DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance DME Rule Concerning DMEPOS Reimbursement, Section 8.590.7
Rule Number: MSB 17-09-22-B
Division / Contact / Phone: Client and Clinical Care Office, Pharmacy Unit / Carrie Smith / 303-866-3406

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency / Board: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 17-09-22-B, Revision to the Medical Assistance DME Rule Concerning DMEPOS Reimbursement, Section 8.590.7
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):
   Sections(s) 8.590.7.E through 8.590.7.P, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.590.7 with the proposed text beginning at 8.590.7 through the end of 8.590.7.P.5. This rule is effective June 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance DME Rule Concerning DMEPOS Reimbursement, Section 8.590.7
Rule Number: MSB 17-09-22-B
Division / Contact / Phone: Client and Clinical Care Office, Pharmacy Unit / Carrie Smith / 303-866-3406

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule will increase the Durable Medical Equipment (DME) encounter rate by 1.402% to account for General Assembly funding appropriation, pursuant to SB17-254; and will bring the Department into compliance with the Consolidated Appropriations and the 21st Century Curest Act (Acts). The Acts require the Department to set their reimbursement for certain DME items to Medicare payment rates. These rule revisions implement the portion of the Acts that pertain solely to used DME items. The proposed revisions will also correct a numeration error.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   A state plan amendment (SPA) pertaining to the provider rate increase, was submitted to CMS with a requested effective date of July 1, 2017. To date, reimbursement for the Durable Medical Equipment encounter rate has been made under the current rate. The SPA was approved on February 1, 2018 and all reimbursements made after July 1, 2017 will be adjusted to reflect the new rate contained in the rule.

   The federal authority to set used Durable Medical Equipment items at the Medicare Upper Payment Limit rate is required by Section 1903(i)(27) of the Social Security Act.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   Senate Bill 17-254

Initial Review	**04/13/18**	Final Adoption	**05/11/18**
Proposed Effective Date	**06/30/18**	Emergency Adoption	

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Initial Review	**04/13/18**	Final Adoption	**05/11/18**
Proposed Effective Date	**06/30/18**	Emergency Adoption	

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance DME Rule Concerning DMEPOS Reimbursement, Section 8.590.7
Rule Number: MSB 17-09-22-B
Division / Contact / Phone: Client and Clinical Care Office, Pharmacy Unit / Carrie Smith / 303-866-3406

REGULATORY ANALYSIS

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

   DME providers will receive increased reimbursement for equipment and supplies provided, pursuant to SB17-254, but may see a fluctuation in reimbursement for those used DME items subject to Medicare's Upper Payment Limit as required by Section 1903(i)(27).

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

   Reimbursement to DME providers is estimated to be increased by $2,360,084 for FY 2017 - 18. However, there may be a reduction of $142,000 in reimbursement for those used DME items subject to Medicare's Upper Payment Limit as required by Section 1903(i)(27).

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

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

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

   The rate increase will give providers the ability to continue supplying DME items to members at their incremental threshold margin. Inaction can result in decreased member services and access to benefits, as well as noncompliance with SB 17-254. Furthermore, inaction would render the Department noncompliant with Section 1903(i)(27) of the Social Security Act concerning Medicare designated used DME items subject to the Upper Payment Limit.

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

There is not a less costly method for achieving the purpose of the proposed rule which is to comply with SB 17-254.

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

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

8.590.7 REIMBURSEMENT

8.590.7.A. A provider, as defined at Section 25.5-4-414, C.R.S. ~~(2016)~~, is prohibited from making a referral to an entity providing DME and Supplies under the Medical Assistance Program if the provider or an Immediate Family member of the provider has a Financial Relationship with the entity unless the Financial Relationship meets the requirements of an exception to the prohibitions established by 42 U.S.C. Section 1395nn, as amended or any regulations promulgated thereunder, as amended. 42 U.S.C. §1395nn is hereby incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S. ~~(2016)~~, the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado.

8.590.7.B. If a provider refers a Medicaid member for DME and Supplies services in violation of Section 25.5-4-414, C.R.S. ~~(2016)~~, or this rule, then the Department may

1. Deny any claims for payment from the provider;

2. Require the provider to refund payments for services or items;

3. Refer the matter to the appropriate agency for investigation for fraud; or

4. Terminate the provider's Colorado Medicaid provider participation agreement.

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

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

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

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

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

8.590.7.H~~G~~. Reimbursement for allowable modifications, service, and repairs on DME is as follows:

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

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

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

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

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

8.590.7.~~I~~H. Reimbursement for used equipment shall include:

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

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

a. For used equipment subject to the upper payment limit provisions of section 1903(i)(27) of the Social Security Act, the maximum allowable reimbursement will be the lower of 100% of the applicable Medicare used reimbursement rate effective as of January 1 and posted by July 1 of each year, or the provider's submitted charges.

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

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

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

3. If item is delivered, set-up and installation of equipment in an appropriate room in the home, if applicable.

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

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

8.590.7.~~K~~J. Reimbursement rate for a purchased item shall be as follows:

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

2. Manually priced items that do not have an assigned fee schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less 18.33~~9.46~~ percent.

3. Manually priced items that do not have an assigned fee schedule rate and have no MSRP shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus 19.50~~7.85~~ percent.

8.590.7.L~~K~~. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Billing Manual.

8.590.7.M~~L~~. Reimbursement for members eligible for both Medicare and Medicaid shall be made in the following manner:

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

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

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

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

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

8.590.7.N~~M~~. Face-to-Face Encounters

1. For DME specified in the Billing Manual, a face-to-face encounter must be performed related to the primary reason a member requires the DME.

2. The face-to-face encounter must occur no more than six months before the DME is first provided to a member.

3. The face-to-face encounter must be conducted by one of the following practitioners:

    a. The physician responsible for prescribing the DME;

    b. A nurse practitioner or clinical nurse specialist, working in collaboration with the prescribing physician; or

    c. A physician assistant under the supervision of the prescribing physician.

4. A practitioner may conduct a face-to-face encounter via telehealth or telemedicine if those services are covered by the Medical Assistance Program.

5. If a non-physician practitioner performs a face-to-face encounter they must communicate the clinical findings of the face-to-face encounter to the physician responsible for prescribing the related DME. Those clinical findings must be incorporated into a written or electronic document included in the member's medical record.

6. A physician who prescribes DME requiring face-to-face encounters must document the following:

    a. The face-to-face encounter was related to the primary reason the member required the prescribed DME;

    b. The practitioner who performed the face-to-face encounter;

    c. The date of the face-to-face encounter; and

d. The face-to-face encounter occurred within the required timeframe.

7. Compliance with this section is required as a condition of payment for DME requiring face-to-face encounters.

8.590.7.O~~N~~. Reimbursement for Complex Rehabilitation Technology provided to members is subject to the following conditions:

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

2. The member has been evaluated or assessed, for selected Complex Rehabilitation Technology identified in the Billing Manual, by:

a. A Qualified Health Care Professional; and

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

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

8.590.7.P~~O~~. Reimbursement for Speech Generating Devices (SGD), accessories, and software provided to members is subject to the following conditions:

1. The member has a medical condition resulting in a severe expressive communication impairment; and

2. The SGD, accessories and software is used primarily as a communication device; and

3. The SGD, accessories or software are recommended by a Speech Language Pathologist after a communication assessment as described at 10 CCR 2505-10, Section 8.590.3.E.1; and

a. The recommended device, software or application should be capable of modifications to meet the needs for supportive functional communication when possible. The recommended software or application must be compatible with the prescribed SGD.

b. Accessories and supplies that do not have a primary medical use will not be covered, which includes any items that are unnecessary for operation of the SGD, or are unrelated to the SGD.

i. Covered accessories include but are not limited to:

1. Replacement lithium ion batteries;

2. Non-electric SGD communication board;

3. Mounting systems designated for securing the SGD within reach of the client;

4. Safety and protection accessories designated to maintain the life expectancy of the device,

5. Accessories not otherwise classified may be approved to enhance the use of the SGD system as the member's condition changes; and

6. Orthotic and prosthetic supplies and accessories, and/or service components of another HCPCS L code.

4. Other forms of treatment have been considered or ruled out; and

5. The member's communication impairment will benefit from the SGD, accessories, or software.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Outpatient Fee-for-Service SUD Providers Eligible Providers, Section 8.746.2
Rule Number: MSB 17-11-22-A
Division / Contact / Phone: Health Programs Office / Colleen McKinney / x5128

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency / Board: Department of Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 17-11-22-A, Revision to the Medical Assistance Rule concerning Outpatient Fee-for-Service SUD Providers Eligible Providers, Section 8.746.2
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) 8.746, 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)?
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing).

