COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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

November 1, 2013

Legislative Council
200 East 14th Avenue
Denver, CO 80203

Legislative Council:

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

The passage of HB 12-1008 (Methods for Providing Input to Executive Branch Agencies About Proposed Rules) requires all state departments to compile an annual Departmental Regulatory Agenda and deliver to staff of the Legislative Council on November 1, 2012 and each November 1 thereafter. The agenda must specify a list of new rules or revisions to existing rules that the Department expects to propose in the next calendar year; the statutory or other basis for adoption of the proposed rules; the purpose of the proposed rules; the contemplated schedule for adoption of the rules; and an identification and listing of persons or parties that maybe affected positively or negatively by the rules. Beginning with regulatory agendas submitted on and after November 1, 2013 and each November 1 thereafter, a list and brief summary of all permanent and temporary rules actually adopted since the previous departmental regulatory agenda was filed must be included.

In addition, the Department is required to submit the Departmental Regulatory Agenda to the Secretary of State for publication in the Colorado Register and post the Agenda on the website.

Please find enclosed the agenda of rules the Department plans to submit for rule-making in 2014. This list includes what is anticipated at this time, but is by no means a complete and comprehensive list. Circumstances vary and it is difficult to predict what additional rule revisions may be necessary based on new federal and state requirements. In addition, some of the proposed rules listed may have to be postponed or canceled due to unforeseen circumstances.

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

Sincerely,

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

SEB:jlc
Enclosure: 2014 Departmental Regulatory Agenda

Cc: State Library
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
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Lorez Meinhold, Community Partnerships Office Director
Tom Massey, Policy and Communications Office Director
MaryKathryn Hurd, Legislative Liaison

2014 Regulatory Agenda of new rules or revisions to existing rules that the department expects* to propose

Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
8.2000 Hospital Provider Fee Program	25.5-4-402.3(3)(e)(I) C.R.S. (2013)	The hospital provider fee is calculated each year and must change to ensure sufficient fee is received to fund hospital reimbursement and to fund Medicaid and CHP+ expansions funded by the program.	September 2014	Colorado hospitals and Low income and disabled Coloradans eligible for hospital provider fee-funded Medicaid and CHP+ expansions.
8.076, Program Integrity Suspension of payments	42 CFR 455.23	Federal requirements necessitate state rules to implement the related to suspension of payments to providers during a credible investigation of fraud.	April 2014	Providers who are out of compliance
8.130, Provider Participation Termination for failure to comply with disclosure requirements for screening	42 CFR 455, Subpart E	Technical correction to existing rule	April 2014	Providers who are out of compliance
8.443.7.A.1 Revision to the Medical Assistance Rule concerning Dual-Role Employees Split Between HC and A&G	25.5-6-202, C.R.S. (2013)	Clarification of terminology and parties.	Summer 2014	Providers. Stakeholder process conducted in 2012 with providers
8.443.7.A Revision to the Medical Assistance Rule concerning Computers and Software expense in Health Care	25.5-6-202, C.R.S. (2013)	Clarification of characterization of computers and software expenses in Health Care.	Summer 2014	Providers. Stakeholder process conducted in 2012 with providers
8.443.7.A.11 Revision to the Medical Assistance Rule concerning Related Party Management Fees and Home Office Costs in Health Care	25.5-6-202, C.R.S. (2013)	Clarification of characterization and calculation of Related Parties Management Fees and Home Office Costs in Health Care.	Summer 2014	Providers. Stakeholder process conducted in 2012 with providers
8.440.2 Revision to the Medical Assistance Rule concerning Non-Covered Special Care Services	25.5-6-202, C.R.S. (2013)	Clarification of services and items not included in the per diem payments to nursing facilities.	Summer 2014	Providers. Stakeholder process conducted in 2012 with providers
8.443.7.A.5 Revision to the Medical Assistance Rule concerning Vaccinations	25.5-6-202, C.R.S. (2013)	Clarification that costs associated with vaccinations are calculated in the per diem rate	Summer 2014	Providers. Stakeholder process conducted in 2012 with providers
8.050.A Revision to the Medical Assistance Rule concerning Timeline and Penalties.	25.5-6-202, C.R.S. (2013)	Clarification of Mandatory Information Reconsideration, specifically that the availability of electronic copies of the rate determination letter functions as sufficient notification.	Summer 2014	Providers. Stakeholder process conducted in 2012 with providers

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
8.443.1.A Revision to the Medical Assistance Rule concerning Medicaid Authorities	25.5-6-202, C.R.S. (2013)	Administrative fix to comply with Administrative Procedures Act (APA) for incorporation by reference	Winter 2014	Providers. Stakeholder process conducted in 2012 with providers
8.441.5.B.3 Revision to the Medical Assistance Rule concerning Allowable Owner and Owner-Related Salary	25.5-6-202, C.R.S. (2013)	Clarification of characterization and calculation of Allowable Owner and Owner-related salaries.	Summer 2014	Providers. Stakeholder process conducted in 2012 with providers
8.504 Revision to the Medical Assistance Rule concerning Home and Community Based Services Pediatric Hospice Waiver, Response to Legislative Audit.	25.5-5-305, C.R.S. (2013)	The Home and Community Based Services - Children with Life Limiting Illness (HCBS-CLLI) (formally HCBS-PHW) was audited by the legislative audit committee. The audit found the waiver was not following the original intentions of the legislation. In order to comply with audit findings and recommendations the program rules need to be revised. The current HCBS-CLLI rules do not clearly define the services or provider qualifications. CLLI services have been redefined and changed. Updated rules are needed to implement the service changes. The HCBS-CLLI program name was recently changed from HCBS-PHW (Pediatric Hospice Waiver) to HCBS-CLLI. The rule revision will also provide an opportunity to update the program name.	February 2014	Children with a Life Limiting Illness, their families, case management staff and providers.
8.485 Revision to the Medical Assistance Rule concerning Home and Community Based Services Elderly, Blind, and Disabled Waiver, Addition of PLWA	25.5-6-301 through 25.5-6-313, C.R.S. (2013)	The HCBS-Elderly, Blind, and Disabled (EBD) Waiver is being merged with the HCBS-Persons Living with AIDS (PLWA) waiver. This merge is the first step towards Colorado's simplification of its Medicaid waiver system. The proposed rule change will include PLWA target criteria (Persons with HIV/AIDS) and hospital level of care.	January 2014	Persons Living with AIDS.

