COLORADO
Department of Health Care Policy & Financing

November 1, 2014

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), as codified at Section 24-4-103 C.R.S., 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 2015. 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 Zach Lynkiewicz, Legislative Liaison, via email at zach.lynkiewicz@state.co.us or by phone at 303-866-2031.

Sincerely,

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

SEB:jlc
Enclosure: 2015 Departmental Regulatory Agenda

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2015 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
Hospital Provider Fee Program	C.R.S. § 25.5-4-402.3(3)(e)(I)	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.	January 2015	Colorado hospitals and Low-income and disabled Coloradans eligible for hospital provider fee-funded Medicaid and CHP+ expansions.
Colorado Dental Health Care Program for Low-Income Seniors	C.R.S. § 25.5-3-404 (4)	Pursuant to Senate Bill 14-180, the purpose of the Colorado Dental Health Care Program for Low-Income Seniors is to promote the health and welfare of Colorado's low-income seniors by providing access to dental care to individuals age 60 and over who are not eligible for dental services under any other dental health care program, such as Medicaid or the Old Age Pension (OAP) Health and Medical Care Program. This program will provide grants throughout the state to local Area Agencies on Aging (AAA), public health agencies, Community Health Centers, private dental practices, and other community-based organizations who meet application criteria developed under the guidance of the Senior Dental Advisory Committee.	December 2014	Low-income seniors who are not eligible for public or private dental benefits, Federally Qualified Health Centers, safety net clinics, Area Agencies on Aging, public health agencies, and private dental practices.

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Implementation of new federal provider screening regulation	Sec. 6401 of the Affordable Care Act and 42 CFR Parts 447 and 455.	The proposed rule will implement new federal requirements for screening providers before they are enrolled in Medicaid. These federal requirements seek to prevent waste, fraud and abuse in Colorado's Medicaid program.	The desired effective date of this rule is June1, 2015. During the spring of 2015, our workgroup hopes to gain approval for this rule from the MSB and from CMS through a state plan amendment.	This rule will impact enrollment for all of Colorado's Medicaid providers in some way. All current providers will be required to revalidate their enrollment in Medicaid by 2016 and institutional and group providers will need to pay a fee to enroll. Additionally some providers may be required to undergo onsite visits before and after enrollment and pass criminal background checks.
Update to rules for deeming sponsor's income for legally present immigrants applying for the Medicaid Program	8 USC 1631 (Sec. 421 of the Personal Responsibility Work Opportunity and Reconciliation Act of 1996 as P.L. 104-208 and P.L. 105-33)	The proposed rule will update the department's rules at 8.100.3.K.1, requiring the deeming of a legally present immigrant's sponsor's income toward their eligibility for Medicaid.	The rule-making schedule will depend on when changes can be made in CBMS. We hope this may be possible no later than the end of 2015.	Sponsored legally present immigrants who are applying for Medicaid eligibility.
Revisions to the Medicaid Eligibility Rules Concerning Clarification updates to section 8.100.1	42 CFR Parts 431, 435	Based on the 2014 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	July 2015	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Medicaid Eligibility Rules Concerning Clarification updates to section 8.100.3	42 CFR Parts 431, 435	Based on the 2014 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	July 2015	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Medicaid Eligibility Rules Concerning Clarification updates to section 8.100.4	42 CFR Parts 431, 435	Based on the 2014 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	July 2015	The change will have a positive affect by providing clarity on the policies for the programs.

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Revisions to the Medicaid Eligibility Rules Concerning Clarification updates to section 8.100.7	42 CFR 435; 20 CFR 416, Title XIX , section 1924 of the Social Security Act	Based on the 2014 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	September 2015	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Children's Basic Health Plan Eligibility Rules Concerning Clarification updates to section 100	42 CFR 457.310,315, 320,2102(b)(1)(B)(v), 2112, CHIPRA Reauthorization 2009 sec 214,SPA CS8, 42 CFR 457.355,42 CFR 435.1102 and 1103, 2112	Based on the 2014 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	July 2015	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Children's Basic Health Plan Eligibility Rules Concerning Clarification updates to section 300	42 CFR 457.310,315 and 320,2102(b)(1)(B)(v), 2112, SPA CS7 and SPA CS8]	Based on the 2014 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	July 2015	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Children's Basic Health Plan Eligibility Rules Concerning Clarification updates to section 400	XXI sec 2112.7(e)	Based on the 2014 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	July 2015	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Medicaid and CHP+ Eligibility Rules Concerning elimination of the 5-year bar for legal permanent children and pregnant women section 8.100.4 and 100 and 400	42 CFR 457.320(b)(6),(c) and (d) and HB 09-1353	Implements policy to provide Medicaid and CHP+ coverage to otherwise eligible legal permanent children and CHP+ Prenatal women.	June 2015	The change will have a positive affect by providing expanding coverage to additional children and pregnant women.
Revisions to the Medicaid Eligibility Rules Concerning Clarification Updates to Section 8.100.6.P	Section 201 of the Ticket to Work and Work Incentive Improvement Act of 1999, Public Law 106-170	Based on client experience with the current policy, making improvements to enhance the client eligibility experience	March 2015	The change will have a positive affect by providing clarity on the policies for the programs.

