DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Prospective Payments to Primary Care Medical Providers, Section 8.200
Rule Number: MSB 20-08-04-C
Division / Contact / Phone: Finance Office / Zoe Marchand / 303-866-6115

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 20-08-04-C, Revision to the Medical Assistance Rule concerning Prospective Payments to Primary Care Medical Providers, Section 8.200

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) OP Pages, 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*

Revise the current text at 8.200 with the proposed text beginning at 8.200.7 through the end of 8.200.7. This rule is effective June 30, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Prospective Payments to Primary Care Medical Providers, Section 8.200
Rule Number: MSB 20-08-04-C
Division / Contact / Phone: Finance Office / Zoe Marchand / 303-866-6115

STATEMENT OF BASIS AND PURPOSE

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

   The rule implements prospective payments to primary care medical providers who voluntarily elect to earn a portion of their revenue as prospective per member per month payments and the other portion as fee for service. The rule also allows them to participate in gainsharing to earn extra revenue. This rule is necessary to move the Department's goal of paying primary care medical providers based on value.

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Prospective Payments to Primary Care Medical Providers, Section 8.200
Rule Number: MSB 20-08-04-C
Division / Contact / Phone: Finance Office / Zoe Marchand / 303-866-6115

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.

   Primary care medical providers and Health First Colorado members will be affected. Primary care medical providers will bear the cost of transitioning to value based care and members will benefit from this transition. The goal is to reward primary care medical providers for being innovative and finding non-traditional ways to meet the needs of their patients.

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 goal of this rule is to financially incentivize primary care medical providers to prioritize value-based care over volume. If primary care medical providers do well in the program, they will be financially rewarded.

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 foresees this program being budget neutral so there will be no additional costs to the Department.

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

   The goal of this rule is to over time transition primary care medical providers away from traditional fee for service and into value-based care arrangements. The outcome will be higher quality care at a lower cost. The cost of inaction is Medicaid members may not have access to improved primary care.

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 methods or less intrusive methods for achieving the purpose of the proposed rule.

DO NOT PUBLISH THIS PAGE

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 has evaluated other value-based payment methods and determined that they are not adequate enough in achieving high quality care.

8.200 PHYSICIAN SERVICES

8.200.5 REIMBURSEMENT

8.200.5.A The amount of reimbursement for physician services is the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.

8.200.5.B Reimbursement for services may be made directly to Advanced Practice Nurses, registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed psychologists unless the non-physician practitioner is acting within the scope of his/her contract with a physician or public or private institution or employment as a salaried employee of a physician or public or private institution.

8.200.5.C Dental hygienists may be directly reimbursed for unsupervised dental hygiene services.

a. Hygienists employed by a dentist, clinic, or institution shall submit claims under the employer's provider identification number.

8.200.5.D The amount of reimbursement for Certified Family Planning Clinic services may be paid directly to the clinic and is the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department of Health Care Policy and Financing which may be a manual pricing.

8.200.5.E A provider shall not be reimbursed directly for services if the provider is acting as a contract agent or employee of a nursing home, hospital, Federally Qualified Health Center, Rural Health Center, clinic, home health agency, school, or physician.

8.200.5.F A provider shall not be reimbursed for services as a billing provider if the provider is a student in a graduate education program and the facility where the provider delivers services receives Graduate Medical Education payments pursuant to Colorado Revised Statutes Section 25.5-4-402.5 or 10 C.C.R. 2505-10, Sections 8.300.7.

8.200.6 INCREASED MEDICAL PAYMENTS TO PRIMARY CARE PHYSICIANS PROGRAM

The Increased Medical Payments to Primary Care Physicians Program provides reimbursement above the fee schedule to defined and attested primary care physicians for certain services provided in calendar years 2013 and 2014.

8.200.6.A Authority

This rule is made pursuant to title 42 of the Code of Federal Regulations, Section 438.6, Section 438.804, Part 441 Subpart L, and Part 447 Subpart G (2012).

8.200.6.B Definitions

1. Primary Care Physician means a medical doctor who attests to the Department that he or she has a primary specialty designation of family medicine, general internal medicine, or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties, or the American Osteopathic Association.

2. Personal Supervision means the physician accepts professional responsibility and legal liability for the services provided by the non-physician provider. Personal Supervision does not require physical presence at the location of the services.

8.200.6.C Attestation

1. A Primary Care Physician is required to self-identify, using the form available on the www.colorado.gov/hcpf, provider's web page, to a specialty designation of family medicine, general internal medicine or pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties, the American Board of Physician Specialties or the American Osteopathic Association. A physician must self-attest that he/she:

    a. Is Board certified with such a specialty or subspecialty; and/or

    b. Has furnished evaluation and management services and vaccine administration services under codes described in 8.200.6.E that equal at least 60 percent of the Medicaid codes he or she has billed during the most recently completed calendar year or, for newly eligible physicians, the prior month.

8.200.6.D Reimbursable Services

1. Primary care services with procedure codes listed in 8.200.6.E provided by a Primary Care Physician, as defined in 8.200.6.B.1, are eligible for increased reimbursement.

2. Primary care services with procedure codes listed in 8.200.6.E provided by a Physician Assistant or Advanced Nurse Practitioner under the personal supervision of a Primary Care Physician, as defined in 8.200.6.B.1, are eligible for increased reimbursement.

    a. For this program, when services by a non-physician provider are provided under the personal supervision of a physician, the physician may be identified as the rendering provider on claims.

8.200.6.E Procedure Codes

The procedure codes covered by the Colorado Medical Assistance program designated in the Healthcare Common Procedure Coding System (HCPCS) for increased reimbursement shall be 99201-99499 and Current Procedural Terminology (CPT) vaccine administration codes 90460, 90461, 90471, 90472, 90473, and 90474.

8.200.6.F Supplemental Payment Procedure

1. Supplemental payments to eligible providers are calculated in the manner defined in 42 C.F.R. part 447.405 and identified in the schedule of maximum payments published on the website of the Department of Health Care Policy and Financing. Title 42 of the Code

of Federal Regulations, Part 447.405 (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or additions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203.

2. Supplemental payments will be made on a quarterly basis.

3. The initial supplemental payment will be made after approval of the State Plan Amendment approving the increase.

8.200.6.G Audits

1. Eligible providers shall maintain all increased payment to primary care provider program-related records including documentation to support attestations.

2. Eligible providers shall permit the Department, the federal government, the Medicaid Fraud Control Unit and any other duly authorized agent of a governmental agency:

   a. To audit, inspect, examine, excerpt, copy and/or transcribe the records related to this incentive program, to assure compliance with the program requirements, Corrective Action Plans and attestations.

   b. To access the provider's premises, to inspect and monitor, at all reasonable times, the provider's compliance with program requirements, Corrective Action Plans and attestations. Monitoring includes, but is not limited to, internal evaluation procedures, examination of program data, special analyses, on-site checking, observation of employee procedures and use of electronic health information systems, formal audit examinations, or any other procedure.

3. Eligible providers shall cooperate with the State, the federal government, the Medicaid Fraud Control Unit and any other duly authorized agent of a governmental agency seeking to audit a provider's compliance with program requirements.

4. The Department may recoup by offset from any payment due to the provider any supplemental payment made to the provider for services rendered during the period that the provider did not meet the requirements for attestation in 8.200.6.C or does not have documentation supporting the required attestation. The Department may recoup by offset any improper or overpaid medical services paid to or on behalf of an eligible provider.

8.200.6.H Informal Reconsideration and Appeal

1. A provider may request an informal reconsideration of his or her exclusion from participation in the Increased Medical Payments to Primary Care Providers Program by submitting a written request within 30 days of date of notice that the provider is not eligible to participate in the program.

2. A provider may request an informal reconsideration of the supplemental payment amount by submitting a written request within 30 days of the receipt of the supplemental payment.

3. The Department shall respond to the request for informal reconsideration with a decision no later than 45 days after receipt of the request.

4. A provider dissatisfied with the Department's decision may appeal the informal reconsideration decision according to the procedures set forth in 10 C.C.R. 2505-10 Section 8.050.3 PROVIDER APPEALS.

8.200.7 Prospective Medical Payments to Primary Care Medical Providers

8.200.7.A Definitions

1. APM code set refers to a set of Evaluation and Management (E&M) codes that are defined by the Department and included on the Department's Primary Care Alternative Payment Model Fee Schedule (https://www.colorado.gov/pacific/hcpf/provider-rates-fee-schedule)

2. Gainsharing refers to upside only shared savings, where a participating PCMP can earn additional reimbursement for meeting metrics/thresholds that are defined by the Department.

