COLORADO
Department of Health Care
Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 2, 2015

Legislative Council
200 East 14th Avenue
Denver, CO 80203

Legislative Council:

The Department of Health Care Policy and Financing (Department) respectfully submits this report to comply with Section 2-7-203, C.R.S. (2015).

Pursuant to Section 24-4-103 C.R.S. (2015), the Department is required to develop an annual Departmental Regulatory Agenda which provides a list of new rules or revisions to existing rules that the Department expects to propose in the next calendar year; a brief summary of all permanent and temporary rules actually adopted since the previous Departmental Regulatory Agenda was filed; and the results of the mandatory review of rules that was completed in calendar year 2015.

In addition, the statute requires the Department to submit the Departmental Regulatory Agenda to the Secretary of State for publication in the Colorado Register and post it on the Department website. These items have been completed.

The list of rules included on this Agenda is 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
FOR SUSAN BIRCH

SEB:jlc
Enclosure: 2016 Departmental Regulatory Agenda

Cc: State Library
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
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Judy Zerzan, Client and Clinical Care Office Director
Tom Massey, Policy and Communications Office Director
Zach Lynkiewicz, Legislative Liaison

2016 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
Add Youth Day Services Benefit	C.R.S. § 25.5-6-409 et seq.	Codify Youth Day Services Benefit into CES Waiver in Rule	January 2016	Persons and families of persons enrolled on the HCBS-CES Waiver, Community Centered Boards, Provider Agencies
Support Level Review Process	C.R.S § 25.5-6-404 et seq.	Revise the requirement to have a panel review when a request for a Support Level Review is Made.	February 2016	Persons receiving HCBS-SLS and HCBS-DD services, Community Centered Boards
Authorized Representative	C.R.S. § 25.5-10-204 (2) (i)	Provide authority for designation of Authorized Representative	February 2016	Persons receiving HCBS-SLS and HCBS-DD Services, Community Centered Boards

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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
Establish Department authority over DIDD based on HB 13-1314 (Technical clean-up)	C.R.S. § 25.5-10-101 et seq.	Replace Division for Developmental Disabilities with Division for Intellectual and Developmental Disabilities; operating agency with Department of Health Care Policy and Financing, remove outdated references to Title 27, correct other typographical errors, make updates to TCM definition	February 2016	Department staff, staff at Department of Human Services, advocates, Community Centered Boards, Provider Service Agencies
Consumer Directed Attendant Support Services (CDASS) into Home and Community Based Services, Supported Living Services (HCBS-SLS) waiver	C.R.S. § 25.5-6-1102 et seq.	Implement the CDASS service delivery model into the HCBS-SLS waiver	December 2015	Persons receiving HCBS-DD or HCBS-SLS services, Community Centered Boards
Revisions to the Medicaid Eligibility Rules Concerning Clarification updates to section 8.100.5	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.	Jan 2016	This will provide 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
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.	May 2016	This will provide 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.	May 2016	This will provide 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.	May 2016	This will provide 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
Revisions to the Medicaid Eligibility Rules Concerning elimination of the 5-year bar for lawfully residing children and pregnant women section 8.100.3	42 CFR 457.320(b)(6),(c) and (d) and HB 09-1353	Implements policy to provide Medicaid coverage to otherwise eligible legal permanent children and Prenatal women.	April 2016	This will provide expanding coverage to additional children and pregnant women.
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.	April 2016	April 2016
Revisions to the Medicaid Eligibility Rules Concerning Considerations of Income Deeming Income and Resources of Sponsors to the Sponsored Non-Citizen 8.100.3.K.1, 8.100.5.G and 8.100.1.	8 U.S.C 1631	Implements policy on how the income and resources of sponsors of non-citizens is deemed available to the sponsored non-citizen.	December 2016	The change will affect any non-citizen applicant who has been sponsored in order to be a legal permanent resident of the United States and could have the effect of non-citizens gaining eligibility due to the lower income and resources deemed available to them.

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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 Medicare Modernization Act – Low-Income Subsidy Eligibility Rules Concerning Clarification updates to section 8.1000	42 CFR 423.772; 42 USC 1396u-5; 42 CFR 423.774(a); 42 CFR 423.904(a); 42 CFR 423.773	Based on the 2015 regulatory review of rule, incorporates changes to wording of rules to provide clarification on the intention of the policy.	September 2016	This will provide clarity on the policies for the program.
Colorado Indigent Care Program (CICP) 8.900 – 8.908	Title 25.5, Article 3, Part 1, C.R.S.	Revise sections of the rule found to be duplicative, unclear, overlapping, outdated, or inconsistent during the 2015 public Regulatory Efficiency Review process	2016	CICP clients and providers
Primary Care Fund 8.950	Title 25.5, Article 3, Part 3, C.R.S.	Revise sections of the rule found to be duplicative, unclear, overlapping, outdated, or inconsistent during the 2015 public Regulatory Efficiency Review process	2016	Clinics that receive Primary Care Fund grant awards
Old Age Pension Health Care Program 8.940 – 8.943	Title 25.5, Article 2, Part 1, C.R.S.	Revise sections of the rule found to be duplicative, unclear, overlapping, outdated, or inconsistent during the 2015 public Regulatory Efficiency Review process	2016	OAP clients and providers

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
Colorado Dental Health Care Program for Low-Income Seniors 8.960	Title 25.5, Article 3, Part 4, C.R.S.	Revise definitions of covered dental services to include details to conform to statutory requirements	2016	Senior Dental Grantees and clients
Hospital Provider Fee Collection and Disbursement 8.2000 – 8.004	25.5-4-402.3 C.R.S. and 25.5-4-402(3) C.R.S.	Revise sections of the rule found to be duplicative, unclear, overlapping, outdated, or inconsistent during the 2015 public Regulatory Efficiency Review process and revise rule as needed following recommendations of the Hospital Provider Fee Oversight and Advisory Board	2016	Colorado hospitals and Medicaid and CHP+ recipients
COUP Rule: CCR 2505-10 8.075	42 CFR 431.54, 42 CFR 431.55, 42 CFR 438.50, 42 CFR 440.168	Allow for program maximization with respect to lock-in. This change would enable the department to lock-in clients to multiple provider types and a combination of providers and pharmacies.	October 2015- November 2016	HCPF, Medicaid clients, primary care providers, pharmacies, behavioral health organizations, federally qualified health centers, managed care organizations.
Program Integrity	42 CFR 455.23	Revision for federally required suspension of payments process.	May 2016	All Providers

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
Screening for Excluded Employees and Contractors	Section 6032 of the Deficit Reduction Act	Technical revisions on compliance with statutory requirement.	May 2016	All Providers
Provider Appeals	CO Administrative Procedures Act	Revisions to deal with issues encountered in past appeals regarding the scope of appeal and recoveries based in a single audit.	June 2016	All Providers
Home Modification	C.R.S. 25.5-6-303, 10 CCR 2505-10 8.493	Revise rules to correspond to needed changes to oversight and forms as well as incorporate workgroup feedback.	March 2016	Clients, providers, OTs/PTs, and the Department.
Non-Medical Transportation	C.R.S. 25.5-6-303, 10 CCR 2505-10 8.494	Rules to change policy to better account for oversight and prevent unnecessary trips. Also add options for clients.	Summer, 2016	Clients and providers.
Augmentative and Alternative Communication Devices	C.R.S. § 25.5-5-202 (1)(f)	Incorporate Benefit Coverage Standard into rule	February 2016	Providers of these services and members who utilize these services.
Wheelchair Services	C.R.S. § 25.5-5-102 (1)(f)	Incorporate Benefit Coverage Standard into rule	March 2016	Providers of these services and members who utilize these services.
Ambulatory Surgery Centers	CRS 25.5-5-203; SSA 1905(a)(9); 42 CFR 440.90	To align the rule with Medicare guidelines and industry best practices	Mid to late 2016	Ambulatory Surgery Centers, Medicaid clients

