COLORADO
Department of Health Care Policy & Financing
Medical Services Board

NOTICE OF PROPOSED RULES

The Medical Services Board of the Colorado Department of Health Care Policy and Financing will hold a public meeting on Friday, January 11, 2019, beginning at 9:00 a.m., in the eleventh floor conference room at 303 East 17th Avenue, Denver, CO 80203. Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-4416 or chris.sykes@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting.

A copy of the full text of these proposed rule changes is available for review from the Medical Services Board Office, 1570 Grant Street, Denver, Colorado 80203, (303) 866-4416, fax (303) 866-4411. Written comments may be submitted to the Medical Services Board Office on or before close of business the Wednesday prior to the meeting. Additionally, the full text of all proposed changes will be available approximately one week prior to the meeting on the Department's website at www.colorado.gov/hcpf/medical-services-board.

This notice is submitted pursuant to § 24-4-103(3)(a) and (11)(a), C.R.S.

MSB 18-07-23-A, Revision to the Medical Assistance Rule concerning Payments to Non-DRG Hospitals for Inpatient Services to include Freestanding Long Term Acute Care Hospitals and Freestanding Rehabilitation Hospital, Sections 8.300.1 8.300.5.A, 8.300.5.C, 8.300.5.D

Medical Assistance. Currently, Freestanding Long Term Acute Care and Freestanding Rehabilitation Hospitals are being reimbursed under APR-DRG and included in section 8.300.A. Changing reimbursement to a step-down per diem methodology to better align with national practices and provides more accurate reimbursement for long-term and short-term stays. Adding per diem rules to existing section 8.300.5.D.

The authority for this rule is contained in 25.5-1-301 through 25.5-1-303, C.R.S. (2018) and C.R.S 25.5-4-402(1) (2018).

MSB 18-08-24-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning the Children's Extensive Supports (CES) waiver to remove: Behavioral Services at Section 8.503.40.3, Personal Care at Section 8.503.40.8, and Vision Service at Section 8.503.40.13

Medical Assistance. The rule change is necessary to remove services no longer approved in the waiver application CO.4180.R04.03 for the Children's Extensive Supports (CES) waiver. Per guidance from the Centers for Medicare and Medicaid Services (CMS), the CES waiver services including: Behavioral Services, Personal Care and Vision Services are duplicative to services available in State Plan pursuant to the Early and Periodic Screening, Diagnostic Treatment (EPSDT) benefit. Those 20 years of age and younger can access the above services through EPSDT and so

the removal of these services from this waiver rule is necessary to have aligned waiver applications and rules.

The authority for this rule is contained in 25.5-1-301 through 25.5-1-303, C.R.S. (2018) and 25.5-6-409, C.R.S. (2017).

MSB 18-05-22-A, Revision to the Medical Assistance Rule concerning Timely Filing Requirements, Section 8.043

Medical Assistance. The proposed Timely Filing Rule is to update the restriction placed on how quickly providers must submit health care claims to Health First Colorado. Prior to the implementation of the Colorado interChange, timely filing was set at 120 days. Some providers experienced billing difficulties during the implementation, so the Department issued a temporary extension of the time frame. Initially, the timely period was extended to 240 days, and then further increased to 365 days, which is the maximum allowed under federal regulations. The Department has reassessed the policy and decided to make this temporary extension a permanent change to assist providers in health care claims submissions and to align with federal regulations.

The authority for this rule is contained in 42 CFR part 447.45(d)(1) and 25.5-1-301 through 25.5-1-303, C.R.S. (2018).

MSB 18-06-25-A, Revision to the Medical Assistance Rule concerning School Health Services Program Claims Submission and Interim Payment, Section 8.290.6.D

Medical Assistance. The proposed changes to the SHS rules are to maintain the 120 days for timely filing and not have the SHS Program go with the new update to 365 days to submit claims. Changing to 365 days would have a negative impact on the school districts because it would delay payments to the school districts. In addition if we do not update the SHS rules the SHS state plan amendment would have to be updated as the two would be contradicting each other.