3. Primary Care Medical Provider (PCMP) refers to an individual physician, advanced practice nurse or physician assistant, who participates in the Accountable Care Collaborative (ACC) as a Network Provider, with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

4. Prospective Payments refer to monthly payments made at the beginning of each month that are intended to cover primary care services for a PCMP's attributed members.

5. Reconciliation refers to a process established by the Department to correct under- or over-payment for services rendered in the APM code set.

8.200.7.B Eligibility for Participation

1. Primary Care Medical Providers (PCMPs) enrolled in the ACC.

2. PCMPs must exceed a mathematical standard which is determined by the Department's actuary and this standard will be communicated to interested participants before the program starts.

3. This payment methodology is voluntary and PCMPs must elect to participate. The Department will send a letter to confirm a PCMP's intent to join the program. The PCMP then has 10 business days from the date of receipt of the letter to confirm or deny participation.

8.200.7.C Prospective Per Member Per Month (PMPM) Payments

1. PCMPs will earn ~~quarterly~~monthly prospective payments for services in the APM code set

    a. The prospective PMPM payments will be PCMP specific.

    b. The PCMP will elect what percentage of their revenue for primary care services they will earn as a prospective PMPM payment.

        i. The amount of PMPM payment a PCMP will receive will be indicated in the letter sent by the Department to confirm participation in the program.

c. PCMPs will earn the rest of their revenue from reduced fee for service in the corresponding percentage for the APM code set.

i. The percentage reduction for the services included in the APM code set received, will be indicated in the letter sent by the Department to confirm participation in the program.

8.200.7.D Gainsharing

1. PCMPs will be eligible to earn extra revenue for participating in gainsharing.

a. Gainsharing thresholds will be specific to each PCMP.

b. The Department will publish thresholds for gainsharing that show the targets PCMPs must meet to be eligible to receive extra payments. Services that comprise the targets will also be published.

i. PCMPs will agree to the thresholds and services for gainsharing in the letter sent by the Department which confirms participation in the program.

2. The PCMP may contest the Department's determination of the gainsharing payments. PCMPs who contest the Department's determination must first submit in writing to the Department the reason for contesting the determination within 60 days of receiving the gainsharing payment. The Department will review all contested determinations within 30 calendar days of receipt of the notice and will respond to the PCMP with its final decision. If the PCMP does not agree with the Department's final decision, the PCMP has the right to file an appeal with the Office of Administrative Courts in accordance with Section 8.050.3.

8.200.7.E Reconciliation

1. A PCMP will be responsible for meeting quality minimums that are established and accepted by the PCMP in the letter sent by the Department which confirms participation in the program. The quality minimums must be met for a PCMP to earn their full prospective PMPM payments.

a. If the PCMP exceeds the quality minimums then they will not be subject to reconciliation.

b. If the PCMP does not meet quality minimums then the Department will reduce the PMPM payment to equal the corresponding amount which would have been earned had the PCMP been reimbursed the fee schedule payment.

2. Appeals Process for Prospective PMPM Payments

a. The PCMP may contest the Department's determination for reconciliation of prospective PMPM payments. PCMPs who contest the Department's determination must submit in writing to the Department the reason for contesting the determination within 60 days of receiving the notice of reconciliation of prospective PMPM payments. The Department will review all contested determinations within 30 calendar days of receipt of the notice and will respond to the PCMP with its final decision. If the PCMP does not agree with the Department's final decision, the PCMP has the right to file an appeal with the Office of Administrative Courts in accordance with Section 8.050.3.

8.200.7.F Withdrawal from Program Participation

1. A PCMP may choose to voluntarily withdraw from the program at any time so long as proper notification is given to the Department.

    a. A PCMP must give 30 days written notice to the Department to be withdrawn from the program. The PCMP will be withdrawn from the program on the first day of the month following the end of the 30 day notice period.

    b. If a PCMP chooses to voluntarily withdraw from the program before the end of the program year, the PMPM and gainsharing payments will be prorated to reflect months of participation in the program.

2. A PCMP may involuntarily be withdrawn from the program in the event the PCMP is terminated as a Medicaid provider and the PCMP will not be eligible to contest the determination. Involuntary withdrawal on this basis will be effective immediately. The Department will notify the PCMP in writing within 10 business days if this occurs.

3. The Department reserves the right to terminate the participation of a PCMP in the program at any time without cause. The Department will notify the PCMP of their termination in writing within 10 business days and the termination will become effective the first day of the month following 30 days of the notice. (Add not appealable)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Invasive Prenatal Testing Prior Authorization, Section 8.732
Rule Number: MSB 20-08-10-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 20-08-10-B, Revision to the Medical Assistance Act Rule concerning Non-Invasive Prenatal Testing Prior Authorization, Section 8.732

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) 8.732.4.E and 8.732.6.A, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? 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 8.732 with the proposed text beginning at 8.732.4.E through the end of 8.732.4.E. Replace the current text at 8.732.6.A with the proposed text beginning at 8.732.6.Athrough the end of 8.732.6.A. This rule is effective June 30, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Invasive Prenatal Testing Prior Authorization, Section 8.732
Rule Number: MSB 20-08-10-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   The Department currently requires prior authorization for most non-invasive prenatal testing (NIPT). The proposed revision updates Department rule to reflect prior authorization may be required for NIPT, which aligns with current Department policy.

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 440.130 (2021)

4. State Authority for the Rule:

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Invasive Prenatal Testing Prior Authorization, Section 8.732
Rule Number: MSB 20-08-10-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Clients eligible for non-invasive prenatal testing (NIPT), and the providers rendering NIPT, are affected by the proposed rule. Prior authorization is currently required for most NIPT, this rule revision updates the rule to align with Department policy.

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

   Under the proposed rule revision, all NIPT may require prior authorization. The majority of NIPT currently require prior authorization.

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 this revision aligns rule with current Department policy, there are no costs to the Department or to any other agency to implement and enforce the proposed rule. There is no anticipated effect on state revenues.

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

   This rule revision aligns with Department policy that NIPT may be prior authorized. The majority of NIPT currently require prior authorization. It is possible NIPT that do not currently require prior authorization may require it in the future, but that is not anticipated by the Department at this time.

   The benefit of the proposed rule is aligning Department rule with current Department policy. The cost of inaction is continued misalignment between Department policy and rule. There are no benefits of inaction.

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

There are no less costly methods of less intrusive methods for aligning Department rule with Department 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.

   There is no alternative method for aligning Department rule with Department policy.

8.732. MATERNITY SERVICES

8.732.4. COVERED SERVICES

8.732.4.E. Genetic Screening, including but not limited to Non-Invasive ~~Diagnostic~~ Prenatal Testing (NIPT), and Genetic Counseling are covered in accordance with nationally recognized standards of care. Screening coverage is available for women carrying a singleton gestation who meet one or more of the following conditions:

1. Maternal age 35 years or older at delivery;

2. Fetal ultrasonographic findings indicated an increased risk of aneuploidy;

3. History of a prior pregnancy with a trisomy;

4. Positive test result for aneuploidy, including first trimester, sequential, or integrated screen, or a quadruple screen; or

5. Parental balanced Robertsonian translocation with increased risk of fetal trisomy 13 or 21.

8.732.6. PRIOR AUTHORIZATION

8.732.6.A. Prior Authorization is not required for services under § 8.732, with the following exception:

1. Services under Section 8.732.4.E may require prior authorization.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the rule authorizing the annual adjustment schedule for Inpatient Hospital Base Rates, Section 8.300.5.A.3.e
Rule Number: MSB 21-01-21-B
Division / Contact / Phone: Rates Section / Diana Lambe / 303-866-5526

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-01-21-B**Error! Reference source not found.**, Revision to the rule authorizing the annual adjustment schedule for Inpatient Hospital Base Rates, Section 8.300.5.A.3.e

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) OP Pages, 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 8.300 with the proposed text beginning at 8.300.5.A.3.e through the end of 8.300.5.A.3.e. Replace the current text at 8.300.7 with the proposed text beginning at 8.300.7.A through the end of 8.700.3.B. This rule is effective June 30, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the rule authorizing the annual adjustment schedule for Inpatient Hospital Base Rates, Section 8.300.5.A.3.e
Rule Number: MSB 21-01-21-B
Division / Contact / Phone: Rates Section / Diana Lambe / 303-866-5526

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 rules authorizing the annual adjustment schedule for Inpatient Hospital Base Rates, 10 CCR 2505-10, Section 8.300.5.A.3.e will be modified to allow the rates to be updated using the State Budget Action as defined by the Legislature for State Fiscal Year 2021-22. Additionally, the rules authorizing how Graduate Medical Education (GME) Payments for Medicaid Managed Care are updated each year, 10 CCR 2505-10 Section 8.300.7.A.1 and Section 8.300.7.B.1 will be modified to follow the update schedule adopted in 10 CCR 2505-10 Section 8.300.5.A.3.e.