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Revisions to the Medicaid Eligibility Rules Concerning Clarification Updates to Section 8.100.6.Q	Patient Protection and Affordable Care Act of 2010, Public Law 11-148	Based on client experience with the current policy, making improvements to enhance the client eligibility experience	March 2015	The change will have a positive affect by providing clarity on the policies for the programs.
Revisions to the Medicaid Eligibility Rules Concerning suspension of Medicaid benefits for incarcerated individuals 8.100.3.G.1.b	42 CFR Parts 431, 435 and SB 08-006	Based on the 2014 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	July 2015	The change will have a positive affect by providing clarity on the policies for the programs.
Prosthetics and Orthotics	C.R.S. § 25.5-5-202 (1)(f)	Incorporate Benefit Coverage Standard into rule	Spring 2015	Medicaid members, supply providers
Apnea Monitors	C.R.S. § 25.5-5-102 (1)(f)	Incorporate Benefit Coverage Standard into rule	Spring 2015	Medicaid members, supply providers
Authorized Representative	C.R.S. § 25.5-10-201, et seq.; CRS 25.5-10-303	Provide authority for designation of Authorized Representative	April 2015	Community Centered Boards, Persons receiving HCBS-DD or HCBS-SLS services
Abuse, Mistreatment, Neglect and Exploitation	C.R.S. § 25.5-10-201, et seq.; CRS 25.5-10-303	Revise authority for investigations regarding abuse, mistreatment, neglect, and exploitation	June 2015	Community Centered Boards, CDHS, Adult Protective Service Agencies, Medicaid Service Agencies
Consumer Directed Attendant Support Services (CDASS) into Home and Community Based Services, Supported Living Services (HCBS-SLS)	C.R.S. § 25.5-10-201, et seq.; CRS 25.5-10-303	Implement the CDASS service delivery model into the HCBS-SLS waiver.	TBD (requires CMS approval for waiver amendment)	Community Centered Boards, Persons receiving HCBS-DD or HCBS-SLS services
Support Level Review Process	C.R.S. § 25.5-10-201, et seq.; CRS 25.5-10-303	Revise the requirement to have a panel review when a request for a Support Level Review is made.	May 2015	Community Centered Boards, Persons receiving HCBS-DD or HCBS-SLS services, Service Provider Agencies
School Based Health Centers	C.R.S. § 25-20.5-503	Define the amount, scope and duration of this benefit.	January 2015	Providers of these services and clients who utilize these services.
Home Health	C.R.S. § 25.5-5-102(1)(f)	Define the amount, scope and duration of this benefit.	January 2015	Providers of these services and clients who utilize these services.
Maternity Services	C.R.S. § 25.5-5-102(1)(d)	Define the amount, scope and duration of this benefit.	January 2015	Providers of these services and clients who utilize these services.

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Women's Health	C.R.S. § 25.5-5-102(1)(d)	Define the amount, scope and duration of this benefit.	January 2015	Providers of these services and clients who utilize these services.
Emergent Transportation	C.R.S. § 25.5-5-202(2)	Define the amount, scope and duration of this benefit.	January 2015	Providers of these services and clients who utilize these services.
Outpatient Substance Use Disorder	C.R.S. § 25.5-5-202(1)(g)	Define the amount, scope and duration of this benefit.	January 2015	Providers of these services and clients who utilize these services.
Adult Dental Services	C.R.S. § 25.5-5-202(1)(w)	Update rule language.	January 2015	Providers of these services and clients who utilize these services.
Imaging	C.R.S. § 25.5-5-102(1)(c)	Define the amount, scope and duration of this benefit.	February 2015	Providers of these services and clients who utilize these services.
Lab and Pathology	C.R.S. § 25.5-5-102(1)(c)	Define the amount, scope and duration of this benefit.	February 2015	Providers of these services and clients who utilize these services.
Wheelchair Services	C.R.S. § 25.5-5-102(1)(l)	Define the amount, scope and duration of this benefit.	March 2015	Providers of these services and clients who utilize these services.
NEMT amount	C.R.S. § 25.5-5-202(2)	Define the amount, scope and duration of this benefit.	March 2015	Providers of these services and clients who utilize these services.
Breast and Cervical Program	C.R.S. § 25.5-5-308	Update rule to comply with new statute.	March 2015	Providers of these services and clients who utilize these services.
Orthodontic Services	C.R.S. § 25.5-5-102(1)(g)	Define the amount, scope and duration of this benefit.	March 2015	25.5-1-301 through 25.5-1-303, C.R.S. (2013)
Cardiac Stress Testing	C.R.S. § 25.5-5-102(1)(d)	Define the amount, scope and duration of this benefit.	March 2015	Providers of these services and clients who utilize these services.
DME Oxygen	C.R.S. § 25.5-5-102(1)(l)	Define the amount, scope and duration of this benefit.	April 2015	Providers of these services and clients who utilize these services.
Intersex Surgery	C.R.S. §§ 25.5-5-102(1)(a) and 25.5-5-102(1)(d)	Define the amount, scope and duration of this benefit.	May 2015	Providers of these services and clients who utilize these services.
Augmentative and Alternative Communication Devices	C.R.S. § 25.5-5-202(1)(f)	Define the amount, scope and duration of this benefit.	May 2015	Providers of these services and clients who utilize these services.
Physical and Occupational Therapy	C.R.S. § 25.5-5-202(1)(l)(II,III)	Define the amount, scope and duration of this benefit.	May 2015	Providers of these services and clients who utilize these services.
PET Scans	C.R.S. § 25.5-5-102(1)(c)	Define the amount, scope and duration of this benefit.	June 2015	Providers of these services and clients who utilize these services.

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Medical Necessity	C.R.S. §§ 25.5-1-301 through 25.5-1-303, C.R.S. (2013)	Define the amount, scope and duration of this benefit.	July 2015	Providers of these services and clients who utilize these services.
Private Duty Nursing	C.R.S. § 25.5-5-202(1)(n)	Update rule language.	August 2015	Providers of these services and clients who utilize these services.
Transplants	C.R.S. § 25.5-5-102(1)(a)	Define the amount, scope and duration of this benefit.	August 2015	Providers of these services and clients who utilize these services.
Office Visits	C.R.S. § 25.5-5-102(1)(d)	Define the amount, scope and duration of this benefit.	September 2015	Providers of these services and clients who utilize these services.
Genetic Testing	C.R.S. § 25.5-5-102(1)(d)	Define the amount, scope and duration of this benefit.	September 2015	Providers of these services and clients who utilize these services.
Transgender	C.R.S. § 25.5-5-102(1)(d)	Define the amount, scope and duration of this benefit.	October 2015	Providers of these services and clients who utilize these services.
Vision	C.R.S. § 25.5-5-202(1)(d)	Define the amount, scope and duration of this benefit.	November 2015	Providers of these services and clients who utilize these services.
Client Overutilization Program	42 CFR 456.3 and 431.54(e)	Changes to authority to accommodate program changes. Specifically, criteria for program enrollment might change as will other program definitions and processes.	Implementation date proposed for November 2016. Rule process should start May 2015.	Those clients who fit the criteria for inclusion in the program. Impact could be positive as the lock-in relationship could lead to changed behaviors and improved outcomes. Impact on providers is dependent on whether additional dollars will be provided.
Medicaid Managed Care Program	42 CFR 438.2 and 438.8	Adding Prepaid Inpatient Health Plan (PIHP) as an option to our managed care options. The Department is exploring payment and program options and having this type of program in the rules would ensure it is an option if appropriate.	Implementation date proposed for May 2015. Rule process should start December 2014.	None – would only be adding Prepaid Inpatient Health Plan (PIHP) as an option to our managed care options.

