COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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John W. Hickenlooper, Governor • Susan E. Birch MBA, BSN, RN, Executive Director

November 1, 2012

Legislative Council
200 East 14th Avenue
Denver, CO 80203

Legislative Council:

The Department of Health Care Policy and Financing (Department) presents this report to comply with House Bill 12-1008, as stipulated in Section 2-7-203, C.R.S.

The passage of HB 12-1008 (Methods for Providing Input to Executive Branch Agencies About Proposed Rules) requires all state departments to compile an annual Departmental Regulatory Agenda and deliver to staff of the Legislative Council on November 1, 2012 and each November 1 thereafter. The agenda must specify a list of new rules or revisions to existing rules that the Department expects to propose in the next calendar year; the statutory or other basis for adoption of the proposed rules; the purpose of the proposed rules; the contemplated schedule for adoption of the rules; and an identification and listing of persons or parties that maybe affected positively or negatively by the rules. In addition, the Department is required to submit the Departmental Regulatory Agenda to the Secretary of State for publication in the Colorado Register and post the Agenda on the website.

Please find enclosed the agenda of rules the Department plans to submit for rule-making in 2013. This list includes what is anticipated at this time, but is by no means a complete and comprehensive list. Circumstances vary and it is difficult to predict what additional rule revisions may be necessary based on new federal and state requirements. In addition, some of the proposed rules listed may be have to be postponed or canceled due to unforeseen circumstances.

For questions about this report please contact MaryKathryn Hurd, Legislative Liaison, via email at Mk.Hurd@state.co.us or by phone at 303-547-8494.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Executive Director

SEB:jlc

Enclosure: 2013 Departmental Regulatory Agenda

Cc: State Library
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Department of Health Care Policy and Financing Regulatory Agenda - 2013
November 1, 2012

Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Schedule 2013	List of Persons or Parties That May Be Affected Positively or Negatively
Rules Regarding Ownership Changes for the Hospitals in the Medicaid Program	25.5-4-401 et seq, Title XIX of the Social Security Act	Put rules in place to govern the process for a hospital to change ownership without the use of state contracts or memorandum of understandings.	February – April	Hospitals within the Medicaid program; potential future owners of those hospitals; HCPF
Prospective Payment System for FQHCs and RHCs	Section 503 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) which amended section 2107(e)(1) of the Social Security Act.	The purpose of this proposed rule is to implement a Prospective Payment System for FQHCs and RHCs and this is to comply with federal law.	February-March	FQHCs and RHCs will be positively impacted
Colorado Indigent Care Program (CICP) Copayment limits	25.5-3-104 (1), C.R.S.	CICP copayments are capped at no more than 10% of income. Currently the cap is determined on a calendar year basis. The proposed rule will change that so that the copayment cap will be determined based on the client's date of application.	January	Low income Coloradans eligible for CICP Safety net hospitals and community health centers
Hospital Provider Fee Program	25.5-4-402.3(3)(e)(I)	The hospital provider fee is calculated each year and must change to ensure sufficient funding is received to fund Medicaid and CHP+ expansions funded by the program.	July -August	Licensed Colorado hospitals Low income and disabled Coloradans eligible for hospital provider fee-funded Medicaid and CHP+ expansions
Consideration of Trusts in Determining Medicaid Eligibility	42 U.S.C. 1396p; C.R.S § 15-14-412.5	Update and revise existing rule, Section 8.100.7.E	December	Individuals in the business of Medicaid eligibility financial planning.
Transfers of Assets Without Fair Consideration	Deficit Reduction Act (DRA) of 2005; P.L. 109-171	Update and revise existing rule, Section 8.100.7.F.	December	Individuals in the business of Medicaid eligibility financial planning.
Health Insurance Buy-In	42 U.S.C. 1396e-1; C.R.S § 25.5-4-210	Update and revise existing rule, Section 8.066	September	Existing Medicaid recipients.
Right of recovery in third party liability cases.	C.R.S. § 25.5-4-301	Update and revise existing rule, Section 8.061.3	December	Personal injury attorneys.