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
8.515 Revision to Medical Assistance Rule concerning Home and Community Based Services Brain Injury Waiver, Development of SLP rules	25.5-6-701—706 C.R.S. (2013)	To establish rules for the HCBS-BI Supported Living Program service. The Supported Living Program provided 24/7 residential support to individuals who have survived a brain injury.	Summer 2014	Clients receiving services, providers and the community.
8.515 Revision to Medical Assistance Rule concerning Home and Community Based Services Brain Injury Waiver, Removal of Respite Cap	25.5-6-701—706 C.R.S. (2013)	Last year the HCBS-BI respite rule was changed to reference the respite rule for the HCBS- waiver the Elderly, Blind and Disabled. This change was a piece of a larger effort to align waiver service definitions and provider qualifications. Prior to this change there was no cap on respite for HCBS-BI waiver participants- the reference to the EBD rule cause an unintentional cap on the services. This rule change will remove EBD language and cap from BI respite	Winter/Spring 2014	BI waiver clients and respite providers
8.515 Revision to Medical Assistance Rule Concerning Home and Community Based Services Brain Injury Waiver, Counseling Services Redesign	25.5-6-701—706 C.R.S. (2013)	To remove language around family counseling that requires client be in the room during session.	Winter/Spring 2014	BI waiver clients, family members, providers
8.515 Revision to Medical Assistance Rule concerning Home and Community Based Services Brain Injury Waiver, Substance Abuse Counseling Redesign	25.5-6-701—706, C.R.S. (2013)	To reduce provider requirement to Certified Alcohol Counselor (CAC) II	Winter/Spring 2014	CACIII, BI waiver clients, and providers
8.515 Revision to Medical Assistance Rule Revision to Medical Assistance Rule concerning Home and Community Based Services Brain Injury Waiver, Level of Care/Eligibility Redesign	25.5-6-701—706 C.R.S. (2013)	To clarify Level of Care and Targeting Criterion to and alleviate confusion between Hospital and Nursing Facility levels of care.	Fall 2014	Clients, providers and case management staff
8.552 Revision to Medical Assistance Rule Revision to Medical Assistance Rule concerning In Home Support Services (IHSS), and Case Management Responsibilities	25.5-6-1203(5) C.R.S. (2013)	Statute requires rules be promulgated requiring case managers discuss the option and potential benefits of IHSS with all eligible long term care clients	January 2014	Clients and IHSS agencies

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
8.517.2 Revision to Medical Assistance Rule Revision to Medical Assistance Rule concerning Home and Community Based Services for Persons with a Spinal Cord Injury To change the current ICD-9 codes to the ICD-10 codes by October 2014	25.5-6-1301 et seq., C.R.S. (2013)	The current ICD-9 codes that are listed in the rule need to be updated and changed to the new ICD-10 codes.	October 2014	Providers
8.517.1 Revision to Medical Assistance Rule Revision to Medical Assistance Rule concerning Home and Community Based Services for Persons with a Spinal Cord Injury To change the Non-Medical Transportation (NMT) to include access to Alternative Therapies	25.5-6-1301 et seq., C.R.S. (2013)	Currently there is a cap on how many NMT trips a client can take and with this cap, clients have to choose between going to services offered on the waiver and to community activities. We would like to remove this barrier so that clients have better access to services offered under the waiver.	June 2014	Clients on the SCI waiver
8.509 Revision to Medical Assistance Rule Revision to Medical Assistance Rule concerning Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS), Addition of waiver specific services under the waiver	25.5-6-601 et seq., C.R.S. (2013)	During the 2011 audit of the CMHS waiver, CMS found that the Department needed to look at adding more “waiver specific” services for client’s who have a mental illness and are enrolled under the CMHS waiver. The Department is currently drafting up new services that may be completed by 2014.	December 2014	Clients on the CMHS waiver and providers
8.506 Revision to Medical Assistance Rule Revision to Medical Assistance Rule concerning Children’s Home and Community Based Services Waiver program (CHCBS)	25-5-901, C.R.S. (2013)	The rules are outdated and do not reflect current practice.	May 2014	Clients and providers
Transfer of DHS rules related to the administration of services for people with intellectual and developmental disabilities to HCPF	27-10.5 et seq C.R.S. (2013)	Transfer existing rules from Department of Human Services to the Department of Health Care Policy and Financing to coincide with the transfer of the Division for Developmental Disabilities from DHS to HCPF.	February 2014	The rules will be transferred over as a whole and no changes will be made to existing language. Language related to the administration of Early Intervention services within DHS will remain in the DHS rules. No persons will be impacted because there will be no changes made to existing language.

