DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules Mental Health Transitional Living Homes, Section 8.509.50
Rule Number: MSB 23-04-12-B
Division / Contact / Phone: Office of Community Living / Cassandra Keller / 5181

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 23-04-12-B, Revision to the Medical Assistance Rules Mental Health Transitional Living Homes, Section 8.509.50

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) 8.509.50, 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 8.509 with the newly proposed text at 8.509.50. Please insert the proposed text beginning at 8.509.50 through the end of 8.509.50.G.2.a.iii. This rule is effective September 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules Mental Health Transitional Living Homes, Section 8.509.50
Rule Number: MSB 23-04-12-B
Division / Contact / Phone: Office of Community Living / Cassandra Keller / 5181

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 has worked with the Colorado Department of Human Services (CDHS) in the development of the new residential settings. There are two levels of service that will be provided within these settings. Under the Community Mental Health Supports (CMHS) Home and Community Based Services (HCBS) waiver, the Department has developed a new residential service titled "Mental Health Transitional Living homes (MHTL). This residential service will include protective oversight and supervision; assistance with medication; community participation; recreational and social activities; intensive case management/care coordination; housing planning and navigation services as appropriate for clients experiencing homelessness/at risk for homelessness; life skills training/ADL support as needed; and therapeutic services, which may include but is not limited to individual and group therapy, medication management, etc. Only the Level 1 homes will be an HCBS benefit and available only to members who are on the CMHS waiver.

   This benefit has been added to the Department's waiver agreement with the Centers for Medicare and Medicaid Services (CMS). In order to operationalize the MHTL homes, the Department must promulgate regulations for the service and align with the waiver agreement. These rules outline member eligibility, provider requirements, environmental standards, and reimbursement information.

   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:

3. State Authority for the Rule:

Initial Review **07/14/23** Final Adoption **08/11/23**
Proposed Effective Date **09/30/23** Emergency Adoption

DOCUMENT #05

DO NOT PUBLISH THIS PAGE

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023); compliance with 27-71-101 C.R.S. (2023)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules Mental Health Transitional Living Homes, Section 8.509.50
Rule Number: MSB 23-04-12-B
Division / Contact / Phone: Office of Community Living / Cassandra Keller / 5181

REGULATORY ANALYSIS

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

   Members on the Community Mental Health Supports (CMHS) waiver will benefit from this proposed rule. Mental Health Transitional Living Home is a residential service designed for individuals that require 24/7 care to develop skills necessary for daily living to assist with successful reintegration into lower-level services and/or into the community. There is a gap in the state's mental-health system in which many patients are ready to step down from an inpatient level of care at the state's Mental Health Institutes but cannot, due to the lack of a transitional, less restrictive residential level of care appropriate to their needs. The Mental Health Transitional Living Home will serve as a step-down setting for individuals who are ready to transition into the community but still require supportive interventions to teach them how to live independently beyond the walls of residential care. Funding for this program has been appropriated through HB 22-1303. There will be no additional costs to the Department or stakeholders.

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

   This new benefit will offer approximately 75 waiver beds, providing much needed transitional support to members. Individuals utilizing this service will be transitioning from institutional settings where there is little autonomy or ability for independent decision making. This service and the specially trained staff will support members in acclimating to community living where they will have more independence and will be required to make decisions for themselves. Staff will focus on life skills training and developing the skills needed to successfully support themselves in community living. By creating a step-down setting, individuals who are ready to leave an institutional setting but cannot, due to the lack of a transitional, less restrictive residential level of care appropriate to their needs, will now have the option to do so.

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.

All funds needed to operate these residential settings have been appropriated through HB 22-1303.

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

   Implementing these rules ensures that the Department is compliant with state law. By being out of compliance with state law, the Department risks state support and funding for these invaluable HCBS services.

   Additional benefits include providing members HCBS services a lower level of care in a community-based setting. The Mental Health Transitional Living Home Service will provide the types of services and supports these individuals need in order to transition from institutional care to living in the community.

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 to achieve the purpose of this proposed rule. These regulations must be implemented in order to come into compliance with a newly signed state law.

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

   No alternative methods were considered.

8.509 HOME AND COMMUNITY-BASED SERVICES FOR COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS)

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the income maintenance technician of any and all changes in the Client's participation in HCBS-CMHS and shall provide the technician with copies of the first page of all URC-approved ULTC-100.2 forms.

2. The case manager shall inform all Alternative Care Facility Clients of their obligation to pay the full and current state-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

3. If the Client has an open service case file at the county department of social services, the case manager shall keep the Client's caseworker informed of the Client's status and shall participate in mutual staffing of the Client's case.

4. The case manager shall inform the Client's physician of any significant changes in the Client's condition or needs.

5. Within five (5) working days of receipt, from the State or it; agent, of the approved Prior Authorization Request form, the case manager shall provide copies to all the HCBS-CMHS providers in the case plan.

6. The case manager shall notify the URC, on a form prescribed by the state of the outcome of all non-diversions, as defined at Section 8.509.14.

7. The case manager shall report to the Colorado Department of Public Health and Environment any congregate facility which is not licensed.

8. The case management agency shall notify the state of any Client appeals which are initiated as a result of denials or terminations made by the case management agency.

B. CASE RECORDING/DOCUMENTATION

1. The case management agency shall maintain records on every individual for whom intake was conducted, including a copy of the intake form. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the case management agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.

2. The case record shall include:

   a. Identifying information, including the state identification (Medicaid) number, and

b. All state-required forms; and

c. Documentation of all case management activity required by these regulations.

3. Case management documentation shall meet all the following standards:

a. A separate case record shall be maintained for each Client receiving services in the Home and Community-based Services for Community Mental Health Supports Program.

b. Documentation shall be legible;

c. Entries shall be written at the time of the activity or shortly thereafter,

d. Entries shall be dated according to the date of the activity, including the year;

e. Entries shall be made in permanent ink or digital signature;

f. The Client shall be identified on every page;

g. The person making each entry shall be identified;

h. Entries shall be concise, but shall include all pertinent information;

i. All information regarding a Client shall be kept together for easy access and review by case managers, supervisors, program monitors and auditors;

j. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact, or is a judgment or conclusion on the part of anyone;

k. All persons and agencies referenced in the documentation shall be identified by name and by relationship to the Client;

l. All forms prescribed by the State shall be filled out by the case manager to be complete, correct and accurate.

m. If the individual is unable to sign a form requiring his/her signature because of a medical condition, a digital signature or any mark the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of guardian or other authorized representative will be accepted.

4. All records shall be kept for the period of time specified in the case management agency contract, and shall be made available to the state as specified in the contract.

8.509.40 HCBS-CMHS PROVIDERS

A. Any provider agency with a valid contract to provide HCBS-EBD services, according to Section 8.487, shall be deemed certified to provide the same services to HCBS-CMHS Clients.

8.509.50 MENTAL HEALTH TRANSITIONAL LIVING HOMES

A. Definitions

1. Activities of daily living (ADLs) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and supervision to support behavior, medical needs and memory/cognition.

2. Authorized Representative means an individual designated by a member, or by the parent or guardian of the member receiving services, if appropriate, to assist the member receiving services in acquiring or utilizing services and supports. This does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) or In-Home Support Services (IHSS).

3. Case Management Agency means a public, private, or non-governmental non-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to section 25.5-10-209.5 C.R.S. and that has signed a provider participation agreement with the state department.

4. Department means the Department of Health Care Policy and Financing, the Single State Medicaid Agency.

5. Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; or it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to, injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

6. Medication Administration as described in 25-1.5-301, C.R.S., means assisting a member with taking medications while using standard healthcare precautions, according to the legibly written or printed order of an attending physician or other authorized practitioner. Medication administration may include assistance with ingestion, application, inhalation, and rectal or vaginal insertion of medication, including prescription drugs. “Administration” does not include judgment, evaluation, assessment, or the injections of medication, the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by the member.

7. Mental Health Transitional Living Home (MHTL) Certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to the Department after the provider has met all licensing and regulatory requirements.

8. Protective Oversight means monitoring and guidance of a member to assure their health, safety, and well-being. Protective oversight includes but is not limited to: monitoring the member while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the member to carry out activities of daily living, and facilitating medical and other health appointments.