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

Initial Review **04/09/21** Final Adoption **05/14/21**
Proposed Effective Date **06/30/21** Emergency Adoption

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the rule authorizing the annual adjustment schedule for Inpatient Hospital Base Rates, Section 8.300.5.A.3.e
Rule Number: MSB 21-01-21-B
Division / Contact / Phone: Rates Section / Diana Lambe / 303-866-5526

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 receiving payments for fee for service inpatient hospital services will be affected by the proposed rule. This update will result in all hospital payment rates being equally adjusted depending on the State Budget Action impacting fee-for-service inpatient hospital payment rates.

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 magnitude of the costs or benefits of this rule update will be dependent on the State Budget Action established through Legislation for State Fiscal Year 2021-2022.

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

   There are no expected increases or decreases of Department revenues associated with this rule change.

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

   Inaction will result in the Department's need to re-allocate 4-6 months of necessary research, analysis, and stakeholder engagement away from the development of a new inpatient hospital base rate setting methodology effective July 1, 2022 towards maintaining the existing methodology for new rates effective July 1, 2021. The proposed rule will simplify the rate setting process for July 1, 2021 and will allow the Department to more effectively collaborate with its stakeholders on the development of a new inpatient hospital base rate setting methodology.

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

There are no less costly or less intrusive methods that will achieve 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.

   This rule change is necessary to update the annual update schedule for fiscal year 2021-2022.

8.300 HOSPITAL SERVICES

8.300.5 Payment for Inpatient Hospital Services

8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services

1. Peer Groups

   For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups. Hospitals which do not fall into the peer groups described in a and b shall default to the peer groups described in c and d based on geographic location.:

   a. Pediatric Hospitals

   b. Urban Safety Net Hospitals

   c. Rural Hospitals

   d. Urban Hospitals

2. Base Payment and Outlier Payment

   DRG Hospitals shall be reimbursed for Inpatient Hospital Services based on a system of DRGs and a hospital-specific Medicaid Inpatient base rate. The reimbursement for Inpatient Hospital Services shall be referred to as the DRG base payment.

   a. The DRG base payment shall be equal to the DRG Relative Weight multiplied by the Medicaid Inpatient base rate as calculated in Section 8.300.5.A.3 – 6.

   b. Outlier days shall be reimbursed at 80% of the DRG per diem rate. The DRG per diem rate shall be the DRG base payment divided by the DRG average length of stay.

   c. The DRG base payment plus any corresponding outlier payment is considered the full reimbursement for an Inpatient Hospital stay where the client was Medicaid-eligible for the entire stay.

   d. When a client was not Medicaid-eligible for an entire Inpatient Hospital stay, reimbursement shall be equal to the DRG per diem rate for every eligible day, with payment up to the full DRG base payment. If applicable, the Hospital shall receive outlier reimbursement.

3. Medicaid Inpatient Base Rate for In-network Colorado DRG Hospitals

   a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate

      i For in-network Colorado DRG Hospitals, excluding Rehabilitation Hospitals, Long-Term Care Hospitals, CAHs, Pediatric Hospitals, and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the hospital-specific Medicare Federal base rate minus any DSH factors. For the purpose of

rate setting effective on July 1 of each fiscal year, the Medicare base rate used shall be the Medicare base rate effective on October 1 of the previous fiscal year.

ii For Pediatric Hospitals, the starting point shall be equal to the cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 for rates effective July 1 of the same calendar year.

iv For CAHs and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the average Medicare base rate minus DSH factors for their respective peer group. The average calculation shall exclude CAHs and those Hospitals with less than twenty Medicaid discharges in the previous fiscal year.

b. Application of Adjustment Based on General Assembly Funding

For all in-network, Colorado DRG Hospitals, excluding Urban Safety Net Hospitals, the starting point for the Medicaid Inpatient base rate, as determined in Section 8.300.5.A.3.a, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Urban Safety Net Hospitals' starting point shall be adjusted by the percentage applied to all other Hospitals plus ten percent. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent.

c. Application of Cost Add-ons to Determine Medicaid Inpatient Base Rate

i The Medicaid Inpatient base rate shall be equal to the rate as calculated in Sections 8.300.5.A.3.a and 8.300.5.A.3.b, plus any Medicaid hospital-specific cost add-ons. The Medicaid hospital-specific cost add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1. Partial year cost reports shall not be used to calculate the cost add-ons.

ii The Medicaid hospital-specific cost add-ons shall be an estimate of the cost per discharge for nursery, neo-natal intensive care units, and Graduate Medical Education (GME). The GME cost add-on information shall be obtained from the audited Medicare/Medicaid cost report, worksheet B, part I; discharges from worksheet S-3, part I, nursery and neo-natal costs, shall be obtained from the audited Medicare/Medicaid cost report, Title XIX in worksheet D-1, part II. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in Section 8.300.9.2.

iii Ten percent of the Medicaid hospital-specific cost add-ons shall be applied.

d. Application of Adjustments for Certain Hospitals

For Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals, the Medicaid Inpatient base rate shall receive an additional adjustment factor for

the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.

e. Annual Adjustments

The Medicaid Inpatient base rates are adjusted annually (rebased) and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department. For fiscal year 21-22, the Medicaid Inpatient Base Rates from fiscal year 20-21 will be adjusted by the percentage change in the budget as appropriated by the General Assembly.

4. Medicaid Inpatient Base Rate for New In-Network Colorado DRG Hospitals

The Medicaid Inpatient base rate for new in-network Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing period after the Hospital's contract effective date. For the next Inpatient rate rebasing period, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in Section 8.300.5.A.3. If the Hospital does not have a Medicare Inpatient base rate or an audited Medicare/Medicaid cost report to compute a starting point as described in Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

The Medicaid Inpatient base rate for border-state Hospitals shall be equal to the average Medicaid Inpatient base rate for the corresponding peer group.

6. Medicaid Inpatient Base Rate for Out-of-network Hospitals

a. The Medicaid Inpatient base rate for out of network Hospitals, including out-of-state Hospitals, shall be equal to 90% of the average Medicaid Inpatient base rate for the corresponding peer group.

b. The Department may reimburse an out-of-state Hospital for non-emergent services at an amount higher than the DRG base payment when the needed services are not available in a Colorado Hospital. Reimbursement to the out-of-state Hospital shall be made at a rate mutually agreed upon by the parties involved.

7. Reimbursement for Inpatient Hospital claims that (a) include serious reportable events identified by the Department in the Provider Bulletin with (b) discharge dates on or after October 1, 2009, may be adjusted by the Department.

8.300.7 Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

GME costs for Medicaid managed care clients shall be paid directly to qualifying Hospitals rather than to managed care organizations (MCOs).

8.300.7.A GME for Medicaid Managed Care – Inpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Medicaid Inpatient GME cost per day for each Hospital that has GME costs in its fee-for-service base rate, excluding State University Teaching Hospitals. Each Hospital's GME cost per day shall be computed when Hospital rates are rebased according to the schedule outlined in 8.300.5.A.3.e. Years when rates are updated with the State Budget Action as set by Legislature, GME cost per day will remain unchanged from the cost report rebasing.

2. MCOs shall provide to the Department Inpatient days by Hospital for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

3. The Medicaid managed care Inpatient days for each Hospital shall be the total of the Inpatient days for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the Inpatient GME reimbursement for each Hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

8.300.7.B GME for Medicaid Managed Care – Outpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's GME cost-to-charge ratio shall be computed when Hospital rates are rebased according to the schedule outlined in 8.300.5.A.3.e. Years when rates are updated with the State Budget Action as set by Legislature, GME cost-to-charge ratio will remain unchanged from the cost report rebasing.

