Stakeholder Comment Summary

MSB *16-06-21-A*

Revision to the Medical Assistance Rates Section Rule Concerning Definitions, Section 8.500.1 Provider Reimbursement, Section 8.500.14

THE FOLLOWING INDIVIDUALS AND/OR ENTITIES WERE CONTACTED, INFORMED THAT THIS RULE MAKING WAS PROPOSED, INVITED TO DISCUSS THE PROPOSED RULE WITH STAFF AND/OR TO OFFER COMMENTS:

DEPARTMENT OF HUMAN SERVICES (DHS)
OFFICE OF ADMINISTRATIVE SOLUTIONS
DIVISION OF FINANCIAL SERVICES
1575 SHERMAN STREET, 10TH FLOOR, DENVER CO 80203

DEPARTMENT OF HUMAN SERVICES (DHS)
OFFICE OF COMMUNITY ACCESS AND INDEPENDENCE
DIVISION OF REGIONAL CENTER OPERATIONS
1575 SHERMAN STREET, 10TH FLOOR, DENVER CO 80203

COMMENTS WERE RECEIVED FROM STAKEHOLDERS ON THE PROPOSED RULE:

☐ YES ☒ NO

IF YES, PLEASE SUMMARIZE AND/OR ATTACH THE FEEDBACK YOU RECEIVED.

Title of Rule: Revision to the Medical Assistance Rates Section Rule Concerning Definitions, Section 8.500.1 Provider Reimbursement, Section 8.500.14
Rule Number: MSB 16-06-21-A
Division / Contact / Phone: Payment Reform / Randie DeHerrera / 6199

STATEMENT OF BASIS AND PURPOSE

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

   The addition to the rule will state reimbursement paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider may receive payments in the aggregate that exceed its actual costs of providing waiver services. The rule change is necessary to ensure compliance with the Departments waiver application with CMS requiring that state and local government providers be reimbursed actual costs and that reimbursement does not exceed costs. This addition was prompted by and Office of State Auditors recommendation which identified the non-compliance with our CMS waiver application.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-6-404

Initial Review	**09/09/2016**	Final Adoption	**10/14/2016**
Proposed Effective Date	**11/30/2016**	Emergency Adoption	

DOCUMENT #09

RLD

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REGULATORY ANALYSIS

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

   The classes of person who will be affected by the proposed rule include state owned Regional Centers providing Home and Community Based Services waiver services for clients with Developmental or Intellectual Disabilities. The Department of Health Care Policy and Financing and Department of Human Services will bear the costs of the proposed rule as DHS is responsible for administration of the Regional Centers and HCPF is responsible for oversight of the Regional Centers.

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

   There are no probable quantitative or qualitative impacts of the proposed rule upon the affected classes of persons.

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

   The Department of Health Care Policy and Financing will be responsible for costs associated with a third party accounting vendor to ensure actual costs are appropriate, necessary, and waiver client related. The cost to the Department for staffing is minimal. The cost to the Department of Human Services in the form of staffing is also minimal.

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

   The cost of inaction is continue non-compliance with the Departments approved waiver application which may result in disallowance of FFP for services

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

   There are no less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

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

   There are no alternatives that will achieve the purpose of the proposed rule.

8.500.1 DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) means basic self care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD Waiver or a HCBS Waiver service.

APPLICANT means an individual who is seeking a long term care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

AUDITABLE: means the information represented on the wavier cost report can be verified by reference to adequate documentation as required by generally accepted auditing standards.

CLIENT means an individual who has met long term care (LTC) eligibility requirements, is enrolled in and chooses to receive LTC services, and receives LTC services.

CLIENT REPRESENTATIVE means a person who is designated by the client to act on the client's behalf. A client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the client to speak for or act on the client's behalf.

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 27-10.5-105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-101, C.R.S. *et seq*, and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.

COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing home and community based services and Medicaid state plan benefits including long term home health services and targeted case management.

COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the client.

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

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. § 6000, *et seq.*, shall not apply.

"Impairment of General Intellectual Functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (seventy (70) or less assuming a scale with a mean of 100 and a standard deviation of fifteen

(15)), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. When an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

"Adaptive Behavior Similar to That of a Person With Mental Retardation" means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

"Substantial Intellectual Deficits" means an intellectual quotient that is between seventy-one (71) and seventy-five (75) assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services for persons with Developmental Disabilities (HCBS-DD) within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).