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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
Home Health	CRS 25.5-5-102; 42 CFR 440.70	To align with the approved rule format (previously incorporated by reference)	Mid to late 2016	Home health providers, Medicaid clients
DME Oxygen	CRS 25.5-5-102; 42 CFR 440.70	To align with the approved rule format (previously incorporated by reference)	Mid to late 2016	DME providers, Medicaid clients
School Based Health Centers (SBHCs)	CRS 25.5-5-203; SSA 1905(a)(9); 42 CFR 440.90	To align with the approved rule format (previously incorporated by reference)	Mid to late 2016	SBHCs providers, Medicaid clients
Intersex Surgery	CRS 25.5-5-102; 42 CFR 440.50	To put the Benefit Coverage Standard content into rule	Early to mid-2016	Intersex providers, Medicaid clients
Imaging	CRS 25.5-5-102; 42 CFR 440.30	To put the Benefit Coverage Standard content into rule	Mid to late 2016	Imaging providers, Medicaid clients
Non Emergent Medical Transportation	CRS 25.5-5-202; SSA 1902(a)(70); 42 CFR 440.170	To put the Benefit Coverage Standard content into rule	Mid to late 2016	NEMT providers, Medicaid clients
Wheelchair Services	CRS 25.5-5-102; 42 CFR 440.70	To put the Benefit Coverage Standard content into rule now that the Benefits Collaborative is complete.	Early 2016	DME providers, Medicaid clients
Transgender Benefit	CRS 25.5-5-102; SSA 1905(a)(5); 42 CFR 440.50	To put the Benefit Coverage Standard content into rule once the Benefits Collaborative process is complete.	Early to mid-2016	Medicaid providers, Medicaid clients

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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
Genetic Testing	CRS 25.5-5-102; SSA 1905(a)(5); 42 CFR 440.50	To put the Benefit Coverage Standard content into rule once the Benefits Collaborative process is complete.	Early 2016	Medicaid providers, Medicaid clients
Private Duty Nursing (PDN)	CRS 25.5-5-303; 42 CFR 440.80	To put the Benefit Coverage Standard content into rule once the Benefits Collaborative process is complete.	Early 2016	PDN providers, Medicaid clients
Vision	CRS 25.5-5-202; SSA 1905(a)(5) and (a)(12); 42 CFR 440.50	To put the Benefit Coverage Standard content into rule once the Benefits Collaborative process is complete.	Mid to late 2016	Medicaid providers, Medicaid clients
Client Over Utilization Program	CRS 25.5-5-316; CRS 25.5-5-506; SSA 1927(g); 42 CFR 456	To align the rule with programmatic and systems changes.	Early to mid-2016	Medicaid providers, Medicaid clients

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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 Rule Revisions	State Plan Amendment, Attachment 4.19 D, 10 CCR 2505-10, Section 8.470, et al.,	In 2015-2016 LTSS will be undergoing a comprehensive stakeholder review process of the Hospital Back Up Program. In 2015 the Division contracted with the University of Colorado School of Medicine to conduct an environmental scan, gap analysis, and regulatory review of the HBU program, the findings of which will be used as the basis for the redesign effort. It is contemplated that the results of the stakeholder process will result in community buy-in as well as substantive rule changes. Also, contemplated rule changes will address program criteria enforcement and establish audit criteria.	December 2016	Long Term Care eligible clients

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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
Program for All-Inclusive Care for the Elderly (PACE)	42 C.F.R §460, C.R.S. §25.5-5-412, and 10 CCR 2505-10, Section 8.500 S. 1362, passed (2015)	Possible State rule changes to the PACE program for additional requirements for PACE Providers, affecting CDPHE survey requirements. PACE Program Innovation Act: Removes eligibility requirement for 55 years or older, allowing for high needs/high costs individuals under the age of 55, which may necessitate a statutory change.	2016	PACE providers, participants, CDPHE, CMS, and other service providers. Broader potential participant base, PACE Providers, CDPHE, CMS, and other service providers.

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Title/Description	Basis and/or Statutory Authority	Purpose of Proposed Rule	Estimated Rule-Making Schedule	List of Persons or Parties That May Be Affected Positively or Negatively
Nursing Facility Internal Audit Program	10 CCR 2505-10, Section 8.050	Regulatory gap in limiting the provision of supporting documentation after Informal Reconsideration and Appeals. Contemplated rule change would provide language to include Nursing Facility Internal Audit process which would preclude Nursing Facilities to extend the Appeals process by providing supporting documentation up to Administrative hearing.	2016	Nursing Facility providers, contract auditors, and Office of Attorney General.
PETI State Plan Amendment to place reasonable limits on amounts for necessary medical or remedial care not covered under Medicaid.	State Plan Amendment, Supplement 3 to Attachment 2.6-A	Purpose is to place reasonable limits on amounts for necessary medical or remedial care not covered under Medicaid. Presently, the SPA does not have explicit limits, but recommendations from the Office of the Attorney General indicates the Department will need to amend the State Plan to set specific limitations (3 months).	2015	Nursing Facility providers and Nursing Facility residents.

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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
Revisiting the Nursing Facility Benefits	C.R.S. 25.5-6-202, 204	Revise regulations to more appropriately allocate cost for Nursing Facilities	TBD	All Nursing Facilities and Nursing Facility clients.

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2015 Regulatory Summary of all permanent and temporary rules actually adopted