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Respite Redesign	C.R.S. § 25.5-6-307	Changing the respite benefit to allow for more consumer direction and to come into compliance with the new HCBS final rule.	Spring-Summer of 2015.	Providers of NFs will be negatively affected as clients will no longer be allowed that choice for respite under an HCBS waiver. Clients, families, and other providers will be positively affected as it will allow for more choice and provider participation in a varying amount of services.
Non-Medical Transportation Redesign	C.R.S. § 25.5-6-307	NMT needs additional oversight to better protect both the Department and clients. Additionally, the Department wants to explore more consumer directed options and modernize the service to serve people in a more flexible manner.	Fall 2015.	Providers and clients will be positively affected. Some NMT providers may seem this change as burdensome but the Department will work with stakeholders to ensure transitions to new service delivery mechanisms and oversight appropriately.
Independent Living Skills Training (ILST) Redesign	C.R.S. § 25.5-6.703	Changing the benefit to better define the service provided to clients, allow for more providers to offer the service, and change limitations on who can be a skills trainer.	Winter/Spring 2015	Providers may be negatively affected. Clients will be positively affected.
Day Treatment Redesign	C.R.S. § 25.5-6.703	Changing the benefit to better serve clients	TBD	Providers and clients will be positively affected.
Home Modification Redesign	C.R.S. § 25.5-6-307	Modifying the benefit to better serve clients and allow more consumer choice.	TBD	Providers and clients will be positively affected by this change in their allowance to offer more choice.
SLP Changes to include ALR Licensing	C.R.S. § 25.5-6-114	Changing the rule to allow for the DPHE change in the ALR license.	TBD (Dependent on DPHE)	Providers will be positively affected as they will have security in the appropriate licensure without the current ambiguity in the rule that allows for two licenses. Clients and other stakeholders will not notice, nor be affected, by the change.

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Home and Community Based Services (CHCBS) In Home Support Services (IHSS) Rules Redesign	C.R.S. § 25.5-5-1202	IHSS within CHCBS has received criticism from the State Auditor, the Medicaid Fraud Unit, and stakeholders for its lack of clarity regarding the benefit and the associated business practices	Spring 2015	CHCBS clients and case managers will receive clarification of the benefit.
CHCBS Rule Adjustment for Point in Time Cap	C.R.S. § 25.5-6-902	The CHCBS waiver currently operates at an upper limit of 1308 clients. This rule is outdated and needs to be adjusted to match current procedures.	Spring 2015	n/a
PETI regulations	42 C.F.R. §435.725	This year, the legislature approved the Adult Dental Benefit. This is great for Colorado's Medicaid population, but necessitates changes to the Nursing Facility Post Eligibility Treatment of Income Regulations to coordinate with the changes.	Spring 2015	All Nursing Facility residents and providers.
MED-13 treatment of travel expenses	C.R.S. § 25.5-6-202, 204	Currently, business travel is not reimbursable as a direct or indirect health care expense for Nursing Facilities. This means that Nursing Facilities are not reimbursed appropriately for the cost of sending their clinical professionals to trainings, or bringing in outside clinical experts to evaluate patients. The proposed rule will delineate between travel expenses that are appropriate for reimbursement as health care expenses, and travel expenses which should continue to be considered administrative and general.	Winter 2014/2015	All Nursing Facilities.
Nursing Facility Audit timeline	C.R.S. § 25.5-4-301	There is no explicit deadline for providers to submit required documentation to the Department. The result is a large expense borne by the Department and providers as audits extend for months longer than necessary. The proposed change will set fair, firm deadlines for the submission of required documentation in the audit process.	Spring 2015	All Nursing Facilities

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Hospital Back-Up Rules – Redesign of the Hospital Back Up program and rules	State Plan Amendment Attachment 4.19D	The MassPro bankruptcy revealed some flaws in our HBU process, as well as changes that need to be made to improve the quality of care that clients receive, as well as clarifying the authority of the Department enforce program criteria.	Spring 2015	All HBU clients and facilities, as well as any Nursing Facilities that would like to participate in the HBU program.
Alternative Care Facility Rules	C.R.S. § 25.5-6-114	The ACF regulations need to be clarified with regards to the requirements for protective oversight. Clarity needs to be brought to the tension between protective oversight and client choice.	TBD	All Alternative Care Facilities and residents of ACFs.
Redesign of the 5615 form	C.R.S. § 25.5-4-201 et seq.	The Department is looking to redesign the 5615 form. When this happens, the regulations relating to the 5615 form will have to	TBD	Counties, Long Term Medicaid clients, Nursing Facilities, Intermediate Care Facilities
Revisiting the Nursing Facility Benefits – Items that may be included in calculating per diem costs	C.R.S. § 25.5-6-202, 204	Revise regulations to more appropriately allocate costs for Nursing Facilities.	TBD	All Nursing Facilities and clients of Nursing Facilities
Nursing Facility Cost Reporting	C.R.S. § 25.5-6-202	The Department's Nursing Facility auditors are reviewing the audit procedures and remedies. We anticipate this may necessitate changes to the Cost Reporting Regulations.	TBD	Nursing Facilities
Enforcement of Penalties against Nursing Facilities	C.R.S. § 25.5-6-205	The Department's Nursing Facility auditors are reviewing the audit procedures and remedies. We anticipate changes to be made to the enforcement of penalties section as a result of this review.	TBD	Nursing Facilities
PASRR (Pre-Admission Screening and Annual Resident Reviews)	42 C.F.R. §440	The ULTC 100.2 assessment tool used in the PASRR screening process is being revised. May need to address the PASRR regulations to be consistent with the new assessment tool.	TBD	All long term care clients and facilities

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Revisions to the MED-13 Regulations	C.R.S. § 25.5-6-202, 204	This year, we have created a workgroup dedicated to working with providers to identify issues with the rules. We anticipate that there will be numerous issues with the MED-13 process, and will be ready to be responsive to these suggestions.	Summer/Fall 2015	All Nursing Facilities
Program Integrity	42 CFR 455.23	Revision for federally required suspension of payments process.	December 2015	All Providers
Screening for Excluded Employees and Contractors	Section 6032 of the Deficit Reduction Act	Technical revisions on compliance with statutory requirement.	May 2015	All Providers

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2014 Regulatory Summary of all permanent and temporary rules actually adopted