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8.553 Community Transition Services (CTS)	25.5-6-307.(i) C.R.S (2013)	To align the CTS rule with the Colorado Choice Transitions rule. To clarify training expectations for a transition coordinator. To clarify the roles and responsibilities of the case management agency. To revise the allowable expenses for house-hold set-up.	February 2014	Clients, Case Managers, Transition Coordinators, Nursing Facilities
8.555 Colorado Choice Transitions	Section 6071 of the Deficit Reduction Act of 2005; Section 2403 of the Patient Protection and Affordable Care Act	To update the definitions of services and supports; To update case management responsibilities.	April 2014	Clients, Caregivers and Case Managers
8.075 Client Over-Utilization Program (COUP)	42 CFR 456.3 and 431.54(e)	Revise current rule to incorporate participation of COUP enrollees in the Accountable Care Collaborative (ACC) program, expand the types of providers who may be added to a client's COUP enrollment and expand the types of over-utilization behavior that will meet COUP criteria.	FY13-14	Medicaid clients who over-utilize prescription drugs, hospital emergency departments and other services.
8.100.7 Revisions to the Medicaid Eligibility Rules Concerning Clarification updates	42 CFR 435; 20 CFR 416, Title XIX , section 1924 of the Social Security Act	Incorporates changes to wording of rules to provide clarification on the intention of the policy.	September 2014	Medicaid program participants
8.100.3.H Revisions to the Medicaid Eligibility Rules Concerning Clarification to the Citizenship and Identity Documentation Requirements	Deficit Reduction Act of 2005; Federal ACA, 42 CFR Parts 431, 433, 435, 457	Implements changes to the citizenship and identity documentation requirements in accordance with the Affordable Care Act (ACA) for Medicaid and CHP+.	December 2014	Medicaid and CHP+ program participants.
8.100.3 Revisions to the Medicaid Eligibility Rules Concerning Clarification updates	42 CFR Parts 431, 435	Incorporates changes to wording of rules to provide clarification on the intention of the policy.	July 2014	Medicaid program participants
8.100.4 Revisions to the Medicaid Eligibility Rules Concerning Clarification updates	42 CFR Parts 431, 435	Incorporates changes to wording of rules to provide clarification on the intention of the policy.	September 2014	Medicaid program participants

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
8.800.13 Change to Pharmacy Dispensing Fees Reimbursement Calculation	25.5-5-501. C.R.S. (2013)	Department updates dispensing fees every other year to account for changes in the average cost of dispensing	Present Rule in March to May 2014	Colorado Medicaid pharmacies
8.010 Apnea Monitor Benefit Coverage Standard	42 CFR 440.120	Incorporation by Reference the DME and Supply rules.	January 2014	Supply providers, clients, UM vendor
8.010 Mattresses and Overlays Benefit Coverage Standard	42 CFR 440.120	Incorporation by Reference the DME and Supply rules.	After February 2014	Supply providers, clients, UM vendor.
8.010 Hospital/Specialty Beds Benefit Coverage Standard	42 CFR 440.120	Incorporation by Reference the DME and Supply rules.	After February 2014	Supply providers, clients, UM vendor.
8.010 Prosthetics and Orthotics Benefit Coverage Standard	42 CFR 440.120	Incorporation by Reference the DME and Supply rules.	After February 2014	Supply providers, clients, UM vendor
8.010 Electrical Stimulation Devices Benefit Coverage Standard	42 CFR 440.120	Incorporation by Reference the DME and Supply rules.	After February 2014	Supply providers, clients, UM vendor
8.520 through 8.529 Home Health overall	Social Security Act 1905(a)(7)	Renumber rule and remove outdated information or information contained in the Benefit Coverage Standard. Update reimbursement information for Certified Nurse Assistants and brief nursing visits	December 2014	Clients receiving home health benefits
8.746Substance Abuse Disorder	CRS 25.5-5-202(1)(s)	Potential changes to scope/delivery system, name change to Substance Use Disorder.	December 2014	Medicaid clients and providers
8.749 Nurse Home Visitor Program	CRS 25.5-5-102	Align the rules with statutes and the State Plan	December 2014	n/a administrative changes will not alter coverage or reimbursement
8.748 Prenatal Plus Program	CRS 25.5-5-309 through 312	Change provider requirements	December 2014	Prenatal Plus Program providers
Exception policy (new section of rule)	42 CFR section 440.230	Establish a policy to review and possibly approve care not covered by Medicaid	December 2014	Medicaid clients
8.740 Rural Health Centers	Social Security Act 1905(a)(2)(B)	Administrative updates	December 2014	Rural Health Centers
Medical Necessity definition (various sections)	42 CFR section 440.230	Consolidate multiple definitions of medical necessity that are currently in rule. Largely a technical change, the proposed changes will clarify experimental\investigational services	December 2014	Medicaid clients and providers
8.765 Residential Child Care Facilities	CRS 25.5-5-306	Administrative updates	May 2014	n/a administrative changes will not alter coverage or reimbursement

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
8.200 PCP supplemental payment	Social Security Act 1902(a)(13)	Delete rule governing the Primary Care Physician Supplemental Payment program which expires December 31, 2014	October 2014	Medicaid providers
8.715 Breast and Cervical Cancer Program	CRS 25.5-5-308	Align rules with changes in the Affordable Care Act	July 2014	Medicaid clients and providers
Medicaid Dental Benefit Coverage Standard, (new section of rule)	25.5-5-207 CRS, 42 CFR § 441.56, 42 CFR § 440.100	Incorporation by Reference of standard that establishes allowable amount, scope and duration of adult and children's dental services	February 2014	All Medicaid clients, Medicaid dental providers
8.600 – 8.699 Magnetic Resonance Imaging (MRI) Benefit Coverage Standard, Section	CRS 25.5-5-102	Incorporation by Reference of standard that establishes allowable amount, scope and duration of magnetic resonance imaging services	January 2014	None – codification of existing practice
8.600 – 8.699 General Radiography Benefit Coverage Standard	CRS 25.5-5-102	Incorporation by Reference of standard that establishes allowable amount, scope and duration of general radiography (x-rays) services	January 2014	None – codification of existing practice
8.600 – 8.699 Computed Tomography Scan (CT Scan) Benefit Coverage Standard	CRS 25.5-5-102	Incorporation by Reference of standard that establishes allowable amount, scope and duration of computed tomography scan services	January 2014	None – codification of existing practice
8.600 – 8.699 Electrocardiogram (EKG) Benefit Coverage Standard	CRS 25.5-5-102	Incorporation by Reference of standard that establishes allowable amount, scope and duration of electrocardiogram services	January 2014	None – codification of existing practice
8.300-8.390 Women's Health Benefit Coverage Standard	1902 of the Social Security Act	Incorporation by Reference of standard that establishes allowable amount, scope and duration of women's health services, including but not limited to cervical cancer and STD screening, breast exams and female specific surgical procedures	February 2014	Medicaid clients and providers
8.300-8.390 Abortion Services Benefit Coverage Standard	1902 of the Social Security Act	Incorporation by Reference of standard that establishes allowable amount, scope and duration of abortion services	February 2014	Medicaid clients and providers
8.300-8.390 Family Planning Services Benefit Coverage Standard	Social Security Act Section 1905(a)(4)(C) and CRS 25.5-5-102	Incorporation by Reference of standard that establishes allowable amount, scope and duration of family planning services	February 2014	Medicaid clients and providers
8.300-8.390 Maternity Services Benefit	42 CFR 440.210 and 42 CFR 440.220	Incorporation by Reference of standard that establishes allowable amount, scope and	February 2014	Medicaid clients and providers