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-07-28-B	Revision to the Health Programs Benefits and Operations Hospital Services Rule Concerning Bariatric Surgery, Section 8.300.C	The Department is updating this rule to include content from the Bariatric Surgery Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	November 2014 Permanent Adoption
MSB 14-07-28-C	Revision to the Medical Assistance Health Programs Benefits and Operations Rule Concerning Dialysis Treatment Centers, Section 8.310	The Department is updating this rule to include content from the Dialysis Services Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	November 2014 Permanent Adoption
MSB 14-05-06-A	Revision to the Medical Assistance Managed Care Contracts Division Rule Concerning Billing Procedures for Certified Health Agencies, Section 8.564	This rule is amending the reference to a specific claim form that will no longer be accepted by the Department of Health Care Policy and Financing. The existing form is the Colorado 1500, the new form will be the CMS 1500. The CMS 1500 is the standard form for claim submission.	November 2014 Permanent Adoption
MSB 14-07-28-D	Revision to the Medical Assistance Health Program Benefits and Operations Physician Services Rule Concerning Benefit Coverage Standards Amount, Scope and Duration of Podiatry Services, Section 8.200.3.D.1	The Department is updating this rule to include content from the Podiatry Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	November 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-09-03-A	Revision to the Medical Assistance Eligibility Rule Concerning Five Percent (5%) Income Disregard, Section 8.100.4.D	The proposed rule changes amend 10 CCR 2505-10 § 8.100.4.D to incorporate changes to the rule mandated by the Patient Protection and Affordable Care Act of 2010 (ACA) as they pertain to MAGI-based methodologies. Among these changes: modification to the current regulation regarding the five percent (5%) disregard at 8.100.4.D. Currently the five percent (5%) disregard is applied across-the-board for all MAGI populations under title XIX and XXI when determining eligibility. The proposed change will only apply the five percent (5%) disregard to MAGI populations under title XIX or XXI with the highest income threshold identified as the following: MAGI Adult Program (adults), Medicaid and CHP+ program (for children), Medicaid and the CHP+ Prenatal program (for pregnant women). In addition, the five percent (5%) disregard will only be applied as a last step in determining eligibility when the individual is above the income threshold.	November 2014 Permanent Adoption
MSB 14-06-19-A	Revision to the Medical Assistance Eligibility Rule Concerning Long-Term Care Institution Recipient Income Calculation of Patient Payment Increase to the Personal Needs Allowance (PNA) for Residents of Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Section 8.100.7.V.3.d and 8.100.7.V.f	Senate Bill 14-130 amends CRS 25.5-6-206-(2)(a) which increases the monthly personal needs allowance (PNA) base amount for persons who are residents of nursing facilities or intermediate care facilities for individuals with intellectual disabilities from $50 to $75 beginning January 1, 2015. Additionally, beginning January 1, 2015 the PNA base amount will be adjusted yearly at the same rate of the statewide average per diem rate increase described at CRS 25.5-6-202(9)(b)(I). The initial increase will be the new $75 base with the addition of the 2015 per diem rate increase applied.	November 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-06-04-A	Revision to the Medical Assistance Home and Community Based Services Home Modification Rule for Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493.3	Description: The rules set forth at 10 CCR 2505-10 Section 8.493 are being revised to allow the Department to meet a Legislative directive and appropriate to raise the cap for the Home Modification benefit. This appropriation indicated the Department was responsible for bringing forward a rule change to the Medical Services Board that increases the amount of money available to the benefit within the feasible amount available within the approved funding. This amount stands to be approximately $2,500 above the current $10,000 limit indicated in Section 8.493.	November 2014 Permanent Adoption
MSB 14-07-15-A	Revision to the Medical Assistance Community Living Benefits Rule Concerning Consumer Directed Attendant Support Services, 10 CCR 2505-10 Section 8.510	The current FMS contract will expire on December 31, 2014. This fact, in addition to the Affordable Care Act requirement to offer health insurance, prompted the Department to begin stakeholder engagement sessions on the FMS structure in Colorado. These sessions occurred over a four month process beginning in August 2013. Based on stakeholder feedback, the Department is amending the rules to reflect the choice of FMS vendors and the choice of FMS models. The two FMS models are allowed and defined by the Centers for Medicaid Services (CMS). The models allow clients who direct their own services to choose the level of employer responsibilities they want.	November 2014 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-10-28-A	Revision to the Medical Assistance Eligibility Rule Concerning Allowable Deductions, Section 8.100.4.C.1.d	The proposed rule changes amend 10 CCR 2505-10 § 8.100.4.C.1.d to incorporate changes to the rule mandated by the Patient Protection and Affordable Care Act of 2010 (ACA) as they pertain to Modified Adjusted Gross Income (MAGI)-based methodologies. Among these changes: revision to the current policy regarding allowable deductions to calculate Adjusted Gross Income. Currently, when determining the adjusted gross income under 8.100.4.C.1.d. the allowable deductions identified in the policy are not all applicable to determine Adjusted Gross Income. The proposed change will define what deductions are allowable as defined under title 26 U.S.C 62 to get the Adjusted Gross Income to determine eligibility for MAGI-Medical Assistance.	December 2014 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-10-17-A	Revision to the Medical Assistance Special Financing Division Rule Concerning the Creation of the Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960	Pursuant to Senate Bill 14-180, 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 Health and Medical Care Program or private insurance. This program will provide grants throughout the state to local Area Agencies on Aging, 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. The rule defines eligible seniors, qualified grantees and providers, and allowable dental services and fee rates including allowed co-payments. The rule describes a formula for distributing funds throughout the state and describes grant criteria for awarding funds to qualified grantees.	January 2015 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-11-04-A	Revision to the Medical Assistance Special Financing Division Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.2000	Under recommendation of the Hospital Provider Fee Oversight and Advisory Board (OAB), the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers. The Colorado Health Care Affordability Act [section 25.5-4-402.3, C.R.S. (2014)] 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 with disabilities up to 450% of FPL and children with disabilities up to 300% of the FPL, and to fund 12 months of continuous eligibility for Medicaid children. The proposed rule updates the hospital provider fee and payment calculations in accordance with the recommendation of the OAB. The proposed rule revisions make changes to the fee and payment calculations that 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, and to cover the Department's administrative costs. The proposed rule eliminates the supplemental payments at 8.2004.C through 8.2004.M. they are being replaced by	January 2015 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-10-31-A	Revision to the Medical Assistance Eligibility Rule Concerning a Rule Citation Correction, Section 8.100.7.B.1.c and 8.100.7.B.2.c,	This is a technical correction to the rule cite in 10 CCR 2505-10 § 8.100.7.B that refers to Working Adults with Disabilities at 10 CCR 2505-10 § 8.100.6.O for when it should be § 8.100.6.P.	January 2015 Permanent Adoption
MSB 14-07-28-A	Revision to the Medical Assistance Health Programs Benefits and Operations Physician Services Rule Concerning Podiatry Services, Section 8.200.3.A.8 (8.200.3.D),	The Department is updating this rule to include content from the Podiatry Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	January 2015 Permanent Adoption
MSB 14-10-28-A	Revision to the Medical Assistance Eligibility Rule Concerning Allowable Deductions, Section 8.100.4.C.1.d	The proposed rule changes amend 10 CCR 2505-10 § 8.100.4.C.1.d to incorporate changes to the rule mandated by the Patient Protection and Affordable Care Act of 2010 (ACA) as they pertain to Modified Adjusted Gross Income (MAGI)-based methodologies. Among these changes: revision to the current policy regarding allowable deductions to calculate Adjusted Gross Income. Currently, when determining the adjusted gross income under 8.100.4.C.1.d. the allowable deductions identified in the policy are not all applicable to determine Adjusted Gross Income. The proposed change will define what deductions are allowable as defined under title 26 U.S.C 62 to get the Adjusted Gross Income to determine eligibility for MAGI-Medical Assistance.	January 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-07-15-B	Revision to the Medical Assistance Community Living Benefit Rule Concerning In-Home Support Services, Section 8.552	The revised version of section 8.552 implements the six programmatic changes to In Home Support Services mandated by HB 14-1357. The programmatic changes include 1) allowing IHSS to be provided in the community; 2) adding spouses as an eligible family member who may act as an attendant providing IHSS; 3) clarifying that the eligible client or the eligible client's authorized representative is responsible for directing the provision of IHSS, including scheduling, managing, and supervising attendants; 4) allowing clients or the client's authorized representative to determine the amount of oversight needed in conjunction with the IHSS agency; 5) removing the 444 hour per year family member reimbursement limit and replacing it with a 40 hour per week limit for personal care for HCBS-EBD and HCBS-SCI clients; and 6) expanding IHSS to persons receiving services under the Spinal Cord Injury waiver pilot program. In addition to the mandated changes, the proposed revisions incorporate stakeholder feedback by allowing willing and able IHSS agencies to provide the support necessary for a client who does not have an AR to participate in IHSS. The proposed revisions also modify the definitions of health maintenance, homemaker, and personal care activities and specify that the daily allotted scope and duration of each IHSS service must be documented in the IHSS plan.	January 2015 Permanent Adoption
MSB 14-05-08-A	Revision to the Medical Assistance Rule Concerning Early & Periodic Screening, Diagnostic & Treatment (EPSDT) Personal Care, Section 8.535	The Centers for Medicare and Medicaid Services (CMS) have directed the Department to develop the Pediatric Personal Care benefit. The Department has engaged in a Benefits Collaborative process to define the amount, scope, and duration of the benefit. This rule implements the benefit as it was developed through the collaborative.	January 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-10-17-A	Revision to the Medical Assistance Special Financing Division Rule Concerning the Creation of the Colorado Dental Health Care Program for Low-Income Seniors, 10 CCR 2505-10, Section 8.960	Pursuant to Senate Bill 14-180, 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 Health and Medical Care Program or private insurance. This program will provide grants throughout the state to local Area Agencies on Aging, 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. The rule defines eligible seniors, qualified grantees and providers, and allowable dental services and fee rates including allowed co-payments. The rule describes a formula for distributing funds throughout the state and describes grant criteria for awarding funds to qualified grantees.	