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-08-27-A	Revision to the Medical Assistance Rule Concerning Consumer Directed Attendant Support Services Expansion into Home and Community Based Service Brain Injury Waiver, Section 8.510	In an effort to create a more person centered approach to providing Home and Community Based Services the Department seeks to expand its Consumer Directed Attendant Support Services (CDASS) into the Brain Injury Waiver. Initially it is expected this program will be utilized by 15-19 individuals currently receiving services on the waiver. As part of the expansion plan the Department will also implement a set of quality metrics to better account for program usage and client satisfaction.	November 2013 Permanent Adoption
MSB 13-07-15-A	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Disorders of Sex Development or Intersex Surgical Remediation (Intersex Surgery) Benefit Coverage Standard Incorporation by Reference, Section 8.300.3.D	The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Disorders of Sex Development (DSD) or Intersex Surgical Remediation 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.	November 2013 Tabled

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-02-22-A	Revision to the Medical Assistance Rule Concerning Consumer Directed Attendant Support Services, 10 CCR 2505-10, Section 8.551	The rules set forth at 10 CCR 2505-10 Section 8.551 were implemented for the Consumer Directed Attendant Support (CDAS) pilot program. After the pilot program ended, new rules were promulgated at 10 CCR 2505-10 Section 8.510 for the long term operation and provision of Consumer Directed Attendant Support Services (CDASS). Section 8.551 is no longer current and is being repealed.	December 2013 Permanent Adoption
MSB 13-10-23-A	Revision to the Medical Assistance Rule Concerning The Alternative Benefit Plan and Habilitative Services for Medicaid Expansion Adults, Section 8.016 and 8.017	Beginning January 1, 2014, the department will implement the Medicaid Expansion as required by the Affordable Care Act (ACA). The ACA requires that all new expansion clients receive a benefit package known as the Alternative Benefit Plan (ABP). CMS sets certain standards for the ABP with regard to the benefits provided and the amount, scope and duration of those benefits. The ABP is largely similar to the current Medicaid benefit package. The ABP has two new benefits that are not currently included in the base Medicaid package: Preventive Services and Habilitative Services. The State therefore is required to add these services to the Alternative Benefit Plan. In an effort to align Medicaid benefits, the current Medicaid package will be expanded to include preventive and wellness services. At the time, habilitative services will only be added to the ABP and once the state retrieves appropriate data on usage and costs, it will consider adding it to State Plan Medicaid. This rule therefore establishes the amount, scope, duration and other service limitations for habilitative services.	December 2013 Emergency Adoption
MSB 13-11-12-A	Revision to the Medical Assistance Eligibility Rule Concerning Changes Set Forth in the Affordable Care Act to Provide Medical Assistance to Former Foster Care Youth, Section 8.100.4.H	The rule addresses youth in foster care under the state's or tribes' responsibility and also enrolled in Medicaid under the state's Medicaid State Plan. The proposed rule change amends 10 CCR 2505-10, Section 8.100.4.H to comply with the Affordable Care Act, Public Law 111-148, extending medical assistance to age 26 for former foster care youth that were in Colorado foster care at ages 18,19, 20 or 21 and receiving Medicaid. It intends to continue their Medicaid beyond the age they would leave the foster care system and provide insurance consistent with peers that have families with insurance that typically can continue to provide health insurance until age 26.	December 2013 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-10-08-A	Revision to the Medical Assistance Rule Concerning the Colorado Indigent Care Program (CICP), Sections 8.904.f.2d., and 8.907.B. a-d	Language will be deleted in Section 8.904.F.2.d. of the CICP regulation that allows Adults without Dependent Children who have incomes below 10% of the Federal Poverty Level and are on a waitlist for Medicaid to receive discounted services under CICP. This policy existed because the number of Adults without Dependent Children Medicaid enrollees was limited and there was a waitlist. The waitlist will be eliminated with the expansion of Medicaid for eligible clients with incomes up to 133% of the Federal Poverty Level. Therefore, there is no longer a need to reference it in the CICP rules. Language will be deleted from Section 8.907.B.a-d. of the CICP regulation which exempts homeless persons from applying for and being denied Medicaid benefits before being eligible for CICP. This policy existed because previously Medicaid did not cover low-income Adults without Dependent Children. Effective January 2014, under the Affordable Care Act (ACA), Medicaid will be expanded to cover all adults age 19-64 with incomes at or below 133% of the Federal Poverty Level. This rule change will align CICP with changes to Medicaid. This rule change clarifies that low-income adults, including homeless persons, must be denied Medicaid before being eligible for CICP. Changes to sections 8.904F.2d and 8.907.B. a-d are needed to comply with program regulations, which require categorically applicants to apply for Medicaid prior to approval for CICP.	January 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-10-18-A	Revision to the Medical Assistance Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.2000	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 Colorado Health Care Affordability Act [25.5-4-402.3, C.R.S. (2013)] instructs the Department to charge hospital provider fees and obtain federal Medicaid matching funds. The hospital provider fee is the source of funding for supplemental Medicaid payments to hospitals and payments associated with the Colorado Indigent Care Program (CICP). It is also the source of funding for the expansion of eligibility for Medicaid adults to 133% of the federal poverty level (FPL), the expansion of the Child Health Plan Plus (CHP+) to 250% FPL implemented, the implementation of a Medicaid Buy-In Program for working adults and children with disabilities up to 450% of the FPL, and to fund 12-months continuous eligibility for Medicaid children. The proposed rule revisions will allow the Department to collect sufficient fees from hospitals to fund the health coverage expansions and hospital payments to comply with state statute and the Medicaid State Plan agreement with the Centers for Medicare and Medicaid Services. The proposed rule revisions ensure continuing health care coverage for the Medicaid and CHP+ expansions funded by hospital provider fees and access to discounted health care services for CICP clients.	January 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-10-23-A	Revision to the Medical Assistance Rule Concerning The Alternative Benefit Plan and Habilitative Services for Medicaid Expansion Adults, Section 8.016 and 8.017	Beginning January 1, 2014, the department will implement the Medicaid Expansion as required by the Affordable Care Act (ACA). The ACA requires that all new expansion clients receive a benefit package known as the Alternative Benefit Plan (ABP). CMS sets certain standards for the ABP with regard to the benefits provided and the amount, scope and duration of those benefits. The ABP is largely similar to the current Medicaid benefit package. The ABP has two new benefits that are not currently included in the base Medicaid package: Preventive Services and Habilitative Services. The State therefore is required to add these services to the Alternative Benefit Plan. In an effort to align Medicaid benefits, the current Medicaid package will be expanded to include preventive and wellness services. At the time, habilitative services will only be added to the ABP and once the state retrieves appropriate data on usage and costs, it will consider adding it to State Plan Medicaid. This rule therefore establishes the amount, scope, duration and other service limitations for habilitative services.	January 2014 Permanent Adoption