8.280 Early And Periodic Screening, Diagnosis And Treatment (EPSDT) (Eff. 10-01-2007) This rule acts as the basis for the EPSDT program, which allows for items and services, deemed medically necessary for children and youth 20 and under and all pregnant women, even if they are not covered in the state plan. It also includes outreach and case management services to the population outlined above. The program is a requirement of the federal government, under the Centers for Medicare and Medicaid.	42 USC 1902(a)(43), 1905(a)(4)(b) and 42 CFR Section 441.50 to 441.62	Clean Up of EPSDT Rule	March-April	All children 20 and under and all pregnant women are included in the rule, but no one should be impacted since it is clean up only
Home health outside the home: Section 8.523 Eligibility	1905(a)(7)	Remove requirement that Home Health must be provided in the home.	December	Persons receiving home health benefits
Home Health overall: Section 8.520 through 8.529	1905(a)(7)	Renumber rule and remove all outdated information, and information that has been spelled out and clarified in the Benefit Coverage Standard. Update reimbursement information for CNA and brief nursing visits.	December	Persons receiving home health benefits
Treatment of oral medical conditions for adult clients: Section 8.201	CRS 25.5-1-301 through 303	Potential changes to scope	December	Medicaid clients and providers
Substance Use Disorder: Section 8.746	CRS 25.5-5-202(1)(s)	Potential changes to scope/delivery system	December	Medicaid providers and clients

Hospice: Section 8.550	ACA Section 2302	To comply with Section 2302 of the ACA which gives terminally ill children who have elected hospice the option to continue to receive curative care.	December	Medicaid clients age 20 and under who have elected hospice
Nurse Home Visitor Program: Section 8.749	CRS 25.5-1-301 through 303	To maintain and align the existing rule with the State Plan Amendment	December	n/a - administration
Prenatal Plus Program: Section 8.748	CRS 25.5-1-301 through 303	Cleanup and modification of provider requirements	December	Prenatal Plus Program Providers
EPSDT Rule - Orthodontics: Section 8.280	42 CFR 441 Subpart B	To clarify requirements	December	Medicaid providers and clients age 20 and under
Exceptions Policy	CRS 25.5-1-301 through 303	To establish an exceptions policy	December	Medicaid clients
Client Copayment: Section 8.754	Section 1916(j)(1)(a)	To include required exemptions for American Indian/Alaska Native clients.	April	American Indian/Alaska Native Medicaid clients
Rural Health Centers: Section 8.740	Section 1905(a)(2)(B)	Administrative updates	December	RHCs
Residential Child Care Facilities: Section 8.765	CRS 25.5-5-306	Administrative updates	December	RCCFs
Client Over-Utilization Program (COUP): Section 8.075	42 CFR §431.54(e)	Streamline and update existing rule requirements. This rule will add additional specific the criteria use to identify potential clients for placement in COUP.	April	Medicaid clients identified for COUP and Medicaid providers who serve COUP clients

Prior Authorization: Section 8.527	42 CFR §456.3	Will streamline and update prior authorization requirements. Also, there are prior authorization requirements specific to each benefit and the rule will consolidate those requirements where appropriate. This rule will also outline the denial reconsideration process for providers and clarify processing timeframes.	April	Medicaid providers
Medical Necessity Definition	42 CFR §440.230(d)	Consolidate multiple definitions currently in rule into one definition for all Medicaid services (taking into consideration any necessary Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements). The consolidation of definitions is a largely technical change, but this rule also will clarify a definition for what constitutes an experimental/investigational service which is a more substantive change.	April	Medicaid clients and Medicaid providers
Dual Demonstration: Section 8.205.4 Client Enrollment and Disenrollment	1115(a)	Allow Medicare and Medicaid Dual eligible clients to disenroll from the Dual Demonstration ACC enrollment at any time for any reason so that it is consistent with the Medicare disenrollment rules	January/February	Medicare and Medicaid dual eligible clients who are enrolled into the Dual Integration demonstration program
MC Rule: Section 8.205.1A Client Eligibility	unknown at this time, assume 1932(a)		March/April	clients who would be enrolled under a 1281 pilot program that required mandatory enrollment
ACC Program: Section 8.205.2.A.2 Client Responsibilities	1932(a)	Need to remove requirement for mandatory referral requirement for non-exempted ACC program services	August	PCMPs, specialists, and clients enrolled in the ACC program

