Title of Rule:	Revision to Medical Assistance Rule Concerning Home Health Special Reimbursement of Non-Homebound Dually Eligible clients
Rule Number:	MSB 11-04-01-A
Division / Contact / Phone:	Medicaid/Benefit Management / Guinevere Blodgett / 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).

   At the present time, home health agencies are required to bill Medicare, and must then wait for partial payment, or a denial, to get payment from Medicaid, the payor of last resort. However, Medicare does not cover services for clients who do not meet the home bound status requirment for home health benefits, and submitting claims to Medicare for these services does not result in any payment. Colorado Medicaid allows home health care to be delivered to clients who are not home bound, but in accordance with the current rule, home health agencies must wait for the Medicare denials to get the claims paid. This can create an unduly burdensome delay in payment for the home health agencies. The proposed rule change will allow home health agencies to bill Medicaid at the time of services for dual eligible clients who are not homebound, which will resolve the payment delay issue. Home health agencies will still be required to obtain a Medicare denial for the client records to ensure that Medicaid is the payor of last resort. This rule revision also includes the deletion of obsolete cost reporting requirments.

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:

   The payment delay caused by the current rule jeopardizes the financial health of the home health agencies. This compromises the agencies' ability to continue serving Medicaid clients, which would constrict the Medicaid clients' provider network, and limit the ability for clients to obtain the care they need.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

Title of Rule:	Revision to Medical Assistance Rule Concerning Home Health Special Reimbursement of Non-Homebound Dually Eligible clients
Rule Number:	MSB 11-04-01-A
Division / Contact / Phone:	Medicaid/Benefit Management / Guinevere Blodgett / 5927

25.5-1-301 through 25.5-1-303, C.R.S. (2010);

Title of Rule:	Revision to Medical Assistance Rule Concerning Home Health Special Reimbursement of Non-Homebound Dually Eligible clients
Rule Number:	MSB 11-04-01-A
Division / Contact / Phone:	Medicaid/Benefit Management / Guinevere Blodgett / 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.

   All Medicare/Medicaid dually eligible clients receiving home health services 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.

   Home health agencies will receive more timely payment for this client population. The amount of reimbursement will remain the same.

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

   This rule has the potential to make Medicaid claims pay more quickly after the service is rendered. The Department believes that should this result in costs shifting, the impact would be minimal. Many providers are currently compliant with the rule change and the dollar amount of claims that could be impacted is relatively low. Should the Department find the cost shift to be higher than expected it will account for the change through the regular budget process.4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   This rule change will allow home health agencies to receive payment for services without waiting for a Medicare denial, which will benefit our home health provider network.

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

   This rule will allow for timely billing of services for this population, but will not affect the cost of these services.

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.

   N/A.

8.528 REIMBURSEMENT

8.528.1 CLAIMS

8.528.1.A. Claims shall be submitted to the fiscal agent according to Section 8.040, RULES GOVERNING SUBMISSION OF CLAIMS, and Section 8.043, TIMELY FILING REQUIREMENTS.

8.528.1.B. Home Health providers shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.2, RULES GOVERNING SUBMISSION OF CLAIMS, and Section 8.130, PROVIDER AGREEMENTS.

8.528.2 UNIT OF REIMBURSEMENT

8.528.2.A. The unit of reimbursement for the Home Health services of nursing, physical therapy, occupational therapy, and speech therapy shall be one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.

8.528.2.B. The Basic Unit of reimbursement for home health aide services shall be up to one hour. A unit of time that is less than fifteen minutes shall not be reimbursable as a basic unit.

8.528.2.C. For home health aide visits that last longer than one hour, Extended Units may be billed in addition to the Basic Unit. Extended Units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes shall not be reimbursable as an extended unit.

8.528.2. D. Reimbursement for supplies used by Home Health agency staff is included in the reimbursement for nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services, to the following extent:

1. Supplies used during provision of any Home Health services by Home Health agency staff for the practice of universal precautions shall be the financial responsibility of the Home Health agency. This excludes gloves used for bowel programs and catheter care but includes all other supplies required for the practice of universal precautions by Home Health agency staff. If a Home Health agency asks a client to provide such supplies, this will constitute a failure to accept Medicaid payment in full, in violation of Section 8.012, PROHIBITION OF CHARGES TO RECIPIENTS.