MSB 13-10-31-B	Revision to the Medical Assistance Eligibility Rule Concerning Continuous Eligibility Section 8.100.4.G	The proposed rule changes amend 10 CCR 2505-10, Section 8.100.4.G to grant continuous eligibility for children eligible for Medicaid. This rule will guarantee coverage without interruption for 12 months regardless of change in income or household size. Continuous coverage ensures that children are not suddenly dropped from coverage, therefore preventing harmful disruptions in their healthcare coverage.	January 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-11-12-A	Revision to the Medical Assistance Eligibility Rule Concerning Changes Set Forth in the Affordable Care Act to Provide Medical Assistance to Former Foster Care Youth, Section 8.100.4.H	The rule addresses youth in foster care under the state's or tribes' responsibility and also enrolled in Medicaid under the state's Medicaid State Plan. The proposed rule change amends 10 CCR 2505-10, Section 8.100.4.H to comply with the Affordable Care Act, Public Law 111-148, extending medical assistance to age 26 for former foster care youth that were in Colorado foster care at ages 18,19, 20 or 21 and receiving Medicaid. It intends to continue their Medicaid beyond the age they would leave the foster care system and provide insurance consistent with peers that have families with insurance that typically can continue to provide health insurance until age 26.	January 2014 Permanent Adoption
MSB 13-11-29-A	Revision to the Medical Assistance Health Programs Rule Concerning the Removal of Co-Payments for Clients Receiving Preventive Services, Section 8.754.5	The Affordable Care Act (ACA) (42 USC § 1396d(a)(13) (2010)) requires that preventive services be included in the new benefit package made available to all Medicaid expansion clients. The law also requires that the services be provided without a co-pay. In order to align the benefit packages for expansion and non-expansion Medicaid clients, the Department is adding preventive services to the benefit package for non-expansion Medicaid clients. To comply with the ACA, the attached rule eliminates cost sharing for all preventive and wellness services for all Medicaid clients.	January 2014 Permanent Adoption
MSB 13-10-03-A	Revision to the Medical Assistance Rule Concerning the Merging of Clients in the Persons Living With AIDS (PLWA) Waiver to the Elderly, Blind, and Disabled (EBD) Waiver, Section 8.485.	The Rule changes the EBD waiver to allow for clients receiving services on the PLWA waiver to now receive services on the EBD waiver.	February 2014 Permanent Adoption
MSB 13-10-03-B	Revision to the Medical Assistance Rule Concerning the Repeal of the Persons Living with AIDS Waiver (PLWA), Section 8.496.	The rule repeals the PLWA waiver to allow for clients receiving services on the PLWA waiver to now receive services on the EBD waiver	February 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-10-22-A	Revision to the Medical Assistance Rule Concerning Early and Periodic Screening Diagnosis and Treatment (EPSDT) Personal Care Section 8.280	This rule change targets four categories. First, it revises the existing wording of the rule to achieve more clarity. Second, there are certain policies which the Department no longer has in place or have otherwise changed and therefore need to be updated. Third, new federal regulations for EPSDT have been promulgated and therefore those changed need to be reflected in the rule. Fourth, the Department will implement a personal care benefit in 2014 which is a component of EPSDT. This rule change therefore defines the purpose of that program.	February 2014 Permanent Adoption
MSB 13-10-22-B	Revision to the Medical Assistance Rule Concerning Adults without Dependent Children Section 8.205.4.A	The Department proposes to remove all references to AwDC in the MSB rules, effective January 1, 2014. All existing AwDC clients and waitlist clients will be converted to MAGI Adults and will be covered by MSB rules related to MAGI Adults. Approximately 20,000 AwDC clients and 9,000 AwDC waitlist clients will be affected by this change. The rules concerning the AwDC waiver program eligibility, enrollment, and benefits will be obsolete, since the waiver will no longer exist. In May 2012, the Department began enrolling adults without dependent children (AwDC) into Medicaid through an 1115 Demonstration Waiver. The waiver allowed childless adults with incomes up to 10 percent of the federal poverty level to receive Medicaid coverage, but the program's enrollment was capped. Initially, the Department enrolled 10,000 clients, later raising the cap to 21,691. The Department maintained a waitlist of eligible clients and used a randomized selection process each month to enroll clients into available slots. On January 1, 2014, AwDC with incomes up to 133 percent of the federal poverty level will be eligible to enroll in Medicaid through the Affordable Care Act. Beginning in January, the Department will receive 100 percent federal match on these clients rather than the 50 percent match available through the waiver. All waiver clients and waitlist clients will be able to enroll through this Medicaid expansion without caps or waitlists, so the waiver program will no longer be needed. The waiver will end on December 31, 2013.	February 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-11-19-A	Revision to the Medical Assistance Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201	Colorado Senate Bill 13-242 requires that the Department create a limited adult dental benefit, available as of April 1, 2014. The Department is engaged in a Benefits Collaborative Process to create a defined benefit that details the full amount, scope and duration of this new benefit. Until such time that process concludes, the Department is amending Section 8.201 to: 1) remove language that prohibits services covered as of April 1 and 2, 2014) add preventive, diagnostic and restorative services (except for those restorative services expressly excluded) as a covered benefit for adults age 21 and older.	February 2014 Permanent Adoption
MSB 13-11-26-A	Revision to the Medical Assistance Rule Concerning Transfer of the Intellectual and Developmental Disabilities Services Program Rules, Section 8.600	This proposed rule is a transfer of existing rules. This rule is necessary in order to implement HB 13-1314, concerning the transfer of programs for persons with intellectual and developmental disabilities (I/DD) to the Department of Health Care Policy and Financing. As a part of this transfer, rules currently located in the Department of Human Services section of the Colorado Code of Regulations are being relocated to the Department of Health Care Policy and Financing section of the Code. There are no changes being made to the provisions in these rules; therefore, there is no impact to clients, providers or other stakeholders.	February 2014 Permanent Adoption