Revisions to the Medicaid Eligibility Rules Concerning Clarification updates to section 8.100.6	Medicare Improvements for Patients and Providers Act 2008, P>L> 110-275, section 112	Incorporates changes to wording of rules to provide clarification on the intention of the policy.	January	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Medicaid Eligibility Rules Concerning Clarification updates to section 8.100.7	42 CFR 435; 20 CFR 416, Title XIX , section 1924 of the Social Security Act	Incorporates changes to wording of rules to provide clarification on the intention of the policy.	March	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Medicaid Eligibility Rules Concerning Direct Certification of Medicaid Eligibility	Code of Federal Regulations, 42 CFR 435.902 and 435.916	Provides opportunity to identify, enroll, and recertify Medicaid eligible families through use of the eligibility findings from other programs such as Food Assistance (SNAP).	March	The change will affect families positively by providing expedited enrollment and or recertification.
Revisions to the Medicaid Eligibility Rules Adult Medical Eligibility Begin Date change	Future State Plan Amendment	Change rule to allow certain Adult Medical programs to obtain eligibility as of the beginning of the month in which eligibility was determined instead of as of application date.	March	The change will affect adult programs positively, potentially providing benefits a few days earlier than the current rule.
Revisions to the Medicaid Eligibility Rules Concerning the Affordable Care Act (ACA)	Federal ACA, 42 CFR Parts 431, 433, 435, 457	Implements changes to in accordance to ACA which includes but is not limited change in income eligibility determination and household composition. Updates sections 8.100.1-8.100.5	July	The changes will affect families, children, adults without dependent children, pregnant women, and a portion of the disabled population.

Ambulatory Surgical Center (ASC) rule change to align grouper methodology language with current State Plan.	Social Security Act, Section 1902(a)(30)(A) et seq. 25.5-4-403, C.R.S. (2011)	To remove the number "nine" from the current grouper language for Ambulatory Surgical Center reimbursement.	February - April	Ambulatory Surgical Centers
Federally Qualified Health Center (FQHC) rule change related to reimbursement, and to clarify requirements for billing of mental health services to Behavioral Health Organizations (BHOs).	Social Security Act, Section 1902(bb) et seq. 25.5-1-301 through 25.5-1-303, C.R.S. (2011)	To allow FQHCs to bill the BHO for covered BHO services on the same day as a physical and/or dental health encounter if the FQHC bills the BHO for these services. FQHC must have a current contract with the BHO. To align Medicaid provider enrollment with the Public Health Service Act Section 330 grant funding. Podiatrists and dental hygienists would be allowed to bill Medicaid for encounter visits. Services not offered to Medicaid clients not included in encounter rate calculation, as well as offsite lab and x-ray.	February	Federally Qualified Health Centers and Behavioral Health Organizations
Rule regarding reimbursement for Non-Medical Transportation (NMT) provided on HCBS waivers	Social Security Act 1915 (c) 42 C.F.R. 441.300-441.310 et seq. 25.5-6-307, C.R.S. (2011)	Provide rules that explain the reimbursement process according to specific vehicle types and client needs	January –July	NMT providers; NMT waiver clients; Single Entry Points and Case Management Agencies

Rule change regarding payments to DRG hospitals for outpatient services	42 C.F.R. 440.20 et seq. 25.5-4-301; 25.5-1-301 through 25.5-1-303, C.R.S (2011)	Include in the rules the transfer of liability related to Outpatient Hospital Cost Settlements when there is a Change of Ownership (CHOW) or similar.	February – April	Hospital providers and potential new owners of hospital providers
Rule change to account for a new base rate methodology for specialty hospitals	42 C.F.R. 440.10 et seq. 25.5-4-402; 25.5-1-301 through 25.5-1-303, C.R.S. (2011)	Describe the new base rate calculation methodology for specialty hospitals.	November - December	Specialty Hospital providers