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
Coverage Standard		duration of maternity services, including but not limited to office visits, ultrasounds, screenings, labor and delivery		

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2013 Regulatory Summary of all permanent and temporary rules actually adopted

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 12-09-18-A	Revision to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003 and 8.4004	Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers. The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2012), and implements the Hospital Quality Incentive Payment (HQIP), as required by the act. HQIP links supplemental payments to measures of quality of care, process, and health outcomes. The proposed rule increases the fees assessed on hospital providers to fund these payments, and to fund expansions of Medicaid and Child Health Plan Plus (CHP+) eligibility authorized under the Act.	November 2012 Emergency Adoption
MSB 12-04-20-A	Revision to the Medical Assistance Rule Concerning Claims Reimbursement and Status, Section 8.041	This rule is necessary to control and prevent improper coding which leads to improper Medicaid payments. The implementation to this rule may ultimately result in a cost savings to the Medicaid program. The basis of this rule is a set of edits, a definition of the type of claims subject to the edits, and rules regarding the application of the edits and provider appeals of denied Medicaid payments.	November 2012 Permanent Adoption
MSB 12-07-03-A	Revision to the Medical Assistance Rule Concerning Income Limits for Children and Pregnant Women, Section 8.100.4.F and 8.100.4.G	SB 11-008 and SB 11-250 were passed to allow for an increase in the income limits for our children's and pregnancy categories. The income limit for our Ribicoff category will increase from 100% FPL to 133% FPL and the income limit for our pregnancy categories will increase from 133% FPL to 185% FPL	November 2012 Permanent Adoption
MSB 12-09-07-A	Revision to Children's Basic Health Plan Rule Concerning Discontinuance of the Premium Assistance (aka CHP+ At Work) Program, Sections 50, 150, 160, 220, 340, 400, 450 and 610	The Department is discontinuing the CHP+ Premium Assistance (aka CHP+ at Work) plan; all mentions of this plan need to be removed from the CHP+ regulations.	November 2012 Permanent Adoption
MSB 12-07-17-C	Revision to the Child Health Plan Plus Rule Concerning Insufficient Access to Other Health Coverage, Section 120	The rule currently outlines who is NOT eligible for CHP+ benefits; the proposed rule amendment changes the rule to allow previously ineligible State employees to apply for CHP+ benefits.	November 2012 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 12-08-31-A	Revision to the Medical Assistance Pharmacy Rule Concerning Medicare Part D Coverage, Section 8.800.4	This rule change is in accordance with a statutory change that was a part of the Patient Protection and Affordable Care Act. Effective January 1, 2013, benzodiazepines and barbiturates that are used for certain indications will become covered Part D drugs under Medicare. Under Part D, once a drug is a covered Part D benefit, Medicaid programs can no longer pay for that drug. Medicaid's pharmacy rule needs to be changed to reflect this change in policy.	November 2012 Permanent Adoption
MSB 11-03-16-A	Revision to the Medical Assistance Rule Concerning Physician Services, Section 8.200	This rule covers basic requirements for physician services in the Colorado Medicaid program, including reimbursement. The existing rule requires physicians to order all care delivered by nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives. The state law and practice is for these providers to order care within their scope of practice. Therefore, the suggested rule change eliminates the supervisory requirements of certain non-physician providers consistent with state law and practice.	November 2012 Permanent Adoption
MSB 12-04-27-A	Revision to the Medical Assistance Rule Concerning Home Health Covered Standards and Prior Authorization, Sections 8.522 and 8.527	The purpose of this rule revision is to incorporate the Home Health Benefit Coverage Standard, developed through the Benefits Collaborative, into the Home Health rule. The second purpose for this rule is to remove the specifically named prior authorization reviewing agencies and replace them with the term “the Department or its designated review entities.” The current form of the rule only includes two of the four entities authorized and contracted by the Department to review Home Health prior authorization requests. At this time the designated review entities include the ColoradoPAR Program, Single Entry Point Case Management Agencies, and Community Centered Board Case Management Agencies. The rule only names ACS and the single entry point case management agencies. By using the term “the Department or its designated review entities,” the rule will remain current despite contract changes. The revision also streamlines the Prior Authorization section and removes redundant or outdated information.	November 2012 Permanent Adoption
MSB 12-09-17-A	Revision to the Children's Basic Health Plan Rule Regarding Presumptive Eligibility and Cost Sharing for Prenatal Care Program, Sections 170 and 330	This rule adds technical clarification regarding presumptive eligibility and cost-sharing requirements for Prenatal Care Program clients. The clarifications will not affect the Department's current practices	December 2012 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 12-08-20-A	Revision to the Medical Assistance Rule Concerning Consumer Directed Attendant Support Services (CDASS) Service Definitions, Section 8.510	This proposed rule amends the Home and Community-Based Services (HCBS) Consumer Directed Attendant Support Services (CDASS) definition for Personal Care service and Health Maintenance Activities, 10 CCR 2505-10 8.510.3(B). The proposed change allows for Personal Care service and Health Maintenance Activities in the CDASS delivery system to be offered in both the home and the community. In order for us to provide the Medicaid Buy-In option for working adults, it is required that we offer personal care in the work place 40 hours a week. This proposed rule removes unnecessary barriers to participant access.	December 2012 Permanent Adoption
MSB 12-06-21-A	Revision to the Medical Assistance Rule Concerning Pharmacy Reimbursement Calculations and Associated Definitions, Section 8.800.13 and 8.800.1	The purpose of the proposed rule change is to implement a new pharmacy reimbursement methodology based on actual acquisition costs (AAC) incurred by Colorado pharmacies. The proposed rule change also implements a dispensing fee tiered on total prescription volume. It is the Department's desire to better align Medicaid reimbursement to actual costs incurred by Colorado pharmacies. The proposed rule transitions reimbursement from the current methodology based on national pricing sources unrepresentative of Colorado pharmacy costs to a methodology based primarily on Colorado pharmacy costs.	December 2012 Permanent Adoption