The authority for this rule is contained in 25.5-5-318 and 25.5-1-301 through 25.5-1-303, C.R.S. (2018).

MSB 18-06-20-A, Revision to the Medical Assistance Rule concerning Drug Benefits, Section 8.800.4

Medical Assistance. First, the Department is moving “agents when used for cosmetics purposes or hair growth” in section 8.800.4.B to section 8.800.4.C, to comply with federal regulation at 1903 (i) (21). CMS required the Department to remove this language from our State Plan and now the Department must move it to 8.800.4.C (drugs that are never a pharmacy benefit). Second, stakeholders requested that the Department make clarifications at 8.800.4.B because it was not clear which drug categories the Department covers; therefore, language was rearranged to clarify. Lastly, the Department is expanding coverage of select non-prescription drugs (Bisacodyl, Docusate Sodium and Ferrous Sulfate) to Medicaid members and clarifying the specific non-prescription drug categories that are currently covered by the Department.

The authority for this rule is contained in Title XIX of the Social Security Act, Sections 1903(i)(21), 1927(d)(2) and 1935(d)(1) and (2); 42 CFR 441.25; and 25.5-1-301 through 25.5-1-303 C.R.S. (2018).

MSB 18-06-01-A, Revision to the Medical Assistance Rule concerning Speech Language Pathology, Section 8.200.3

Medical Assistance. Certain Speech Languag Pathology (SLP) benefit documentation requirements are being revised to improve program fidelity by replacing permissive language with mandatory language. This revision is necessary to ensure provider documentation of a client's initial evaluation include an assessment of the factors which influence the treatment diagnosis and prognosis, and a discussion of the inter-relationship between the diagnoses and disabilities for which the referral was made. In addition, care plans must cover a period no longer than 90 days or the time frame documented in the Individual Family Service Plan. Finally, documenation must follow the Subjective, Objective, Assessment and Plan (SOAP) format for each visit and include a subjective element, an objective element, an assessment component, and a plan component. Mandatory documentation requirements are necessary for program integrity and compliance oversight. Revision also clarifies that payment for therapies provided as part of a client's school requirement are not separately billable to Medicaid. The Department reimburses school districts for SLP services rendered to clients. Providers rendering SLP services to clients as part of the school requirement are reimbursed by the school district and may not submit additional claims to the Department for reimbursement. Finally, the revision includes miscellaneous citation updates, terminology updates, and removal of obsolete language.

The authority for this rule is contained in 42 USC 1396d(a)(11); 42 CFR 440.110; and 25.5-1-301 through 25.5-1-303, C.R.S. (2018).

MSB 18-04-09-A, Revision to the Medical Assistance Rule concerning Psychiatric Residential Treatment Facilities and Residential Child Care Facilities, Section 8.765

Medical Assistance. The Psychiatric Residential Treatment Facility (PRTF) and Residential Child Care Facility (RCCF) rule section at 10 C.C.R. 2505-10, Section 8.765, requires an update to reflect the most current diagnostic manual, agency names, statutory references, State Plan Amendments, assessment tools, and federal requirements concerning restraint and seclusion. To align the rule with current practice, the update also identifies the Colorado Department of Human Services' (CDHS) Office of Behavioral Health (OBH) as the agency responsible for designating and licensing RCCFs and the requirement that PRTFs be certified by CDHS has been removed. Finally, the update includes a provision concerning RCCFs' ability to enroll as a separate provider type to render medically necessary services not included in the RCCF benefit. While this has always been the case, it is not specified in the current rule.

The authority for this rule is contained in 42 USC §§ 1396d(a)(16), (h)(1) (2018); 42 CFR §§ 440.160 (2010), 441.151-.184 (2016), 483.350-.376 (2018); 25.5-4-103(19.5), 25.5-5-306(1), (3), C.R.S. (2017); and 25.5-1-301 through 25.5-1-303 C.R.S. (2018).