9. Person-Centered Support Plan means a service and support plan that is directed by the member whenever possible, with the member’s representative acting in a participatory role as needed, is prepared by the case manager under Sections 8.393.2.E or 8.519.11, identifies the supports needed for the individual to achieve personally identified goals, and is based on respecting and valuing individual preferences, strengths, and contributions.

10. Provider means the entity that is enrolled with the Department and holds the Assisted Living Residence license and MHTL certification.

B. Member Eligibility

1. MHTL services are available to members who meet the following requirements:

   a. Members are enrolled in the HCBS-CMHS waiver; and

   b. Members require the specialized services provided under the MHTL as determined by assessed need.

C. Member Benefits

1. The MHTL service will assist the member to reside in the most integrated setting appropriate to their needs. Staff will be specifically trained to support members with a severe and persistent mental illness and who may be experiencing a mental health crisis or episode.

2. This residential service will include the following:

   a. Protective oversight and supervision;

   b. Assistance with administering medication and medication management;

   c. Assistance with community participation and support in accessing the community;

   d. Assistance with recreational and social activities;

   e. Housing planning and navigation services as appropriate for members experiencing homelessness/at risk for homelessness;

   f. Life skills training; and

   ~~a.~~g. ADL support as needed.

3. Room and board is not a benefit of MHTL services. Members are responsible for room and board in an amount not to exceed the Department's established rate.

4. Additional services that are available as a State Plan benefit or other HCBS-CMHS waiver service are not a MHTL benefit.

5. Member engagement opportunities shall be provided by the MHTL home, as outlined in 6 CCR 1011-1, Chapter VII, Section 12.19-26.

D. Member Rights

1. Members shall be informed of their rights, according to 6 CCR 1011-1, Chapter VII, Section 13 and 10 CCR 2505-10 8.484. Any modification of those rights shall be in accordance with Section 8.484.5. Pursuant to 6 CCR 1011-1, Chapter VII, Section 13.1, the policy on resident rights shall be in a visible location so that they are always available to members and visitors.

2. Members shall be informed of all policies specific to the MHTL setting upon admission to the setting, and when changes to policies are made, rules and/or policies shall apply consistently to the administrator, staff, volunteers, and members residing in the facility

and their family or friends who visit. Member acknowledgement of rules and policies must be documented in the support plan or a resident agreement.

3. If requested by the member, the MHTL home shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal possessions.

E. Provider Eligibility

1. To be certified as an MHTL provider, the entity seeking certification must be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. VII.

2. Applicants for MHTL Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by the Colorado Division of Fire Prevention and Control (DFPC).

3. MHTL providers must receive a recommendation for MHTL Certification. CDPHE issues a recommendation for MHTL Certification to the Department when the provider is in full compliance with the requirements set forth in these regulations.

4. No recommendation for MHTL Certification shall be issued if the owner, applicant, or administrator of the MHTL has been convicted of a felony or misdemeanor involving a crime of moral turpitude or that involves conduct that the Department determines could pose a risk to the health, safety, or welfare of the members residing in the MHTL setting.

5. All MHTL homes are operated or contracted by the Department of Human Services or Behavioral Health Administration.

F. Provider Roles and Responsibilities

1. Service Requirements

a. The facility shall provide Protective Oversight and MHTL services to members every day of the year, 24 hours per day.

b. MHTL providers shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 CCR 1011-1, Chapter VII and XXIV, Medication Administration Regulations.

c. MHTL providers shall not discontinue services to a member unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services in accordance with 6 CCR 1011-1, Ch. VII Section 11.

d. Providers shall maintain the following records/files:

i. Personnel files for all staff and volunteers shall include:

1) Name, home address, phone number and date of hire.

2) Job description, chain of supervision and performance evaluation(s).

3) Trainings completed by the staff member and date of completion.

ii. Member files shall be kept confidential and shall include:

1) The member's intake assessment, support plan and signed resident agreement.

2) Providers must document and keep a record of each medication administered, including the time and the amount taken.

e. The provider shall encourage and assist members' participation in engagement opportunities and activities within the MHTL home community and the wider community, when appropriate.

f. The provider shall develop emergency policies that address, at a minimum, a plan that ensures the availability of, or access to, emergency power for essential functions and all member-required medical devices or auxiliary aids.

2. Person Centered Support Plan

a. The support plan must outline the goals, choices, preferences, and needs of the member. Medical information must also be included, specifically:

i. If the member is taking any medications and how they are administered, with reference to the Medication Administration Record (MAR);

ii. Supports needed with ADLs;

iii. Special dietary needs, if any; and

iv. Reference to any documented physician orders.

b. The support plan must contain evidence that the member and/or their guardian, designated representative, or legal representative has had the opportunity to participate in the development of the support plan, has reviewed it, and has signed in agreement with the plan.

3. Incident Reporting

a. An Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a member. An incident may endanger or negatively impact the mental and/or physical well-being of a member.

b. Case management agencies and providers shall have a written policy and procedure for the timely reporting, recording and reviewing of incidents which shall include, but not be limited to:

i. Death of member receiving services;

ii. Hospitalization of member receiving services;

iii. Medical emergencies, above and beyond first aid, involving member receiving services;

iv. Allegations of abuse, neglect, exploitation, or mistreatment;

v. Injury to member or illness of member;

vi. Damage or theft of member's personal property;

vii. Errors in medication administration;

viii. Lost or missing person receiving services;

ix. Criminal activity;

x. Incidents or reports of actions by member receiving services that are unusual and require review; and

xi. Use of a rights modification.

c. A provider must submit a verbal or written report of every incident to the HCBS member's Case Management Agency (CMA) case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

i. Name of person reporting;

ii. Name of member who was involved in the incident;

iii. Member's Medicaid identification number;

iv. Name of persons involved or witnessing the incident;

v. Incident type;

vi. Date, time, and duration of incident;

vii. Location of incident;

viii. Persons involved;

ix. Description of incident;

x. Description of action taken;

xi. Whether the incident was observed directly or reported to the provider;

xii. Name of person notified;

xiii. Follow-up action taken or where to find documentation of further follow-up;

xiv. Name of the person responsible for follow up; and

xv. Resolution, if applicable.

a. If any of the above information is not available within 24 hours of the incident and not reported to the CMA case manager, a follow-up to the initial report must be completed.

b. Additional follow up information may also be requested by the case manager, or the Department. A provider agency is required to submit all follow up information within the timeframe specified by the requesting entity.

c. Case management agencies and providers shall review and analyze information from incident reports to identify trends and problematic practices which may be occurring in specific services and shall take appropriate corrective action to address problematic practices identified.

4. Staffing

a. The MHTL home must have appropriate staffing levels to meet the individual acuity, needs and level of assistance required of the members in the setting.

b. In addition to the trainings outlined in 6 CCR 1011-1, Ch. VII, Section 7, staff must be trained in the following topics prior to working independently with members:

i. Mental Health First Aid.

ii. Question, Persuade, Refer (QPR).

iii. Suicide and Homicide Risk Screenings.

iv. Trauma Informed Care Methodologies and Techniques.

v. Symptom Management.

vi. Behavior Management.

vii. Motivational Interviewing.

viii. Transitional Planning.

ix. Community Reinforcement and Family Training.

G. Reimbursement

1. MHTL services are reimbursed on a per diem basis, as determined by the Department. Providers must be certified and enrolled with the Department prior to rendering services.

2. Additional Charges

a. Providers shall not bill supplemental charges to any members, except for amounts designated as copayments by the Department.

i. Federal regulations require that Medicaid providers accept Medicaid reimbursements as payment in full (42 C.F.R. § 447.15). Section 25.5-4-301(1), C.R.S., prohibits providers from charging members or their responsible parties for Medicaid services covered under Title XIX of the Social Security Act.

ii. HCBS members are not liable for the cost or additional cost of any waiver service

iii. Disallowed supplemental charges include, but are not limited to, any fees such as enrollment fees or one-time fees, annual or monthly fees, registration fees, program placement hold fees, fees for supplies, basic utilities.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960
Rule Number: MSB 23-06-29-A
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 23-06-29-A, Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960

3. This action is an adoption of: an amendment

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

   Sections(s) 25.5-1-301 through 25.5-1-303, 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 in Appendix A with the proposed text beginning at Appendix A through the end of Appendix A. This rule is effective September 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960
Rule Number: MSB 23-06-29-A
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).