No

<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.746 with the proposed text beginning at 8.76.1 through the end of 8.746.8.A. This rule is effective June 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Outpatient Fee-for-Service SUD Providers Eligible Providers, Section 8.746.2
Rule Number: MSB 17-11-22-A
Division / Contact / Phone: Health Programs Office / Colleen McKinney / x5128

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 revisions to Section 8.746 will align the rule to changes made in the State Plan Amendment 17-0002, which was approved by the Center for Medicaid and Medicare Services for an effective date of 5/1/2018.

   The rule proposes the following revisions to Section 8.746:

   - Remove additional licensure requirements for licensed clinicians
   - Change provider terminology and recategorize provider types
   - Remove Nurse Practitioner as a provider type
   - Add Advanced Practice Nurse and Physician Assistant as eligible provider types
   - Add Psychiatrist to Physician provider type
   - Edit definitions
   - Remove the unit limits for substance use disorder assessment
   - Remove the unit limits for individual and family therapy
   - Remove the unit limits for group therapy
   - Remove the unit limits for alcohol/drug screening and counseling
   - Remove the unit limits for social/ambulatory detoxification
   - Remove the unit limit for medication-assisted treatment
   - Remove the unit limit for targeted case management
   - Clarify benefit structure of alcohol/drug screening counseling
   - Edit unit of service for Targeted Care Management

Initial Review
Proposed Effective Date **06/30/18**
Final Adoption **05/11/18**
Emergency Adoption

DOCUMENT #07

- Clarify benefit structure of Medication Assisted Treatment

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   State Plan Amendment 17-0002

   C.F.R. 42 §440.130(d)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-5-202(s)(i), C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Outpatient Fee-for-Service SUD Providers Eligible Providers, Section 8.746.2
Rule Number: MSB 17-11-22-A
Division / Contact / Phone: Health Programs Office / Colleen McKinney / x5128

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 people who will benefit from this rule change are licensed providers and Health First Colorado members who receive FFS SUD services. Licensed providers will be able to provide SUD treatment, within the scope of their licensure, without requiring an additional credential. Members receiving these services will no longer be subject to unit limitations. Members receiving these services will be further protected from unscrupulous providers that may seek to abuse the member's Medicaid enrollment for financial gain without providing medically necessary and useful care.

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 rule will ease regulatory burden on providers by consolidating credentialing requirements. Members will benefit by having a benefit package aligned to that available through the Community Behavioral Health Services Program.

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 does not anticipate any costs related to removing the separate licensure for already licensed providers. No costs are associated with removing the unit limits to the benefits because only a small fraction of members (less than 100) are eligible to access the outpatient substance use disorder benefit through the fee-for-service delivery system rather than through the Community Behavioral Health Services Program.

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

   If the proposed rule does not go into effect, the state will not be compliant with the changes made to the State Plan.

DO NOT PUBLISH THIS PAGE

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

   The rule must be changed in order to comply with the State Plan.

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

   No other alternative methods were considered, as this rule must be changed to comply with the State Plan.

8.746 OUTPATIENT FEE-FOR-SERVICE SUBSTANCE USE DISORDER TREATMENT

8.746.1 DEFINITIONS

Community Behavioral Health Services Program means the program described at 10 CCR 2505-10 Section 8.212, by which program-enrolled Medicaid clients receive behavioral health treatment services.

Day Treatment Program means a non-residential treatment program designed for children and adolescents under the age of 21 who have an emotional, behavioral, and neurobiological, or substance use disorder diagnosis, and may be at high risk for out-of-home placement. Day Treatment Program services include family, group, and individual psychotherapy; parent-child education; skill and socialization training focused on improving functional and behavioral deficits; and intensive coordination with schools or other child service agencies.

Health First Colorado is Colorado's Medicaid Program, the free or low cost public health insurance program that provides health care coverage to low-income individuals, families, children, pregnant women, seniors, and people with disabilities. Colorado Medicaid is funded jointly by the federal and state government, and is administered by the Colorado Department of Health Care Policy and Financing.

Intensive Outpatient Psychiatric Rehabilitation Services are those that focus on maintaining and improving functional abilities for the client through a time-limited, multi-faceted approach to treatment.

~~Masters Level~~Licensed Clinician means a provider who is a clinical social worker licensed pursuant to CRS 12-43-404, marriage and family therapist licensed pursuant to CRS 12-43-504, professional counselor licensed pursuant to CRS 12-43-603, ~~or advanced practice nurse licensed pursuant to CRS 12-38-111.5.~~ addiction counselor licensed pursuant to CRS 12-43-804, or psychologist (Psy.D/Ph.D) licensed pursuant to CRS 12-43-304.

Licensed Health Practitioner means an advanced practice nurse licensed pursuant to CRS 12-38-111.5, physician/psychiatrist licensed pursuant to CRS 12-36-101, or physician assistant licensed pursuant to CRS 12-36-107.4.

~~Peer Advocate Services means a scheduled therapeutic activity led by a trained client who is self-identified as receiving behavioral health services.~~

~~Psychologist, Psy.D/PhD means a provider who has a doctoral degree from an accredited program offering psychology courses approved by the American Psychological Association and is licensed as a psychologist by the State Board of Psychologist Examiners pursuant to CRS 12-43-304.~~

~~Physician Assistant means a provider who is a graduate of an education program accredited by the Accreditation Review Commission on Education for the Physician Assistant, certified by the National Commission on Certification of Physician Assistants, and licensed as a physician assistant pursuant to CRS 12-36-107.4.~~

Residential Treatment means a short-term residential treatment program offering 24-hour intensive residential treatment, habilitative, and rehabilitative services for up to 30 days in a highly structured, community-oriented environment.

State Fiscal Year (SFY) is July 1 – June 30.

8.746.2 ELIGIBLE PROVIDERS

1. Providers eligible to render services are limited to the following:

a. Licensed ~~physicians~~ Health Practitioners ~~who are also~~ who are also:

i) Certified in addiction medicine by the American Society of Addiction Medicine (ASAM), the American Board of Addiction Medicine (ABAM), or the American Board of Preventive Medicine (ABPM); or

ii) ~~Certified as~~ Certified Addiction Counselors (CAC II or CAC III) or Licensed Addiction Counselors (LAC) by the Department of Regulatory Agencies (DORA); or

iii) ~~Certified as~~ National Certified Addiction Counselors II (NCAC II) or Master Addiction Counselors (MAC) by the National Association of Alcohol and Drug Abuse Counselors (NAADAC); or

iv) Certified in addiction psychiatry by the American Board of Psychiatry and Neurology certified in Addiction Psychiatry (ABPN).

b. Licensed ~~non-physicians~~Clinicians. ~~who are also:~~

~~i) Psychologists (PhD, PsyD),~~

~~ii) Nurse Practitioners,~~

~~iii) Licensed Addiction Counselors, or~~

~~iv) Master's Level Clinicians:~~

~~1) Licensed Clinical Social Worker (LCSW)~~

~~2) Licensed Professional Counselor (LPC)~~

~~3) Licensed Marriage and Family Therapist (LMFT)~~

~~4) Licensed Advanced Practice Nurse (LAPN)~~

~~and either:~~

~~i) Certified by DORA as a CAC II or CAC III; or~~

~~ii) Certified by NAADAC as an NCAC II or MAC.~~

~~c. Licensed facilities that are supervised by one or more licensed physicians or non-physicians; supervised professional personnel who are:~~

~~i) Working at a facility licensed by the Office of Behavioral Health to provide substance use disorder treatment services; and~~

~~ii) Supervised by one or more licensed physicians or licensed non-physicians found in Part 1 or 2 of this Eligible Providers section.~~

8.746.3 TREATMENT PLANNING

8.746.3.A. An approved treatment plan must be in place for each client prior to the client receiving services. An initial assessment is required to establish a treatment plan. Treatment plans require

approval from a licensed provider indicated in Section 8.746.2 with the authority to approve treatment plans within their scope of practice.

8.746.3.B. All rendered services must be medically necessary, as defined in Section 8.076.1.8., and must be detailed in the client's treatment plan and progress notes. Initial substance use disorder assessments are exempt from inclusion in the approved treatment plan.

8.746.3.C. Approved treatment plans must identify treatment goals and must explain how the proposed treatment services will achieve those stated goals.

8.746.3.D. Approved treatment plans must identify the treatment services planned for use over the course of treatment. The amount, frequency, and duration of these treatment services must be included in the approved treatment plan.

8.746.4 ELIGIBLE CLIENTS

1. To be eligible for the Outpatient Fee-for-Service Substance Use Disorder Treatment benefit, client:

    a. Must currently be enrolled in Colorado Medicaid; and

    b. Must not be enrolled in the Community Behavioral Health Services program pursuant to 10 C.C.R. 2505-10 Section 8.212.

        i) All Colorado Medicaid clients are automatically enrolled in the Community Behavioral Health Services program, unless one of the following is true:

            1) Client is not eligible for enrollment in the Community Behavioral Health Services program, per 10 CCR 2505-10 Section 8.212.1.A.; or

            2) Client is approved for an individual enrollment exemption, as set forth at 10 CCR 2505-10 Section 8.212.2.