2. MCOs shall provide to the Department Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

3. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the FQHC Rule Concerning COVID-19 Vaccine and Treatment Reimbursement, Section 8.700.6.B
Rule Number: MSB 21-03-25-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-03-25-A, Revision to the FQHC Rule Concerning COVID-19 Vaccine and Treatment Reimbursement, Section 8.700.6.B

3. This action is an adoption of: an amendment

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

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

5. Does this action involve any temporary or emergency rule(s)? 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 8.700 with the proposed text beginning at 8.700.6.B through the end of 8.700.6.B. This rule is effective June 30, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the FQHC Rule Concerning COVID-19 Vaccine and Treatment Reimbursement, Section 8.700.6.B
Rule Number: MSB 21-03-25-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

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 change Federally Qualified Health Center (FQHC) reimbursement for the administration of the COVID-19 vaccine and monoclonal antibody therapy treatments. Currently, a COVID-19 vaccine administration is only directly reimbursable when administered by a billable provider such as a physician. When a non-billable provider, such as a registered nurse, administers a COVID-19 vaccine there is no direct reimbursement but the cost of this service is included in future FQHC encounter rate. This rule will change reimbursement so FQHCs will receive the fee schedule reimbursement every time they administer a COVID-19 vaccine. Monoclonal antibody products treat COVID-19 to help the body fight the virus or slow the virus' growth. Monoclonal antibody therapy treatments are expensive and the current FQHC encounter rate does not cover the cost of providing these treatments. This rule will revise reimbursement to reimburse FQHCs at the fee schedule amount for the administration of monoclonal antibody therapy treatments.

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:

   1902(bb) SSA

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

Initial Review Final Adoption **05/14/21**
Proposed Effective Date **06/30/21** Emergency Adoption

DOCUMENT #05

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Title of Rule: Revision to the FQHC Rule Concerning COVID-19 Vaccine and Treatment Reimbursement, Section 8.700.6.B
Rule Number: MSB 21-03-25-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

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.

   Federally Qualified Health Centers will be impacted by this rule. This rule revision will increase FQHC reimbursement for the administration of the COVID-19 vaccine and monoclonal antibody treatments. Therefore, FQHCs will not incur budgetary concerns to provide these services. This rule will also improve access to Medicaid members that receive services at FQHCs.

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

   FQHCs will be directly reimbursed at the fee schedule rates for administering COVID-19 vaccines and monoclonal antibody treatments. Due to the COVID-19 pandemic, FQHCs have changed their practices to provide necessary services such as telemedicine services. FQHCs are an important part of Colorado's COVID-19 vaccine effort. FQHCs will likely stop providing some of their core services to administer COVID-19 vaccines and treatment. This rule will reimburse FQHCs for these efforts directly instead of an indirect reimbursement through their encounter rates in the future.

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

   This rule revision will impact the Department and state revenues. The Department will directly reimburse FQHCs for administering COVID-19 vaccines and monoclonal antibody treatments. Without this rule, the costs of these services would be included in future rates. Therefore, there should be no significant budgetary impact as FQHC rates will not increase in the future due to their direct reimbursement due to this rule revision.

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

If the Department does not adopt this rule change FQHCs will likely suffer budgetary concerns due to not having direct reimbursement for administering COVID-19 vaccines and monoclonal antibody treatments. FQHCs will also be less incentivized to provide these services due to lack of direct reimbursement.

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

   There are no other methods that are less costly or less intrusive to achieve 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.

   The Department has considered other ways of reimbursing for COVID-19 vaccines such as temporarily increasing FQHC rates. However, the Department was concerned that if FQHCs are focused on providing COVID-19 vaccines they will not be providing traditional encounter services. Therefore, an increase to FQHC rates would not have the desired effect of increasing access. The Department considered not reimbursing FQHCs the fee schedule amount for monoclonal antibody products, but decided it was better to reimburse at the fee schedule amount to improve access and to match the current Medicare policy.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

A. 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:

B. Visit means a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the services set forth in Section 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

1. A visit includes a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado providing services set forth in Section 8.700.3.A. The supervised person must hold a candidate permit as a licensed professional counselor or a candidate permit as a licensed marriage and family therapist, or a candidate permit as a psychologist, or a be a licensed social worker. Group sessions do not generate a billable encounter for any FQHC services.

C. The visit definition includes interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounters.

1. Any health benefits provided through interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) must meet the same standard of care as in-person care.

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, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor or supervised person pursuing mental health licensure as defined in their respective practice acts.

i. Outpatient primary care services that are furnished by a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado 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 Section 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 Section 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, clinical social worker, licensed marriage and family therapist, licensed professional counselor and licensed addiction counselor and licensure candidates for clinical psychologist, clinical social worker, licensed marriage and family therapist, and licensed professional 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, 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 clinics or cost centers which do not provide services to Medicaid clients; and,

3. 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 separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: physical health encounter, dental encounter, or specialty behavioral health encounter. 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.

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.

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. An 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. Antagonist injections for substance use disorders provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

9. COVID-19 vaccine administration provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

b. Fee schedule as determined by the Department

10. Monoclonal Antibody COVID-19 infusions administration provided at the FQHC shall be reimbursed the lower of:

a. Submitted charges; or

b. Fee schedule as determined by the Department.

8.700.6.C A physical health encounter, a dental encounter, and a 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.

8.700.6.D Encounter rates calculations

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 an FQHC has been paid below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.

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. 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:

a. 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.

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

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

3. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set 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 an FQHC. These shall be the FQHCs base rates until the FQHC's final base rates are set.

   a. New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

4. 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.

   a. 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. 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.

   b. The new reimbursement encounter rates for 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 limit for each day the required information is late; if the old reimbursement encounter rates are more than the new rate, the new rates shall be effective the 120th day after the FQHCs fiscal year end.

5. If an 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.

a. An 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:

   i. 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.

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

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

   iv. 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.

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

b. 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.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.

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

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

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

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

   v. 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;

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

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

b. 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);

c. 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,

d. 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.

c. The following items do not prompt a scope-of-service rate adjustment:

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

ii. An increase or decrease in the number of encounters;

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

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

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

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

vii. The addition or removal of administrative staff;

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

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

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

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

xii. A change in ownership.

d. An 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.

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.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. An 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.

f. 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:

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

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

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

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

        d. 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

        e. 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;

    ii. 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.

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

i. 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.

ii. 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.

iii. 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.

iv. 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.

v. 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

h. 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.

i. 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.

i. If the Department identifies a change in scope of services, the Department may request the documentation as described in

Section 8.700.6.D.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.

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

iii. 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.

iv. 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.

j. An 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, an FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

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

7. Pending federal approval, the Department will offer a second Alternative Payment Methodology (APM 2) that will reimburse FQHCs a Per Member Per Month (PMPM) rate. FQHCs may opt into APM 2 annually. This reimbursement methodology will convert the FQHC's current Physical Health cost per visit rate into an equivalent PMPM rate using historical patient utilization, member designated attribution, and the Physical Health cost per visit rate for the specific FQHC. Physical health services rendered to patients not attributed to the FQHC, or attributed based on geographic location, will pay at the appropriate encounter rate. Dental and specialty behavioral health services for all patients will be paid at the appropriate encounter rate. Year 2 rates for FQHCs participating in APM 2 will be set using trended data. Year 3 rates will be set using actual data.

8. The Department will perform an annual reconciliation to ensure the PMPM reimbursement compensates APM 2 providers in an amount that is no less than their PPS per visit rate. The Department shall perform PPS reconciliations should

the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC.

9. PMPM and encounter rates for FQHC participating in APM 2 shall be effective on the 1st day of the month that falls at least 120 days after an FQHC's fiscal year end.

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, this outstationing payment shall be made based upon actual cost and is included as an allowable cost in an FQHC cost report.

8.700.8.B

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Rule Concerning changes to Income Data Source for sections 8.100.3.N, 8.100.4.B, and 8.100.5.B
Rule Number: MSB 19-08-21-A
Division / Contact / Phone: Eligibility Policy Section / Mellissa Torres-Murillo / 4416

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 19-08-21-A,Revisions to the Medical Assistance Rule Concerning changes to Income Data Source for sections 8.100.3.N, 8.100.4.B, 8.100.4.C, 8.100.5.B, and 8.100.5.F

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) 8.100.3.N, 8.100.4.B, 8.10.4.C, 8.100.5.B, and 8.100.5.F, 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 8.100.3 with the proposed text beginning at 8.100.3.N.7.f all through the end of 8.100.3.N.7.f. Replace the current text at 8.100.4 with the proposed text beginning at 8.100.4.B.1 through the end of 8.100.4.B.6. Replace the current text at 8.100.4.C with the proposed text beginning at 8.100.4.C.1 through the end of 8.100.4.C.2. Replace the current text at 8.100.5 with the proposed text beginning at 8.100.5.B.1 through the end of 8.100.5.B.1. Replace the current text at 8.100.5 with the proposed text beginning at 8.100.5.F.5 through the end of 8.100.5.F.5. This rule is effective June 30, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Rule Concerning changes to Income Data Source for sections 8.100.3.N, 8.100.4.B, and 8.100.5.B
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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 proposed rule change will amend 10 CCR 2505-10 sections 8.100.3.N, 8.100.4.B, 8.100.4.C, 8.100.5.B, and 8.100.5.F based on 42 C.F.R 435.945, 435.949, and 435.952 as this pertains to the Income and Eligibility Verification Requirements. There will be two new data sources added to verify earned income for both MAGI and Non-MAGI Programs. The two new interfaces being implemented are the Federal Data Services Hub (FDSH) and Equifax The Work Number (TWN). Policy will be updated to reflect changes in the Colorado Benefits Management System (CBMS). The Interfaces will be added for Medical Assistance programs to increase efficiency in eligibility determinations and to reduce improper eligibility determinations by providing income details that are from the most recent pay period reported from employers. Policy has added additional changes to the lottery and gambling winnings to allow applicants or members the ability to request a hardship exemption when being denied or terminated due to lottery and gambling winnings.