   Current rule states the max program fees of the Dental Health Program for Low-Income Seniors must not fall below Medicaid dental rates. Medicaid received a 3% increase for the dental rates for FY2023-24. This made some of the program rates in Schedule A fall below the Medicaid rate. This change is necessary to stay in compliance with rule.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

Initial Review
Proposed Effective Date **09/30/23**
Final Adoption **08/11/23**
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960
Rule Number: MSB 23-06-29-A
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.

   The increase in program rates will not affect any classes and there will be no incurred costs for any classes.

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

   There will be no quantitative or qualitative impact to any classes.

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 will have no fiscal impact with this rule change. The funds for the Dental Health Care Program for Low-Income Seniors are appropriated, and this rule update will have no effect on the appropriation.

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

   There will be no costs to the Department. The benefits will be for the Department to be in compliance with current rule.

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

   The Department does not foresee any fiscal impact on this rule change and there are not any less costly methods that were considered.

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.

DO NOT PUBLISH THIS PAGE

There are no alternative methods for staying in compliance with current rule.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.A Definitions

1. 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.

2. 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.

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

4. 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.

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

6. Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2020).

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

8. 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.

9. Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, 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.

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

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

12. 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.

13. 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).

14. 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.

15. 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.

16. 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.

17. Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2020).

18. Medicare 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.

19. Medicare Advantage Plans 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.

20. 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. (2020).

21. 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.

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

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

24. 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.

25. 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.

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

27. 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:

    a. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2020);

    b. A community-based organization or foundation;

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

    d. A local public health agency; or

e. A private dental practice.

28. 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.

29. 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.

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

31. Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2020).

8.960.B Legal Basis

8.960.B.1 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. (2020).

8.960.C Request of Grant Proposals and Grant Award Procedures

8.960.C.1. Request for Grant Proposals

8.960.C.1.a 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.C.2 Evaluation of Grant Proposals

8.960.C.2.a 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.C.3 Grant Awards

8.960.C.3.a 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.C.4 Qualified Grantee Responsibilities

8.960.C.4.a 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) Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;

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

8) Submit an annual report as specified under section 8.960.3.F.

8.960.C.5 Invoicing

8.960.C.5.a 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;

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

8.960.C.6 Annual Report

8.960.C.6.a 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.

8.960.C.6.b 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

5) 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 includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the client. Report additional diagnostic procedures separately. Frequency: One time per 6 month period per client.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Limited oral evaluation - problem focused	D0140	$62.00	$52.00	$10.00	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. Frequency: Two of D0140 per year per grantee. Not reimbursable on the same date as D0120 or D0150. Dental hygienists may only provide for an established client of record.

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - comprehensive series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, intended to display the crowns & roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. 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	Six of D0220 per 12 months per client. Report additional radiographs as D0230. Working and final endodontic treatment films are not covered. Any combination of D0220 through 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
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 must be utilized for additional films taken beyond D0220. Working and final endodontic treatment films are included in the endo codes. Not covered if billed with D3310, D3320, or D3330. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewing - single radiographic image	D0270	$26.00	$26.00	$0.00	Frequency: 1 in a 12 month period. Any combination of D0220 through 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 through 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 through 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 - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through 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
Vertical bitewings – seven to eight radiographic images	D0277	$68.32	$68.32	$0.00	Frequency: 1 time in a 12-month period. Counts as an intraoral complete series. Any combination of D0220 through 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.
Application of caries arresting medicament – per tooth	D1354	$5.8871	$5.8871	$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 tooth number.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Caries preventive medicament application – per tooth	D1355	$5.6347	$5.6347	$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 tooth number.
Amalgam Restorations (including polishing): Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).					
Amalgam - one surface, primary or permanent	D2140	$117.862.67	$107.862.67	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - two surfaces, primary or permanent	D2150	$147.831.20	$137.831.20	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - three surfaces, primary or permanent	D2160	$179.020.88	$169.020.88	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	$214.8304.96	$204.83194.96	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-Based Composite Restorations – Direct: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).					

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	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	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	Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.

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

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

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - full cast predominantly base metal	D2791	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast noble metal	D2792	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
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.
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care) Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of 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.					

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	Frequency: One D3310 per lifetime per client per tooth. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Frequency: One D3320 per lifetime per client per tooth. 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	Frequency: One D3330 per lifetime per client per tooth. 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. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in others.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. • 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. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in. 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 oral evaluation and diagnosis on a subsequent visit	D4355	$98.27~~4.02~~	$88.27~~4.02~~	$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 and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It 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	$914.72~~874.52~~	$834.72~~794.52~~	$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. 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	$916.22~~875.94~~	$836.22~~795.94~~	$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. 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	$914.72~~874.52~~	$834.72~~794.52~~	$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 Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	$916.22~~875.94~~	$836.22~~795.94~~	$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. Immediate Denture Form must be on file.

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	$884.0044.31	$824.00784.31	$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	$884.0044.31	$824.00784.31	$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	$635.32~~07.61~~	$575.32~~47.61~~	$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. Immediate Denture Form must be on file.

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	$635.32~~07.61~~	$575.32~~47.61~~	$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. Immediate Denture Form must be on file.

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	$884.0044.31	$824.00784.31	$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. Immediate Denture Form must be on file.