FAMILY means a relationship as it pertains to the client and is defined as:

A mother, father, brother, sister or any combination,

Extended blood relatives such as grandparent, aunt, uncle, cousin,

An adoptive parent,

One or more individuals to whom legal custody of a client with a developmental disability has been given by a court

A spouse; or,

The client's children.

FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for long term care services as determined by the Department's prescribed instrument.

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long Term Care instrument and medical verification on the Professional Medical Information Page to determine if the client meets the institutional level of care (LOC).

GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) clients receiving services who live in a single residential

setting, which is licensed by the Colorado Department of Public Health and Environment as a residential care facility or residential community home for persons with developmental disabilities and certified by the Operating Agency.

GUARDIAN means an individual at least twenty-one years (21) of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Guardianship may include limited, emergency or temporary substitute court appointed guardian but not a guardian ad litem.

Home And Community Based Services (HCBS) Waiver means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR).

INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation services provided to three (3) or fewer clients in a single residential setting or in a host home setting that does not require licensure by the Colorado Department of Public Health and Environment. IRSS settings are certified by the Operating Agency.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the client's spouse.

INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) for which the Department makes Medicaid payment under the Medicaid State Plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR) means a publicly or privately operated facility that provides health and habilitation services to a client with mental retardation or related conditions.

LEVEL OF CARE (LOC) means the specified minimum amount of assistance a client must require in order to receive services in an institutional setting under the Medicaid State Plan.

LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services or the program of all-inclusive care for the elderly (PACE), swing bed and hospital back up program (HBU).

MEDICAID ELIGIBILE means an applicant or client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination.

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

NATURAL SUPPORTS means informal relationships that provide assistance and occur in the client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

POST ELIGIBILITY TREATMENT OF INCOME (PETI) means the determination of the financial liability of an HCBS Waiver client as defined in 42 CFR 435.217.

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, the Operating Agency, a State Fiscal Agent or the Case Management Agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional level of care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1 16.200 *et seq.*, that has received program approval to provide HCBS-DD Waiver services.

PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use, including vehicles for hire.

RELATIVE means a person related to the client by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service.

SERVICE PLAN means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department and the Operating Agency's rules set forth in 10 CCR 2505-10 Section 8.400.

STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER: means the state owned and operated agency providing home and community based services (HCBS) to clients enrolled in the HCBS waiver for Persons with Developmental Disabilities.

SUPPORT is any task performed for the client where learning is secondary or incidental to the task itself or an adaptation is provided.

SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

TARGETED CASE MANAGEMENT (TCM) means a Medicaid State Plan benefit for a target population which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social,

educational and other resources to ensure nonduplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources.

THIRD PARTY RESOURCES means services and supports that a client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to, community resources, services provided through private insurance, non-profit services and other government programs.

WAIVER SERVICE means optional services defined in the current federally approved waiver documents and do not include Medicaid State Plan benefits.

8.500.14 PROVIDER REIMBURSEMENT

8.500.14.A Providers shall submit claims directly to the Department's Fiscal Agent through the Medicaid Management Information System (MMIS); or through a qualified billing agent enrolled with the Department's Fiscal Agent.

8.500.14.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally-approved HCBS-DD Waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the client's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.14.C Provider claims for reimbursement shall be subject to review by the Department and the Operating Agency. This review may be completed after payment has been made to the provider.

8.500.14.D When the review identifies areas of noncompliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

8.500.14.E When the provider has received reimbursement for services and the review by the Department or Operating Agency identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.500.14.F For private provider's ~~Except where otherwise noted,~~ payment is based on a statewide fee schedule. ~~State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin accessed through the Department's fiscal agent's web site.~~

8.500.14.G Reimbursement paid to State or local government HCBS waiver providers differs from the amount paid to private providers of the same service. No public provider may receive payments in the aggregate that exceed its actual costs of providing HCBS waiver services.

1. Reimbursement paid to State and local government HCBS waiver providers must reflect actual costs and require the submission of an annual cost report for HCBS waiver services.