February 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-11-04-A	Revision to the Medical Assistance Special Financing Division Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.200	Under recommendation of the Hospital Provider Fee Oversight and Advisory Board (OAB), the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers. The Colorado Health Care Affordability Act [section 25.5-4-402.3, C.R.S. (2014)] 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 with disabilities up to 450% of FPL and children with disabilities up to 300% of the FPL, and to fund 12 months of continuous eligibility for Medicaid children. The proposed rule updates the hospital provider fee and payment calculations in accordance with the recommendation of the OAB. The proposed rule revisions make changes to the fee and payment calculations that 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, and to cover the Department's administrative costs. The proposed rule eliminates the supplemental payments at 8.2004.C through 8.2004.M. they are being replaced by supplemental payments now found at 8.2004.C through 8.2004.E. The Department is making these changes to	February 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-02-06-A	Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Section 8.100.4.G.3	The purpose of the rule change is to make a revision to the current policy regarding MAGI Parent/Caretaker Relatives Federal Poverty Level (FPL) changing from 100% FPL to 60% MAGI-converted. The state will be updating the Colorado Benefits Management System (CBMS) to be in alignment with our federal regulations effective April 1, 2015. This rule also needs to be updated to ensure the state is in compliance with federal regulations.	March 2015 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-04-15-A	Revision to the Medical Assistance Rule Concerning Long Term Care, Sections 8.400-8.499	The Long Term Care rules define Colorado's Medical Assistance Programs for long term care, including Nursing Facilities, HCBS waivers, Alternative care facilities, and other programs. These regulations have been enacted over the past several decades to address changes in programs available, changes in state policy, and for other reasons. In March 2014, the Department of Health Care Policy and Financing (the "Department") completed a review of these rules. This review identified over 300 issues with the rules, ranging from spelling errors, inaccurate citations, invalid incorporations by reference, grammatical errors, and use of outdated terminology. This rule change will address the non-substantive issues identified by this review. The changes that are being made in this rule change do not affect the Department's policies, but are solely designed to clean up the rules and make them more reader friendly. The changes include: (1) Removing outdated offensive language and replacing it with the contemporary acceptable language. (2) Correcting identified spelling errors. (3) Correcting identified grammatical errors that do not affect the intent or meaning of the rule provisions. (4) Standardizing the format for citations within the rules to state statutes and rules. (5) Correcting inaccurate citations within the rules. (6) Updating rule language to reflect current practice.	March 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-12-03-A	Revision to the Medical Assistance Eligibility Determination Rule Concerning the Medicaid Buy-In Program for Working Adults with Disabilities and the Medicaid Buy-In Program for Children with Disabilities, Section 8.100.6.P and Section 8.100.6.Q.	This rule amendment intends to enhance the consumer experience allowing ample time to inform clients about their Buy-In eligibility prior to charging premiums. The rule allows an individual to dis-enroll from a Buy-In program.	March 2015 Permanent Adoption
MSB 14-10-02-A	Revision to the Medical Assistance Delivery System and Payment Innovation Program Rule Concerning Emergency Transportation Services, Section 8.018	The Department is updating this rule to include content from the Ambulance Services Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	March 2015 Permanent Adoption
MSB 14-11-19-A	Revision to the Medical Assistance Health Programs Provider Relations and Dental Program Rule Concerning Adult Dental Services, Section 8.201	The Department is amending the adult dental rule in order to better define amount, scope and duration. The rule amendment is designed to increase access for adults and to reduce burden on providers. The Department is also correcting typos and other technical errors.	March 2015 Permanent Adoption
MSB 15-02-11-A	Revision to the Health Programs Office Benefits and Operations Division Ambulatory Surgery Center (ASC) Rule Concerning a Technical Correction to the Amount, Scope and Duration of Services, Section 8.570	The purpose of this update is to clarify language in the Non-Covered Services section to comply with the Department's Benefit Coverage Standard (BCS).	April 2015 Permanent Adoption
MSB 14-02-12-A	Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services, Section 8.553.1	This rule will revise Community Transition Services (CTS), a benefit of the Home and Community Based Services - Elderly, Blind and Disabled (HCBS-EBD) waiver since 2006. The revision will implement CTS as a demonstration service of the Colorado Choice Transitions (CCT) program. CTS will continue to be a benefit of the HCBS-EBD waiver. The revision will expand eligibility of CTS to individuals with intellectual disabilities, brain injuries and mental illness.	April 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-02-06-A	Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Section 8.100.4.G.3	The purpose of the rule change is to make a revision to the current policy regarding MAGI Parent/Caretaker Relatives Federal Poverty Level (FPL) changing from 100% FPL to 60% MAGI-converted. The state will be updating the Colorado Benefits Management System (CBMS) to be in alignment with our federal regulations effective April 1, 2015. This rule also needs to be updated to ensure the state is in compliance with federal regulations.	April 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-04-03-A	Revision to the Medical Assistance Special Financing Division Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003 and 8.2004	Under recommendation of the Hospital Provider Fee Oversight and Advisory Board (OAB), the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers. The Colorado Health Care Affordability Act [section 25.5-4-402.3, C.R.S. (2014)] 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 with disabilities up to 450% of FPL and children with disabilities up to 300% of the FPL, and to fund 12 months of continuous eligibility for Medicaid children. The proposed rule updates the hospital provider fee and payment calculations in accordance with the recommendation of the OAB. The Department brought emergency rule changes to the MSB in January 2015 to 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, and to cover the Department's administrative costs. Subsequent to the adoption of those rules, significant data errors were discovered that required revisions to the provider fee and supplemental payment calculations, and revisions to the State Plan submission. The Hospital Provider Fee Oversight and Advisory	May 2015 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-02-23-A	Revision to the Medical Assistance Eligibility Rules Concerning Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), sections 8.100.1 and 8.100.4.G.2	The purpose of the rule change is to make revisions to the current policy regarding lawfully residing children who do not meet the 5-year waiting period. In 2009 Colorado House Bill 09-1353 authorized the Department to remove the 5-year waiting period for all lawfully residing children and pregnant women. Also as part of this revision the definition for "Legal Immigrant" and Legal Prenatal will be updated. Changes to the Colorado Benefits Management System (CBMS) will be made to be in alignment with federal and state regulations effective July 1, 2015.	May 2015 Permanent Adoption
MSB 15-02-23-B	Revision to the Child Health Plan *Plus* Rule Concerning Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Section 110	The purpose of the rule change is to make revisions to the current policy regarding lawfully residing children who do not meet the 5-year waiting period. In 2009 Colorado House Bill 09-1353 authorized the Department to remove the 5-year waiting period for all lawfully residing children and pregnant women. Changes to the Colorado Benefits Management System (CBMS) will be made to be in alignment with federal and state regulations effective July 1, 2015.	May 2015 Permanent Adoption
MSB 14-11-19-D	Revision to the Medical Assistance Health Programs Office Benefits and Operations Division Rule Concerning Women's Health Services, Section 8.731	The Department is updating this rule to include content from the Women's Health Services Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	May 2015 Permanent Adoption
MSB 14-09-16-B	Revision to the Medical Assistance Health Programs Benefits and Operations Division Rule Concerning Family Planning Services Section 8.730.4 and 8.770 Abortion Services	The Department is updating this rule to remove Abortion Services from the Family Planning rule 8.730.4 and moving it to 8.770 as a stand-alone rule.	May 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-01-26-A	Revision to the Medical Assistance Home and Community Based Services for Elderly, Blind and Disabled Rule Concerning Respite Care, Section 8.492	Clients in the EBD, SCI and BI waiver will all benefit from the proposed rule change by removing unintended limitations to the service and that will accommodate the targeted rate increase. The cost of the proposed rule change is not projected to have any impact and will be covered by the current appropriation for HCBS-EBD, SCI and BI waiver services.	May 2015 Permanent Adoption
MSB 15-02-18-C	Revision to the Medical Assistance Health Information Office Rule Concerning Enrollment Procedures, Section 8.013.1	Out of state providers attempt to enroll with a limited amount of information due to the existing rule found at 8.013.1. Due to CMS provider screening rules, we must treat out of state providers the same as in state and follow the same enrollment requirements.	May 2015 Permanent Adoption
MSB 15-02-18-B	Revision to the Medical Assistance Health Information Office Rule Concerning Provider Screening Regulations, Section 8.125	The Department intends to implement the ACA Provider Screening Requirements as issued by CMS. This rule applies to Medicaid and CHP+ providers and is designed to prevent fraud, waste and abuse. Providers are required to revalidate enrollment at least every five years, and all current providers must be revalidated by March 2016. Ordering, referring, and prescribing providers will be required to enroll with the Department. An application fee will be required from some providers. There are three risk categories assigned to providers and based on the risk level, some providers will be required to have site visits, some will require background checks and fingerprint submissions. Licensure verifications, exclusion database checks, and meeting federal and state rules are required for all. Providers, fiscal agents, and managed care organizations will be required to disclose ownership and control interest.	May 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-10-15-B	Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning Family Planning, Section 8.730	The Department is updating this rule to: remove abortion services which will be placed in its own rule under 8.770; remove hysterectomy and place it in the new women's health rule under 8.731; and reformat the existing family planning services rule.	May 2015 Permanent Adoption
MSB 15-02-19-A	Revision to the Medical Assistance Long-Term Services and Supports Benefit Division Rule Concerning Home and Community Based Services for Persons with Spinal Cord Injury, Section 8.517	Section 8.517 outlines all aspects The Home and Community-Based Services for persons with Spinal Cord Injury (HCBS-SCI) waiver pilot program. The current rules have limited complementary and integrative health providers participating in the pilot program. The proposed rule changes will expand provider type and requirements allowing more providers to enroll. Other changes will align the rule with language and changes proposed in the waiver renewal application and in the legislation to extend the waiver. These changes are necessary to meet requirements outlined in legislation and the states application for a waiver renewal to Centers for Medicare & Medicaid Services. Additional benefits of the proposed rule changes are increased client choice and increased client accessibility to receive services.	June 2015 Emergency Adoption