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	$884.0044.31	$824.00~~784.31~~	$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. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5225	$784.34~~63.24~~	$724.34~~03.24~~	$60.00	Reimbursement made upon delivery of a partial maxillary denture to the client. D5225 and D5226 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 flexible 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 flexible 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 maxillary per every three 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 – flexible base (including retentive/clasping materials, rests, and teeth)	D5226	$784.3463.24	$724.3403.24	$60.00	Reimbursement made upon delivery of a partial mandibular denture to the client. D5225 and D5226 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 flexible 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 flexible 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 three years - documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair broken complete denture base, mandibular	D5511	$129.453.70	$119.453.70	$10.00	Repair broken complete mandibular denture base. Frequency: two of D5511 per 12 months per client.
Repair broken complete denture base, maxillary	D5512	$129.453.70	$119.453.70	$10.00	Repair broken complete maxillary denture base. Frequency: two of D5512 per 12 months per client.
Replace missing or broken teeth - complete denture (each tooth)	D5520	$97.112.91	$87.112.91	$10.00	Replacement/repair of missing or broken teeth. Teeth 1 – 32 and must report tooth number.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Repair resin partial denture base, mandibular	D5611	$97.795.00	$87.795.00	$10.00	Repair resin partial mandibular denture base. Frequency: two D5611 per 12 months per client.
Repair resin partial denture base, maxillary	D5612	$97.795.00	$87.795.00	$10.00	Repair resin partial maxillary denture base. Frequency: two D5612 per 12 months per client.
Repair cast partial framework, mandibular	D5621	$126.931.29	$116.931.29	$10.00	Repair cast partial mandibular framework. Frequency: two D5621 per 12 months per client.
Repair cast partial framework, maxillary	D5622	$126.931.29	$116.931.29	$10.00	Repair cast partial maxillary framework. Frequency: Two D5622 per 12 months per client.
Repair or replace broken retentive/clasping materials – per tooth	D5630	$137.121.00	$127.121.00	$10.00	Repair of broken clasp on partial denture base – per tooth. Teeth 1 – 32, report tooth number(s).
Replace broken teeth-per tooth	D5640	$98.274.02	$88.274.02	$10.00	Repair/replacement of missing tooth. Teeth 1 – 32, report tooth number(s).
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. Teeth 1 – 32, report tooth number(s).
Add clasp to existing partial denture	D5660	$142.4336.05	$132.4326.05	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Rebase complete maxillary denture	D5710	$322.00	$297.00	$25.00	Frequency: one 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 complete mandibular denture	D5711	$322.00	$297.00	$25.00	Frequency: one 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	Frequency: one 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 mandibular partial denture	D5721	$304.00	$279.00	$25.00	Frequency: one 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	$186.552.00	$176.552.00	$10.00	Frequency: One 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	$186.552.00	$176.552.00	$10.00	Frequency: One 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	$184.2175.82	$174.2165.82	$10.00	Frequency: one 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 mandibular partial denture (chairside)	D5741	$185.9777.49	$175.9767.49	$10.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete maxillary denture (laboratory)	D5750	$248.663.00	$223.6618.00	$25.00	Frequency: one 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	$249.813.00	$224.8118.00	$25.00	Frequency: one 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	$246.8939.00	$221.8914.00	$25.00	Frequency: one 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	$246.8939.00	$221.8914.00	$25.00	Frequency: one 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	$116.931.78	$106.931.78	$10.00	Removal of tooth structure, minor smoothing of socket bone, and closure as necessary. Frequency: One D7140 per lifetime per client per tooth. Teeth 1 – 32.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$181.12~~72.88~~	$171.12~~62.88~~	$10.00	Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure. Frequency: One of D7210 per lifetime per client per tooth. Teeth 1 - 32
Removal of impacted tooth-soft tissue	D7220	$216.73~~07.25~~	$196.73~~87.25~~	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32. Frequency: One of D7220 per 1 lifetime per client per tooth.
Removal of impacted tooth-partially bony	D7230	$267.45~~55.53~~	$247.45~~35.53~~	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7230 per 1 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	$310.37~~296.38~~	$290.37~~76.38~~	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$407.88~~389.20~~	$387.88~~69.20~~	$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. Frequency: One of D7241 per lifetime per patient per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of residual tooth roots (cutting procedure)	D7250	$191.02~~82.30~~	$181.02~~72.30~~	$10.00	Includes cutting of soft tissue and bone, removal of tooth structure, and closure. Cannot be charged for removal of broken off roots for recently extracted tooth. Teeth 1 – 32 Frequency: One D7250 per lifetime per patient per tooth.
Primary closure of a sinus perforation	D7261	$476.03~~52.46~~	$466.03~~42.46~~	$10.00	Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fisulous tract. Narrative of medical necessity may be required and if the sinus perforation was caused by a current grantee or provider of the program.
Incisional biopsy of oral tissue-soft	D7286	$381.00	$381.00	$0.00	For partial removal of an architecturally intact specimen only. D7286 is not used at the same time as codes for apicoectomy/periradicular curettage and does not entail an excision. 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	D7310 is distinct (separate procedure) from extractions. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7310 or D7311 per lifetime per patient per quadrant. Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$145.97~~39.42~~	$135.97~~29.42~~	$10.00	D7311 is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7311 or D7310 per lifetime per patient per quadrant. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$210.11~~00.47~~	$200.11~~190.47~~	$10.00	No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	$210.11~~00.47~~	$200.11~~190.47~~	$10.00	No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of lateral exostosis (maxilla or mandible)	D7471	$304.28~~290.11~~	$294.28~~80.11~~	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Reported per arch (LA or UA)
Removal of torus palatinus	D7472	$357.83~~41.08~~	$347.83~~31.08~~	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Must list quadrant.
Removal of torus mandibularis	D7473	$349.01~~32.69~~	$339.01~~22.69~~	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Must list quadrant.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins. One of D7510 per lifetime per client per tooth. Report per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Palliative treatment of dental pain – per visit	D9110	$80.9278.23	$55.923.23	$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	$42.971.72	$42.971.72	$0.00	One of D9219 or D9310 per 12 month(s) per grantee
Deep sedation/general anesthesia-each 15 minute increment	D9223	$108.133.40	$98.133.40	$10.00	Nine of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	$122.5109.23	$112.5199.23	$10.00	One of D9239 per 1 day per patient.
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$108.133.40	$98.133.40	$10.00	Thirteen of D9243 per 1 day per patient. Not allowed with D9223

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-06-29-B
Home and Community Based Services Division / Erin Thatcher / 5788

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 23-06-29-B, Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers

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) 8.511 and 8.535, Colorado Department of Health Care Policy and Financing, Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? N0
   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 8.511 with the proposed text beginning at 8.511.1 through the end of 8.511.4.G. Replace the current text at 8.535 with the proposed text beginning at 8.535.1 through the end of 8.535.2.D.7. This rule is effective September 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-06-29-B
Home and Community Based Services Division / Erin Thatcher / 5788

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).

   An increase to the currently approved direct care worker Base Wage has been approved by the General Assembly effective July 1, 2023. The Base Wage rule will be amended to remove exact dates and rates, so that future increases can be implemented quickly without further amendments. Additionally, the rule has been simplified and reorganized. For example, the Department will remove Base Wage regulations from the Pediatric Personal Care Rule (8.535) and reference the main Base Wage rule within 8.511. Future notices of Base Wage increases will be posted on the Provider Rates and Fee Section of the website.

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:

   Senate Bill 23-214 approved May 1, 2023;

   25.5-6-18 C.R.S. (2021) & Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023)

Initial Review — Final Adoption **08/11/23**
Proposed Effective Date **09/30/23** — Emergency Adoption

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-06-29-B
Home and Community Based Services Division / Erin Thatcher / 5788

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.

   Direct Care Workers are the most impacted by this proposed rule. They continue to benefit from an increased base wage, which promotes stability for the workers themselves, HCBS providers and members receiving services. The Department has increased reimbursement rates to offset costs to HCBS provider agencies in implementation of this rule. Provider agencies and Department staff will be impacted in the effort to implement and monitor compliance with this rule.

2. 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 received approval and funding to increase the Base Wage via Senate Bill 23-214. Providers will receive increased reimbursement rates and are responsible for ensuring Direct Care Workers' wages are compliant with the Base Wage. The Department has existing policies and mechanisms in place to monitor compliance of the Base Wage. HCBS provider agencies and Direct Care Workers will benefit from streamlined processes and simplified rules.

   The existing rule outlines that HCBS providers may incur penalties and recoupment if they do not comply with the necessary reporting requirements of this rule. This provision has not changed.

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

   The Department will utilize funding authorized through the General Assembly to fund the associated rate increases and complete the auditing requirements needed for the implementation of this rule. No additional budgetary impact is expected from the implementation of this rule.

   If this rule is not approved, the Department will be unable to hold providers accountable for ensuring Direct Care Workers receive an increase to their Base

Wage. This will further exacerbate workforce challenges and retention of staff, impacting members receiving these critical home and community-based services.

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

   The Department is amending the rule to remove rates and dates that would require an amendment for every rate change impacting the Base Wage. This is the most effective way to ensure the Base Wage is enforced.

5. 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 less costly solutions to achieve the purpose of this proposed rule.

8.511 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.511.1 DEFINITIONS

Definitions below only apply to Section 8.511.

A. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of Home and Community-Based Services (HCBS) required by the Colorado Department of Health Care Policy and Financing. ~~For the purposes of this rule, the base wage shall be $15.00 effective January 1, 2022~~ The Department shall publish current and previous Base Wage rates and related effective dates on the Provider Rates and Fee Schedule website.

B. Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

C. Direct Care Worker means a non-administrative employee or independent contractor of a Provider Agency or Participant Directed Program Employer of Record who provides hands-on care, services, and support to older adults and individuals with disabilities across the long-term services and supports continuum within home and community-based settings.

D. Minimum Wage means the rate of pay established in accordance with Section 15 of Article XVIII of the State Constitution and any other minimum wage established by federal or local laws or regulations. In addition to state wage requirements, federal or local laws or regulations may apply minimum, overtime, or other wage requirements to some or all Colorado employers and employees. If an employee is covered by multiple minimum or overtime wage requirements, the requirement providing a higher wage, or otherwise setting a higher standard, shall apply.

E. Plan of Correction means a formal, written response from a provider agency to the Department on identified areas of non-compliance with requirements listed in Section 8.511.4.

F. Participant Directed Program means a service model that provides participants who are eligible for Home and Community-Based Services the ability to manage their own in-home care, or have care managed by an authorized representative, provided by a direct care worker. Participant Directed Program participants, or their authorized representative, operate as Employers of Record with an established FEIN.

G. Provider means any person, public or private institution, agency, or business enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods. Pursuant to this rule, a provider that renders qualifying service(s) accepts responsibility to ensure qualifying Direct Care Workers currently under their employment are paid, at a minimum, the base wage.

H. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of Home and Community-Based Services (HCBS). For purposes of this rule, the per diem wage shall apply to Direct Care Workers of residential service providers.