8.746.5 LIMITATIONS

1. Clients are not required to obtain a referral from their Primary Care Physician (PCP) or Primary Care Medical Provider (PCMP) to receive these services.

2. Clients must have a treatment plan that is approved by a licensed practitioner listed in Section 8.746.2.

3. Outpatient Fee-for-Service Substance Use Disorder Treatment services may only be rendered by providers outlined in Section 8.746.2, with an exception for certain providers of Medication Assisted Treatment described below.

4. Services are covered only when the client has been diagnosed with at least one of the following:

    a. Alcohol use or induced disorder

    b. Amphetamine use or induced disorder

    c. Cannabis use or induced disorder

    d. Cocaine use or induced disorder

e. Hallucinogen use or induced disorder

f. Inhalant use or induced disorder

g. Opioid use or induced disorder

h. Phencyclidine use or induced disorder

i. Sedative Hypnotic or Anxiolytic use or induced disorder

j. Tobacco use disorder

8.746.6 COVERED SERVICES

8.746.6.A. Substance Use Disorder Assessment

1. A substance use disorder assessment is an evaluation designed to determine the most appropriate level of care based on criteria established by the American Society of Addiction Medicine (ASAM), the extent of drug or alcohol use, abuse, or dependence and related problems, and the comprehensive treatment needs of a client with a substance use disorder diagnosis.

   a. Course of treatment and changes in level of care must be based on best practices as defined by the current ASAM Patient Placement Criteria.

   b. Re-assessments must be spaced appropriately throughout the course of treatment to ensure the treatment plan is effectively managing the client's changing needs.

   c. ~~Substance use disorder assessments are limited to two encounter-based units of service per State Fiscal Year.~~ Each complete assessment corresponds to one unit of service.

   d. An assessment may involve more than one session and may span multiple days. If the assessment spans multiple days, the final day of the assessment is reported as the date of service.

8.746.6.B. Individual and Family Therapy

1. Individual and family therapy is the planned treatment of a client's problem(s) as identified by an assessment and listed in the treatment/service plan. The intended outcome is the management and reduction, or resolution of the identified problem(s).

2. Individual and family therapy is limited to one client per session.

~~3. Individual and family therapy is limited to a combined 35 sessions per State Fiscal Year, and billed at 15 minutes per unit, with up to four units (one hour) per session.~~ Individual and family therapy are billed at 15 minutes per unit.

   a. A session is considered a single encounter with the client that can encompass multiple timed units.

~~4~~3. Family therapy must be directly related to the client's treatment for substance use disorder or dependence.

~~5~~4. Individual therapy and family therapy sessions are allowed on the same date of service.

8.746.6.C. Group Therapy

1. Group therapy refers to therapeutic substance use disorder counseling and treatment services, administered through groups of people who have similar needs, such as progression of disease, stage of recovery, and readiness for change.

2. Group therapy must include more than one patient.

~~3. Group therapy is limited to 36 sessions per State Fiscal Year.~~

3. ~~a~~. A session of group therapy may last up to three hours and is billed in units of one hour each (e.g., a three hour group session would consist of three units).

~~b~~a. A unit of service may be billed separately for each client participating in the group therapy session.

8.746.6.D. Alcohol / Drug Screening and Counseling

1. Alcohol / drug screening and counseling is the collection of urine followed by a counseling session with the client to review and discuss the results of the screening.

a. The ~~laboratory~~ analysis of the urine specimen (urinalysis) ~~must be billed by a laboratory using that laboratory's Medicaid Provider ID.~~may only be billed by a provider with the appropriate CLIA certification for the test performed. Urinalysis is not part of the Outpatient Fee-For-Service SUD benefit.

b. Substance use disorder providers will only be reimbursed for collecting the urine specimen and providing a counseling session to review and discuss the results of the urinalysis. Claims submitted for the collection of the urine sample without the subsequent counseling of urinalysis results will not be reimbursed.

i~~)~~. If the client does not return for the counseling of their urinalysis results, the collection of the sample cannot be claimed.

c. Substance use disorder counseling services to discuss and counsel the client on the test results must be provided by an eligible rendering provider, as outlined in Section 8.746.2.

d. The counseling portion of the service may be conducted during a session of individual or family therapy.

e. Multiple urine collections per date of service are not additionally reimbursed.

f. ~~Alcohol / drug screening and counseling is limited to 52 specimen collections per State Fiscal Year.~~

~~g~~f. Alcohol / drug screening and counseling is limited to one unit per date of service.

i~~)~~. A unit of service is the single collection and subsequent counseling session.

8.746.6.E. Targeted Case Management

1. Targeted case management refers to coordination and planning services provided with, or on behalf of, a client with a substance use disorder diagnosis.

a. The client does not need to be physically present for this service to be performed if it is done on the client's behalf.

2. Targeted case management services are limited to service planning, advocacy, and linkage to other appropriate medical services related to substance use disorder diagnosis, monitoring, and care coordination.

~~3. Targeted case management services are limited to:~~

~~a. 52 units of service per State Fiscal Year.~~

~~b. Up to four units of service per date of service.~~

4~~3~~. A unit of service equals one ~~30~~ 15-minute ~~sessions~~ increment of targeted case management, and consists of at least one documented contact with a client or person acting on behalf of a client, identified during the case planning process.

8.746.6.F. Social / Ambulatory Detoxification

1. Facilities licensed by the Office of Behavioral Health (OBH) to provide detoxification services are the only provider ~~type~~ eligible to render social / ambulatory detoxification services.

2. Social / ambulatory detoxification services:

   a. Include supervision, observation, and support from qualified personnel for clients exhibiting intoxication or withdrawal symptoms.

   b. Are provided when there is minimal risk of severe withdrawal (including seizures and delirium tremens) and when any co-occurring mental health or medical conditions can be safely managed in an ambulatory setting.

~~3~~. ~~Social / ambulatory detoxification is limited to five sessions per State Fiscal Year.~~

~~a~~3. A session is defined as the continuous treatment time from the first day to the last day of social/ambulatory detoxification.

   ~~b~~a. Each session may last a maximum of three days.

~~4~~. Room and board is not a covered social / ambulatory detoxification service. Claims billed for room and board will not be reimbursed.

~~5~~5. Social / ambulatory detoxification is divided into four distinct services—physical assessment of detoxification progress, evaluation of level of motivation, safety assessment, and provision of daily living needs—with corresponding procedure codes, which may be provided and billed on the same date of service if medically necessary, as defined in rule at 10 CCR 2505-10 Section 8.076.1.8.

8.746.6.G. Medication-Assisted Treatment (MAT)

1. Medication Assisted Treatment (MAT) is a benefit for opioid addiction that includes a medication approved by the U.S. Food and Drug Administration (FDA) for opioid addiction detoxification or maintenance treatment.

2. ~~For the purposes of the Outpatient Fee-for-Service Substance Use Disorder Treatment benefit, MAT is defined as the administration, acquisition, and dispensing of Methadone to the client.~~When methadone is administered for MAT, the reimbursement for the medication's acquisition is bundled with the reimbursement for administration and dispensing under a single billing code. When other medications are used for MAT (e.g. Suboxone), the reimbursement for

the medication is billed separately from the administration and dispensing using physician administered drug billing codes.

a. Only licensed physicians, physician assistants, or nurse practitioners are eligible to administer MAT. All providers must comply with the Office of Behavioral Health's Opioid Medication Assisted Treatment program requirements set forth at 2 C.C.R. 502-1 21.320.

~~b~~. ~~MAT is limited to one unit per date of service. A unit is a single dose administered to the client.~~

~~c~~b. Take-home dosing is permitted in accordance with Office of Behavioral Health rules at 2 CCR 502-1 21.320.8. Therefore, one unit of MAT must be reported for each date of service the client ingests the dose of methadone.

~~d~~c. If the client ingests their dose at the facility, the place of service must be reported as office. If the client ingests their dose at home, the place of service must be reported as home. Records must include documentation to substantiate claims for take-home doses.

~~e~~d. ~~Ongoing counseling and therapy services associated with MAT have the same respective benefit limitations as individual, family, and group therapy services listed in Sections 8.746.6.B. and 8.746.6.C.~~

8.746.7 PRIOR AUTHORIZATION REQUIREMENTS

8.746.7.A. There are no prior authorization requirements for the Outpatient Fee-for-Service Substance Use Disorder Treatment benefit.

8.746.8 NON-COVERED SERVICES

8.746.8.A. The following services are not covered under the Outpatient Fee-for-Service Substance Use Disorder Treatment benefit:

1. Day ~~Treatment~~ treatment ~~Program~~ program ~~Services~~services.

2. Intensive ~~Outpatient~~ outpatient ~~Psychiatric~~ psychiatric ~~Rehabilitation~~rehabilitation.

3. Peer ~~Advocate~~ advocate ~~Services~~services.

4. Residential treatment services, with the exception of those provided in a Residential Child Care Facility, as set forth in Section 8.765.