MSB 15-04-23-A	Revision to the Medical Assistance Pharmacy Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I	The proposed rule will increase the DME encounter rate by 0.5% to account for General Assembly funding appropriation.	June 2015 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-05-04-A	Revision to the Medical Assistance Rates Section Rule Concerning Payments For Outpatient Hospital Services, Section 8.300.6	On April 24, 2015, Governor Hickenlooper signed Senate Bill 15-234, which set the Colorado state budget for FY 2015-16. 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 0.5% 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 71.6% 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, 2015, the proposed rule will change the reimbursement to 72% of cost, which represents a payment increase of 0.5% as required by Senate Bill 15-234.	June 2015 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-04-03-A	Revision to the Medical Assistance Special Financing Division Rule Concerning the Hospital Provider Fee Collection and Disbursement, Sections 8.2003 and 8.2004	Under recommendation of the Hospital Provider Fee Oversight and Advisory Board (OAB), the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers. The Colorado Health Care Affordability Act [section 25.5-4-402.3, C.R.S. (2014)] 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 with disabilities up to 450% of FPL and children with disabilities up to 300% of the FPL, and to fund 12 months of continuous eligibility for Medicaid children. The proposed rule updates the hospital provider fee and payment calculations in accordance with the recommendation of the OAB. The Department brought emergency rule changes to the MSB in January 2015 to 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, and to cover the Department's administrative costs. Subsequent to the adoption of those rules, significant data errors were discovered that required revisions to the provider fee and supplemental payment calculations, and revisions to the State Plan submission. The Hospital Provider Fee Oversight and Advisory	June 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-02-26-A	Revision to the Medical Assistance Health Programs Benefits and Operations Rule Concerning Creation of Maternity Services, Section 8.732	The Department is creating this rule to include content from the Maternity Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.	June 2015 Permanent Adoption
MSB 14-09-09-A	Revision to the Medical Assistance Community Living Rule Concerning Colorado Choice Transitions (CCT), a Money Follows the Person Demonstration, Section 8.555	As a demonstration program, we are continually working to improve and make more efficient our operating processes and procedures. When the rule was first written and adopted, the program had not yet been operationalized. Therefore, changes to the rule are required to better reflect how the program actually operates. Based on underutilization and the availability of other similar services which can be used in their place, we are removing two demonstration services from the benefits and services available to clients: transitional substance abuse and transitional specialized rehabilitation services. The substance abuse benefit is now available through the State Plan and cannot be duplicated through the CCT program. Activities offered through the transitional specialized day rehabilitation service can be offered through the adult day programs and day habilitation services instead. Funds allocated for these services will be redirected to other demonstration services used by clients to support successful transitions and community living.	June 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-02-19-A	Revision to the Medical Assistance Long-Term Services and Supports Benefit Division Rule Concerning Home and Community Based Services for Persons with Spinal Cord Injury, Section 8.517	Section 8.517 outlines all aspects The Home and Community-Based Services for persons with Spinal Cord Injury (HCBS-SCI) waiver pilot program. The current rules have limited complementary and integrative health providers participating in the pilot program. The proposed rule changes will expand provider type and requirements allowing more providers to enroll. Other changes will align the rule with language and changes proposed in the waiver renewal application and in the legislation to extend the waiver. These changes are necessary to meet requirements outlined in legislation and the states application for a waiver renewal to Centers for Medicare & Medicaid Services. Additional benefits of the proposed rule changes are increased client choice and increased client accessibility to receive services.	July 2015 Permanent Adoption
MSB 15-04-23-A	Revision to the Medical Assistance Pharmacy Rule Concerning Durable Medical Equipment and Disposable Medical Supplies Provider Rate Increase, Section 8.590.7.I	The proposed rule will increase the DME encounter rate by 0.5% to account for General Assembly funding appropriation.	July 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-05-04-A	Revision to the Medical Assistance Rates Section Rule Concerning Payments For Outpatient Hospital Services, Section 8.300.6	On April 24, 2015, Governor Hickenlooper signed Senate Bill 15-234, which set the Colorado state budget for FY 2015-16. 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 0.5% 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 71.6% 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, 2015, the proposed rule will change the reimbursement to 72% of cost, which represents a payment increase of 0.5% as required by Senate Bill 15-234.	July 2015 Permanent Adoption
MSB 15-04-17-A	Revision to the Medical Assistance Home and Community Based Services Home Modification Rule for the Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493	Description: The rules set forth at 10 CCR 2505-10 Section 8.493 are being revised to allow the Department to meet a Legislative directive and appropriate to raise the cap for the Home Modification benefit. This appropriation indicated the Department was responsible for bringing forward a rule change to the Medical Services Board that increases the amount of money available to the benefit within the feasible amount available within the approved funding. A change in the dollar threshold at which occupational therapist evaluations are required and case managers may approve without a PAR was also determined within the Home Modification Stakeholder Workgroup. The lifetime cap was increased from $12,500 to $14,000 and the OT evaluation/CM approval threshold was increased from $1,000 to $1,500	August 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-05-27-B	Revision to the Medical Assistance Eligibility Rule Concerning the Use of Private Disability Income, Section 8.100.4.C	The proposed rule change amends 10 CCR 2505-10, Section 8.100.4.C, to reflect changes in the use of private disability income in MAGI methodology determination process for all applicants and MAGI-based beneficiaries. The purpose of this rule change is to bring the MAGI methodology for income calculations into alignment with tax law that says taxable private disability income should be counted as a source of gross income. The IRS construes 26 USC § 61(b), 26 USC §104(a)(3)(A), (B) and 26 USC § 105(a), (3) as meaning that disability benefits paid by an employer (either through an insurance policy or state disability fund) is taxable private disability income because the employee did not pay taxes on the premiums for the policy or contributions to the fund.	August 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-05-27-D	Revisions to the Medicaid Eligibility Rules pursuant to changes set forth in the Balanced Budget Act of 1997 to offer up to 12- months of continuous eligibility, affecting Section 8.100.3	The proposed rule changes amend 10 CCR 2505-10 8.100.3 to provide up to 12-month continuous eligibility for additional categories of children who are under 19 years-old and enrolled in Medicaid. This rule will incorporate changes elected by the state under section 1902(e)(12) of the Social Security Act, which allows up to 12 months of continuous eligibility for children eligible under section 1902(a)(10)(A) of the Act. This rule will be a positive impact to children by providing continuity of care by reducing the likelihood that children will cycle on and off of Medicaid. Children currently enrolled in MAGI-Medicaid already have continuous eligibility for up to 12 months, regardless of changes in income or household size. As such, the proposed rule will extend continuous eligibility to children enrolled in SSI Mandatory, Buy-In, Long-Term Care, Pickle, Disabled Adult Child (DAC) Medicaid programs. Continuous eligibility will also apply to children who no longer qualify for foster care services. Children who would have otherwise been discontinued from these programs due to changes in certain eligibility factors, such as income resources or household size, will now maintain coverage for up to 12 months. Under the proposed rule changes, the continuous eligibility period will end early under certain specified conditions, only. By October, 2015, the Department will have updated the Colorado Benefits Management System (CBMS) to align it with our conditionally approved State Plan Amendment implementing this extended continuous eligibility for children. Once CBMS has been updated, CMS has represented that it will give final approval to our state plan Amendment.	August 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-07-29-A	Revision to the Medical Assistance Health Programs Benefit Rule Concerning Pediatric Personal Care Services Rule, 10 CCR 2505-10, Section 8.535	The Centers for Medicare and Medicaid Services (CMS) informed the Department that it may not include protective oversight as a covered service under the Pediatric Personal Care Services benefit. In response, the Department removed the protective oversight provision from the EPSDT Personal Care Services State Plan Amendment, which was subsequently approved by CMS on June 18, 2015. This emergency rule change aligns the Pediatric Personal Care Services administrative rule with the State Plan by striking the protective oversight provision, thereby bringing the Department into compliance with CMS requirements.	September 2015 Emergency Adoption
MSB 15-06-16-A	Revision to the Medical Assistance Home and Community Based Services for Community Mental Health Supports, Section 8.509.15, Home and Community Based Services for Persons with Brain Injury, Section 8.515.3, and Home and Community Based Services for Persons with a Spinal Cord Injury, Section 8.517.2	The BI, CMHS and SCI rules for targeting waiver eligibility are being updated in order to come into compliance with the Federal Mandate to migrate from ICD-9 to ICD-10 codes by October 1, 2015.	September 2015 Emergency Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 14-10-15-A	Revision to the Medical Assistance Health Programs Benefits Management Rule Concerning Substance Use Services, Section 8.746	The proposed revision amends 10 CCR 2505-10, Section 8.746 to incorporate the Outpatient Fee-for-Service Substance Use Disorder Treatment Services Benefit Coverage Standard into rule. The Benefit Coverage Standard, which went into effect April 8, 2015, will be incorporated directly into the Department's administrative rules as an appendix. The current Section 8.746 rule language will be struck and replaced with language indicating that Outpatient Fee-for-Service Substance Use Disorder Treatment benefits are provided in accordance with the provisions of Appendix A. Additionally, the proposed revision to Section 8.746 makes the following substantive changes: 1) Adds Medication-Assisted Treatment as a covered service. 2) Increases the limit on Individual and Family Therapy from 25 sessions to 35 sessions per state fiscal year. 3) Increases the limit on Alcohol/Drug Screening Counseling specimen collections from 36 to 52 per state fiscal year. 4) Increases the limit on Targeted Case Management services from 36 contacts per state fiscal year to 52 units per state fiscal year. For consistency, the term "units" is used in place of the term "contacts;" no change in meaning is intended by this revision. 5) Increases the limit on Social/Ambulatory Detoxification from 7 days to 15 days per state fiscal year.	September 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-07-08-A	Revision to the Medical Assistance Health Information Office General Eligibility Rules at Sections 8.100.1 and 8.100.3	The proposed rule change is to incorporate revisions mandated by Executive Order D 2012-002 (EO 2), as codified at Section 24-4-103.3 CRS (2014). The governor has issued and an Executive Order which requires state agencies to review state rules every five years to ensure rules are effective, efficient and essential. A regulatory review is solely for the purpose of identifying those rules which are duplicative, overlapping, outdated and inconsistent. The Colorado Benefits Management System (CBMS) does not need to be updated for sections 8.100.1 and 8.100.3 since all CBMS algorithms are in alignment with our federal regulations.	September 2015 Permanent Adoption
MSB 15-07-08-B	Revision to the MAGI Medical Assistance Health Information Office Eligibility Rules at Section 8.100.4	The proposed rule change is to incorporate revision mandated by Executive Order D 2012-002 (EO 2), as codified at Section 24-4-103.3 CRS (2014). The governor has issued an Executive order which requires states agencies to review state rules every five years to ensure rules are effective, efficient and essential. A regulatory review is solely for the purpose of identifying those rules which are duplicative, overlapping, outdated and inconsistent. The Colorado Benefits Management System (CBMS) does not need to be updated for section 8.100.4 since all rules are in alignment with our federal regulations.	September 2015 Permanent Adoption