8.511.2 QUALIFYING SERVICES

A. When applicable, t~~Effective January 1, 2022, T~~the Department will increase reimbursement rates for select ~~Home and Community-Based S~~services to support the base wage. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher within the timeframe established by the Department. Services requiring Direct Care Workers to be paid at least the base wage ~~are as follows~~include:

1. Adult Day Services

2. Alternative Care Facility (ACF)

3. Community Connector

4. Consumer Directed Attendant Support Services (CDASS)

5. Foster Care Home (Children's Habilitation Residential Program)

6. Group Home Habilitation (CHRP)

7~~5~~. Group Residential Support Services (GRSS)

8~~6~~. Homemaker

9~~7~~. Homemaker Enhanced

10. Host Home~~-~~ (CHRP)

11~~8~~. In-Home Support Services (IHSS)

12~~9~~. Individual Residential Support Services (IRSS)

13~~10~~. Job Coaching

14~~1~~. Job Development

15. Mental Health Transitional Living Homes

16~~2~~. Mentorship

17~~3~~. Pediatric Personal Care

18. Personal Care

19~~4~~. Prevocational Services

20~~15~~. Respite

~~16~~21. Specialized Habilitation

~~17~~22. Supported Community Connections

~~18~~23. Supported Living Program

B. In the event that a Direct Care Worker, based on state or local minimum wage laws, is eligible for a minimum wage that exceeds the base wage requirement, the Provider is required to compensate at the higher wage.

C. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage ~~effective January 1, 2022~~ by the percent of the Department's ~~January 1, 2022~~ reimbursement rate increase.

D. ~~Effective July 1, 2022, the Department will increase reimbursement rates for Foster Care Home, Host Home, and Group Home Habilitation service in the Home and Community Based Services-Children's Habilitation Residential Program (CHRP) waiver. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher.~~

~~1. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage effective July 1, 2022 by the percent of the Department's July 1, 2022 reimbursement rate increase.~~The Department may add additional qualifying services that are applicable to this rule and not listed above.

8.511.3 PROVIDER RESPONSIBILITIES

A. The Provider must ensure that contact information on file with the Department is accurate; information shall be utilized by the Department to complete oversight responsibilities per Section 8.511.4.

B. ~~Providers shall notify Direct Care Workers who are affected by the base wage requirement each fiscal year. up to and including Fiscal Year 2023-2024.~~

~~1. Provider shall utilize the Department provided letter.~~Providers shall notify Direct Care Workers annually who are affected by the base wage requirement about Direct Care Worker rights, Direct Care Employer obligations, and the minimum state and local direct care employment standards.

C. Providers shall publish and make readily available the Department's designated contact for Direct Care Workers to submit questions, concerns or complaints regarding the base wage requirement.

D. ~~On or before June 30, 2022 and June 30, 2023th of each calendar year, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.~~

~~1. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:~~

~~a. Full-time or part-time employment status.~~

~~b. Whether the Direct Care Worker is an Employee or Independent Contractor.~~

~~c. Employee start date if after January 1, 2022 of the current calendar year.~~

~~d. Direct Care Workers' hourly base wage as of November 1 of the prior calendar year, 2021 and current hourly base wage.~~

~~e. Current service(s) provided by each employee.~~

~~2. IRSS Providers and/or Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:~~

~~a. Full-time or part-time employment status.~~

~~b. Whether the Direct Care Worker is an Employee or Independent Contractor.~~

~~c. Employee start date if after January 1, 2022 of the current calendar year.~~

d. Direct Care Workers' per diem wage as of December 1 of the prior calendar year, 2021 and per diem wage as of January 1, 2022 of the current calendar year.

3. CDASS Authorized Representatives/Employers of Record are exempt from attestation requirements.Providers shall submit specific information for each Direct Care Worker regarding wage rates, working hours, benefits, work location, employment status, employment type, services provided, independent contractor agreements, and any other wage related information as requested by the Department. Providers shall submit the requested information to the Department within the Department-specified timeframe.

E. For CHRP Habilitation Foster Care Home, Host Home, and Group providers, on or before June 30, 2023, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

1. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after July 1, 2022.

d. Direct Care Workers' hourly base wage as of May 1, 2022 and current hourly base wage.

e. Current service(s) provided by each employee.

2. Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

a. Full-time or part-time employment status.

b. Whether the Direct Care Worker is an Employee or Independent Contractor.

c. Employee start date if after July 1, 2022.

d. Direct Care Workers' per diem wage as of June 1, 2022 and per diem wage as of July 1, 2022.

FE. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the applicablelisted services within Section 8.511 received at a minimum the base wage or a per diem wage increase.

GF. Records shall be retained for no less than six (6) years and shall be made available for inspection by the Department upon request. Records may include, but are not limited to:

1. Payroll summaries and details, pay stubs with details
2. Timesheets
3. Paid time off records
4. Cancelled checks (front and back)

5. Direct deposit confirmations

6. Independent contractor documents or agreements

7. Per diem wage documents

8. Accounting records such as: accounts receivable and accounts payable

8.511.4 REPORTING & AUDITING REQUIREMENTS

A. The Department has ongoing discretion to request information from providers to demonstrate that all Direct Care Workers received the wage (base or per diem) increase. All records related to the base wage requirement received by the Provider for the applicable services ~~listed in Section 8.511.2~~ shall be made available to the Department upon request, within specified deadlines.

B. Providers shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department.

C. Failure to submit Direct Care Worker information as required or failure to provide adequate documents and timely responses may result in the Provider being required to submit a plan of correction and/or recoupment of funds. The Department may suspend payment of claims until requested information is received and approved by the Department.

D. If a plan of correction is requested by the Department, the Provider shall ~~have forty-five (45) business days from the date of the request to respond.~~submit the plan of correction by the date specified by the Department. The Provider must notify the Department in writing within five (5) business days of receipt of the request if they will not be able to meet the deadline. The Provider must explain the rationale for the delay and the Department may or may not grant an extension in writing.

E. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider must resubmit a new plan of correction along with any requested documentation to the Department for review within five (5) business days of notification.

F. The Department may recoup part or all of the funding resulting from the base wage increase if the Department determines the Provider is not in compliance with Section 8.511.

G. If such determination is made to recoup funds, the Provider will be notified by the Department. All recoupments will be conducted pursuant to C.R.S. Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.050.6, Informal Reconsideration and Appeals of Overpayments Resulting from Review or Audit Findings.

8.535 PEDIATRIC PERSONAL CARE SERVICES

8.535.1 Pediatric Personal Care Services are provided in accordance with the provisions of Appendix A, which sets forth the coverage standards for the benefit.

8.535.2 Pediatric Personal Care providers are required to comply with all Base Wage requirements established in Section 8.511.

8.535.2 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.535.2.A DEFINITIONS

1. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of pediatric personal care services. For the purposes of this rule, the base wage shall be $15.00 effective January 1, 2022.

2. Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

3. Direct Care Worker means a non-administrative employee or independent contractor of a Provider Agency or Participant Directed Program Employer of Record who provides hands-on care, services, and support for personal pediatric care.

4. Minimum Wage means the rate of pay established in accordance with Section 15 of Article XVIII of the State Constitution and any other minimum wage established by federal or local laws or regulations. In addition to state wage requirements, federal or local laws or regulations may apply minimum, overtime, or other wage requirements to some or all Colorado employers and employees. If an employee is covered by multiple minimum or overtime wage requirements, the requirement providing a higher wage, or otherwise setting a higher standard, shall apply.

5. Plan of Correction means a formal, written response from a provider agency to the Department on identified areas of non-compliance with requirements listed in Section 8.535.2.D.

6. Provider means any person, public or private institution, agency, or business enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods. Pursuant to this rule, a provider that renders qualifying service(s) accepts responsibility to ensure qualifying Direct Care Workers currently under their employment are paid, at a minimum, the base wage.

7. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of pediatric personal care services. For purposes of this rule, the per diem wage shall apply to Direct Care Workers of residential service providers.

8.535.2.B QUALIFYING SERVICES

1. Effective January 1, 2022, the Department will increase reimbursement rates for pediatric personal care services. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher.

2. In the event that a Direct Care Worker, based on state or local minimum wage laws, is eligible for a minimum wage that exceeds the base wage requirement, the Provider is required to compensate at the higher wage.

3. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage effective January 1, 2022 by the percent of the Department's January 1, 2022 reimbursement rate increase.

8.535.2.C PROVIDER RESPONSIBILITIES

1. The Provider must ensure that contact information on file with the Department is accurate; information shall be utilized by the Department to complete oversight responsibilities per Section 8.535.2.D.