~~5. Court-ordered DUI services that are independent of a substance use disorder diagnosis.~~

~~6~~5. Services provided by a third party that is under contract with the provider.

~~7~~6. Any substance use disorder treatment service not specified as covered in Section 8.746.6.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 18-01-30-A
Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-01-30-A, Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
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) 8.960, 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)?
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing).

No

Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.960 Appendix A with the proposed text beginning at Appendix A through the end of Appendix A. This rule is effective June 30, 2018.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 18-01-30-A
Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

STATEMENT OF BASIS AND PURPOSE

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

   This rule change incorporates a change to restorative code, D2330; periodontic code D4355, prosthodontic (removable) codes D5621 and D5622; oral and maxillofacial surgery codes D7220, D7230, D7240, and D7241; and anethesia codes, D9219, D9223 and D9243 and program payments into Appendix A.

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:

   N/A

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-3-404, C.R.S. (2017)

Initial Review **04/13/18** Final Adoption **05/11/18**
Proposed Effective Date **06/30/18** Emergency Adoption

DOCUMENT #05

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Title of Rule: Revision to the Medical Assistance Special Financing Rule Concerning Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 18-01-30-A
Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

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 incorporates a change to restorative code, D2330; periodontics code D4355, prosthodontic (removable) codes D5621 and D5622; oral and maxillofacial surgery codes D7220, D7230, D7240, and D7241; and anesthesia codes, D9219, D9223 and D9243 and program payments into Appendix A. These additions will add an extra benefit for eligible seniors. The only cost the eligible seniors will have is the Max Patient Co-pay listed on Appendix A.

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 incorporation of the periodontics, prosthodontic, oral and maxillofacial surgery codes will have the same max- co-pay as others in the appropriate sections listed in Appendix A. Therefore, there is no change in cost or economic impact on eligible seniors.

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 Colorado Dental Health Care Program for Low-Income Seniors has a fixed appropriation and the addition of these services will not increase the Department's administrative costs for the program.

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

   The incorporation of these codes allows the eligible seniors to maintain healthy eating while also having less stress while receiving dental procedures.

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

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This rule change is necessary to incorporate these valuable services to the eligible seniors.

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.

   This rule change is necessary to incorporate the change and new codes for periodontics, prosthodontics (removable), oral and maxillofacial surgery, and anesthesia into Appendix A. There are no alternatives to amending the existing rule.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.1 Definitions

Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.

Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in Appendix A.

C.R.S. means the Colorado Revised Statutes.

Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.

Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2014).

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.

Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.

Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is able to demonstrate lawful presence in the country, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective August 30, 2016), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.

Endodontic Services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues, including pulpectomy.

Evaluation means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.

Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).

Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.

Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in Appendix A. The Max Allowable Fee is the sum of the Program Payment and the Max Client Co-Pay.

Max Client Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in Appendix A for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.

Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2014).

Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2014)

Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Palliative Treatment for dental pain means emergency treatment to relieve the client of pain; it is not a mechanism for addressing chronic pain.

Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal disease progression.

Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

Program Payment means the maximum amount by procedure listed in Appendix A for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors

Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.

Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:

1. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2014);

2. A community-based organization or foundation;

3. A Federally Qualified Health Center, safety-net clinic, or health district;

4. A local public health agency; or

5. A private dental practice.

Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.

Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the eligible senior.

Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic needs of the client.

Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2014).

8.960.2 Legal Basis

The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2014).

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at https://www.colorado.gov/hcpf/research-data-and-grants at least 30 days prior to the due date.

8.960.3.B Evaluation of Grant Proposals

Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1. The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any particular applicant.

2. The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.

3. Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:

    a. Outreach to and identify Eligible Seniors;

    b. Collaborate with community-based organizations; and

    c. Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.

4. The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

8.960.3.C Grant Awards

The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.3.D Qualified Grantee Responsibilities

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

1. Identify and outreach to Eligible Seniors and Qualified Providers;

2. Demonstrate collaboration with community-based organizations;

3. Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;

4. Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;

5. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;

6. Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and

7. Submit an annual report as specified under 8.960.3.F.

8.960.3.E Invoicing

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

1. Invoices shall include the number of Eligible Seniors served, the alphanumeric code and procedure description as listed in Appendix A, and any other information required by the Department.

2. The Department will pay no more than the established Program Payment per procedure rendered.

3. Eligible Seniors shall not be charged more than the Max Client Co-Pay as listed in Appendix A.

4. Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

8.960.3.F Annual Report

On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

The annual report shall be completed in a format specified by the Department and shall include:

1. The number of Eligible Seniors served;
2. The types of Covered Dental Care Services provided;
3. An itemization of administrative expenditures; and
4. Any other information deemed relevant by the Department.

10 CCR 2505-10 § 8.960 APPENDIX A: COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS COVERED SERVICES AND PROCEDURE CODES

Capitalized terms within this appendix shall have the meaning specified in the Definitions section.

Procedure Description	**Alpha-numeric Code**	**Max Allowable Fee**	**Program Payment**	**Max Client Co-Pay**	**PROGRAM GUIDELINES**
Periodic oral evaluation - established client	D0120	$46.00	$46.00	$0.00	Evaluation performed on a client of record to determine any changes in the client's dental and medical health status since a previous comprehensive or periodic evaluation. This may include an oral cancer evaluation and periodontal evaluation, diagnosis, treatment planning. Frequency: One time per 6 month period per client.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Limited oral evaluation - problem focused	D0140	$62.00	$52.00	$10.00	Evaluation limited to a specific oral health problem or complaint. This code must be used in association with a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. Cannot be used for adjustments made to prosthesis provided within previous 6 months. Cannot be used as an encounter fee.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established client	D0150	$81.00	$81.00	$0.00	Evaluation used by general dentist or a specialist when evaluating a client comprehensively. Applicable to new clients; established clients with significant health changes or other unusual circumstances; or established clients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the client's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0180.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive periodontal evaluation - new or established client	D0180	$88.00	$88.00	$0.00	Evaluation for clients presenting signs & symptoms of periodontal disease & clients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the client's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0150.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - complete series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, usually consisting of 14-22 periapical & posterior bitewing images intended to display the crowns & roots of all teeth, periapical areas of alveolar bone. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall not be billed as a D0210. Payment for additional periapical radiographs within 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - periapical first radiographic image	D0220	$25.00	$25.00	$0.00	D0220 one (1) per day per client. Report additional radiographs as D0230. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 must be utilized for additional films taken beyond D0220. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Bitewing - single radiographic image	D0270	$26.00	$26.00	$0.00	Frequency: 1 in a 12 month period. Report more than 1 radiographic image as: D0272 two (2); D0273 three (3); D0274 four (4). Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - two radiographic images	D0272	$42.00	$42.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	$52.00	$52.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Bitewings - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, or D0274 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Panoramic radiographic image	D0330	$63.00	$63.00	$0.00	Frequency: 1 per 5 years per client. Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	$88.00	$88.00	$0.00	Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Frequency: • 1 time per 6 calendar months; 2 week window accepted. • May be billed for routine prophylaxis. • D1110 may be billed with D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Topical application of fluoride varnish	D1206	$52.00	$52.00	$0.00	Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Cannot be used with D1208.
Topical application of fluoride - excluding varnish	D1208	$52.00	$52.00	$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction with prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Amalgam - one surface, primary or permanent	D2140	$107.00	$97.00	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Amalgam - two surfaces, primary or permanent	D2150	$138.00	$128.00	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - three surfaces, primary or permanent	D2160	$167.00	$157.00	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	$203.00	$193.00	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, anterior	D2330	$115.00	$105.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	$212.00	$202.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - porcelain/ceramic	D2740	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to high noble metal	D2750	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - porcelain fused to predominantly base metal	D2751	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	$780.00	$730.00	$50.00	Only one the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - 3/4 cast predominantly base metal	D2781	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast noble metal	D2782	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - 3/4 porcelain/ceramic	D2783	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast high noble metal	D2790	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - full cast predominantly base metal	D2791	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast noble metal	D2792	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - titanium	D2794	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Not payable on the same tooth and same day as D2951.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Pin retention per tooth	D2951	$50.00	$40.00	$10.00	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.
Cast post and core in addition to crown	D2952	$332.00	$307.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Prefabricated post and core in addition to crown	D2954	$269.00	$244.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Core is built around a prefabricated post. This procedure includes the core material and refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar tooth (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	$177.00	$167.00	$10.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. D4341 and D1110 can be reported on same service date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Diagnosis and classification of the periodontology case type must be in accordance with documentation as currently established by the American Academy of Periodontology. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	$128.00	$128.00	$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. D4342 and D1110 can be reported on same service date when date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. • Any follow-up and re-