MSB 12-09-18-A	Revision to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003 and 8.4004	Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers. The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2012), and implements the Hospital Quality Incentive Payment (HQIP), as required by the act. HQIP links supplemental payments to measures of quality of care, process, and health outcomes. The proposed rule increases the fees assessed on hospital providers to fund these payments, and to fund expansions of Medicaid and Child Health Plan Plus (CHP+) eligibility authorized under the Act.	December 2012 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-01-24-A	Revision to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003	Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers. The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2012), and implements the Hospital Quality Incentive Payment (HQIP), as required by the act. HQIP links supplemental payments to measures of quality of care, process, and health outcomes. The proposed rule increases the fees assessed on hospital providers to fund these payments, and to fund expansions of Medicaid and Child Health Plan Plus (CHP+) eligibility authorized under the Act.	February 2013 Emergency Adoption
MSB 12-08-06-A	Revision to the Medical Assistance Rule Concerning Colorado Indigent Care Client Annual Co-payment Capitation, Section 8.907	8.907.C. currently states that the "…client annual copayment cap (annual cap) is based on a calendar year (January 1st through December 31st), even if a client's rating is for a different year (i.e., April 1st through March 31st)." The proposed rule will change the annual copayment cap date to the client's application date, which will be administratively simpler for the client and provider.	February 2013 Permanent Adoption
MSB 12-11-01-A	Revision to the Medical Assistance Rule Concerning Eligibility Direct Certification, Section 8.100.4	The rule creates a pathway between Food Stamps, Colorado Works, and Medicaid applications for families applying for Food Stamps or Colorado Works. By implementing this rule, the county worker is granted the authority to ask the Food Stamps or Colorado Works applicant whether they want to be determined for Medicaid eligibility. This will benefit the applicant because it will provide an opportunity for them to receive a larger array of benefits	February 2013 Permanent Adoption
MSB 12-07-27-A	Revision to the Medical Assistance Rule Concerning Family and Children's Express Lane Eligibility, Section 8.100.4	The Department received clarification from the Centers for Medicare and Medicaid Services (CMS) stating the current methodology for Express Lane Eligibility needs to be changed to an “affirmative consent” in order to determine if a child is eligible for Family Medical Assistance. In order to make this change, language must be modified to allow families to “opt-in” to have their eligibility determined for Medical Assistance instead of “opt-out.”	February 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 12-10-03-A	Revision to the Children's Basic Health Plan Rule Concerning Express Lane Eligibility, Section 180	The Department received clarification from the Centers for Medicare and Medicaid Services (CMS) stating the current methodology for Express Lane Eligibility needs to be changed to an "affirmative consent" in order to determine if a child is eligible for Family Medical Assistance. In order to make this change, language must be modified to allow families to "opt-in" to have their eligibility determined for Medical Assistance instead of "opting-out."	March 2013 Permanent Adoption
MSB 13-01-08-A	Revision to the Child Health Plan Plus Program Concerning Direct Certification, Section 180.2	The Direct Certification provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provide states new options to reach and enroll the nearly six million low-income uninsured children who are eligible for Medicaid or CHIP. Direct Certification enables state Medicaid and CHIP agencies to identify, enroll, and recertify children by relying on eligibility findings from other programs, such as Colorado Works or Food Stamps, rather than having to re-analyze eligibility under their own rules. Further, CHIPRA authorizes greater use of electronic means to demonstrate eligibility. By relying on information available, the State can avoid unnecessary and repetitive requests.	March 2013 Permanent Adoption
MSB 12-10-30-A	Revision to the Medical Assistance Rule Concerning Ambulatory Surgical Center Reimbursement, Section 8.570.6	Currently the Ambulatory Surgical Center payment reimbursement rule specifies the number of ASC groupers. By removing the specified number of groupers the Department will gain the flexibility to develop more or fewer Ambulatory Surgical Center groupers	March 2013 Permanent Adoption
MSB 13-01-14-A	Revision to the Department of Health Care Policy Cooperative Health Care Agreements Board 10 CCR 2505-1	Repeals regulatory oversight of Cooperative Health Care Agreements Board by the Department of Health Care Policy and Financing. SB 06-219 repealed Title 25.5 Article 1 Part 5 effective July 1, 2006 to conform to the statutory transfer of regulatory responsibility for Health Care Coverage Cooperatives to the Division of Insurance that was enacted under SB 04-105, effective August 4, 2004. The rule repeal is necessary to conform to statutory intent.	March 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 12-08-06-B	Revision to the Medical Assistance Rule Concerning Home and Community Based Services-for Persons With Mental Illness HCBS-MI, Section 8.509	This proposed rule revises the regulation for the Home and Community-Based Services for Persons with Mental Illness (HCBS-MI), 10 CCR 2505-10 8.509. The proposed changes are intended to improve the efficiency of the waiver program operations, to correct dated or inaccurate references to statutes and regulations, and to provide guidance and clarification on case management functions. Section 8.509.32(A) of On-Going HCBS-MI Cases changes the Single-Entry Point Requirement for quarterly face-to-face contact with clients to a bi-annual face-to-face contact. The requirement for quarterly contact with the client's has not been removed but has allowed the case manager and client to determine if this contact should be conducted over the telephone, at the client's place of residence, place of service, or other appropriate setting determined by the client's needs. This language change removes inconsistencies with the federally approved waiver application. The proposed rule also changes the name of the waiver from Home and Community-Based Services for persons with Mental Illness (HCBS-MI) to Home and Community-Based Service for Community Mental Health Supports (HCBS-CMHS).	March 2013 Permanent Adoption