2. Providers shall notify Direct Care Workers who are affected by the base wage requirement each fiscal year up to and including Fiscal Year 2024-2025.

    a. Provider shall utilize the Department approved letter.

3. Providers shall publish and make readily available the Department's designated contact for Direct Care Workers to submit questions, concerns or complaints regarding the base wage requirement.

4. On or before June 30, 2022, providers shall attest to the Department that all Direct Care Workers receive at a minimum the required base wage or per diem wage increase.

    a. Providers with Direct Care Workers eligible for the base wage must attest that the base wage has been applied. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

        i. Full-time or part-time employment status.

        ii. Whether the Direct Care Worker is an Employee or Independent Contractor.

        iii. Employee start date if after January 1, 2022.

        iv. Direct Care Workers' hourly base wage as of November 1, 2021 and current hourly base wage.

        v. Current service(s) provided by each employee.

    b. IRSS Providers and/or Providers with Direct Care Workers earning a per diem wage must attest to the per diem wage increase. The attestation must include information regarding all eligible Direct Care Workers to include but not limited to:

        i. Full-time or part-time employment status.

        ii. Whether the Direct Care Worker is an Employee or Independent Contractor.

        iii. Employee start date if after January 1, 2022.

        iv. Direct Care Workers' per diem wage as of December 1, 2021 and per diem wage as of January 1, 2022.

5. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the pediatric personal care services received at a minimum the base wage or a per diem wage increase.

6. Records shall be retained for no less than six (6) years and shall be made available for inspection by the Department upon request. Records may include, but are not limited to:

    a. Payroll summaries and details

b. Timesheets

c. Paid time off records

d. Cancelled checks (front and back)

e. Direct deposit confirmations

f. Independent contractor documents or agreements

g. Per diem wage documents

h. Accounting records such as: accounts receivable and accounts payable

8.535.2.D REPORTING AND AUDITING REQUIREMENTS

1. The Department has ongoing discretion to request information from providers to demonstrate that all Direct Care Workers received the wage (base or per diem) increase. All records related to the base wage requirement received by the Provider for the services listed in Section 8.535.2.B shall be made available to the Department upon request, within specified deadlines.

2. Providers shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department.

3. Failure to provide adequate documents and timely responses may result in the Provider being required to submit a plan of correction and/or recoupment of funds.

4. If a plan of correction is requested by the Department, the Provider shall have forty-five (45) business days from the date of the request to respond. The Provider must notify the Department in writing within five (5) business days of receipt of the request if they will not be able to meet the deadline. The Provider must explain the rationale for the delay and the Department may or may not grant an extension in writing.

5. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider must resubmit a new plan of correction along with any requested documentation to the Department for review within five (5) business days of notification.

6. The Department may recoup part or all of the funding resulting from the base wage increase if the Department determines the Provider is not in compliance with Section 8.511.

7. If such determination is made to recoup funds, the Provider will be notified by the Department. All recoupments will be conducted pursuant to C.R.S. Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.050.6, Informal Reconsideration and Appeals of Overpayments Resulting from Review or Audit Findings.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1
Rule Number: MSB 23-06-29-C
Division / Contact / Phone: Health Policy 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 23-06-29-C, Revision to the Medical Assistance Act Rule concerning Cost Sharing

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) 8.754.1, 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 8.754 with the proposed text beginning at 8.754.1 through the end of 8.754.1.M.1. This rule is effective September 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1
Rule Number: MSB 23-06-29-C
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule removes member copayments for the following services in accordance with the 2023 Colorado Long Bill (Senate Bill 23-214), effective July 1, 2023: outpatient hospital visits; physician (M.D. or D.O.) office or home visits; rural health clinic visits; brief, individual, group and partial care community mental health center visits (except services which fall under Home and Community Based Service programs); pharmacy prescription or refill; optometrist visits; podiatrist visits; psychiatric services; durable medical equipment/disposable supply services; laboratory services; and radiology services.

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. (2023);
   Colorado Senate Bill 23-214

Initial Review
Proposed Effective Date **09/30/23**
Final Adoption **08/11/23**
Emergency Adoption

DOCUMENT #05

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1
Rule Number: MSB 23-06-29-C
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

   Members will be affected by the proposed rule.

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

   Members will not be required to provide copayments for the affected services.

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

   The Department estimates that removal of member copayments from affected services will cost $9,429,686 in total funds annually.

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

   The costs of the proposed rule are provided in question three response above. The benefit of the proposed rule is aligning Department rule with Senate Bill 23-214. The cost of inaction is misalignment between Department rule and Senate Bill 23-214. There are no benefits to inaction.

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

   There are no less costly methods or less intrusive methods for aligning Department rule with Senate Bill 23-214.

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

   There are no alternative methods to align Department rule with Senate Bill 23-214.

8.754 CLIENT CO-PAYMENT

8.754.1 CLIENT RESPONSIBILITY

Clients shall be responsible for the following co-payments:

8.754.1.A. Hospital outpatient, $~~4.00~~0.00 per visit, effective July 1, 2023.

8.754.1.B. Physician (M.D. or D.O) office or home visit, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.C. Rural health clinic, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.D. Brief, individual, group and partial care community mental health center visits except services which fall under Home and Community Based Service programs, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.E. Pharmacy, $~~3.00~~0.00 per prescription or refill, effective July 1, 2023.

8.754.1.F. Optometrist, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.G. Podiatrist, $~~2.00~~0.00 per visit, effective July 1, 2023.

8.754.1.H. Inpatient hospital, $~~25.00~~0.00 per admission, July 1, 2023.

~~8.754.1.I. Psychiatric services, $.50 per unit of service. A unit is a 15 minute segment.~~

8.754.1.~~J~~I. Durable medical equipment/disposable supply services, $~~1.00~~0.00 per date of service, effective July 1, 2023.

8.754.1.~~J~~K. Laboratory services, $~~1.00~~0.00 per date of service, July 1, 2023.

8.754.1.K~~L~~. Radiology services, $~~1.00~~0.00 per date of service, July 1, 2023.

8.754.1.L~~M~~. Emergency services, $0.00 co-pay.

1. ~~I~~For services that continue to have a co-pay under Section 8.754.2, it is the provider's responsibility to identify emergency on the claim form so that the fiscal agent can exempt the service from co-payment.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-06-29-D
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

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 23-06-29-D, Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443

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) 8.440 & 8.443, 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 8.440 with the proposed text beginning at 8.440.1 through the end of 8.440.39. Replace the current text at 8.443 with the proposed text beginning at 8.443 through the end of 8.443 title. Replace the current text at 8.443.1.B with the proposed text beginning at 8.443.1.B through the end of 8.443.1.B. Replace the current text at 8.443.6 through the end of 8.443.6.B.5.c. Replace the current text at 8.443.10 with the proposed text beginning at 8.443.10.A through the end of 8.443.10.B.6. This rule is effective September 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-06-29-D
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

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).

   House Bill (H.B.) 23-1228 increases nursing home reimbursement starting in state fiscal year (SFY) 2023-24. The proposed rule increases the SFY 2023-24 statewide average nursing home per-diem reimbursement rate by 10%, compared to a limited 2% or 3% increase in previous years. The proposed rule also increases the Cognitive Performance Scale (CPS) and Preadmission Screening and Resident Review (PASRR) II supplemental payment starting in SFY 2023-24, reimbursement for providing care to residents with cognitive and/or behavioral disabilities.

   The propose rule also makes necessary changes to the case mix adjustment applied to nursing home per diem reimbursement rates due to the current Resource Utilization Group (RUG) tool no longer utilized by the Center for Medicare & Medicaid Services (CMS) after October 1, 2023.

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.

3. Federal authority for the Rule, if any:

   42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

   25.5-4-402.4(4)(b), (g), C.R.S.

Initial Review — Final Adoption **08/11/23**
Proposed Effective Date **09/30/23** — Emergency Adoption

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-06-29-D
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

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.

   Nursing homes will benefit from the proposed rule. The statewide average nursing home per-diem reimbursement rate will increase by 10% in SFY 2023-24, compared to previous years where the increase was limited to 2% or 3%. Nursing homes providing care to more residents with mental health conditions, cognitive dementia, and/or developmental disabilities will benefit as their CPS and PSRR supplemental payments will increase starting in SFY 2023-24.