Rule Number	Rule Title	Rule Summary	Adoption Month/Status
MSB 15-07-08-D	Revision to the Medical Assistance Health Information Office Eligibility Rule Concerning Long-Term Care Medical Eligibility, Section 8.100.7	The proposed rule change is to incorporate revisions mandated by Executive Order D 2012-002 (EO 2), as codified at Section 24-4-103.3 CRS (2014). The governor has issued an Executive Order which requires state agencies to review state rules every five years to ensure rules are effective, efficient and essential. A regulatory review is solely for the purpose of identifying those rules which are duplicative, overlapping, outdated and inconsistent. The Colorado Benefits Management System (CBMS) does not need to be updated for sections 8.100.7 since all CBMS algorithms are in alignment with our federal regulations. The changes address non-substantive issues such as correcting inaccurate rule citations, removing redundant rules, clarifications and removing tables that should be issued as guidance and not set in rule.	October 2015 Permanent Adoption
MSB 15-06-16-A	Revision to the Medical Assistance Home and Community Based Services for Community Mental Health Supports, Section 8.509.15, Home and Community Based Services for Persons with Brain Injury, Section 8.515.3, and Home and Community Based Services for Persons with a Spinal Cord Injury, Section 8.517.2	The BI, CMHS and SCI rules for targeting waiver eligibility are being updated in order to come into compliance with the Federal Mandate to migrate from ICD-9 to ICD-10 codes by October 1, 2015.	October 2015 Permanent Adoption