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 C.F.R §435.940, §435.945, §435.948, §435.949(a)and(b), and §435.952(c)(1) and (2), Section 1902(e)(14)(K)(iii) of the Act

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, and 25.5-4-205(3)(b)(I), C.R.S. (2020);

Initial Review	**04/09/21**	Final Adoption	**05/14/21**
Proposed Effective Date	**06/30/21**	Emergency Adoption	

DOCUMENT #01

DO NOT PUBLISH THIS PAGE

Initial Review	**04/09/21**	Final Adoption	**05/14/21**
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DOCUMENT #01

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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 proposed rule will impact applicants/members who are applying or enrolled in MAGI and Non-MAGI Medical Assistance Programs. The rule update will benefit applicants/members who declare employment income and meet financial eligibility requirements, by helping to reduce the need for applicants/members to provide proof of financial verifications when determining eligibility for MAGI and Non-MAGI Medical Assistance.

   The proposed rule will impact applicants/members who are denied or terminated from MAGI and Non-MAGI Medical Assistance Programs. The rule update will benefit applicants/members who declare the need for an undue hardship exemption due to a severe medical or financial hardship and were denied or terminated as a result of Lottery and Gambling winnings

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

   The proposed rule will help determine eligibility correctly by using the new interfaces that will increase efficiency in eligibility determinations, reduce improper eligibility determinations by providing income details that are from the most recent pay period reported from employers for MAGI and Non-MAGI Medical assistance programs.

   The proposed rule will help applicants/members who have experienced a severe medical or financial hardship. Providing applicants/members the opportunity to have their medical assistance program reinstated for the period in which they where denied as a result of the Lottery and Gambling winnings.

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 that linking with these systems would put downward pressure on caseload growth, particularly for the MAGI Parents and Adults eligibility categories, which are income-sensitive populations. It would prevent MAGI and Non-

MAGI program (Medicaid and CHP+) members from enrolling who are later found to be ineligible due to income and save money for the State.

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

   The probable costs of this policy include paying for queries of the TWN hub.

   The probable benefits to the policy include less improper enrollments which will result in savings that offset the costs.

   The probable costs of inaction will be that the process of income verification will continue to have significant built-in delay with members enrolling into a MAGI and Non-MAGI program (Medicaid and CHP+) only to be determined ineligible months later, causing the Department to continue to make these payments.

   There are no obvious benefits to inaction.

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

   The Department does not have any less costly method of implementing real-time income verification.

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

   There are no alternative methods for the proposed rule that were considered.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.3.N. Confidentiality

1. All information obtained by the eligibility site concerning an applicant for or a recipient of Medical Assistance is confidential information.

2. A signature on the Single Streamlined Application and the Application for Public Assistance allows an eligibility site worker to consult banks, employers, or any other agency or person to obtain information or verification to determine eligibility. The identification of the worker as an eligibility site employee will, in itself, disclose that an application for the Medical Assistance Program has been made by an individual. In this type of contact, as well as other community contacts, the eligibility site should strive to maintain confidentiality. The signature on the Single Streamlined Application and the Application for Public Assistance also provides permission for the release of the client's medical information to be provided by health care providers to the State and its agents for purpose of administration of the Medical Assistance Program.

3. Eligibility site staff may release a client's Medical Assistance state identification number and approval eligibility spans to a Medical Assistance provider for billing purposes.

   Eligibility site staff may inform a Medical Assistance provider that an application has been denied but may not inform them of the reason why.

4. Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State and the eligibility site.

5. The eligibility site must obtain permission from a family, individual, or authorized representative, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of Medical Assistance payment. This permission must be obtained unless the request is from State authorities, federal authorities, or State contractors acting within the scope of their contract. If, because of an emergency situation, time does not permit obtaining consent before release, the eligibility site must notify the family or individual immediately after supplying the information.

6. The eligibility site policies must apply to all requests for information from outside sources, including government bodies, the courts, or law enforcement officials. If a court issues a subpoena for a case record or for any eligibility site representative to testify concerning an applicant or recipient, the eligibility site must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

7. The following types of information are confidential and shall be safeguarded:

   a. Names and addresses of applicants for and recipients of the Medical Assistance Program;

   b. Medical services provided;

   c. Social and economic conditions or circumstances;

   d. Agency evaluation of personal information;

e. Medical data, including diagnosis and past history of disease or disability;

f. All information obtained through the Income and Eligibility Verification System (IEVS), the Federal Data Services Hub (FDSH), Equifax The Work Number (TWN), Colorado Department of Labor and Employment, SSA or Internal Revenue Service;

g. Any information received in connection with identification of legally liable third party resources;

h. Any information received for verifying income and resources if applicable, or other eligibility and the amount of Medical Assistance payments;

i. Social Security Numbers.

8. The confidential information listed above may be released to persons outside the eligibility site only as follows:

a. In response to a valid subpoena or court order;

b. To State or Federal auditors, investigators or others designated by the Federal or State departments on a need-to-know basis;

c. To individuals executing Income and Eligibility Verification System;

d. Child Support enforcement officials;

e. To a recipient or applicant themselves or their designated representative.

f. To a Long Term Care institution on the AP-5615 form.

9. The applicant/recipient may give a formal written release for disclosure of information to other agencies, such as hospitals, or the permission may be implied by the action of the other agency in rendering service to the client. Before information is released, the eligibility site should be reasonably certain the confidential nature of information will be preserved, the information will be used only for purposes related to the function of the inquiring agency, and the standards of protection established by the inquiring agency are equal to those established by the State Department. If the standards for protection of information are unknown, a written consent from the recipient shall be obtained.

8.100.4.B. MAGI Category Verification Requirements

1. Minimal Verification – At minimum, applicants seeking Medical Assistance shall provide all of the following:

a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

i) Due to the COVID-19 Public Health Emergency, at the time of application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the federally-declared COVID-

19 Public Health Emergency, verification for SSN eligibility criteria will be required.

1) Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet federal and state citizenship and immigration status requirements, are only eligible to receive emergency medical services.

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

c. Earned Income: Income ~~shall~~ may be self-attested by an applicant or member and verified through an electronic data source. Individuals who provide self-attestation of income ~~must also~~ may provide a ~~Social Security Number~~ SSN for electronic wage verification purposes.

If the self-attested earned income ~~is not or~~ cannot be verified electronically~~self-attested~~, due to a missing SSN, the applicant must provide documentation of income. Earned income must ~~it shall~~ be verified by wage stubs, tax documents, written documentation from the employer stating the employee's gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

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. 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.

Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify that the individual's income has changed for all Medical Assistance programs in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded.

d. Unearned income: Unearned income ~~can~~ may be self-attested by an applicant or member. If the self–attested unearned income cannot be verified electronically, the applicant must provide documentation of income. Certain types of unearned income, ~~such as unemployment and survivor benefits~~ may be verified through electronic data sources, such as Social Security income types. Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify that the individual's income has changed for all Medical Assistance programs in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded, for all people whose eligibility was maintained during the emergency declaration, for these individuals to maintain eligibility.

e. Verification of Legal Immigrant Status: Immigration status ~~can~~ may be self-declared by an applicant applying for Medical Assistance, to determine eligibility for full Medical Assistance benefits. This declaration of legal immigration status will be verified through the Verify Lawful Presence (VLP) interface. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) program to verify legal immigration status. See section 8.100.3.G for a description of the VLP interface. If status cannot be

verified, or if the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

2. Additional Verification: No other verification shall be required of the client unless information is found to be questionable on the basis of fact.

3. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

4. Information that exists in another case record or in CBMS shall be used by the eligibility site to verify those factors that are not subject to change, if the information is reasonably accessible.