2. Supplies other than those required for practice of universal precautions which are used by the Home Health agency staff to provide Home Health care services shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

3. Supplies used for the practice of universal precautions by the client's family or other informal caregivers shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the

physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

8.528.3 The following restrictions shall be placed on Home Health services for purposes of reimbursement:

8.528.3.A. Nursing visits shall not be reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Mental Health Assessment and Services Agencies. Nursing visits for mentally ill clients shall be reimbursed under Medicaid Home Health for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

8.528.3.B. The state shall not authorize nor reimburse home health aide services for the purpose of providing only unskilled personal care and/or homemaking services. Units during which unskilled personal care and/or homemaking services are provided and billed under the home health aide benefit must be contiguous with units during which services defined as skilled personal care are provided. For clients who are also eligible for HCBS personal care and homemaker services, the units spent on unskilled personal care and homemaker services and billed as aide services shall be reasonable in relation to the skilled care provided on the contiguous units. For example, if the transfer and bath are skilled, it would be reasonable for the aide to also dress the client, and to wipe up any water spills on the bathroom floor, and to prepare a meal if the aide is there at mealtime. It would not be reasonable for the aide to stay four more hours to do all the weekly cleaning and laundry, unless the client is not eligible for homemaker services under HCBS.

8.528.3.C. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed $270, effective July 1, 2002, for Acute Home Health Services or Long Term with Acute Episode Home Health Services; and shall not exceed $211, effective July 1, 2002, for Long Term Home Health Services.

Effective September 1, 2002, the maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed $291 for Acute Home Health Services or Long Term with Acute Episode Home Health Services, and shall not exceed $227 for Long Term Home Health Services.

Criteria for the three different categories of care are found at 8.523.11, K in this section. The maximum daily reimbursement includes reimbursement for nursing visits, home health aide units, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.

8.528.3.D. Medicaid will not reimburse for two nurses during one visit, two home health aides at the same time, two physical therapists during one visit, two occupational therapists during one visit, or two speech therapists during one visit. An exception to this rule is for two home health aides, when two are required for transfers, and there are no other persons available to assist, and when there is a justifiable reason why adaptive equipment cannot be used instead. Another exception is for two nurses when two are required to perform a procedure. For these exceptions, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.

8.528.3.E. If a client is seen simultaneously by two persons to provide a single service, for which one person supervises or instructs the other, the Home Health agency shall only bill and be reimbursed for one employee's visit or units. For example, if two nurses visit the client, and the first nurse provides care and also orients and trains the second nurse in the client's care, only the first nurse's time counts as a reimbursable visit.

8.528.3.F. Any visit made solely for the purpose of supervising the home health aide shall not be reimbursed.

8.528.3.G. Any visit made by a nurse or therapist to simultaneously serve two or more clients residing in the same household shall be reimbursed as one visit only, unless services to each client are separate and distinct. If two or more clients residing in the same household receive Medicaid home health aide services, the personal care for each client shall be documented and billed separately for each client. Any homemaker services provided during units contiguous to skilled personal care units shall be billed to any one of the clients in the household, but the homemaker services shall not be duplicated and/or billed for more than one client. For example, if more than one client in the household needs meal preparation, it is expected that one aide prepare the meal for all of them. If the clients in the same household use different agencies, the agencies shall coordinate with each other to prevent duplication of homemaking.

8.528.3.H. No more than one Home Health agency shall be reimbursed for providing Home Health services during a specific plan period to the same client, unless the second agency is providing a Home Health service that is not available from the first agency. The first agency must take responsibility for the coordination of all Home Health services. Home and Community Based Services, including personal care, are not Home Health services.

8.528.3.I. Physical, occupational, or speech therapy visits shall be reimbursed only when:

1. Improvement of functioning is expected or continuing;

2. The therapy assists in overcoming developmental problems;

3. Therapy visits are necessary to prevent deterioration;

4. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration; and to teach home health aides or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; and/or

5. Therapy visits are indicated to assess the safety or optimal functioning of the client in the home, or to train in the use of equipment used in implementation of the therapy plan of care.