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	D4355	$80.06	$70.06	$10.00	One of (D4335) per 3 year(s) per patient. Prophylaxis D1110 is not reimbursable when provided on the same day of service as D4355. D4355 is not reimbursable if patient record indicates D1110 or D4910 have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as D4355.
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy D4341 or D4342. This procedure includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. Frequency: • Up to four times per fiscal year per client. • Cannot be charged within the first three months following active periodontal treatment.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	$793.00	$713.00	$80.00	Reimbursement made upon delivery of a complete maxillary denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	$793.00	$713.00	$80.00	Reimbursement made upon delivery of a complete mandibular denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	$793.00	$713.00	$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	$793.00	$713.00	$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	D5211	$700.00	$640.00	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5211 and D5212 are considered definitive treatments. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin maxillary per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	D5212	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5211 and D5212 are considered definitive treatment. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin mandibular per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	$509.00	$449.00	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	$509.00	$449.00	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5223	$778.00	$718.00	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5223 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	$778.00	$718.00	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5224 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Repair broken complete denture base, mandibular	D5511	$87.00	$77.00	$10.00	Repair broken complete denture base, mandibular
Repair broken complete denture base, maxillary	D5512	$87.00	$77.00	$10.00	Repair broken complete denture base, maxillary
Replace missing or broken teeth - complete denture (each tooth)	D5520	$73.00	$63.00	$10.00	Replacement/repair of missing or broken teeth.
Repair resin partial denture base, mandibular	D5611	$95.00	$85.00	$10.00	Repair resin partial denture base, mandibular
Repair resin partial denture base, maxillary	D5612	$95.00	$85.00	$10.00	Repair resin partial denture base, maxillary
Repair cast partial framework, mandibular	D5621	$87.00	$77.00	$10.00	Repair cast partial framework, mandibular
Repair cast partial framework, maxillary	D5622	$87.00	$77.00	$10.00	Repair cast partial framework, maxillary
Repair or replace broken clasp	D5630	$123.00	$113.00	$10.00	Repair of broken clasp on partial denture base – per tooth.
Replace broken teeth-per tooth	D5640	$80.00	$70.00	$10.00	Repair/replacement of missing tooth.
Add tooth to existing partial denture	D5650	$109.00	$99.00	$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months.
Add clasp to existing partial denture	D5660	$131.00	$121.00	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Rebase complete maxillary denture	D5710	$322.00	$297.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	$322.00	$297.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase maxillary partial denture	D5720	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Rebase mandibular partial denture	D5721	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Reline complete maxillary denture (chairside)	D5730	$182.00	$172.00	$10.00	Chair side reline that resurfaces without processing denture base. Frequency: One (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside)	D5731	$182.00	$172.00	$10.00	Chair side reline that resurfaces without processing denture base. Frequency: One (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline maxillary partial denture (chairside)	D5740	$167.00	$157.00	$10.00	Chair side reline that resurfaces without processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside)	D5741	$167.00	$157.00	$10.00	Chair side reline that resurfaces without processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete maxillary denture (laboratory)	D5750	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with processing denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline complete mandibular denture (laboratory)	D5751	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with processing denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	$82.00	$72.00	$10.00	Routine removal of tooth structure, including minor smoothing of socket bone, and closure as necessary. Treatment notes must include documentation that an extraction was done per tooth.
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$135.00	$125.00	$10.00	Includes removal of bone, and/or sectioning of erupted tooth, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.
Removal of impacted tooth-soft tissue	D7220	$178.40	$158.40	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32 One of D7220 per 1 lifetime per patient per tooth
Removal of impacted tooth-partially bony	D7230	$224.39	$204.39	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7230 per 1 lifetime per patient per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of impacted tooth-completely bony	D7240	$263.31	$243.31	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$351.75	$331.75	$20.00	Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Teeth 1-32 One of D7241 per lifetime per patient per tooth.
Surgical removal of residual tooth roots (cutting procedure)	D7250	$143.00	$133.00	$10.00	Includes removal of bone, and/or sectioning of residual tooth roots, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth. Can only be charged once per tooth. Cannot be charged for removal of broken off roots for recently extracted tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Incisional biopsy of oral tissue-soft	D7286	$381.00	$381.00	$0.00	Removing tissue for histologic evaluation. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$138.00	$128.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$150.00	$140.00	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	$138.00	$128.00	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Removal of torus palatinus	D7472	$308.00	$298.00	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Removal of torus mandibularis	D7473	$300.00	$290.00	$10.00	To remove a malformation of bone for proper prosthesis fabrication.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins.
Palliative (emergency) treatment of dental pain - minor procedure	D9110	$61.00	$36.00	$25.00	Emergency treatment to alleviate pain/discomfort. This code cannot be used for filing claims or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.
Evaluation for deep sedation or general anesthesia	D9219	$38.96	$38.96	$0.00	One of D9219 or D9310 per 12 month(s) per provider or location
Deep sedation/general anesthesia-each 15 minute increment	D9223	$88.99	$78.99	$10.00	Ten of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$88.99	$78.99	$10.00	Fourteen of D9243 per 1 day per patient. Not allowed with D9223

EXPLANATION OF RESTORATIONS		
Location	Number of Surfaces	Characteristics
Anterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Incisal, Lingual, or Labial.
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial–Lingual.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual–Mesial–Labial.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Incisal-Lingual-Labial.
Posterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Occlusal, Lingual, or Buccal.
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Occlusal.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Occlusal-Distal.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Occlusal-Lingual-Distal.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
Rule Number: MSB 18-01-30-B
Division / Contact / Phone: Payment Reform / Erin Johnson / x4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Health Care Policy and Financing / Medical Services Board
2. MSB 18-01-30-B, Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
3. This action is an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):
   Sections(s) Section 8.700, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. No Does this action involve any temporary or emergency rule(s)?
   If yes, state effective date:
   Yes Is rule to be made permanent? (If yes, please attach notice of hearing).

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700 with the proposed text beginning at 8.700.1 through the end of 8.700.8.B. This rule is effective June 30, 2018.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
Rule Number: MSB 18-01-30-B
Division / Contact / Phone: Payment Reform / Erin Johnson / x4370

STATEMENT OF BASIS AND PURPOSE

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

This rule revision contains multiple changes to current FQHC rules, including: adding new billable behavioral health provider types; revising outstationing payment to FQHCs; changing the current Alternative Payment Methodology (APM) to reimburse different cost-based rates for physical health, dental, and specialty behavioral health services; and adding a quality component to FQHC rates that will be effective July 1, 2020. This rule change is necessary to account for several changes occurring for ACC 2.0. This rule change is also necessary to change the FQHC payment methodology. The Department has been working on this payment reform activity for FQHCs for over two years.

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:

Federal authority for the Rule, if any:

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

State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2017);

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Title of Rule: Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
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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 293,503 Medicaid members that receive medical services at Federally Qualified Health Centers.

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 $166,604,324.16 or approximately $567.64 per member. The rule change is intended to be budget neutral as the Department is modifying the single encounter rate to three separate encounter rates. Expenditures will increase for certain services and decrease for other services, however, the total cost per visit will remain the same.

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. The addition of eligible behavioral health providers is a change in policy that primarily codifies already existing practices, therefore there will be no additional reimbursable visits. The change in policy regarding the separate rates for separate services will cause rates for specific services to increase or decrease depending on the individual health center's allocation of costs - however, the total costs per visit will remain the same. The quality component that puts a portion of the FQHC APM rates at-risk will potentially decrease FQHC rates, however, the budget impact will not occur until 2020.

Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.
Through this rule revision, the Department is making many policy changes that impact FQHCs. However, the intention of each policy change is to incentivize quality over volume and give FQHCs more flexibility in delivering care. If the Department does not make these changes, the current incentive structure would remain in place.

Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.
It would be less intrusive to not make these changes, however, current policy reimburses FQHCs an all-inclusive encounter rate that does not take into account

the specific service rendered. The new policy for separate rates will incentivize MCEs to contract with FQHCs as they will reimburse FQHCs at a service specific rate. The quality component will create an incentive structure that allows FQHCs to prove their quality and for the Department to hold FQHCs accountable for the quality of service they provide.

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 maintaining the current all-inclusive encounter rate instead of creating three separate rates for separate services. However, this idea was rejected as it would lead to inconsistencies in payment across the Department's FQHC APMs and decreases MCE willingness to contract with FQHCs.

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, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor 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, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor 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 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, licensed marriage and family therapist, licensed professional counselor and licensed addiction counselor 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, licensed marriage and family therapist, licensed professional counselor or licensed addiction counselor..