MSB 13-10-31-A	Revision to the Child Health Plan Plus Rule Concerning Continuous Eligibility, Section 430	The proposed rule changes amends 10 CCR 2505-3, section 430 to grant continuous eligibility for CHP+. This rule will guarantee coverage without interruption for 12 months regardless of change in income or household size. Continuous coverage ensures that children are not suddenly dropped from coverage, therefore preventing harmful disruptions in their healthcare coverage	March 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-02-06-A	Revision to the Medical Assistance Special Financing Division Rule Concerning Hospital Provider Fee Collection and Disbursement, Sections 8.2003.A., 8.2004.D., and 8.2004.E.	The Bipartisan Budget Act of 2013 (Public Law number 113-67), signed into law by President Obama on December 26, 2013, eliminated the reduction in the FFY 2013-14 DSH allotment, which increased Colorado's DSH allotment from $91,612,207 to $98,648,517. Hospital provider fees serve as the state share to draw the DSH allotment. In order to draw the full DSH allotment as recommended by the Hospital Provider Fee Oversight and Advisory Board, the Department must increase the outpatient services fee rate and increase payment rates for the Colorado Indigent Care Program (CICP) in rule. The federal Centers for Medicare and Medicaid Services (CMS) is currently reviewing an amendment to the Department's Medicaid State Plan and approval is expected before the rules are presented to the Medical Services Board in March 2014.	March 2014 Emergency Adoption
MSB 13-08-16-A	Revision to the Medical Assistance Pharmacy Section Rule Concerning Excluded Drug Coverage	Effective January 1, 2014, section 2502 of the Affordable Care Act amends Section 1927 (d)(7) of the Social Security Act by prohibiting the exclusion of coverage of smoking cessation products, barbiturates and benzodiazepines, under the Medicaid program. These agents are currently covered drugs; however, the Medicaid rules permit the exclusion of these agents. Therefore, the rule change deletes these agents from the list of drugs which may be excluded from coverage. In addition, this rule revises outdated language.	March 2014 Permanent Adoption
MSB 13-10-22-D	Revision to the Medical Assistance Rule Concerning the Community Mental Health Services Program Section 8.212	This rule addresses enrollment, exemptions, rights/protections, required services and emergency services concerning the Community Mental Health Services program. The revision of this rule includes the addition of substance use disorder services, and eliminates benefit limits. Additionally, the Department is changing the name of the Community Mental Health Service program to the Community Behavioral Health Services program.	April 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-01-09-A	Revision to the Medical Assistance Nursing Facility Rule Concerning Services and Items Not Included in the Per Diem Payment, Section 8.440.2	This rule lists items and services that are not included in a facility's per diem reimbursement rate. The first portion of this rule lists items and services that are not reimbursed in the per diem, but that may be charged to clients' personal needs funds. The second portion lists items and services that are not included in the per diem reimbursement, and may not be charged to the clients' personal needs funds. The current rule lists a service that is not covered, but the language currently used is unclear and has caused some confusion on the part of long term care facilities and the department. The revision will clarify this item, reducing the frustration of providers and the number of appeals.	April 2014 Permanent Adoption
MSB 14-01-09-B	Revision to the Medical Assistance Long Term Service and Supports Rule Concerning Provider Appeals, Section 8.050	The current rule only addresses the process if a nursing facility receives a physical copy of notifications. With the department's recent efforts to increase the use of technology and electronic copies, there is a need to codify a new process for nursing facilities that addresses receipt of electronic copies as opposed to physical copies. This revision provides the legal support for delivering rate determinations to nursing facilities by electronic copy, and details the steps nursing facilities may take to challenge these determinations. This will provide the department insulation from legal liability when the department does issue notifications electronically. It will also enable the department to make full use of electronic notification, which will make both the department and nursing facilities more efficient.	April 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-01-09-C	Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Health Care Reimbursement Rate Calculation, Section 8.443.7.A	This rule lists the costs that may be considered health care costs for the purpose of calculating the per diem reimbursement rate. The current rule requires owners and owner related parties to keep contemporaneous time logs in order to allocate the cost of their services to separate facilities. This is administratively burdensome on both the facility and department auditors. The proposed revision removes the burden by replacing this requirement with a simple formula intended to accurately reflect the cost, without the burden of contemporaneous time keeping. This may make both facilities and the department more efficient. In Section A.2, admissions personnel was too broad a category for inclusion in the health care cost allocation. The change to admissions coordinator narrows this category to align with policy objectives. In Section A.5, vaccinations are being explicitly included as health care services that may be reimbursed so that the rule is consistent with current practices. In Section A.7, changes are being made to reflect the changing delivery of health care and the ubiquitous use of computers in direct and indirect delivery of healthcare. This change will allow Facilities to be reimbursed as a healthcare cost for the cost of computers and software used in the delivery of healthcare.	April 2014 Permanent Adoption
MSB 14-01-10-B	Revision to the Medical Assistance Long Term Supports and Services Rule Concerning Reimbursement for Administrative and General Costs, Section 8.443.8.A	This rule defines which costs must be considered administrative and general for the purpose of calculating the per diem reimbursement rate. The current rule is ambiguous with how it allocates computer service fees and software costs. This revision will clarify how these costs are to be allocated. Clarifying how we treat these costs may reduce the number of appeals, and will make it easier for nursing facilities to comply with the regulations. It will also simplify the task of auditors.	April 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-01-22-A	Revision to the Medical Assistance Health Programs Service and Supports Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201	Colorado Senate Bill 13-242 requires that the Department create a limited adult dental benefit. The Department engaged in a Benefits Collaborative Process to define the amount, scope and duration of this new benefit. This rule therefore implements the full dental benefit.	April 2014 Permanent Adoption
MSB 14-01-24-A	Revision to the Medical Assistance Special Financing Division Rule Concerning the Old Age Pension Health Care Program Dental Benefit, Section 8.940	Under the Old Age Pension State Only Program, the following State funded benefits are provided: physician and practitioner services, inpatient hospital, outpatient services, lab and x-ray, emergency transportation, emergency dental, pharmacy, home health services and supplies, and Medicare cost sharing. Currently, Old Age Pensioners receive an emergency dental benefit. The proposed rule change will provide a dental benefit that mirrors the new adult Medicaid benefit. The proposed rule will also delete obsolete language referencing the Old Age Pension Health Care Supplemental Program. Funding for the Supplemental Program was abolished through SB 11-210 in July 2012. The proposed rule also deletes language that references reimbursement rates. This language will be replaced with language added that states information pertaining to reimbursement rates is published in the Provider Bulletin.	April 2014 Permanent Adoption
