Attachment C

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

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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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
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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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
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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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
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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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 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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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 13-10-08-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 13-10-23-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 13-10-22-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 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-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 14-02-25-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 14-04-21-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 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 14-09-16-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