5. The criteria of age and relationship ~~can~~ may be declared by the client unless questionable. If questionable, these criteria ~~can~~ may be established with information provided from:

   a. official papers such as: a birth certificate, order of adoption, marriage license, immigration or naturalization papers; or

   b. records or statements from sources such as: a court, school, government agency, hospital, or physician.

6. Establishing that a dependent child meets the eligibility criteria of:

   a. age, if questionable requires (1) viewing the birth certificate or comparably reliable document at eligibility site discretion, and (2) documenting the source of verification in the case file and CBMS case comments;

   b. living in the home of the caretaker relative, if questionable requires (1) viewing the appropriate documents which identify the relationship, (2) documenting these sources of verification in the case file and CBMS case comments.

8.100.4.C. MAGI Methodology for Income Calculation

1. For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated by reference. The incorporation of 26 U.S.C. § 61 (2014) 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. Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all income from all derived sources, The Modified Adjusted Gross Income calculation for the purposes of determining a household's financial eligibility for Medical Assistance shall consist of, but is not limited to, the following:

   a. Earned Income:

      i) Wages, salaries, tips;

      ii) Gross income derived from business;

      iii) Gains derived from dealings in property;

      iv) Distributive share of partnership gross income (not a limited partner);

v) Compensation for services, including fees, commissions, fringe benefits and similar items; and

vi) Taxable private disability income.

b. Unearned Income:

i) Interest (includes tax exempt interest);

ii) Rents;

iii) Royalties;

iv) Dividends;

v) Alimony received counts as unearned income if the divorce or legal separation is executed on or before December 31, 2018. Alimony received will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019;

vi) Pensions and annuities;

vii) Income from life insurance and endowment contracts;

viii) Income from discharge of indebtedness;

ix) Income in respect of a decedent;

x) Income from an interest in an estate or trust;

xi) Social Security (SSA) income;

xii) Distributive share of partnership gross income (limited partner);

xiii) Capital gains;

xiv) Lottery/Gambling Winnings;

1) If less than $79,999 winnings are counted as income in the month received.

2) If over $80,000 but less than $90,000 it is counted as income and it is divided equally between two months.

3) For every additional $10,000 over $90,000, ~~-~~an additional month is added to the period over which the winnings are evenly spread. ~~one month is added, and divided equally and counted as income for each month~~.

4) Lottery/gambling winnings of an individual will continue to count only in the month received in determining the eligibility for the members of their household.

5) An applicant/member may request a hardship exemption when an application is denied or enrollment is terminated due to Lottery/Gambling winnings.

a. The applicant/member must demonstrate a severe medical or financial hardship.

~~a.~~b. The applicant/member must provide a written request and documentation to their County Department of Human Services, within 30 calendar days from the date of their denial or termination notice.

xv) Student loan debt that is discharged, forgiven, or cancelled is ~~generally~~ treated as taxable income to the borrower, with certain exceptions.

1) This debt will not be considered income for the borrower in the event of death or permanent and total disability of the student (the borrower and the student may or may not be the same person) if discharged during tax years 2018 through 2025.

2) At the Departments discretion, ~~T~~this debt will not be considered countable income for the borrower if discharged, forgiven, or cancelled under ~~the following~~ programs which include, ~~(~~but not limited to~~)~~:

a) Public Service ~~L~~loan ~~F~~forgiveness ~~program~~;

b) ~~Certain~~ T~~t~~eacher loan forgiveness ~~programs~~;

c) Healthcare loan forgiveness ~~programs~~; and

d) ~~Loans discharged under the~~ Closed School discharge ~~process~~.

c. Additional Income: In addition to the types of income identified in section 8.100.4.C.1.a-b., the following income is included in the MAGI calculation.

i) Any tax exempt interest income.

ii) Untaxed foreign wages and salaries.

iii) Social Security Title II Benefits (Old Age, Disability and Survivor's benefits).

d. The following are Income exclusions:

i) An amount received as a lump sum is counted as income only in the month received;

ii) Scholarships, awards, or fellowship grants used for educational purposes and not for living expenses;

iii) Child support received;

iv) Worker's Compensation;

v) Supplemental Security Income (SSI);

vi) Veteran's Benefits;

vii) The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act Recovery Rebate, also known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.

viii) Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra $600.00 a week for qualified individuals, is exempt as countable unearned income.

ix) American Indian/Alaskan Native income exceptions listed at 42 C.F.R. § 435.603(e) (2012) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 435.603(e) (2012) 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.

e. Allowable Deductions: For an in-depth treatment of allowable deductions from gross income, ~~please~~ refer to 26 U.S.C. 62, which is hereby incorporated by reference. The incorporation of 26 U.S.C. 62 (2014) 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.

The following deductions ~~can~~ may be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income (AGI) including (but not limited to):

i) Student loan interest deductions;

ii) Certain Self- employment expenses SEP, SIMPLE and qualified plans, and health insurance deductions;

iii) Deductible part of self-employment tax;

iv) Health savings account deduction;

v) Certain business expenses of reservists, performing artist, and fee-basis government officials;

vi) Reimbursed expenses of employees;

vii) Moving expenses for active duty military who are moving due to a permanent change of station;

viii) IRA deduction: Regular Individual Retirement Account (IRA) contributions claimed on a federal income tax return and which does not exceed the IRA contributions limits; (Pre-tax contributions to a 401(k) or 403(b) retirement plan are excluded from earned income);

ix) Penalty on early withdrawal of savings;

x) Domestic production activities deduction;

xi) Alimony paid ~~can~~ may be deducted only if the divorce or legal separation is executed on or before December 31, 2018. It cannot be deducted if the divorce or separation is modified or executed on or after January 1, 20019;

xii) Certain educator expenses;

xiii) Certain pre-tax contributions;

xiv) Net operating losses; and

xv) Capital losses.

f. Income of children and tax dependents:

i) The income of a child who is included in the household of their natural, adopted, or step parent will not be included in the household income unless that child has income above the tax filing threshold..

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a child is required to file taxes.

ii) The income of a person, other than a child or spouse, who expects to be claimed as a tax dependent will not be included in the household income of the taxpayer unless that tax dependent has income above the tax filing threshold.

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a tax dependent is required to file taxes.

ii) The income of a child or tax dependent who does not live with their natural, adopted, or step parent will always count towards the determination of their own eligibility, even if the child's or tax dependent's income is below the tax filing threshold.

2. Income verifications: When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive a 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~~ supporting documentation within the Reasonable Opportunity Period ~~(ROP)~~ of 30 calendar days.

a. 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 MAGI Medical Assistance program income standard, 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 MAGI Medical Assistance program income standard, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 20%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable MAGI Medical Assistance program income standard the income shall be determined reasonably compatible, and the applicant shall continue to be determined eligible during the federal Coronavirus COVID-19 Public Health Emergency.

b. 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 will not be requested during the federal Coronavirus COVID-19 Public Health Emergency. When the federal COVID-19 Public Health Emergency has ended, a reasonable explanation will be requested from the member.

i) During the federal Coronavirus COVID-19 public health emergency the Department may request paper documentation when the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency.

3. Self-Employment – If the applicant is self-employed the ledger included in the Single Streamlined Application shall be sufficient verification of earnings, unless questionable.

4. Budget Periods for MAGI-based Income determination – The financial eligibility of applicants for Medical Assistance shall be determined based on current or previous monthly household income and family size.

a. Applicants who are found financially ineligible based on current or previous monthly household income and family size, and whose household has earned income from self-employment, seasonal employment, and/or commission-based employment, shall have their financial eligibility determined using annualized self-employment, seasonal employment, and commission-based employment income.

5. If an applicant does not meet the financial eligibility requirements for Medical Assistance based on MAGI, but meets all other eligibility requirements, the applicant shall be found eligible for MAGI Medical Assistance if the applicant's income, as calculated using the methodology for determining eligibility for Advanced Premium Tax Credits or Cost Sharing Reductions through the marketplace, is below 100% of the federal poverty level.

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. Social Security Number: Each individual requesting assistance on the application shall provide a ~~Social Security Number (~~SSN~~)~~, or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

i) Due to the Coronavirus COVID-19 Public Health Emergency, at application, self-attestation is acceptable for SSN criteria, with the exception of verification of

citizenship and immigration status. At the end of the COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.

1) Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet the federal and state criteria of citizenship and immigration status are only eligible to receive emergency medical services.