8.528.3.J. Nursing visits provided solely for the purpose of assessing and/or teaching shall be reimbursed by Medicaid only under the following guidelines:

1. For an initial assessment visit ordered by a physician when there is a reasonable expectation that ongoing nursing or home health aide care may be needed. Initial nursing assessment visits shall not be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.

2. If a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the client or the client's unpaid family/caregiver how to perform the task, that visit shall not be considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the client or unpaid family/caregiver performing the task to verify that the task is being performed correctly shall be considered a visit that is solely for the purpose of assessing and teaching.

3. Nursing visits solely for the purpose of assessing the client and/or teaching the client or the client's unpaid family/caregiver shall not be reimbursed unless the care is Acute Home Health or Long Term Home Health With Acute Episode, as defined in Section 8.523, ELIGIBILITY, or the care is for extreme instability of a chronic condition under Long Term Home Health, as defined in Section 8.523, ELIGIBILITY.

4. Nursing visits provided solely for the purpose of assessment and/or teaching shall not exceed the frequency that is justified by the client's documented medical condition and symptoms, up to the maximum reimbursement limits. Assessment visits shall continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific conditions and/or symptoms which are not stable and/or not resolved. Teaching visits shall be as frequent as necessary, up to the maximum reimbursement limits, to teach the client or the client's unpaid family/caregiver, and shall continue only as long as needed for the client or the client's unpaid family/caregiver to demonstrate understanding or to perform care, or until it is determined that the client or unpaid family/caregiver is unable to learn or to perform the skill being taught. The visit on which the nurse determines that there is no longer a need for assessment and/or teaching shall be reimbursed if it is the last visit provided solely for assessment and/or teaching.

5. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if the client is capable of self-assessment and of contacting the physician as needed; and if the client's medical records do not justify a need for client teaching beyond that already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment.

6. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if there is an available and willing unpaid family/caregiver who is capable of assessing the client's condition and needs and contacting the physician as needed; and if the client's medical records do not justify a need for teaching of the client's unpaid family/caregiver beyond the teaching already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment.

8.528.3.K. Nursing visits provided solely for the purpose of assessment and/or teaching and foot care shall not be reimbursed unless the visit meets the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, and/or the guidelines to be reimbursed as a foot care visit.

Nursing visits provided solely for the purpose of providing foot care shall be reimbursed by Medicaid only if the client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the client and/or unpaid family/caregiver is not able or willing to provide the foot care. This will include documented and supported diagnoses that involve severe peripheral involvement, anti-coagulation therapy, or other conditions such as, but not limited to, spasticity and compromised immune system which could lead to a high risk of medical complications from injuries to the feet.

Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit. The clinical record must indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for footcare to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:

1. absent (not palpable) posterior tibial pulse;

2. absent (not palpable) dorsalis pedis pulse;

3. three of the advanced trophic changes such as:

    a. hair growth (decrease or absence),

    b. nail changes (thickening),

    c. pigmentary changes (discoloration),

    d. skin texture (thin, shiny),

    e. skin color (rubor or redness);

4. claudication (limping, lameness);

5. temperature changes (cold feet);

6. edema;

7. parasthesia;

8. burning.

8.528.3.L. Nursing visits provided solely for the purpose of assessment and/or teaching and pre-pouring of medications shall not be reimbursed unless the visit meets either the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, or the guidelines for reimbursement as a visit solely for the purpose of pre-pouring medications. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers shall be reimbursed by Medicaid under the following guidelines:

1. The client is not living in a licensed personal care boarding home, including Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at 25-1-107 (ee) (I.5), C.R.S., as amended

by House Bill 98-1015. No later amendments to or editions of 25-1-107 (ee) (I.5), C.R.S., as amended by House Bill 98-1015 are included. Copies of 25-1-107 (ee) (I.5), C.R.S., as amended by House Bill 98-1015 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714 or the material may be examined at any State Publications Depository Library; and

2. The client is not physically or mentally capable of pre-pouring his/her own medications or has a medical history of non-compliance with taking medications if they are not pre-poured; and

3. The client has no unpaid family/caregiver who is willing or able to pre-pour the medications for the client; and

4. There is documentation in the client's chart that the client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular client.