2015 Results of Mandatory Review of Rules

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
10 CCR 2505-10 8.1000.1	Definitions	42 CFR 423.772	6/2015	Rev	Pending	

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
10 CCR 2505-10 8.1000.2	Application For The Low-Income Subsidy Through The Social Security Administration	42 USC 1396u-5; 42 CFR 423.774(a); 42 CFR 423.904(a)	6/2015	No		After review, it was determined that this rule was sufficient and minimized the impact on individuals to the extent allowed by regulation. This rule was reviewed to ensure it was stated in plain language, offered clarity, and created uniformity as appropriate. Efforts to minimize impact on individuals are being made through enhancements and modification to the application process and verifications when possible. Eligibility rules follow Federal and/or State statute or regulation, and are no more burdensome then statute and regulation require. This rule is in compliance with regulations without going outside our

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
10 CCR 2505-10 8.1000.3	Application For The Low-Income Subsidy At Colorado Medicaid Eligibility Sites	42 USC 1396u-5; 42 CFR 423.774(a); 42 CFR 423.904(a)	6/2015	Rev	Pending	
10 CCR 2505-10 8.1000.4	Eligibility For The Low-Income Subsidy	42 CFR 423.773	6/2015	Rev	Pending	

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
10 CCR 2505-10 8.1000.5	Benefits	42 USC 1860D-14 (c)(1)(C); 42 U.S.C. 1396u-5; 42 USC 1860D-14 (3)(B)(iii); 42 CFR 423.780; 42 CFR 423.782	6/2015	No		After review, it was determined that this rule was sufficient and minimized the impact on individuals to the extent allowed by regulation. This rule was reviewed to ensure it was stated in plain language, offered clarity, and created uniformity as appropriate. Efforts to minimize impact on individuals are being made through enhancements and modification to the application process and verifications when possible. Eligibility rules follow Federal and/or State statute or regulation, and are no more burdensome then statute and regulation

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
10 CCR 2505-10 8.130.2	Maintenance of Records	42 CFR 431.17	September 2015	No	N/A	The rule is to remain as is to meet federal requirements stated in 42 CFR 431.17. Also, this rule is in compliance with the Colorado Medicaid State Plan, Section 4.7 Maintenance of Records.
10 CCR 2505-10 8.130.3	Advance Directives	42 CFR 431.107	September 2015	No	N/A	The rule is to remain as is to meet federal requirements stated in 42 CFR 431.107.
10 CCR 2505-10 8.130.35	Screening for Excluded Employees and Contractors	42 CFR Part 1002	September 2015	No	N/A	The rule is to remain as is to meet federal requirements stated in 42 CFR Part 1002.
10 CCR 2505-10 8.130.4	Termination	42 CFR 455.100-106	September 2015	No	N/A	The rule is to remain as is to meet federal requirements stated in 42 CFR 455.100-106.

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10 CCR 2505-10 8.170	State Identification Number	No regulatory authority required to assign a unique identifier as a state identification number	September 2015	No	N/A	The rule is to remain as is so that individual Medicaid recipients are uniquely identified.
10 CCR 2505-10 8.180	Medical Identification Cards and Duration of Eligibility	Social Security Handbook 2107.2 Social Security Act Section 1902 [42 U.S.C. 1396(a)] (a)(48) Some CFR references to "Medicaid Card": • 42 CFR 435.121 • 42 CFR 460.156	September 2015	No	N/A	The rule is to remain as is; however, the Department is currently evaluating the rule and if it is determined that a rule change is needed the Department will engage stakeholders before initiating a rule change.
8.390	Long Term Care Single Entry Point Services	25.5-6-105	August 2015	REV	Pending	
8.390.1	Definitions	25.5-6-105	August 2015	REV	Pending	

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8.390.2	Single Entry Point Clients	25.5-6-105	August 2015	REV	Pending	
8.391	District Designation	25.5-6-106	August 2015	REV	Pending	
8.391.20	SEP Agency Selection	25.5-6-106	August 2015	REV	Pending	
8.392	Financing of the SEP System	25.5-6-107	August 2015	REV	Pending	
8.393	Functions of A SEP Agency	25.5-6-106	August 2015	REV	Pending	
8.393.1	Administration of a SEP Agency	25.5-6-105	August 2015	REV	Pending	
8.393.2	Service Functions of a SEP Agency	25.5-6-106	August 2015	REV	Pending	
8.393.3	Inter-county and Inter-district Transfer Procedures	25.5-6-105 and 25.5-6-106	August 2015	REV	Pending	
8.393.4	Staffing of a SEP Agency	25.5-6-105 and 25.5-6-106	August 2015	REV	Pending	
8.393.5	Resource Development	25.5-6-105 and 25.5-6-106	August 2015	REV	Pending	
8.393.6	Provision of Direct Service	25.5-6-105 and 25.5-6-106	August 2015	REV	Pending	

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
8.394	Accountability Mechanisms for SEP Agencies	25.5-6-105 and 25.5-6-106	August 2015	REV	Pending	
8.394.1	Performance Based Contract	25.5-6-105 and 25.5-6-106	August 2015	REV	Pending	
8.394.2	Certification of SEP Agencies	25.5-6-105 and 25.5-6-106	August 2015	REV	Pending	
10 CCR 2505-10 8.900 Program Overview	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.901 Definitions	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.902 Discounted Health Care Services	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable