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;~~

2~~3~~. Costs associated with clinics or cost centers which do not provide services to Medicaid clients; and,

4~~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~~separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. A~~n~~ 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~~ physical health encounter, dental encounter, or ~~mental~~ specialty behavioral 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.~~ Distinct dental encounters are allowable only when rendered services are covered and paid by the Department's dental Administrative Service Organization (ASO). Distinct specialty behavioral health encounters are allowable only when rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy. ~~Duplicate encounters of the same service category occurring on the same day and at the same location are prohibited.~~

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. Dental services provided in an outpatient hospital setting shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

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

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

7. 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 A ~~medical~~ physical health encounter, a dental encounter, and a ~~mental~~ specialty behavioral 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 Encounter rates calculations

a) Effective July 1, 2018, FQHCs will be paid three separate encounter rates for three separate services: physical health services, dental services, and specialty behavioral health services. Physical health services are covered services reimbursed through the Department's MMIS, except the short-term behavioral health services in the primary care setting policy. Dental services are services provided by a dentist or dental hygienist that are reimbursed by the Department's dental ASO. Specialty behavioral health services are behavioral health services covered and reimbursed by either the RAE or by the MMIS through the short-term behavioral health services in the primary care setting policy. The Department will perform an annual reconciliation to ensure each FQHC has been paid at least their per visit Prospective Payment System (PPS) rate. If a FQHC has been paid below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.~~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~~ Each alternative payment rate shall be the lower of the service specific~~-~~ annual rate or the service specific 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.~~The annual rate for the physical health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for physical health services and visits. The annual rate for the dental rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for dental services and visits provided by a dentist or dental hygienist. The annual rate for the specialty behavioral health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for behavioral health services and visits either covered and reimbursed by the RAE or by the short-term behavioral health services in the primary care setting policy.

2. The new base rates shall be the audited, calculated, inflated, and weighted average encounter rate for each separate rate~~, after audit~~, for the past three years. Base rates are recalculated (rebased) annually. ~~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.~~ Initial Base rates shall be calculated when the Department has two year's data of costs and visits.~~recalculated (rebased) every three years.~~

3. Beginning July 1, 2020, A portion of the FQHCs physical health and specialty behavioral health alternative payment methodology rates are at-risk based on the FQHC's quality modifier. A FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year.

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 rates for the first year. The base rates shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. These~~is~~ shall be the FQHCs base rates until the ~~next rebasing period~~FQHC's final base rates are set.

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.

44. 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 and hospital-based 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. An extension of up to 75 days may be granted based upon circumstances. 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 encounter rates for ~~freestanding~~ FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement encounter rates (if less than the new audited rate) shall remain in effect for an additional day above the ~~120-day~~120-day limit for each day the required information is late; if the old reimbursement encounter rates are~~is~~ more than the new rate, the new rates 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~~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.D~~C~~.5~~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.DC~~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.D~~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.D~~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.

66. 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 The Department shall notify the FQHC of its rates.

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. Beginning with the 2019 Cost Report Cycle, Tthis outstationing payment shall be made based upon actual cost and is included as an allowable cost in a FQHC cost report. ~~with a reasonable cost per application limit to be estimated 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 payments for FQHCs exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities.~~

8.700.8.BA~~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 THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Adding the Reasonable Compatibility Methodology to Non-MAGI Verification Requirements. Section 8.100.5.B.1.c
Rule Number: MSB 18-02-12-A
Division / Contact / Phone: Eligibility / Eric Stricca / 303-866-4475

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency: Department of Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-02-12-A, Revision to the Medical Assistance Rule Concerning Adding the Reasonable Compatibility Methodology to Non-MAGI Verification Requirements. Section 8.100.5.B.1.c
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) 8.100.5.B.1.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)? No
   If yes, state effective date:
6. Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.5.B.1 with the proposed text beginning at 8.100.5.B.1 through the end of 8.100.5.B.1. This rule is effective June 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Adding the Reasonable Compatibility Methodology to Non-MAGI Verification Requirements. Section 8.100.5.B.1.c
Rule Number: MSB 18-02-12-A
Division / Contact / Phone: Eligibility / Eric Stricca / 303-866-4475

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 update is to further align Non-MAGI and MAGI eligibility verification policy by applying the Reasonable Compatibility to the Non-MAGI groups. The Reasonable Compatibility Methodology is an allowable difference between the income that a person self-attests and what is reported through an electronic data source. The Colorado Department of Labor and Employment (CDLE) income record is the electronic data source and is already being used to verify the income for Non-MAGI eligibility. Adding Reasonable Compatibility to the Non-MAGI groups will align the records that are being used for the MAGI and non-MAGI eligibility determination.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 435.952

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-4-205 C.R.S. (2016)

Initial Review **04/13/18** Final Adoption **05/11/18**
Proposed Effective Date **06/30/18** Emergency Adoption

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Adding the Reasonable Compatibility Methodology to Non-MAGI Verification Requirements. Section 8.100.5.B.1.c
Rule Number: MSB 18-02-12-A
Division / Contact / Phone: Eligibility / Eric Stricca / 303-866-4475

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 persons in the Non-MAGI categories will benefit from the proposed rule. Earned income can already be self-attested by these individuals since this can be verified through the IEVS earned income electronic data source.

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

   By applying reasonable compatibility to these groups, it will reduce the amount of physical verifications required. This will help with streamlining the eligibility determination and ease the burden on county staff when reviewing CDLE records for Reasonable Compatibility for MA purposes.

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.

   In order to implement this rule there will be costs from the associated change to the CBMS eligibility system. However, since the rule does not change any of the core eligibility income standards, an increase of Medicaid eligible individuals is not anticipated.

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

   By applying reasonable compatibility to these groups, the benefit will be the reduction of the amount of physical verifications required which will help with streamlining the eligibility determination and ease the burden on county staff when reviewing CDLE records for Reasonable Compatibility for MA purposes. Inaction will continue to place burden of submitting physical verifications on members.

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

There are not less costly or less intrusive methods for achieving the purpose of the proposed rule.

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 not alternative methods to achieve the purpose of the proposed rule.

8.100.5.B. Verification Requirements

1. The particular circumstances of an applicant will dictate the appropriate documentation needed for a complete application. The following items shall be verified for individuals applying for Medical Assistance:

   a. A Social Security Number shall be provided for each individual on the application for whom Medical Assistance is being requested, or proof shall be submitted that an application for a Social Security Number has been made. Members of religious groups whose faith will not permit them to obtain Social Security Numbers shall be exempt from providing a Social Security Number.

   b. Verification of citizenship and identity as outlined in the section 8.100.3.H under Citizenship and Identity Documentation Requirements.

   c. Earned income may be self-declared by an individual and verified by the Income and Eligibility Verification System (IEVS). Individuals who provide self-declaration of earned income must also provide a Social Security Number for wage verification purposes. If a discrepancy occurs between self-declared income and IEVS wage data reports, IEVS wage data will be used to determine eligibility. An individual may dispute IEVS wage data by submitting all wage verification for all months in which there is a wage discrepancy.

      When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see section 8.100.3.H.9.

      Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

      i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

      ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 10%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

      iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall be determined ineligible due to income.

      If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy shall be requested. If the applicant is unable to provide a reasonable explanation, paper documentation shall be requested.

i) The Department may request paper documentation only if the Department does not find income to be reasonably compatible and if the applicant does not provide a reasonable explanation or if electronic data are not available.

If the applicant is self-employed, ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable. The ledger included in the Medical Assistance application is sufficient verification of earnings, unless questionable. If an individual cannot provide verification through self-declaration, income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

As of CBMS implementation, estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call shall also be acceptable verification of earned income. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Long-Term Care Institution Recipient Income - Other Deductions Reserved from the Recipient's Income Section 8.100.7.V.3.g.ii)
Rule Number: MSB 18-02-12-B
Division / Contact / Phone: Eligibility Policy / Eric Stricca / 303-866-4475

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency / Board: Department of Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-02-12-B, Revision to the Medical Assistance Rule concerning Long-Term Care Institution Recipient Income - Other Deductions Reserved from the Recipient's Income Section 8.100.7.V.3.g.ii)
3. This action is an adoption of:
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):
   Sections(s) 8.100.7.V.3.g.ii, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. No Does this action involve any temporary or emergency rule(s)?
   If yes, state effective date:
   <Select One> Is rule to be made permanent? (If yes, please attach notice of hearing).

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.7.V.3 with the proposed text beginning at 8.100.7.V.3 through the end of 8.100.7.V.3. This rule is effective June 30,2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Long-Term Care Institution Recipient Income - Other Deductions Reserved from the Recipient's Income Section 8.100.7.V.3.g.ii)
Rule Number: MSB 18-02-12-B
Division / Contact / Phone: Eligibility Policy / Eric Stricca / 303-866-4475

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 changing the rule at 10 CCR 2505-10 § 8.100.7.V.3.g.ii is to increase Home Maintenance Allowance (HMA) which is an adjustment to patient liability for Medicaid recipients in a nursing facility. The intent of this allowance is to provide individuals with no family in the home, to maintain their home during temporary nursing facility stays. The benefit is limited to 6 months and requires a physician statement documenting return to the community is reasonable within 6 months. By increasing this allowance for maintaining the home, it eases and accelerates the transition back to community placement. The philosophy is in line with The Departments focus on maintaining home based placement whenever possible.