8.528.3.M. Nursing visits solely for the purpose of performing venipuncture, or for venipuncture and assessment and/or teaching, shall be reimbursed only if all the regulations in Section 8.520 through 8.530.10, B, HOME HEALTH SERVICES, are met.

8.528.4 RATES OF REIMBURSEMENT

8.528.4.A. Payment for Home Health services, other than nursing visits, shall be the lower of the billed charges or the maximum unit rate of reimbursement.

8.528.4.B. For nursing visits the payment shall be the lower of the billed charges, the maximum unit rate of reimbursement or prior authorized charges.

8.528.4.C. Prior authorized charges for stable clients requiring daily visits shall not exceed $50.00 for the first brief nursing visit of the day and $35.00 for the second or subsequent brief nursing visit of the day.

8.528.4.D. Maximum interim payment unit rates are

Effective July 1, 2002:

1. Nursing visits: $67.85

2. Acute Home Health Aide Basic unit: $22.37

3. Long Term Home Health Aide Basic unit: $30.08

4. Home Health Aide Extended unit: $8.99

5. Physical Therapy visits: $58.36

6. Occupational Therapy visits: $61.98

7. Speech Therapy visits: $63.60

Effective September 1, 2002:

1. Nursing visits: $71.42

2. Any Home Health Aide Basic unit: $31.66

3. Home Health Aide Extended unit: $9.46

4. Physical Therapy visits: $61.43

5. Occupational Therapy visits: $65.24

6. Speech Therapy visits: $66.95

Effective February 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 99-00. The interim rates shall not be reduced, if total Medicaid home health expenditures in State FY 99-00 do not exceed $73,571,787, the Department shall determine which Home Health Agencies received average per unduplicated client payments for State FY 99-00 Home Health services which were more than 16.5% over State FY 98-99 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each agency's unit rates, retro-active to February 1, 2000, by a percentage that will bring each agency's average payment per unduplicated client for State FY 99-00 to no more than a 16.5% increase over its State FY 98-99 average per unduplicated client payment. Agencies that became newly certified as Medicare/Medicaid providers in State FY 99-00 and have no Medicaid Home Health payment history for State FY 98-99 shall be exempt.

8.528.4.E. Effective September 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 00-01 with the following exemptions:

1. Exempt Agencies

   a. Agencies that became newly certified as Medicare/Medicaid providers in State FY 00-01 and have no Medicaid Home Health payment history for State FY 99-00 shall be exempt.

   b. Agencies that had total Medicaid Home Health payments of less than $125,000 in FY 99-00 shall be exempt.

2. Exempt Clients

   a. Clients who are newly enrolled in Medicaid shall be exempt if they receive Medicaid Home Health services within thirty days of their very first Medicaid enrollment. Clients with prior spans of Medicaid eligibility shall not be considered newly enrolled even if there was a period of non-enrollment between eligibility spans.

   b. Clients who are deinstitutionalized from nursing facilities shall be exempt if the nursing facility care was billed to Medicaid and was not billed as respite care; if they begin receiving Home Health services no later than thirty days after discharge from the nursing

facility; and if they do not return to nursing facility placement after an interim period of Home Health care.

8.528.4.F. The FY 00-01 interim rates shall not be reduced if total Medicaid community long term care expenditures in State FY 00-01 do not exceed $198,862,688. If total expenditures for the community long term care budget do exceed $198,862,688, the Department shall determine which non-exempt Home Health Agencies received average per non-exempt unduplicated client payments for State FY 00-01 Home Health services which were more than 16.5% over State FY 99-00 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each non-exempt agency's unit rates, retroactive to September 1, 2000, by a percentage that will bring each agency's average payment per non-exempt unduplicated client for State FY 00-01 to no more than 16.5% increase over its State FY 99-00 average per unduplicated client payment.

8.528.4.F. Services shall be billed according to category of service upon publication of instructions in the provider-billing manual.