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-attested ~~declared~~ by an applicant or ~~individual~~ member and verified through an electronic data source ~~by~~ through the ~~Income and Eligibility Verification System (~~IEVS~~)~~, FDSH, or the TWN. Individuals who provide self-attestation~~declaration~~ of earned income ~~must~~ may also provide a ~~Social Security Number~~ SSN for wage verification purposes. If the self-attested earned income cannot be verified electronically due to a missing SSN, the applicant must provide documentation of income. Verification of earned income must be provided in accordance to the requirements outlined in 8.100.4.B.1.c ~~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 a 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 within the Reasonable Opportunity Period (ROP) of 30 calendar days.

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 Medical Assistance program income standard, 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 Medical Assistance program income standard, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 20%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable Medical Assistance program income standard, the income shall be determined reasonably compatible, and the applicant shall continue to be determined eligible during the federal Coronavirus COVID-19 Public Health Emergency.

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 will not be requested due to the federal COVID-19 Public Health Emergency. When the federal Public Health Emergency has ended, a reasonable explanation will be requested from the member.

iv) During the federal Coronavirus COVID-19 public health emergency the Department may request paper documentation when the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period.

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.

v) During the federal COVID-19 Public Health Emergency, all earned income and self-employment may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified income shall be provided.

d. Verification of all unearned income shall be provided if the unearned income was received in the month for which eligibility is being determined or during the previous month. If available, information that exists in another case record or verification system shall be used to verify unearned income.

i) During the federal COVID-19 Public Health Emergency, all unearned income may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified income shall be provided.

e. Verification of all resources shall be provided if the resources were available to the applicant in the month for which eligibility is being determined.

Resource information that is verified through an electronic data source, such as the Asset Verification Program, shall be a valid verification. Supplemental physical verifications for the same resource is not required unless further information is needed for clarification.

i) During the federal COVID-19 Public Health Emergency, all resources may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified resources shall be provided.

f. Immigrant registration cards or papers, if applicable, to determine if the client is eligible for full Medical Assistance benefits. If an applicant does not provide this, he/she shall only be eligible for emergency Medical Assistance if they meet all other eligibility requirements.

g. Additional verification-If the requested verification is submitted by the applicant, no other additional verification shall be required unless the submitted verification is found to be questionable on the basis of fact.

h. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

8.100.5.F. Income Requirements

1. This section reviews how income is looked at for the ABD and Long Term Care Medical Programs and determining premiums for the Medicaid Buy-In Program for Working Adults with Disabilities. For more general income information and income types refer to the Medical Assistance General Eligibility Requirements section 8.100.3.

2. Income for the ABD Medical Programs eligibility is income which is received by an individual or family in the month in which they are applying for or receiving Medical Assistance, or the previous month if income for the current month is not yet available to determine eligibility.

3. A self-declared common law spouse retains the same financial responsibility as a legally married spouse. Once self-declared as married under the common law, financial responsibility remains unless legal separation or divorce occurs. If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other. This is not changed by the fact that the unmarried individuals may share a common child.

4. Earned income is countable as income in the month received and a countable resource the following month. Earned Income includes the following:

   a. Wages, which include salaries, commissions, bonuses, severance pay, and any other special payments received because of employment;

   b. Net earnings from self-employment;

   c. Payments for services performed in a sheltered workshop or work activities center;

   d. Certain Royalties and honoraria.

5. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment.

   Unearned income is countable as income in the month received and any unspent amount is a countable resource the following month. Unearned income includes, but is not limited to, the following:

   a. Death benefits, reduced by the cost of last illness and burial;

   b. Prizes and awards;

   c. Gifts and inheritances;

   d. Interest payments on promissory notes established on or after March 1, 2007;

e. Interest or dividend payments received from any resources;

f. Lump sum payments from workers' compensation, insurance settlements, etc.

g. Dividends, royalties or other payments from mineral rights or other resources listed for sale within the resource limits

h. Income from annuities that meet requirements for exclusion as a resource

i Lottery/Gambling winnings

1) An applicant/member may request a hardship exemption when denied/or terminated due to Lottery/Gambling winnings.

a. The applicant/member must demonstrate a severe medical or financial hardship, as determined by the Department.

~~a.~~b. The applicant/member must provide a written request and documentation to their County Department of Human Services, within 30 calendar days from the date of their denial or termination notice.

j. Pensions and other period payments, such as:

i) Private pensions or disability benefits;

ii) Social Security benefits (Retirement, survivors, and disability);

iii) Workers' Compensation payments;

iv) Railroad retirement annuities;

v) Unemployment insurance payments;

vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME);and

vii) Alimony and support payments.

k. Support and maintenance in kind - The support and maintenance in kind amount should not be greater than one third of the Federal Benefit Rate (FBR). Use the Presumed Maximum Value (PMV) of 1/3 of the recipient's portion of the rent to determine the support and maintenance in kind amount. Use one third of the FBR if an amount is not declared by the client.

6. For the purpose of determining eligibility for the Long Term Care and Aged, Blind, and Disabled Medical Assistance categories the following shall be exempt from consideration as either income or resources:

a. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a repayment agreement. Declaration of such loans is sufficient verification.

b. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act.

c. Title XVI (SSI) or Title II (Retirement Survivors or Disability Insurance) retroactive payments (lump sum) for nine months following receipt and the remainder countable as a resource thereafter.

d. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for women, infants and children (WIC).

e. Home produce utilized for personal consumption.

f. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act; relocation payments to a displaced homeowner toward the purchase of a replacement dwelling are considered exempt for up to 6 months.

g. The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

   i) Experimental Housing Allowance Program (EHAP) payments made by HUD under section 23 of the U.S. Housing Act.

   ii) The United States Housing Act of 1937 (§ 1437 et seq. of 42 U.S.C.);

   iii) The National Housing Act (§ 1701 et seq. of 12 U.S.C.);

   iv) Section 101 of the Housing and Urban Development Act of 1965 (§ 1701s of 12 U.S.C., § 1451 of 42 U.S.C.);

   v) Title V of the Housing Act of 1949 (§ 1471 et seq. of 42 U.S.C.); or

   vi) Section 202(h) of the Housing Act of 1959.

h. Payments made from Indian judgment funds and tribal funds held in trust by the Secretary of the Interior and/or distributed per capita; and initial purchases made with such funds. (Public Law No 98-64 and Public Law No. 97-458).

i. Distributions from a native corporation formed pursuant to the Alaska Native Claims Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to exceed $ 2000 per individual per calendar year; stock; a partnership interest; or an interest in a settlement trust. Cash payments, up to $ 2000, received by a client in one calendar year which is retained into subsequent years is excluded as income and resources; however, cash payments up to $ 2000 received in the subsequent year would be excluded from income in the month(s) received but counted as a resource if retained beyond that month(s).

j. Assistance from other agencies and organizations.

k. Major disaster and emergency assistance provided to individuals and families, and comparable disaster assistance provided to states, local governments and disaster assistance organizations shall be exempt as income and resources in determining eligibility for Medical Assistance.

l. Payments received for providing foster care.

m. Payments to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than the minimum wage, and Title II and Title III of the Domestic Volunteer Services Act.

n. The benefits provided to eligible persons or households through the Low Income Energy Assistance (LEAP) Program.

o. Training allowances granted by the Workforce Investment Act (WIA) to enable any individual whether dependent child or caretaker relative, to participate in a training program

p. Payments received from the youth incentive entitlement pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs under the Youth Employment and Demonstration Project Act.

q. Social Security benefit payments and the accrued amount thereof to a client when an individual plan for self-care and/or self-support has been developed. In order to disregard such income and resources, it shall be determined that (1) SSI permits such disregard under such developed plan for self-care-support goal, and (2) assurance exists that the funds involved will not be for purposes other than those intended.

r. Monies received pursuant to the “Civil Liberties Act of 1988” P.L. No. 100-383, (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts).

s. Payments made from the Agent Orange Settlement Fund or any fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No 381 (E.D.N.Y).

t. A child receiving subsidized adoption funds shall be excluded from the Medical Assistance budget unit and his income shall be exempt from consideration in determining eligibility, unless such exclusion results in ineligibility for the other members of the household.

u. The Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month.

v. Any money received from the Radiation Exposure Compensation Trust Fund, Including the Energy Employees Occupational Illness Compensation Program Act, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510.

w. Reimbursement or restoration of out-of-pocket expenses. Out-of-pocket expenses are actual expenses for food, housing, medical items, clothing, transportation, or personal needs items.

x. Payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286.

y. General Assistance, SSI, OAP-A and cash assistance under the Temporary Assistance to Needy Families (TANF) funds.

z. All wages paid by the United States Census Bureau for temporary employment related to the decennial Census.

aa. Any grant or loan to an undergraduate student for educational purposes made or insured under any programs administered by the Commissioner of Education (Basic Education Opportunity Grants, Supplementary Education Opportunity Grants, National Direct Student Loans and Guaranteed Student Loans), Pell Grant Program, the PLUS Program, the BYRD Honor Scholarship programs and the College Work Study Program.

bb. Any portion of educational loans and grants obtained and used under conditions that preclude their use for current living cost (need-based).

cc. Financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act that is made available for attendance cost shall not be considered as income or resources. Attendance cost includes tuition, fees, rental or purchase of equipment, materials or supplies required of all students in the same course of study, books, supplies, transportation, dependent care and miscellaneous personal expenses of students attending the institution on at least a half-time basis, as determined by the institution.

dd. The additional unemployment compensation of $25 a week enacted through the American Recovery and Reinvestment Act of 2009.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 21-03-25-B
Division / Contact / Phone: Special Financing Division / Chandra Vital / 303-866-5506

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 21-03-25-B, Revision to Medical Assistance Special Financing rule concerning the 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):

   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 at 8.960 with the proposed text beginning at 8.960 through the end of 8.960. Replace the current text at Appendix A with the proposed text beginning at Appendix A through the end of Appendix A. This rule is effective June 30, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 21-03-25-B
Division / Contact / Phone: Special Financing Division / 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).