MSB 14-02-06-A	Revision to the Medical Assistance Special Financing Division Rule Concerning Hospital Provider Fee Collection and Disbursement, Sections 8.2003.A., 8.2004.D., and 8.2004.E	Under recommendation from the Hospital Provider Fee Oversight and Advisory Board, the proposed rule increases hospital provider fees and Disproportionate Share Hospital (DSH) reimbursement to qualified hospitals due to the increase in Colorado's Federal Fiscal Year (FFY) 2013-14 federal DSH allotment under the Bipartisan Budget Act of 2013 (Public Law number 113-67).	April 2014 Permanent Adoption
MSB 14-02-25-A	Revision to the Medical Assistance Home and Community Based Services Brain Injury Waiver Rule Concerning the Transitional Living Program, Section 8.516.30	The revision to the rules under the Home and Community Based Services Brain Injury waiver enables providers to offer a more robust array of services by altering definitions and time limits on therapeutic treatment for clients. These proposed revisions also alter the definition of medically stable in order to expand therapeutic services to clients.	May 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-02-25-B	Revision to the Medical Assistance Home and Community based Services for Person with Brain Injury Rule Concerning Counseling, Section 8.516.50	This revision to the rules for the Home and Community Based Services Counseling services within the Brain Injury waiver enables families to receive counseling and training services without the waiver recipient in the room. This revision expands family services.	May 2014 Permanent Adoption
MSB 14-02-25-C	Revision to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Respite Care, Section 8.516.70	The revision to the rules for the Home and Community Based Services Respite Care service within the Brain Injury waiver requires changes to clarify limits and better define processes for clients and case managers to request additional units of the service.	May 2014 Permanent Adoption
MSB 14-02-25-D	Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Substance Abuse Counseling, Section 8.516.60	The rule change expands the provider pool for substance abuse services as specified under the HCBS-BI waiver by changing the level of certification required for the Certified Addictions Counselor. The proposed rule change also revises typographical errors from previous versions.	May 2014 Permanent Adoption
MSB 14-02-25-E	Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Concerning Eligible Persons, Section 8.515.5	Revisions to the Eligible Persons section within the Home and Community Based Services Brain Injury Waiver rule expands eligibility by eliminating barriers to enrollment such as age restrictions of when the injury occurred and requirements for a prognosis showing continued functional improvement.	May 2014 Permanent Adoption
MSB 14-02-25-F	Revision to the Medical Assistance Home and Community-Based Services Rule Concerning Persons with Spinal Cord Injury (HCBS-SCI). Rule 10 C.C.R. 2505-10, Sections 8.517.5, 8.517.6	The Home and Community-Based Services for persons with Spinal Cord Injury (HCBS-SCI) waiver pilot program reached its 67 client capacity limit in November of 2013. Currently there is a waiting list with resources opening onto the program on July 1st, 2014. The current rule only offers broad guidance regarding the waiting list. This amended rule will meet the need for more specific guidance regarding the criteria and processes for managing the waiting list	May 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-02-26-A	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Pediatric Hospice Waiver, Section 8.504	The proposed rule amends the regulations for the Home and Community Based Services for Children with Life Limiting Illness Waiver (HCBS-CLLI) 10 CCR 2505-10 8.504. The 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 and provider qualifications have been updated in the waiver. Updated rules are needed to implement these changes. The HCBS-CLLI (Children with Life Limiting Illness) 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.	May 2014 Permanent Adoption
MSB 14-02-28-A	Revision to the Medical Assistance Pharmacy Section Rule Concerning Application To Participate In The Medical Assistance Pharmacy Program Repeal of Form Med - 11E	FORM MED-11E, attached to the Medical Assistance rule, is a pharmacy provider enrollment application form from c. 1984. The form is no longer used to enroll pharmacy providers. The department has a standard enrollment application form that is accessible through its website for all providers. Repealing the MED -11E form will eliminate unnecessary confusion for providers and staff.	May 2014 Permanent Adoption
MSB 14-04-04-A	Revision to the Medical Assistance Health Program Services and Supports Division Rule Concerning Speech – Language and Hearing Services, 8.200.3.D.2	The Department is updating this rule to include content from the Speech-Language & Hearing Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	May 2014 Emergency Adoption
MSB 14-04-04-A	Revision to the Medical Assistance Health Program Services and Supports Division Rule Concerning Speech – Language and Hearing Services, 8.200.3.D.2	The Department is updating this rule to include content from the Speech-Language & Hearing Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	June 2014 Permanent Adoption
MSB 14-04-21-A	Revision to the Medical Assistance Pharmacy Section Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I	The proposed rule will increase the DME reimbursement rate by 2% to account for General Assembly funding appropriation	June 2014 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-04-21-B	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6	On April 30, 2014, Governor Hickenlooper signed House Bill 14-1336, which set the Colorado state budget for FY 2014-15. After much debate by the General Assembly, the signed budget includes reimbursement increases for Medicaid providers, including hospitals. As a result, Medicaid hospitals are receiving a 2% increase in their reimbursement rate for outpatient services. This outpatient reimbursement rate change requires a new rule since the rate history is included in the regulation for cost settlement purposes. Currently, hospitals are reimbursed at 70.2% of cost for outpatient services (excluding those services reimbursed based upon the fee schedule such as lab, physical therapy, and occupational therapy). Effective July 1, 2014, the proposed rule will change the reimbursement to 71.6% of cost, which represents a payment increase of 2.0% as required by House Bill 14-1336.	June 2014 Emergency Adoption
MSB 14-04-21-C	Revision to the Medical Assistance Federally Qualified Health Centers Rule Concerning Encounter Rate Calculation, Section 8.700.6	The purpose of this rule is to preserve the public health, safety, and welfare. Since 2009, FQHC providers have been receiving rate cuts during the budget shortfall. This rule will eliminate the midpoint reduction for services provided by Federally Qualified Health Centers participating in Medicaid. After multiple years of rate cuts, the increase contained in this rule may allow these facilities to provide improved services to more recipients	June 2014 Emergency Adoption