1. For Acute Home Health Services, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health.

2. For Long Term Home Health Services provided to a minor, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy as Long Term Home Health. For Long Term Home Health Services provided to an adult, Home Health Agencies shall bill nursing, and home health aide services as Long Term Home Health. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

3. For Long Term with Acute Episode Home Health Services, Home Health Agencies shall bill all nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health, until the client's care becomes Long Term Home Health again.

4. For all nursing visits provided solely for the purpose of assessment and teaching, not including initial assessment visits at the start of care, Home Health Agencies shall bill a revenue code assigned for nursing assessment and teaching visits.

8.528.4.G. Maximum unit rates may be adjusted by the State as funding becomes available.

8.528.5 SPECIAL REIMBURSEMENT CONDITIONS

8.528.5.A. Reimbursement for third party resource and Medicare crossover claims shall not exceed Medicaid costs.

8.528.5.B. When Home Health agencies provide Home Health services, in accordance with these regulations, to clients who receive Home and Community Based Services for the Developmentally Disabled (HCBS-DD), the Home Health agency shall be reimbursed:

1. Under normal procedures for Home Health reimbursement, if the client resides in an Intensive Adult Residential Service group home, a personal care host home, or personal care alternatives home; or

2. By the group home provider, if the client resides in a Moderate Supervision Group Home, or Specialized Group Home, because the group home has already received Medicaid funding for the home health services and is responsible for payment to the Home Health agency.

8.528.5.C. Acute Home Health services provided to Medicaid HMO clients, including Medicaid HMO clients who are also HCBS recipients, shall not be reimbursed under the Medicaid Home Health program, but shall be reimbursed under Medicaid HMO rules. If a client's Home Health service need exceeds 60 days, the Home Health Agency shall submit a Prior Authorization for Long Term Home Health to the Case Management Agency, if the client is 18 years old or more; or to the Medicaid fiscal agent if the client is less than 18 years old.

8.528.5.D. All Medicare requirements shall be met and exhausted prior to any dual eligible client's ~~clam~~claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except in the specific cases listed at 8.528.5.D.1 and 8.525.5.D.2.

1. A Home Health Agency may bill Medicaid without billing Medicare if the services below are the only services on the claim:

a. Pre-pouring of medications;

b. Certified Home Health Aide services;

c. Occupational Therapy services when provided as the sole skilled service; or

d. Routine Laboratory Draw services.

2. A Home Health Agency may bill Medicaid at the time of services, if the conditions below apply. The claim must also be submitted to Medicare so that the denial, when received, is part of the client's file.

a. The client is stable;

b. The client is not experiencing an acute episode; and

c. The client routinely leaves the home ~~without taxing effort and unassisted~~ for social, recreational, educational, or employment purposes.

3. The Home Health Agency shall maintain clear documentation in the client's record of the conditions and services that are billed to Medicaid without billing Medicare.

4. A Home Health Advance Beneficiary Notice (HHABN) shall be filled out as prescribed by Medicare.

8.528.5.E. A dual eligible Long Term Home Health Care client who has an Acute Episode shall be switched from Medicaid to Medicare reimbursement. Medicaid resumes as the payer of record when Medicare denies payment as a non-covered benefit

and the service is a Medicaid benefit, or when the service consists of those listed in 8.528.5.D.2.

8.528.5.F. If both Medicare and Medicaid reimburse for the same visit or service provided to a client in the same episode, the reimbursement shall be considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

1. Upon receiving a duplicate payment, Home Health agencies shall return the payment to Medicaid within sixty (60) calendar days of final Medicare payment.

2. Failure to return the Medicaid payment to the Department shall be deemed a false claim and subject to the provisions set forth in 25.5-4-303.5, C.R.S., et seq. and referred to the Medicaid Fraud Control Unit in the Colorado Department of Law for criminal investigation.

~~**8.528.6 COST REPORTING**~~

~~8.528.6.A. All Home Health agencies shall report and submit to the Department cost report information on a Department prescribed form for home health aides, nurses, occupational, physical and speech therapists.~~

~~8.528.6.B. By dates set forth by the Department, home health providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or State fiscal year.~~

~~8.528.6.C. Providers that do not comply with Section 8.528.15 shall have their Medicaid provider agreement terminated.~~