   Nursing homes providing care to less residents with mental health conditions, cognitive dementia, and/or developmental disabilities will bear the costs as other nursing home supplemental payments will be reduced to offset the CPS/PASRR supplemental payment increase. There are limited provider fee funds and an increase in one supplemental payment means a decrease to the other supplemental payments. The state and federal governments will bear the costs of the proposed rule by funding the increase to per-diem reimbursement rates to nursing homes.

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 10% increase in reimbursement rates equates to a $43 million reimbursement increase to nursing homes starting in SFY 2023-24. CPS and PASRR supplemental payments will increase by $5.75 million with a corresponding $5.75 million decrease to other supplemental payments.

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 state funding obligation is approximately $21.5 million per SFY. Additional costs include an increased administrative burden on Department staff for the implementation of these changes.

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

The benefit of the proposed rule includes additional reimbursement to nursing homes. The cost of the proposed rule is the additional administrative burden on Department staff to implement these changes. The cost of the proposed rule also includes an increased state funding obligation.

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 intrusive that still 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.

   No alternative methods were seriously considered by the Department to achieve the desired goal of the proposed rule.

8.440 NURSING FACILITY BENEFITS

Special definitions relating to nursing facility reimbursement:

1. "Acquisition Cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

2. "Actual cost" or "cost" means the audited cost of providing services.

3. "Administration and General Services Costs" means costs as defined at Section 8.443.8.

4. "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the valuation system as determined by the Department.

The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by the state board.

5. "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility providers in the state.

6. a. "Base value" means:

i. The appraised value of a capital-related asset for the fiscal year 1986-87 and every fourth year thereafter.

ii. The most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index, for each year in which an appraisal is not done pursuant to subparagraph (a) of this paragraph (1).

b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

c. An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

7. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

8. "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

9. "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to DONs, registered nurses, licensed practical nurses, certified nurse aides and restorative nurses.

DO NOT PUBLISH THIS PAGE

10. "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.
11. "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.
12. "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of Medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's Medicaid residents as further specified in this section.
13. "Class I nursing facility provider" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia. Swing bed facilities are not included as Class I nursing facility providers.
14. "Core Component per diem rate" means the per diem rate for direct and indirect health care services costs, administrative and general services costs, and fair rental allowance for capital-related assets for Class 1 nursing facility providers.
15. "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.
16. "Direct or indirect health care services costs" means the costs incurred for patient support services as defined at Section 8.443.7.
17. "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each Case-Mix group as of a specific point in time. ~~The current system in use is the resource utilization group (RUG).~~
18. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.
19. "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.
20. "Index" means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.
21. "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.
22. "Median per diem cost" means the daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.
23. "Medicare patient day" means all days paid for by Medicare. For instance, a Medicare patient day includes those days where Medicare pays a Managed Care Organization for the resident's care.

DO NOT PUBLISH THIS PAGE

24. "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the Medicare and Medicaid programs.
25. "MMIS per diem reimbursement rate" means the per diem rate used for Medicaid Management Information Systems (MMIS) claims-based reimbursement.
26. "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.
27. "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.
28. "Nursing facility provider" means a facility provider that meets the state nursing facility licensing standards established pursuant to C.R.S. §25-1.5-103, and is maintained primarily for the care and treatment of inpatients under the direction of a physician.
29. "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse's aides.
30. "Nursing weights" means numeric scores assigned to each category of the Case-Mix groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents. ~~The current system in use is the resource utilization group (RUG).~~
31. "Occupancy-imputed days" means the use of a predetermined number for patient days rather than actual patient days in computing per diem cost.
32. "Per diem cost" means the daily cost of care and services per patient for a nursing facility provider.
33. "Per diem fee" means the dollar amount of provider fee that the Department shall charge a nursing facility provider per non-Medicare day.
34. "Provider fee" means a licensing fee, assessment, or other mandatory payment as specified under 42 C.F.R. § 433.55.
35. "Raw food" means the food products and substances, including but not limited to nutritional supplements, that are consumed by residents.
36. "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.
~~37. "Resource utilization group" (RUG) means the system for grouping a nursing facility's residents according to their clinical and functional status identified from data supplied by the facility's minimum data set as published by the United States Department of Health and Human Services.~~
~~38~~37. "Statewide average per diem rate" means the average per diem rate for all Medicaid-participating nursing facility providers in the state.
~~39~~38. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under 42 C.F.R § 483.12 Freedom from abuse, neglect, and

exploitation, 42 C.F.R. § 483.24 Quality of life, or 42 C.F.R. § 483.25, Quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

~~40~~39. "Supplemental Payment" means a lump sum payment that is made in addition to a nursing facility provider's MMIS per diem reimbursement rate. A supplemental Medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

8.443 NURSING FACILITY PROVIDER REIMBURSEMENT

8.443.1.B CLASS 1 NURSING FACILITY PROVIDER REIMBURSEMENT

i. ~~2.~~ For state fiscal year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement rate or the SFY 2019-20 Core Component per diem rate.

b. For SFY 2020-21 and SFY 2021-22, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by a two percent (2.00%) statutory limit.

c. For SFY 2023-24, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by a ten percent (10.00%) statutory limit.

~~3. In the event that MMIS per diem reimbursement rate is greater than the Core Component per diem rate, the Department shall reduce the rate to no greater than the Core Component per diem rate.~~

The Core Component per diem rate shall be the sum of the following per diem rates:

a. ~~1.~~ Medicaid utilization supplemental payment described in Section 8.443.10.C,

b. ~~2.~~ Acuity Adjusted Core Component supplemental payment described in Section 8.443.11.B,

c. ~~3.~~ Pay-For-Performance supplemental payment described in Section 8.443.12,

d. ~~4.~~ Cognitive Performance Scale supplemental payment described in Section 8.443.10.A,

e. ~~5.~~ Preadmission Screening and Resident Review II Resident supplemental payment described in Section 8.443.10.B,

f. ~~6.~~ Preadmission Screening and Resident Review II Facility supplemental payment described in Section 8.443.10.B, and

g. ~~7.~~ Core Component supplemental payment described in Section 8.443.11.A.

8.443.6 CASE MIX ADJUSTMENTS

8.443.6.A. ~~The resource utilization group- III (RUG-III) 34 category, index maximizer model, version 5.12b, as published by the Centers for Medicare and Medicaid Services (CMS), the resource utilization group- III (RUG-III) 34 category, index maximizer model, version 5.12b is hereby incorporated by reference. The incorporation of RUG-III 34 category, index maximizer model, version 5.12b excludes later amendments to, or editions of, the referenced material. 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.~~A resident's case mix index shall be determined using a case mix classification system. The case mix classification system shall be maintained through public postings on the Department's website. The ~~Department may update the~~ case mix classification system~~methodology~~ may be updated to reflect advances in resident assessment or classification subject to federal requirements.

8.443.6.B. A resident's case mix index shall be determined on a Quarterly basis.

1. The Department shall distribute facility listings identifying current assessments for residents in the nursing facility on the 1st day of the first month of each quarter as reflected in the Department's MDS assessment database.

   a. ~~1.~~ The listings shall identify resident social security numbers, names, assessment reference date, the calculated ~~RUG-III category~~ case mix index, and the payor source as reflected on the prior full assessment and/or current claims data.

2. Resident listings shall be reviewed by the nursing facility for completeness and accuracy.

3. If data reported on the resident listings is in error or if there is missing data, facilities shall have until the last day of the second month of each quarter to correct data submissions, or until a later date if approved by the Department pursuant to 10 CCR 2505-10 section 8.442.2.

   a. Errors or missing data on the resident listings due to untimely submissions to the CMS database maintained by CDPHE shall be corrected by the nursing facility transmitting the appropriate assessments or tracking documents to CDPHE.

   b. Errors in key field items shall be corrected by following the CMS key field specifications through CDPHE

   c. Errors on the current payor source shall be noted on the resident listings prior to signing and returning to the Department.

4. Each nursing facility shall sign and return its resident listing to the Department no later than 15 calendar days after it was mailed by the Department.

