.A.6. Insert the proposed text beginning at 8.300.4 through the end of 8.300.4. Insert the proposed text beginning at 8.300.5.F through the end of 8.300.5.F. This rule is effective September 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 21-08-30-A
Division / Contact / Phone:Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   During the Coronavirus Disease 2019 (COVID-19) public health emergency, subacute care may be administered by an enrolled hospital in its inpatient hospital or alternate care facilities. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Patients may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital. Subacute care will be paid at the rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State Plan. Adding subacute care to the covered hospital services in an inpatient hospital, or an associated alternate care facility, increases access to such services for the duration of the COVID-19 public health emergency.

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:

   Addition of subacute care to the list of the covered services for inpatient hospitals, and associated alternate care facilities, increases access to such care for the duration of the COVID-19 public health emergency and is imperatively necessary for the preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

   42 CFR §447, Subpart C (2020)

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   C.R.S. 25.5-5-102(1)(a) (2019)

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 21-08-30-A
Division / Contact / Phone:Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Inpatient hospitals, and associated alternate care facilities (AFC), will be affected by, and benefit from, the proposed rule with the addition of subacute care as a covered treatment modality for the duration of the COVID-19 public health emergency. Clients receiving subacute care in an inpatient hospital, or in an AFC, for the duration of the COVID-19 public health emergency will also be affected by, and benefit from, the proposed rule. The Department will bear the cost of reimbursement for subacute care services authorized under the proposed rule.

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

   The qualitative impact of the proposed rule is adding the subacute care treatment modality to the inpatient hospital, and associated AFC, covered services for the duration of the COVID-19 public health emergency. The proposed rule increases access to such services during the COVID-19 public health emergency by allowing hospitals to treat clients that would normally be discharged from the hospital in order to receive a lower level of care. It may be difficult for hospitals to discharge and place such clients in a skilled nursing facility during the COVID-19 public health emergency due to COVID-19 positive or presumptive status. The proposed rule allows hospitals to treat such clients on-site and be reimbursed for such care. Because the clients are being treated at an inpatient hospital or alternate care facility for the

same care they would have otherwise received at a skilled nursing facility, the proposed rule is budget neutral.

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.

   Because the clients treated at an inpatient hospital or alternate care facility for the subacute care under the authority of this rule would have otherwise received such care at a skilled nursing facility, the proposed rule is budget neutral. There are no probable implementation or enforcement costs to the Department or to any other agency. There is no anticipated effect on state revenues.

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

   The probable cost of the proposed rule is reimbursement for subacute care at inpatient hospitals and associated AFCs. The probable benefit of the proposed rule is increased access to subacute care for the duration of the COVID-19 public health emergency. There are no benefits to inaction. Diminished access to subacute care, as described in question two above, for the duration of the COVID-19 public health emergency could be a cost of inaction.

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

   There are no less costly or less intrusive methods for adding subacute care to the covered services for inpatient hospitals and associated AFCs for the duration of the COVID-19 public health emergency.

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 adding subacute care to the covered services for inpatient hospitals and associated AFCs for the duration of the COVID-19 public health emergency.

8.300 HOSPITAL SERVICES

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. Inpatient Hospital services include:

    a. bed and board, including special dietary service, in a semi-private room to the extent available;

    b. professional services of hospital staff;

    c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;

    d. emergency room services;

    e. drugs, blood products;

    f. medical supplies, equipment and appliances as related to care and treatment; and

    g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.

2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

3. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

    Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

4. Psychiatric Hospital Services

    Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-network Hospital.

    a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department

representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.

b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:

i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and

ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

5. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-network DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or

b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or

c. placement or repair of the dialysis route (“shunt”, “cannula”).

6. Inpatient Subacute Care

Administration of subacute care by an enrolled hospital in its inpatient hospital or alternate care facilities is covered for the duration of the Coronavirus Disease 2019 (COVID-19) public health emergency. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Members may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital.

8.300.4 Non-Covered Services

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.