MSB 14-06-02-A	Revision to the Medical Assistance Health Programs Services and Supports Rule Concerning Dental Services, Section 8.201	The Joint Budget Committee authorized funding for complete dentures during the 2014 legislative session. The appropriation included approximately $26.8 million total funds from the Adult Dental Fund and the Hospital Provider Fee Cash Fund. The purpose of this rule change is to add dentures to our existing rules regarding Dental Services. The specific unit limits were developed through the Benefits Collaborative Process and with the input/advice from our consultants and other key stakeholders such as the Colorado Dental Association. This benefit will be subject to prior authorization and will not be subject to the $1,000 annual maximum for Dental Services.	June 2014 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 13-12-20-A	Revision to the Medical Assistance Rule Concerning the Program of All-Inclusive Care for the Elderly, Section 8.497	The statute authorizing the Program of All-Inclusive Care for the Elderly (PACE), Section 25.5-5-412, C.R.S. was modified pursuant to SB 12-023. Therefore, rules implementing aspects of the program, 10 C.C.R. 2505-10, Section 8.497, have been added to account for the changes authorized in SB 12-023. SB 12-023 added two requirements to the PACE state statute: 1) To allow Medicaid clients that are eligible for PACE but enrolled in a managed care organization, RCCO, or other risk based entity to disenroll and enroll in PACE (if a client chooses to do so); and 2) To allow PACE organizations to contract with an enrollment broker to include information on PACE in the enrollment broker's marketing materials to eligible long-term care clients.	July 2014 Permanent Adoption
MSB 14-04-21-A	Revision to the Medical Assistance Pharmacy Section Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I	The proposed rule will increase the DME reimbursement rate by 2% to account for General Assembly funding appropriation	July 2014 Permanent Adoption
MSB 14-04-21-B	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6	On April 30, 2014, Governor Hickenlooper signed House Bill 14-1336, which set the Colorado state budget for FY 2014-15. After much debate by the General Assembly, the signed budget includes reimbursement increases for Medicaid providers, including hospitals. As a result, Medicaid hospitals are receiving a 2% increase in their reimbursement rate for outpatient services. This outpatient reimbursement rate change requires a new rule since the rate history is included in the regulation for cost settlement purposes. Currently, hospitals are reimbursed at 70.2% of cost for outpatient services (excluding those services reimbursed based upon the fee schedule such as lab, physical therapy, and occupational therapy). Effective July 1, 2014, the proposed rule will change the reimbursement to 71.6% of cost, which represents a payment increase of 2.0% as required by House Bill 14-1336.	July 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-04-21-C	Revision to the Medical Assistance Federally Qualified Health Centers Rule Concerning Encounter Rate Calculation, Section 8.700.6	The purpose of this rule is to preserve the public health, safety, and welfare. Since 2009, FQHC providers have been receiving rate cuts during the budget shortfall. This rule will eliminate the midpoint reduction for services provided by Federally Qualified Health Centers participating in Medicaid. After multiple years of rate cuts, the increase contained in this rule may allow these facilities to provide improved services to more recipients	July 2014 Permanent Adoption
MSB 14-06-02-A	Revision to the Medical Assistance Health Programs Services and Supports Rule Concerning Dental Services, Section 8.201	The Joint Budget Committee authorized funding for complete dentures during the 2014 legislative session. The appropriation included approximately $26.8 million total funds from the Adult Dental Fund and the Hospital Provider Fee Cash Fund. The purpose of this rule change is to add dentures to our existing rules regarding Dental Services. The specific unit limits were developed through the Benefits Collaborative Process and with the input/advice from our consultants and other key stakeholders such as the Colorado Dental Association. This benefit will be subject to prior authorization and will not be subject to the $1,000 annual maximum for Dental Services.	July 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-03-05-B	Revision to the Medical Assistance Rule Concerning the Limitation to Medicaid Estate Recovery, Section 8.063	The purpose of this rule amendment is to remove the Department's ability to make recoveries under its estate recovery program that are optional under federal law. The amendment reflects the various recoveries that the Department is required to make under its program. This change is necessary to encourage newly eligible individuals under the Affordable Care Act to apply for Medicaid who might perceive estate recovery as a reason not to apply. Reports in the media suggested that individuals coming to Medicaid for the first time through the exchanges created in response to the Affordable Care Act might be reluctant to apply because of Medicaid estate recovery programs. Colorado's program had implemented the optional provisions of federal law by permitting estate recoveries for any medical assistance services for clients over the age of 55. The rule amendment removes the optional recoveries and limits Colorado's estate recovery rights to those items required by federal law.	August 2014 Permanent Adoption
MSB 14-04-02-B	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Brain Injury Waiver, Section 8.515.85	The addition of Section 8.515.85 will provide Supportive Living Program providers with guidelines for service provision. Prior to this addition, there were no rules for Supportive Living Program providers under the HCBS Brain Injury Waiver.	August 2014 Permanent Adoption
MSB 14-04-24-A	Revision to the Medical Assistance Rule Concerning Reasonable Opportunity Period for Citizens and Non-Citizens, Section 8.100.3.G and 8.100.3.H.	The proposed rule changes amend 10 CCR 2505-10, Section 8.100.3.G and 8.100.3.H, to reflect changes to Reasonable Opportunity Period for citizens and national, and incorporate the ROP into the eligibility determination process for non-citizens.	August 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-09-16-A	Revision to the Medical Assistance Provider Relations and Dental Program Rule Concerning Oral Surgery, Section 8.200	The purpose of this rule is to update the dental billing requirements to allow oral surgeons in the Medicaid program who hold dual licensures to enroll as both a dental and medical provider so they may bill both dental and medical codes. The Department previously restricted oral surgeons, only allowing them to enroll and bill medical or dental but not both, in order to prevent billing twice for performing the same service. Now the Department has contracted with a Dental Administrative Services Organization which will monitor utilization and ensure that oral surgeons do not bill twice for the same service.	October 2014 Emergency Adoption
MSB 14-07-03-A	Revision to the Medical Assistance Provider Relations and Dental Program Division Rule Concerning Dental Services for Children, Section 8.202	Colorado currently provides a dental benefit to children 20 years of age and younger in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. However, the Department engaged in a Benefits Collaborative Process to define the amount, scope and duration of Dental Services for Children. This rule therefore implements the recommendations and policies that were developed through that process.	October 2014 Permanent Adoption
MSB 14-06-25-A	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Amount, Scope and Duration of Ambulatory Surgery Centers, Section 8.570.3.D	The Department is updating this rule to include content from the Ambulatory Surgery Center Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	October 2014 Permanent Adoption