5. Residents shall be assigned a ~~RUG-III~~ case mix index ~~group calculated~~ based on their most current non-delinquent assessment available on the 1st day of the first month of each quarter as amended during the correction period.

   a. The RUG-III group shall be translated to the appropriate case mix index or weight.

b. Two average case mix indices for each Medicaid nursing facility shall be determined from the individual case mix weights for the applicable quarter:

i. The facility average case mix index shall be a simple average, carried to four decimal places, of all resident case mix indices.

ii. The Medicaid average case mix index shall be a simple average, carried to four decimal places, of all residents where Medicaid is the per diem payor source anytime during the 30 days prior to their current assessment.

c. Any incomplete assessments and current assessment in the database older than 122 days shall be included in the calculation of the averages using the case mix index established in these rules.

8.443.10 COGNITIVE PERFORMANCE SCALE, PREADMISSION SCREENING AND RESIDENT REVIEW II, AND MEDICAID UTILIZATION SUPPLEMENTAL PAYMENTS

8.443.10.A COGNITIVE PERFORMANCE SCALE SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers who have residents with moderate to very severe mental health conditions, cognitive dementia, or acquired brain injury, based upon the resident's score on the Cognitive Performance Scale (CPS).

1. Annually, the Department shall calculate the payment by multiplying a CPS per diem rate by CPS Medicaid days.

2. The CPS per diem rate is calculated based on the number of standard deviations a nursing facility provider's CPS percentage is above the statewide average CPS percentage. The CPS per diem rate shall be determined in accordance with the following table:

Standard Deviation Above Statewide Average	CPS Per Diem
Greater Than or Equal to Statewide Average + 1 Standard Deviation	1x
Greater Than or Equal to Statewide Average + 2 Standard Deviation	2x
Greater Than or Equal to Statewide Average + 3 Standard Deviation	3x

The CPS per diem rate multiplier (x) shall equal an amount such that the total statewide CPS supplemental payment divided by total statewide CPS Medicaid days equal ~~one~~ two percent of the statewide average ~~MMIS~~ July 1 Core Component per diem ~~reimbursement~~ rate.

3. The CPS percentage is the sum of Medicaid residents with a CPS score of 4, 5, or 6 divided by the sum of Medicaid residents.

   a. Medicaid residents with a CPS score of 4, 5, or 6 are determined using the Department utilized case mix ~~RUG-III~~ classification system and reported on the MDS form.

   b. The determination of Medicaid residents with a CPS score of 4, 5, or 6 shall be made using the April MDS roster.

4. CPS Medicaid patient days shall equal the count of Medicaid residents with a CPS score of 4, 5, 6, or equivalent, multiplied by the days in the year.

5. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.10.B PREADMISSION SCREENING AND RESIDENT REVIEW II SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers who have residents with severe mental health conditions or developmental disabilities that are classified at Level II by the Medicaid program's preadmission screening and resident review assessment tool (PASRR II).

1. Annually, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.

2. Medicaid PASRR II days shall equal the count of PASRR II residents on May 1, multiplied by the days in the year.

3. The PASRR II per diem rate shall equal ~~two~~ four percent of the statewide July 1~~MMIS~~ Core Component per diem ~~reimbursement~~ rate ~~as described Section 8.443.1.B~~.

4. The Department shall pay an additional PA~~S~~SRR II supplemental payment to facilities that offer specialized behavioral services to residents who have severe behavioral health needs. These services shall include enhanced staffing, training, and programs designed to increase the resident's skills for successful community reintegration.

5. The additional PASRR II supplemental payment for nursing facility providers that have an approved specialized behavioral services program shall be calculated using the methodology described in Section 8.443.10.B.1 through Section 8.443.10.B.3.

6. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Dental Therapists, Section 8.201.1
Rule Number: MSB 23-06-29-E
Division / Contact / Phone: Health Policy Office / Alex Lyons / 303-866-2865

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 23-06-29-E, Rule Concerning Dental Therapists

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) 8.201.1

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 8.201.1 with the proposed text beginning at 8.201.1. through the end of 8.201.1. This rule is effective September 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Dental Therapists, Section 8.201.1
Rule Number: MSB 23-06-29-E
Division / Contact / Phone: Health Policy Office / Alex Lyons / 303-866-2865

STATEMENT OF BASIS AND PURPOSE

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

   This rule clarifies that dental therapists are dental provider types who can be reimbursed by Medicaid, as part of implementing Colorado Senate Bill 22-219.

   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:

   N/A

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

Initial Review
Proposed Effective Date

Final Adoption:
Emergency Adoption:

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Dental Therapists, Section 8.201.1
Rule Number: MSB 23-06-29-E
Division / Contact / Phone: Health Policy Office / Alex Lyons / 303-866-2865

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.

   Dental therapists will benefit from this rule because their ability to be reimbursed by Medicaid for their services will be clarified. Whatever costs this change generates will be borne, as with Medicaid generally, by a combination of state and federal funds.

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

   The rule's main impact will be on dental therapists, who will be able to more easily be reimbursed for their services under Medicaid. Additionally, Medicaid members will benefit from greater access to a wider range of dental service providers.

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 will be a cost for the Department with monitoring appropriate payments to dental providers, and for the Department of Regulatory Affairs for administering the licensure of dental therapists.

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

   The costs of the proposed rule involve the usual costs of administering and monitoring proper reimbursement payments to Medicaid providers, while the benefits include potentially broadening access to dental services in underserved areas, particularly in rural communities. Not adopting this rule saves the cost of additional provider payments but eliminates the potential benefit to Medicaid members in underserved areas of the state.

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

There is not likely to be a less costly method for clarifying that dental therapists are covered providers under the Medical Services Rule other than to include them within the list of covered providers.

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 did not consider any alternative methods for achieving the purpose of this rule because the clarifying language in the proposed text was felt to be the most efficient means of achieving the rule's purpose.

8.201 ADULT DENTAL SERVICES

8.201.1 DEFINITIONS

A. Adult Client means an individual who is 21 years or older and eligible for medical assistance benefits.

B. Comprehensive Oral Evaluation – New or Established Patient means a thorough evaluation and documentation of a client's dental and medical history to include extra-oral and intra-oral hard and soft tissues, dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screening, as defined by the Current Dental Terminology (CDT).

C. Comprehensive Periodontal Evaluation means the procedure that is indicated for patients showing signs or symptoms of periodontal disease and for patients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the patient'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, as defined by the CDT.

D. Dental Caries is a common chronic infectious transmissible disease resulting from tooth-adherent specific bacteria that metabolize sugars to produce acid which demineralizes tooth structure over time (tooth decay).

E. Dental professional means a licensed dentist, ~~or~~ dental hygienist, or dental therapist enrolled with Colorado Medicaid.

F. Detailed and Extensive Oral Evaluation – Problem Focused, By Report means a detailed and extensive problem focused evaluation entailing extensive diagnostic and cognitive modalities based on the findings of a comprehensive oral evaluation. Integration of more extensive diagnostic modalities to develop a treatment plan for a specific problem is required. The condition requiring this type of evaluation shall be described and documented. Examples of conditions requiring this type of evaluation may include dentofacial anomalies, complicated perio-prosthetic conditions, complex temporomandibular dysfunction, facial pain of unknown origin, conditions requiring multi-disciplinary consultation, etc., as defined by the CDT.

G. Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation, as defined by the CDT.

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

I. Emergency Services means the need for immediate intervention by a physician, osteopath or dental professional to stabilize an oral cavity condition.

J. Evaluation means a patient assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions, as defined by the CDT.

K. High Risk of Caries is indicated in Adult Clients who present with demonstrable caries, a history of restorative treatment, dental plaque, and enamel demineralization.

L. Immediate Intervention or Treatment is when a patient presents with symptoms and/or complaints of pain, infection or other conditions that would require immediate attention.

M. Limited Oral Evaluation – Problem Focused means an evaluation limited to a specific oral health problem or complaint, as defined by the CDT.

N. Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.

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

P. Periodic Oral Evaluation means an evaluation performed on a client of record to determine any changes in the patient's dental and medical status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures, as defined by the CDT.

Q. Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal (gum) disease progression.

R. 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, as defined by the CDT.

S. Prophylaxis (Cleaning) is the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.

T. Re-Evaluation - Limited, Problem Focused (Established Patient; Not Post-Operative Visit) means assessing the status of a previously existing condition. For example, a traumatic injury where no treatment was rendered but patient needs follow-up monitoring, an evaluation for undiagnosed continuing pain, or a soft tissue lesion requiring follow-up evaluation, as defined by the CDT.

U. Restorative means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic requirements of the client, as defined by the CDT.

V. Year begins on the date of service.