MSB 13-01-24-A	Revision to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003	Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers. The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2012), and implements the Hospital Quality Incentive Payment (HQIP), as required by the act. HQIP links supplemental payments to measures of quality of care, process, and health outcomes. The proposed rule increases the fees assessed on hospital providers to fund these payments, and to fund expansions of Medicaid and Child Health Plan Plus (CHP+) eligibility authorized under the Act.	March 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-01-A	Revision to the Medical Assistance Rule Concerning ICF/IID Reimbursement, Sections 8.440.2, 8.443.4	House Bill 03-1292 authorized the Colorado Department of Human Services (DHS) to collect a provider fee on Class II and Class IV nursing facilities, also known as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The fee program was suspended in FY 2011-12 due to questions about whether it was compliant with federal regulations. Suspending the fee program allowed the Department of Health Care Policy and Financing (the Department) to develop a strategy to work with the Centers for Medicare and Medicaid Services (CMS) to ensure the program meets regulatory standards. In April 2012 the Department reached an agreement with CMS to reinstate the provider fee program in a manner that complies with federal regulations. With federal approval of the fee program, the Joint Budget Committee (JBC) appropriated funds for the fee and fee reimbursement for both FY 2011-12 and FY2012-13 as part of Senate Bill 13-167. The ICF/IID provider fee program saves the state General Fund approximately $1 million annually, while maintaining reimbursement rates for the facilities. The current rules governing ICF/IID reimbursement are ambiguous as to the inclusion of provider fees as an allowable cost. Current statute (C.R.S. 25.5-6-204) states that ICFs/IID should be reimbursed for the actual cost of services provided, which would include the cost of the provider fee. Provider fees are not explicitly defined as an allowable cost for reimbursement purposes in rule. In order to ensure that ICFs/IID are reimbursed their full cost, the Department is proposing rule changes to explicitly define provider fees as an allowable cost.	April 2013 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-11-A	Revision to the Medical Assistance Program Rule Concerning Increased Medical Payments to Primary Care Physicians, Section 8.200.6	Increased reimbursement for selected services from identified primary care physicians is required under the Affordable Care Act. The increase raises payment to Medicare rates which are higher than the published Medicaid fee schedule. Regulatory authority is required to exceed fee schedule reimbursement. The State Plan Amendment was submitted March 22, 2013 and may be approved at any time. Once the State Plan Amendment is approved, the payments will be required but cannot be made without a rule authorizing payment higher than the published fee schedule. The increased payment is only for evaluation and management services and vaccine administration services included in the Medical Assistance Program coverage. The increased payment is available from January 1, 2013, through December 31, 2014 for services provided on or after January 1, 2013 and before December 31, 2013. The federal regulations, 42 C.F.R. Subpart G, were final in November 2012, to become effective January 1, 2013.	April 2013 Emergency Adoption
MSB 13-04-04-A	Revision to 10 CCR 2505-3, Financial Management of the Children's Basic Health Plan Rule Concerning Eligibility, Insufficient Access to Other Health Coverage, Subsection 120	The Governor signed a bill on March 29, 2013 that eliminates the requirement that CHP+ applicants be uninsured for three months prior to becoming eligible. See 25.5-8-109, C.R.S, SB 13-008. In order to comply with this regulation, the department wishes to update the CHP+ rule. This proposed rule would eliminate the requirement of three-months of uninsurance for CHP+ applicants.	May 2013 Emergency Adoption
MSB 13-02-14-A	Revision to the Medical Assistance Rule Concerning Submission of Cost Reporting Information Audit Timeline, Section 8.442.3	Proposed change seeks to address the time frame in which the department/contract auditor has to obtain additional documentation from a provider after they have received a proposed adjustment. This allows the provider an extension of days in which to submit information.	May 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-01-A	Revision to the Medical Assistance Rule Concerning Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Reimbursement, Sections 8.440.2, 8.443.4	House Bill 03-1292 authorized the Colorado Department of Human Services (DHS) to collect a provider fee on Class II and Class IV nursing facilities, also known as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The fee program was suspended in FY 2011-12 due to questions about whether it was compliant with federal regulations. Suspending the fee program allowed the Department of Health Care Policy and Financing (the Department) to develop a strategy to work with the Centers for Medicare and Medicaid Services (CMS) to ensure the program meets regulatory standards. In April 2012 the Department reached an agreement with CMS to reinstate the provider fee program in a manner that complies with federal regulations. With federal approval of the fee program, the Joint Budget Committee (JBC) appropriated funds for the fee and fee reimbursement for both FY 2011-12 and FY2012-13 as part of Senate Bill 13-167. The ICF/IID provider fee program saves the state General Fund approximately $1 million annually, while maintaining reimbursement rates for the facilities. The current rules governing ICF/IID reimbursement are ambiguous as to the inclusion of provider fees as an allowable cost. Current statute (C.R.S. 25.5-6-204) states that ICFs/IID should be reimbursed for the actual cost of services provided, which would include the cost of the provider fee. Provider fees are not explicitly defined as an allowable cost for reimbursement purposes in rule. In order to ensure that ICFs/IID are reimbursed their full cost, the Department is proposing rule changes to explicitly define provider fees as an allowable cost.	May 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-11-A	Revision to the Medical Assistance Program Rule Concerning Increased Medical Payments to Primary Care Physicians, Section 8.200.6	Increased reimbursement for selected services from identified primary care physicians is required under the Affordable Care Act. The increase raises payment to Medicare rates which are higher than the published Medicaid fee schedule. Regulatory authority is required to exceed fee schedule reimbursement. The State Plan Amendment was submitted March 22, 2013 and may be approved at any time. Once the State Plan Amendment is approved, the payments will be required but cannot be made without a rule authorizing payment higher than the published fee schedule. The increased payment is only for evaluation and management services and vaccine administration services included in the Medical Assistance Program coverage. The increased payment is available from January 1, 2013, through December 31, 2014 for services provided on or after January 1, 2013 and before December 31, 2013. The federal regulations, 42 C.F.R. Subpart G, were final in November 2012, to become effective January 1, 2013.	May 2013 Permanent Adoption