   The rule changes the methodology that establishes the HMA. Currently, it is set as being no more than the Shelter and Utilities component of the Old Age Pension assistance amount. The new methodology aligns the HMA with rules that allow for a spouse who remains in the community from becoming impoverished when the other spouse becomes institutionalized in a nursing facility. The MMMNA is based on the 150% Federal Poverty Limit (FPL) for a household of 2; the new HMA methodology is adjusted and calculated on the FPL for a household of 1. This also allows for the HMA to adjust for cost of living since the MMMNA is adjusted yearly.

   Although there is an increase in the HMA, the change is expected to be budget neutral due to speedier placement back in the community and avoiding short-term stays from unnecessarily becoming long-term stays due to the loss of a community residence and the increasing cost of finding a replacement.

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:

Initial Review **04/13/18** Final Adoption **05/11/18**
Proposed Effective Date **06/30/18** Emergency Adoption

DOCUMENT #09

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3. Federal authority for the Rule, if any:

   42 CFR 435.725

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Long-Term Care Institution Recipient Income - Other Deductions Reserved from the Recipient's Income Section 8.100.7.V.3.g.ii)
Rule Number: MSB 18-02-12-B
Division / Contact / Phone: Eligibility Policy / Eric Stricca / 303-866-4475

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 classes of persons who will be affected by the proposed rule are individuals who are admitted to a nursing facility for a stay of 6 months or less who do not have family remaining in the home.

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

   Increasing the Home Maintenance Allowance will impact individuals in short-term nursing facility stays of 6 months or less by increasing their ability to maintain and retain a residence in the community. This will ease and accelerate the transition back to community placement.

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.

   Although there is an increase in the Home Maintenance Allowance, the change is expected to be budget neutral due to speedier placement back in the community and avoiding longer term costs of institutional placements that result from the loss of a community residence.

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

   Over time, inaction will cause more short-term institutional stays to unnecessarily become long-term stays due to the loss of a community residence and the increasing cost of finding a replacement.

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

   There are not less costly or less intrusive options that were identified.

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

   There were not any alternative methods identified to achieve the purpose of this rule.

8.100.7.V. Long-Term Care Institution Recipient Income

3. Calculation of Patient Payment

g. Other Deductions Reserved from Recipient's Income:

i) In the case of a married, long-term care recipient who is institutionalized in a Long-Term Care institution and who has a spouse (and, in some cases, other dependent family members) living in the community, there are “spousal protection” rules which permit the contribution of the institutionalized spouse's income toward their living expenses. See section 8.100.7.K.

ii) For a Long-Term Care institution recipient with no family at home, an amount in addition to the personal needs allowance may be reserved for maintenance of the recipient's home for a temporary period, not to exceed 6 months, if a physician has certified that the person is likely to return to his/her home within that period.

This additional reserve from recipient income is referred to as Home Maintenance Allowance and the amount of the deduction must be based on actual and verified shelter expenses such as mortgage payments, taxes, utilities to prevent freeze, etc.

The Home Maintenance Allowance:

1) Prior to July 1, 2018 shall not exceed the total of the current shelter and utilities components of the applicable standard of assistance (OAP for aged recipients; AND/SSI-CS or AB/SSI-CS for disabled or blind recipients).

2) Beginning July 1, 2018

a) The Home Maintenance Allowance shall not exceed the Home Maintenance Allowance Maximum described in this section.

Claimable utility costs will be limited to the lessor of the following amounts:

The standard utility allowance used by Colorado under 7 U.S.C. 2014(e) (2018), which is hereby incorporated by reference.

The incorporation of 7 U.S.C. 2014(e) (2018) excludes later amendments to, or editions of, the referenced material. 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.

Or;

The individual’s actual, verified, utility expenses.

b) The Maximum Home Maintenance Allowance is The Individual Needs Standard minus 105% Federal Poverty Limit (FPL) for a household of 1, rounded to the nearest whole dollar, and is determined as follows:

(1) The Department will calculate the Individual Needs Standard by dividing the Federal Minimum Monthly Maintenance Needs Allowance maximum by the Federal Minimum Monthly Maintenance Needs Allowance (MMMNA), described at 8.100.7.Q, which is in place on January 1st of each calendar year. The result of this division will be multiplied by 150% of FPL for a household of 1.

(2) The Home Maintenance Maximum is determined by subtracting 150% FPL for a household of 1 from the Individual Needs Standard and adding 30% of 150% FPL for a household of 1. The result will be rounded to the nearest whole dollar. ~~In regard to this additional reserve from recipient income for home maintenance, the amount of the deduction:~~

~~1) must be based on actual expenses such as mortgage payments, taxes, utilities to prevent freeze, etc.;~~

~~2) may not exceed the total of the current shelter and utilities components of the applicable standard of assistance (OAP for aged recipients; AND/SSI-CS or AB/SSI-CS for disabled or blind recipients).~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Update to the 340B Drug Discount in EAPGs and EAPG Rate Maintenance Methodology, Section 8.300.6
Rule Number: MSB 18-02-12-D
Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency / Board: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-02-12-D, Revision to the Medical Assistance Rule concerning Update to the 340B Drug Discount in EAPGs and EAPG Rate Maintenance Methodology, Section 8.300.6
3. This action is an adoption of an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):
   Sections(s) 8.300.6, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.6.A wit the proposed text beginning at 8.300.6.A through the end of 8.300.6.A. This rule is effective June 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Update to the 340B Drug Discount in EAPGs and EAPG Rate Maintenance Methodology, Section 8.300.6
Rule Number: MSB 18-02-12-D
Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

STATEMENT OF BASIS AND PURPOSE

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

   Rule MSB 18-02-12-D increases payment to hospitals participating in the 340B Drug Discount Program by reducing the discount applied during the EAPG pricing calculation for 340B Drugs for outpatient hospital claims. Currently, the discount for 340B Drugs is set to 50%, which reduces the payment for 340B drugs to 50% of the payment for similar, non-340B drugs. The proposed rule update reduces the discount percent to 20%, meaning that providers will have their payment increased for 340B drugs when provided to Medicaid beneficiaries. This proposed rule change will also add non-specific language to the EAPG rate setting methodology, which will allow the Department to more easily implement rate updates as required through budget appropriations, which will alleviate operational stresses for the Department, its fiscal agent, and its hospital providers. The proposed changes will be effective July 1, 2018.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   § 24-4-103(6); §25.5-4-402.4(5)(b)(I).

Initial Review — Final Adoption **05/11/18**
Proposed Effective Date **06/30/18** — Emergency Adoption

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Update to the 340B Drug Discount in EAPGs and EAPG Rate Maintenance Methodology, Section 8.300.6
Rule Number: MSB 18-02-12-D
Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

REGULATORY ANALYSIS

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

   Hospitals participating in the 340B Drug Discount Program will receive increased reimbursement for providing 340B drugs to Medicaid patients. The Department will bear the costs of 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.

   Increasing reimbursement for 340B drugs will have an increase of $23,092,155 in annualized payments to its providers for 340B drugs. Updating the rate methodology will reduce the work for the Department in seeking various authorities to perform periodic rate updates as established through budget appropriations by the General Assembly.

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 adjustment to the rule will have a probable increase of $23,092,155 in annualized payments to its providers of 340B drugs in the outpatient hospital setting.

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

   Inaction would preserve the state forecasted expenditure outlined above, but this would have the consequence of reducing access to care to Outpatient Hospital Services for Medicaid patients, as hospitals are currently being reimbursed substantially below cost of these drugs. The benefits of this rule are that it better aligns 340B drug reimbursement with actual hospital cost and would allow the Department to adjust EAPG base rates annually.

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

The Department determined that this was the least costly and least intrusive method for achieving the purpose of the proposed rule. Through various analyses the Department determined that a change to a 20% reduction in payment for 340B drugs is most closely in alignment with hospital provider cost experience and intended payment policy.

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 is considering alternatives in payment structures for drugs provided in the outpatient hospital setting, but is in the process of working with its stakeholders to determine an optimal methodology. The proposed rule change is less intrusive than a shift in reimbursement methodology as it relies on the existing EAPG payment methodology and requires minimal updates to existing authorities. Additionally, the prospective nature of the EAPG payment system allows the Department to more easily forecast outpatient hospital expenditures.

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

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

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

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

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

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

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

adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

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

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

Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital Services shall be referred to as the EAPG Payment.

a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10, Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.

b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.

c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:

    (1) Per Diem

    (2) Significant Procedure. Subtypes of Significant Procedures Are:

        (a) General Significant Procedures

        (b) Physical Therapy and Rehabilitation

        (c) Mental Health and Counseling

        (d) Dental Procedure

        (e) Radiologic Procedure

(f) Diagnostic Significant Procedure

(3) Medical Visit

(4) Ancillary

(5) Incidental

(6) Drug

(7) Durable Medical Equipment

(8) Unassigned

d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.

e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are of subtypes Physical Therapy and Rehabilitation and Radiologic Significant Procedure do not cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.

f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.

g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.

i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

j. Details describing 340B Drugs will have an EAPG Payment calculated using ~~50~~ 80 percent (~~50~~80%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

k. The Hospital-specific Medicaid Outpatient base rate for the year of the methodology implementation for each hospital is calculated using the following method.