2. Actual costs will be determined on the basis of the information on the HCBS waiver cost report and obtained by the Department or its designee for the purposes of cost auditing.

   a. The costs submitted by the provider for the most recent available final cost report for a 12 month period shall be used to determine the interim rates for the ensuing 12 month period effective July 1 of each year.

      i. The interim rate will be calculated as total reported costs divided by total units per HCBS waiver service.

      ii. An interim rate shall be determined for each HCBS waiver service provided.

      iii. The most recent available final cost report will be used to set the next fiscal year's interim rates.

   b. Reimbursement to State and local government HCBS waiver providers shall be adjusted retroactively after the close of each 12 month period.

   c. Total costs submitted by the provider shall be reviewed by the Department or its designee and result in a total allowable cost.

   d. The Department will determine the total interim payment through the MMIS.

   e. The Department will reconcile total interim payment through the MMIS to the total allowable and make adjustment to the payment as necessary.

3. Submission of the HCBS waiver cost report shall occur annually for costs incurred during the prior fiscal year.

   a. The cost report for HCBS waiver services must be submitted to the Department annually on October 31 to reflect costs from July 1-June 30.

   b. The cost report will determine the final adjustment to payment for the period for which the costs were reported.

   c. Reconciliation to align the fiscal year reimbursement with actual fiscal year costs after the close of each fiscal year shall be determined by the Department annually.

e. A State or local government HCBS waiver provider may request an extension of time to submit the cost report. The request for extension shall:

i. Be in writing and shall be submitted to the Department.

ii. Document the reason for failure to comply.

iii. Be submitted no later than ten (10) working days prior to the due date for submission of the cost report.

e. Failure of a State or local government HCBS waiver provider to submit the HCBS waiver cost report by October 31 shall result in the Department withholding all warrants not yet released to the provider as described below:

i. When a State or local government HCBS waiver provider fails to submit a complete and auditable HCBS waiver cost report on time, the HCBS waiver cost report shall be returned to the facility with written notification that it is unacceptable.

1. The State or local government HCBS waiver provider shall have either 30 days from the date of the notice or until the end of the cost report submission period, whichever is later, to submit a corrected HCBS waiver cost report.

2. If the corrected HCBS waiver cost report is still determined to be incomplete or un-auditable, the State or local government HCBS waiver provider shall be given written notification that it shall, at its own expense submit a HCBS waiver cost report prepared by a Certified Public Accountant (CPA). The CPA shall certify that the report is in compliance with all Department rules and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

3. The Department may withhold all warrants not yet released to the provider once the original cost report submission period and 30-day extension have expired and an -auditable HCBS waiver cost report has not been submitted.

ii. If the audit of the HCBS waiver cost report is delayed by the state or local government HCBS waiver provider's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall mean failure to provide documents,

personnel or other resources within its control and necessary for the completion of the audit.

4. Non-allowable costs for State and local government providers offering HCBS waiver services include:

a. Room and Board;

b. Costs which have been allocated to an ICF/IID;

c. Costs for which there is either no supporting documentation or for which the supporting documentation is not sufficient to validate the costs;

d. Costs for services that are available through the Medicaid State Plan or provided on an HCBS waiver other than the HCBS waiver for Persons with Developmental Disabilities;

e. Costs for services that are not authorized on an approved HCBS waiver for Persons with Developmental Disabilities PAR.

f. Costs for services that are not authorized by the Department as an HCBS waiver service;

g. Costs which are not reasonable, necessary, and client related.

5. Adjustment(s) to the HCBS waiver cost report shall be made by the Department's contract auditor to remove reported costs that are non-allowable.

a. Following the completion of an audit of the cost report the Department or its contract auditor shall notify the affected State or local government HCBS waiver provider of any proposed adjustment(s) to the costs reported on the HCBS waiver cost report and include the basis of the proposed adjustment(s).

b. The provider may submit additional documentation in response to a proposed adjustment. The Department or its contract auditor must [QK1]receive the additional documentation or other supporting information from the provider within 14 calendar days of the date of the proposed adjustments letter or the documentation will not be considered.

c. The Department may grant a reasonable period, no longer than 30 calendar days, for the provider to submit such documents and information, when necessary and appropriate, given the providers' particular circumstances.

d. The Department or its's contract auditor shall complete the audit of the cost report within 30 days of the submission of documentation by the provider.