MSB 13-04-09-C	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6	This rule is being changed to comply with Senate Bill 13-230, Long Appropriations Bill, which mandates an increase of two percent for reimbursement for hospitals providing outpatient services effective July 1, 2013. Thus, the proposed rule will change the reimbursement for outpatient hospital services to 70.2% of cost which represents a payment increase of 2.0% as required by Senate Bill 13-230.	June 2013 Emergency Adoption
MSB 13-04-22-A	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7	This rule is being changed to comply with Senate Bill 13-230 Long Appropriations Bill, which mandated an increase of 2% for Federally Qualified Health Centers (FQHCs) effective July 1, 2013. The rate increase is not, however, allowed to exceed the higher of the Alternative Payment Methodology (APM) rate or the PPS rate.	June 2013 Emergency Adoption
MSB 13-04-23-A	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, Section 8.590.7.I	The proposed rule will increase the DME encounter rate by 2% to account for General Assembly funding appropriation.	June 2013 Emergency Adoption
MSB 13-04-04-A	Revision to 10 CCR 2505-3, Financial Management of the Children's Basic Health Plan Rule Concerning Eligibility, Insufficient Access to Other Health Coverage, Subsection 120	The Governor signed a bill on March 29, 2013 that eliminates the requirement that CHP+ applicants be uninsured for three months prior to becoming eligible. See 25.5-8-109, C.R.S, SB 13-008. In order to comply with this regulation, the department wishes to update the CHP+ rule. This proposed rule would eliminate the requirement of three-months of uninsurance for CHP+ applicants.	June 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-I	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning DME Oxygen Benefit Coverage Standard Incorporation by Reference, Section 8.580	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for DME Oxygen into the Medical Assistance Health Program Rule. Incorporation by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	June 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-J	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Podiatry Services Benefit Coverage Standard Incorporation by Reference, Section 8.200.3.A.8	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Podiatry Services into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants	June 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-D	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Ambulatory Surgery Center Benefit Coverage Standard Incorporation by Reference, Section 8.570.3.D	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Ambulatory Surgery Centers into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	July 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-F	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Dialysis Treatment Center Benefit Coverage Standard Incorporation by Reference, Section 8.310	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Dialysis Treatment Centers into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	July 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-L	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Bariatric Surgery Benefit Coverage Standard Incorporation by Reference, Section 8.300.3	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Bariatric Surgery into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	July 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-A	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning School-Based Health Centers Benefit Coverage Standard Incorporation by Reference, Section 8.295	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for School-Based Health Centers into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	July 2013 Permanent Adoption
MSB 13-04-22-B	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers Rule Language, Section 8.700	This rule change is intended to clarify existing policies, to align the current FQHC rules with current system parameters, and to remove inappropriate costs from the encounter rate.	July 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-B	Revision to the Medical Assistance Physician Services Rule Concerning Immunization Services Benefit Coverage Standard Incorporation by Reference, Section 8.200.3.C	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Immunization Services into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	July 2013 Permanent Adoption
MSB 13-04-09-C	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6	This rule is being changed to comply with Senate Bill 13-230, Long Appropriations Bill, which mandates an increase of two percent for reimbursement for hospitals providing outpatient services effective July 1, 2013. Thus, the proposed rule will change the reimbursement for outpatient hospital services to 70.2% of cost which represents a payment increase of 2.0% as required by Senate Bill 13-230.	July 2013 Permanent Adoption
MSB 13-04-22-A	Revision to the Medical Assistance Rule Concerning Federally Qualified Health Centers, Section 8.700.7	This rule is being changed to comply with Senate Bill 13-230 Long Appropriations Bill, which mandated an increase of 2% for Federally Qualified Health Centers (FQHCs) effective July 1, 2013. The rate increase is not, however, allowed to exceed the higher of the Alternative Payment Methodology (APM) rate or the PPS rate	July 2013 Permanent Adoption
MSB 13-04-23-A	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increases, Section 8.590.7.I	The proposed rule will increase the DME encounter rate by 2% to account for General Assembly funding appropriation.	July 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-J	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Podiatry Services Benefit Coverage Standard Incorporation by Reference, Section 8.200.3.A.8	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Podiatry Services into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	July 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-02-27-A	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Alternative and Augmentative Communication Devices Benefit Coverage Standard, Section 5.590.2.G	The purpose of this rule is to incorporate by reference the Alternative and Augmentative Communication Device Benefit Coverage Standard, developed through the Benefits Collaborative, into the Durable Medical Equipment section of the Volume 8 rules. The Benefit Coverage Standards were drafted to comply with federal regulations that mandate the Department define sufficient, amount, duration, and scope of the Colorado Medicaid covered services. The purpose of this benefit coverage standard is to achieve the goal of ensuring appropriate utilization as well as statewide equity and consistency in the delivery of services. "Incorporation by reference" means that the Benefit Coverage Standards themselves will not be repeated in rule, but are a part of the rule. The incorporation of the Benefit Coverage Standards excludes later amendments to, or editions of, the referenced material, and all referenced materials are available on Colorado Medicaid's Benefits Collaborative Web site. Whenever there is a change to a Benefit Coverage Standard, it must be presented to and adopted by the Medical Services Board before the change is implemented just as the Department must do for any other rule.	