(1) Assign each hospital to one of the following peer groups based on hospital type and location:

(a) Pediatric Hospitals

(b) Urban Hospitals

(c) Rural Hospitals

(2) Process Medicaid outpatient hospital claims from state fiscal year 2015, known as the Base Year, through the methodology described in 8.300.6.A.1.a-j using Colorado's EAPG Relative Weights. For lines with incomplete data, estimations of EAPG Adjusted Weights will be used.

(3) Calculate costs from hospital charge data using the computation of the ratio of costs to charges from the CMS-2552-10 Cost Report. After the application of inflation factors to account for the difference in cost and caseload from state fiscal year 2015 to the implementation period, costs and EAPG Adjusted Weights are aggregated by peer group and are used to form peer group base rates. Each hospital is assigned the peer group base rate depending on their respective peer group assigned in 8.300.6.A.1.k.(1).

(4) For each hospital, calculate the projected EAPG payment by multiplying its peer group base rate by its hospital-specific EAPG Adjusted Weights as calculated in 8.300.6.A.1.k.(2). If the projected payment exceeds a +/- 10% difference in payment from the prior outpatient hospital reimbursement methodology, the hospital will receive an adjustment to their base rate to cap its resulting gains or losses in projected EAPG payments to 10%.

(5) ~~Effective July 1, 2017, hospitals will receive a 1.4% increase to the rate calculated in sections 8.300.6.A.1.k.(1)-(4).~~For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(4), shall be adjusted by an equal percentage, when required due to changes in the available funds appropriated by the General Assembly. The application of this change to the Medicaid Outpatient base rate shall be determined by the Department.

2. Payments to Out-of-Network DRG Hospitals

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

Effective October 31, 2016, Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based the system of Enhanced Ambulatory Patient Grouping described in 10 CCR 2505-10 Section 8.300.6.A.1. Such hospitals will be assigned to a Rural or Urban peer group depending on hospital location and will receive a base rate of 90% of the respective peer group base rate as calculated in 8.300.6.A.1.k.(3). Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in 8.300.6.A.k.(5),

~~Effective July 1, 2017, Out-of-Network DRG Hospitals will have their rates increased by 1.4% from their rates effective October 31, 2016.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Stiripentol Coverage, Section 8.800.4.C.5.a
Rule Number: MSB 18-02-16-A
Division / Contact / Phone: Client and Clinical Care Office- Pharmacy / Kristina Gould / 303-866-6715

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency / Board: Department of Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-02-16-A, Revision to the Medical Assistance Rule concerning Stiripentol Coverage, Section 8.800.4.C.5.a
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) 8.800.4.C.5.a, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.800.4 with the proposed text beginning at 8.800.4.A through the end of 8.800.4.G. This rule is effective June 30, 2018.

*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 expand coverage of Stiripentol, a drug used to treat Dravet Syndrome, a rare genetic dysfunction of the brain that results in seizures, to members over 20 years of age. The drug is covered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria for members up to 20 years of age. The rule will extend coverage of Stiripentol for members past the age of 20. Clobazam has been deleted because it is a covered FDA approved drug and does not need to be addressed in this section of rule.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. § 1396d(a)(12); 42 CFR § 440.120, 42 CFR § 447.502.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   C.R.S. § 25.5-5-201(1)(a)(2017).

Initial Review — Final Adoption **05/11/18**
Proposed Effective Date **06/30/18** — Emergency Adoption

DOCUMENT #08

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REGULATORY ANALYSIS

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

   The Department covers Stiripentol for members under age 21 with Dravet Syndrome, a rare disease that causes frequent, severe seizures. The proposed rule benefits members over age 20 by expanding coverage of the drug to them. The costs of the proposed rule will be borne by the program.

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

   There will be no adverse quantitative or qualitative impacts to the Department's members, overall. Qualitatively and quantitatively, this will positively impact members over age 20 with Dravet Syndrome by providing coverage of the cost of the only treatment known to significantly reduce seizures and improve quality of life.

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 Dravet Syndrome is rare, and affects only a few members, the rule will result in a negligible increase in program costs. The annual, average cost to the program, per member, for Stiripentol is $9,158.13. No other agency is expected to be impacted by the rule.

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

   The cost of the proposed rule is negligible, at approximately $9,158.13 per year, with only a few members affected. The benefit derived from that cost is a significantly improved quality of life for members over age 20 who will continue to experience fewer seizures with the drug. The benefit of inaction would be that the program avoids a very small expense for coverage of the drug. The cost of inaction would be that members with Dravet Syndrome over age 20 will incur out-of-pocket

costs for the drug, or, if they cannot afford it, suffer a drastically poor quality of life, due to frequent seizures.

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

   As Stiripentol is the only drug known to effectively reduce seizures for members with Dravet Syndrome, and there is no other public benefit program offering coverage of the drug, there were no less costly or less intrusive options.

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.

   Stiripentol is the only drug known to effectively treat seizures associated with Dravet Syndrome. The program currently covers the cost of the drug for children under EPSDT criteria. For members over age 20, the proposed rule is the only method for making the drug available under the program.

8.800.4 DRUG BENEFITS

8.800.4.A. Only those drugs designated by companies participating in the federally approved Medical Assistance Program drug rebate program and not otherwise excluded according to these rules are regular drug benefits. Notwithstanding the foregoing, drugs not covered by rebate agreements may be reimbursed if the Department has made a determination that the availability of the drug is essential, such drug has been given an “A” rating by the U. S. Food and Drug Administration (FDA), and a prior authorization has been approved. Reimbursement of any drugs that are regular drug benefits may be restricted as set forth in these rules.

8.800.4.B. The following drug categories may be excluded from being a drug benefit or may be subject to restrictions:

1. Agents when used for anorexia, weight loss or weight gain;

2. Agents when used to promote fertility;

3. Agents when used for cosmetic purposes or hair growth;

4. Agents when used for symptomatic relief of cough and colds;

5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;

6. Non-prescription Drugs;

7. Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and

8. Agents used for the treatment of sexual or erectile dysfunction unless such agents are used to treat a condition, other than a sexual or erectile dysfunction, for which the agents have been approved by the FDA.

8.800.4.C. The following are not pharmacy benefits of the Medical Assistance Program:

1. Spirituous liquors of any kind;

2. Dietary needs or food supplements;

3. Personal care items such as mouth wash, deodorants, talcum powder, bath powder, soap of any kind, dentifrices, etc.;

4. Medical supplies;

5. Drugs classified by the FDA as "investigational" or "experimental”; except for the following:

   a. Stiripentol ~~and clobazam (prior to availability of Onfi in the US)~~ may ~~qualify for coverage (generic coverage, if available, brand coverage if no generic is available)~~ be covered if the ~~for clients up through age 20, if the~~ coverage has been ordered by the ~~child's~~ member's physician, has been ~~determined~~ deemed medically necessary by the Department ~~Colorado Medical Assistance Program Medical Director (or clinical appointee of the Executive Director),~~ and has been

authorized for the specific ~~child's~~ member's use by the U.S. Food & Drug Administration.

6. Less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program; and

7. Medicare Part D Drugs for Part D eligible individuals.

8.800.4.D. Aspirin, OTC insulin and medications that are available OTC and that have been designated as Preferred Drugs on the PDL are the only OTC drugs that are regular benefits without restrictions.

8.800.4.E. Restrictions may be placed on drugs in accordance with Title 42 of the United States Code, Section 1396r-8(d)(2014). Title 42 of the United States Code, Section 1396r-8(d)(2014) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(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.

1. Without limiting the foregoing, restrictions may be placed on drugs for which it has been deemed necessary to address instances of fraud or abuse, potential for, and history of, drug diversion and other illegal utilization, overutilization, other inappropriate utilization or the availability of more cost-effective comparable alternatives.

8.800.4.F. To the extent the drug categories listed in Section 8.800.4.B are not Medicare Part D Drugs, they shall be covered for Part D eligible individuals in the same manner as they are covered for all other eligible Medical Assistance Program members.

8.800.4.G. Generic drugs shall be dispensed to members in fee-for-service programs unless:

1. Only a brand name drug is manufactured.

2. A generic drug is not therapeutically equivalent to the brand name drug.

3. The final cost of the brand name drug is less expensive to the Department.

4. The drug is in one of the following exempted classes for the treatment of:

   a. Mental Illness;

   b. Cancer;

   c. Epilepsy; or

   d. Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.

5. The Department shall grant an exception to this requirement if:

a. The member has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand name drug would be unacceptably disruptive; or

b. The member is started on a generic drug but is unable to continue treatment on the generic drug.

Such exceptions shall be granted in accordance with procedures established by the Department.