   Clarifies an Eligible Senior may have Medicare or Medicare Advantage Plan that has dental coverage. This rule change also incorporates the rule that Grantees of the Colorado Dental Health Care Program for Low-Income Seniors bill Medicare for procedures covered by Medicare or the Medicare Advantage Plan and the Colorado Dental Health Care Program is secondary to the Medicare dental coverage.

   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:

2. Federal authority for the Rule, if any:

   42 C.F.R. 162-1002(a)(4)

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   Sections 25.5-3-404(4), C.R.S. (2020)

Initial Review — Final Adoption **05/14/21**
Proposed Effective Date **06/30/21** — Emergency Adoption

DOCUMENT #06

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Title of Rule: Revision to Medical Assistance Special Financing rule concerning the Colorado Dental Health Care Program for Low-Income Seniors, Section 8.960
Rule Number: MSB 21-03-25-B
Division / Contact / Phone: Special Financing Division / 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.

   Changing the rule will allow seniors with dental coverage through Medicare Advantage Plans to receive the dental care through the Colorado Dental Health Care Program for Low Income Seniors for services not covered by Medicare Advantage or after Medicare Advantage benefits have been exhausted. This rule change will benefit Colorado's low income seniors by ensuring they continue to access needed dental 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.

   There is no change in the 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 this rule change 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.

   Numerous seniors receiving services through the Colorado Dental Health Care Program for Low-Income Seniors had to cease treatment plans due to changes in the Medicare Advantage Plans. This rule change will allow these treatment plans to continue and seniors can continue receiving the needed dental health care to remain healthy.

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 ensure that eligible seniors continue to receive the much-needed dental health care.

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 ensure eligible seniors receive the necessary dental health care to remain healthy. There are no other alternative methods for achieving this purpose.

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. (2019).

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 or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans. 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. (2019).

Medicare ~~is~~means the federal health insurance program for people who are 65 or older; certain younger people with disabilities; or people with End-Stage Renal Disease.

Medicare Advantage Plans ~~are~~mean the plans offered by Medicare-approved private companies that must follow rules set by Medicare and may provide benefits for services Medicare does not, such as vision, hearing, and dental care.

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. (2019).

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. Program Payment must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in Articles 4, 5, and 6 of 10 CCR 2505-10.

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. (2019);

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. (2019).

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. (2019).

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. For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage;

6~~5~~. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;

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

8~~7~~. Submit an annual report as specified under section 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, as listed in Appendix A.

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

4. Qualified Grantees shall not bill the Department for any procedures covered by Medicare Advantage Plans that have been billed and paid by the Medicare Advantage Plans;

5. Qualified Grantees shall indicate on the invoice if the Eligible Senior has dental coverage through a Medicare Advantage Plan and any claim to the Medicare Advantage Plan was adjudicated prior to billing the Department;

64. 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;

4. The procedures and amounts billed to Medicare Advantage Plans for Eligible Seniors; and

54. 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.
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.
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.
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, D0274, or D0277 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
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, D0274, or D0277 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.
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, D0274, or D0277 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, D0274, or D0277 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, D0274, D0277 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, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Vertical bitewings – seven to eight radiographic images	D0277	$68.32	$68.32	$0.00	Frequency: 1 time in a 12-month period. This does not constitute a full mouth intraoral radiographic series. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 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. • May be alternated with D4910 for maintenance of periodontally-involved individuals. • D1110 cannot be billed on the same day as D4346 • Cannot be used as 1 month re-evaluation following nonsurgical periodontal therapy.

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.
Interim caries arresting medicament application – per tooth	D1354	$5.47	$5.47	$0.00	Two of D1354 per 12 months per patient per tooth for primary and permanent teeth. Not to exceed 4 times per tooth in a lifetime. Cannot be billed on the same day as D1355 or any D2000 series code (D2140–D2954). Must Report both tooth number and surface(s).

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Caries preventive medicament application – per tooth	D1355	$5.47	$5.47	$0.00	For primary prevention or remineralization. Medicaments applied do not include topical fluorides. Medicaments that may be applied during the delivery of D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). Cannot be billed on the same day as: D1206, D1208, D1354, D0140, D9110, or any restoration codes on the same day or within 12 months of D2140 thru D2954. Maximum of four D1355 per tooth per lifetime. Must report both tooth number and surface(s).
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.
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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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.
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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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.
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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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.
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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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.
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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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-hospital setting. Documentation of other treatment provided at same time will be requested. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

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. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	$102.00	$92.00	$10.00	The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: once in a lifetime. • Any follow-up and re-evaluation are included in the initial reimbursement. • Cannot be charged on the same date as D1110, D4341, D4342, or D4910.
Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	D4355	$92.81	$82.81	$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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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 on the same date as D4346. • 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	$862.98	$782.98	$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	$864.38	$784.38	$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	$862.98	$782.98	$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.
Immediate denture – mandibular	D5140	$864.38	$784.38	$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 retentive/clasping materials, 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 retentive/clasping materials, 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	$832.92	$772.92	$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	$832.92	$772.92	$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	$599.66	$539.66	$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	$599.66	$539.66	$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	$832.92	$772.92	$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	$832.92	$772.92	$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.
Repair broken complete denture base, mandibular	D5511	$122.05	$112.05	$10.00	Repair broken complete denture base, mandibular
Repair broken complete denture base, maxillary	D5512	$122.05	$112.05	$10.00	Repair broken complete denture base, maxillary
Replace missing or broken teeth - complete denture (each tooth)	D5520	$91.71	$81.71	$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	$119.68	$109.68	$10.00	Repair cast partial framework, mandibular
Repair cast partial framework, maxillary	D5622	$119.68	$109.68	$10.00	Repair cast partial framework, maxillary
Repair or replace broken retentive/clasping materials – per tooth	D5630	$129.24	$119.24	$10.00	Repair of broken clasp on partial denture base – per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Replace broken teeth-per tooth	D5640	$92.81	$82.81	$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	$134.22	$124.22	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months.
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.
Reline maxillary partial denture (chairside)	D5740	$173.42	$163.42	$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	$175.06	$165.06	$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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
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.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	$110.30	$100.30	$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.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$170.52	$160.52	$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	$204.54	$184.54	$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	$252.11	$232.11	$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
Removal of impacted tooth-completely bony	D7240	$292.37	$272.37	$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	$383.84	$363.84	$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	$179.80	$169.80	$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	$197.71	$187.71	$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	$197.71	$187.71	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Removal of lateral exostosis (maxilla or mandible)	D7471	$286.04	$276.04	$10.00	Removal of a benign bony outgrowth (bone spur) for proper prosthesis fabrication. Reported per arch.
Removal of torus palatinus	D7472	$336.27	$326.27	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Removal of torus mandibularis	D7473	$328.00	$318.00	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Palliative (emergency) treatment of dental pain - minor procedure	D9110	$77.47	$52.47	$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 moderate sedation, deep sedation or general anesthesia	D9219	$40.31	$40.31	$0.00	One of D9219 or D9310 per 12 month(s) per provider or location
Deep sedation/general anesthesia-each 15 minute increment	D9223	$102.05	$92.05	$10.00	Ten of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$102.05	$92.05	$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.

NOTE: Tooth surfaces are reported using the letters in the following table.

Surface	Code
Buccal	B
Distal	D
Facial (or Labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O