August 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-18-A	Revision to the Medical Assistance Rule Concerning Nursing Facility Provider Fees, non-Medicare Patient Days Review, Section 8.443.17.A.4.f	8.443.17.A.4.f addresses the review of non-Medicare patient days used in the calculation of the provider fee to be assessed to facilities. The rule currently allows all providers to request a review if their actual days in the fiscal year (FY) differ by more than 5% from the calendar year (CY) days used to calculate the fee. This rule was in conjunction with monthly days reporting at 8.443.17.A.4.e when the program was established. In the first year of the provider fee program, providers were submitting data monthly and the fees and payments were being set contemporaneously. With the passage of Senate Bill (SB) 09-263, the program shifted to a prospective payment system based on historical rather than contemporaneous estimates. With the program now being based on historical data, the data used is actual data. For example, in FY 2013-14 the fee will be calculated using actual non-Medicare days from CY 2012. In FY 2014-15, the fee will be calculated using actual non-Medicare days from CY 2013. Because of this, a provider's actual experience will be captured by the program. The environment that this rule was created to address no longer exists, and as such, the original need that the rule was intended to satisfy is not present. For new facilities, the Department must still use estimated non-Medicare days, and, therefore, the need to review those days still exists. The Department has revised the rule from requiring a provider to request the review to stating that the days will be reviewed for facilities that have estimated non-Medicare days.	August 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-05-22-A	Revision to the Medical Assistance Rule Concerning Intermediate Care Facilities for Individuals with Intellectual Difficulties	Senate Bill (S.B.) 13-167 authorized the Colorado Department of Health Care Policy and Financing (the Department) to assess a service fee on Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). The fee is used to generate increased federal matching funds that are used to maintain the continuity and quality of care at these facilities. The fee program was initially established in House Bill 03-1292, which gave the Department of Human Services (DHS) the authority to administer the fee program. Due to the Department's expertise in federal financing programs and role as the State's Medicaid agency, the General Assembly determined that the administration of the fee program would be more appropriately housed within the Department. The proposed rule change establishes the fee program as described in S.B. 13-167. The administrative rules change first establishes the fee rate calculation methodology pursuant to S.B. 13-167. The rule change then describes the process for collecting the fee from ICFs/IID. The rule change also delineates the class I nursing facility provider fee from the class II and class IV nursing facility service fee	August 2013 Permanent Adoption
MSB 13-04-10-A	Revision to the Medical Assistance Eligibility Rule Concerning Rule Changes Pursuant to the Patient Protection and Affordable Care Act, Section 8.100.1 through 8.100.6	The proposed rule amends 10 CCR 2505-10 Sections 8.100.1, 8.100.2, 8.100.3, 8.100.4, 8.100.5 and 8.100.6 to incorporate eligibility rule changes pursuant to the passage and implementation of the Affordable Care Act (ACA). The ACA introduced several new regulations that did not previously exist for determining financial eligibility and household composition, especially within the former Family and Children's Medical Assistance at Section 8.100.4. New regulations based around the IRS calculation for Modified Adjusted Gross Income include significant changes, deletions and rewritten paragraphs and subsections in 8.100.4. Section 8.100.1 has had several deletions of obsolete definitions and also includes new additions pursuant to the law. The legal basis at 8.100.2 was augmented by adding reference to the ACA; some of the requirements in 8.100.3 were moved to 8.100.5 as some no longer generally apply to the new MAGI coverage groups.	August 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-06-12-A	Revision to the CHP+ Eligibility Rule Concerning Rule Changes Pursuant to the Patient Protection and Affordable Car Act, 10 CCR 2505-3, Sections 50, 110, 130, 150, 170 and 430	The proposed rule changes amend 10 CCR 2505-3 §50, 110, 130, 150, 170, and 430 to incorporate changes to our rules mandated by the Patient Protection and Affordable Care Act of 2010 (ACA). Among these changes: altering definitions within section 50, clarifying the income level within section 110, and updating the documentation requirements within section 130. Section 150 has been altered and rewritten to reference the Medicaid rules for the Modified Adjusted Gross Income (MAGI) methodologies to determine household size and income. Section 430 has been updated to provide eligibility as of the beginning of the month.	August 2013 Permanent Adoption
MSB 13-03-12-H	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Hospice Services Benefit Coverage Standard Incorporation by Reference, Section 8.550.4.C	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Hospice Services into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	September 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-03-12-K	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Speech-Language and Hearing Services Benefit Coverage Standard Incorporation by Reference, Section 8.230	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Speech -- Language and Hearing Services into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations. The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers. Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.	September 2013 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-04-26-B	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Children with Autism Waiver, Section 8.519.5 and 8.519.7	The proposed rule amends the regulations for the Home and Community Based Services Children with Autism Waiver (HCBS-CWA) Definitions 10 CCR 2505-10 8.519.1, Waitlist 10 CCR 2505-10 8.519.5, and Provider Responsibilities 10 CCR 2505-10 8.519.7. The proposed changes will bring the Department and the waiver into compliance with state statue 25-5-6-804, et. Seq. CRS (2012). The proposed rule will allow the Department to prioritize the waitlist based on an objective norm-referenced assessment of the child's adaptive functioning. The proposed rule will also amend provider responsibilities to include the provider will conduct or obtain an objective norm-referenced assessment when the child enters the waiver and every six months the child is on the waiver, as well as upon exit of the waiver. This will allow the provider a chance to compare the assessments and make appropriate adjustments to the plan of care as needed. The providers must also provide the assessment results to the parent or guardian and case manager. The definition section was updated to include a definition of Standardized, norm-referenced assessment.	September 2013 Permanent Adoption