2. Inpatient Hospital Services which are not a covered Medicare benefit.

3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department's utilization review vendor or other Department representative.

~~4. Days awaiting placement or appropriate transfer to a lower level of care are not a covered benefit unless otherwise Medically Necessary.~~

~~5~~. ~~Substance abuse rehabilitation treatment is not covered unless individuals are aged 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement.~~

8.300.5 Payment for Inpatient Hospital Services

8.300.5.F Payment for Inpatient Subacute Care

1. Inpatient Subacute Care days shall be paid at a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved by the Centers for Medicare and Medicaid Services (CMS), for the State in which such hospital is located.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765
Rule Number: MSB 21-07-26-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-07-26-A, Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765

3. This action is an adoption of: an amendment

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

   Sections(s) 8.765, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 10/1/2021
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.765 with the proposed text beginning at 8.765 through the end of 8.765.1. Insert the newly proposed text beginning at 8.765.14 through the end of 8.765.14.F. This rule is effective October 1, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765
Rule Number: MSB 21-07-26-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

2. An emergency rule-making is imperatively necessary

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

   Explain:

   The Qualified Residential Treatment Program provisions of the Family First Prevention Services Act, Pub.L. 115-123, Div. E, Title VII, § 50734, Feb. 9, 2018, 132 Stat. 252, were to go into effect October 1, 2018. However, the U.S. Department of Health and Human Services issued Program Instruction PI-18-07 permitting requests for delayed effective dates up to two years past the statutory deadline. The Colorado Department of Human Services applied for, and received, an extension until December 31, 2020, but no later than September 29, 2021. This rule is imperatively necessary to comply with federal law to implement the delayed effective date for the Family First Prevention Services Act provisions pertaining to Qualified Residential Treatment Programs and to align with the parallel Colorado Department of Human Services license.

3. Federal authority for the Rule, if any:

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

   42 CFR 440.160 (2021)

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   CRS § 25.5-5-202(1)(i) (2021)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765
Rule Number: MSB 21-07-26-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

   There are no alternative methods to align Department rule with the FFPSA and with Colorado Department of Human Services license requirements.

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

8.765.1 DEFINITIONS

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

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

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

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

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

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

Emergency Services means emergency medical and crisis management services.

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

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

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

Licensed Mental Health Professional means a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a psychiatrist licensed pursuant to part 1 of article 36 of title 12, C.R.S., a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S., or a social worker licensed pursuant to part 4 of article 43 or title 12, C.R.S., that is supervised by a licensed clinical social worker. Sections 12-43-301, et seq, 12-36-101, et seq, 12-43-401, et seq, 12-43-501, et seq and 12-43-601, et seq, C.R.S. (2005) are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care

Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

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

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

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

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

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

Qualified Residential Treatment Programs (QRTP) means a facility that provides residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances. As appropriate, QRTP treatment facilitates the participation of family members in the child's treatment program, including siblings, and documents outreach to family members, including siblings.

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

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

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

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

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

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

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

8.765.14 QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP)

8.765.14.A CLIENT ELIGIBILITY

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

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

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

8.765.14.B QRTP AND PROVIDER ELIGIBILITY

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

   a. Be enrolled with Colorado Medicaid;

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

   c. Be accredited by:

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

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

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

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

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

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

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

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

1. The facility maintains its own license;

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

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

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

2. Eligible providers.

a. The following services must be rendered by an enrolled Licensed Mental Health Professionals in a QRTP:

i. Individual therapy,

ii. Group therapy, and

iii. Family therapy.

8.765.14.C COVERED SERVICES

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

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

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

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

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

8.765.14.D NON-COVERED SERVICES

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

a. Room and board;

b. Educational, vocational, and job training services;

c. Recreational or social activities; and

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

8.765.14.E PRIOR AUTHORIZATION REQUIREMENTS

1. Prior authorization may be required for this benefit.

8.765.14.F REIMBURSEMENT.

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

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

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

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

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