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10 CCR 2505-10 8.903 Provisions Applicable to Qualified Health Care Providers	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.904 Provisions Applicable to Clients	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.905 Financial Eligibility	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.906 CICP Rating	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.907 Client Copayment	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.908 Appeal Process	Colorado Indigent Care Program (CICP)	Title 25.5, Article 3, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable

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10 CCR 2505-10 8.950.1 General Description	Primary Care Fund	Title 25.5, Article 3, Part 3, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.950.2 Definitions	Primary Care Fund	Title 25.5, Article 3, Part 3, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.950.3 Provider Eligibility	Primary Care Fund	Title 25.5, Article 3, Part 3, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.950.4 Application	Primary Care Fund	Title 25.5, Article 3, Part 3, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.950.5 Disbursement	Primary Care Fund	Title 25.5, Article 3, Part 3, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 Section 8.941 Extent and Limitations of Medical Care	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	No	Not applicable	Section 8.941 is a title section, and needs no revision

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10 CCR 2505-10 Section 8.941.1 General Description – Old Age Pension Health Care Program	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 Section 8.941.2 Definition	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rep	Pending	Not applicable
10 CCR 2505-10 Section 8.941.3 Groups Assisted Under the Old Age Pension Health Care Program	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 Section 8.941.4 Financial Assistance	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 Section 8.941.5 Certification of Payment for Providers	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable

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10 CCR 2505-10 Section 8.941.6 General Exclusions	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rep	Pending	Not applicable
10 CCR 2505-10 Section 8.941.7 Out-of-State Medical Care	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 Section 8.941.8 Submission of Claims	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 Section 8.941.9 Reimbursement to Providers	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 Section 8.941.10 Client Co-payment	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable

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10 CCR 2505-10 Section 8.942 Change of Supplemental Income Status Code (SISC) to Medicaid	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rev	Pending	Not applicable
10 CCR 2505-10 Section 8.943 Identification and Affidavit Requirements	Old Age Pension Health Care Program	Title 25.5, Article 2, Part 1, C.R.S.	July 2015	Rep	Pending	Not applicable
10 CCR 2505-10 Section 8.960.1 Definitions	Colorado Dental Health Care Program for Low-Income Seniors	Title 25.5, Article 3, Part 4, C.R.S.	August 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.960.2 Legal Basis	Colorado Dental Health Care Program for Low-Income Seniors	Title 25.5, Article 3, Part 4, C.R.S.	August 2015	No	Not applicable	The legal basis is correct for this new rule and no changes to this section are needed

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10 CCR 2505-10 8.960.3 Request of Grant Proposals and Grant Award Procedures	Colorado Dental Health Care Program for Low-Income Seniors	Title 25.5, Article 3, Part 4, C.R.S.	August 2015	Rev	Pending	Not applicable
10 CCR 2505-10 8.2000	Hospital Provider Fee Collection and Disbursement	25.5-4-402.3 C.R.S. and 25.5-4-402(3) C.R.S.	August 2015	Rev	Pending	
10 CCR 2505-10 8.2001	Definitions	25.5-4-402.3 C.R.S. and 25.5-4-402(3) C.R.S.	August 2015	Rev	Pending	
10 CCR 2505-10 8.2002	Responsibilities of the Department and Hospitals	25.5-4-402.3 C.R.S. and 25.5-4-402(3) C.R.S.	August 2015	Rev	Pending	
10 CCR 2505-10 8.2003	Hospital Provider Fee	25.5-4-402.3 C.R.S. and 25.5-4-402(3) C.R.S.	August 2015	Rev	Pending	

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10 CCR 2505-10 8.2004	Supplemental Medicaid and Disproportionate Share hospital Payments	25.5-4-402.3 C.R.S. and 25.5-4-402(3) C.R.S.	August 2015	Rev	Pending	

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8.190	Acute Medical Benefits Determination	42 CFR 440.230(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose. 42 CFR 441.57 Under the EPSDT program agencies may provide other medical or remedial care specified in part 440 of this subchapter, even if the agency does not otherwise provide these services to other recipients	September 2015	No	N/A	This Rule is how a new code gets opened for the adult benefits program. This section is where the exception to coverage rule will live when it becomes operational Under EPSDT this substantiates 10 CCR 25-05 8.820

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8.800.1	Definitions	We need a definitions section to define terms used in the rest of the rule. To the extent any of the definitions are based on statutory authority, that fact is indicated in the definitions themselves.	August 2015	Rev	Pending	

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8.800.2	Conditions of Participation	8.800.2 A and B clarify how general provider enrollment requirements apply to pharmacies. This also implements CRS 25.5-5-504. Portions of 8.800.2.C are necessary to comply with state statutes that limit the use of out of state pharmacies for Medicaid recipients; these provisions simply implement the requirements set forth in those statutes	August 2015	Rev	Pending	

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8.800.3	Mail Order	This regulation is necessary because there is a statute (CRS 25.5-5-505) that states that a rule shall be adopted to allow certain recipients to receive maintenance medication through mail order; this rule complies with that requirement.	August 2015	N/A	N/A	Rule can stay as is because it implements the state statute and nothing has changed with regard to that statute.

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8.800.4	Drug Benefits	This section sets out the basic parameters of the pharmacy benefit. 8.800.4. A-G are based on Federal law (42 USC § 1396r-8 and Medicare Part D, 42 USC §1395w and 42 CFR Part 423 as well as state law, CRS 25.5-5-503). 8.800.4.H implements the Colorado statute CRS 25.5-501.	August 2015	Rev	Pending	

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8.800.5	Drugs Administered or Provided in Physician Offices or Clinics	Every Medicaid program needs to define whether physician administered drugs are a medical or pharmacy benefit so that there is not duplicate billing for these drugs. This section clarifies that in Colorado it is a medical benefit.	August 2015	Rev	Pending	

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8.800.6	Compounded Prescriptions	This rule is necessary to clarify how compounded drugs are reimbursed by Medicaid. Compounded drugs can be a covered benefit pursuant to 42 USC § 1396r-8	August 2015	Rev	Pending	
8.800.7	Prior Authorization Requirements	This rule implements the prior authorization requirements that are allowed pursuant to Federal law, 42 USC § 1396r-8(d)	August 2015	Rev	Pending	

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8.800.8	Limit Requirements	This rule implements the limit requirements that are allowed pursuant to Federal law, 42 USC § 1396r-8(d)	August 2015	N/A	N/A	Rule does not need to be changed – it is accurate, it is consistent with Federal law, and there are no confusing elements in the rule.
8.800.9	Drug Utilization Review	This rule implements the Federal and state requirements regarding Drug Utilization Review (42 USC § 1396r-8(g), 42 CFR 456.700 et seq., and CRS 25.5-5-506).	August 2015	Rev	Pending	
8.800.10	Billing Procedures	This rule explains the claim that is needed to bill Medicaid for a prescription.	August 2015	N/A	N/A	This rule does not need to be changed – it is accurate and policy is consistent with this rule. There are no questions about this rule.

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8.800.11	Prescription Record Requirements	Portions of this rule discuss what must be included on a prescription and record retention requirements and this is consistent with Colorado Board of Pharmacy requirements as well as other Medicaid requirements. 8.800.11.D is required based on a Federal law that requires the use of tamper-resistant prescription pads (Section 7002(b) of the US Troop Readiness, Veterans' Care, Katrina Recovery, Iraq Accountability Appropriations Act of 2007). 8.800.11.E was implemented in	August 2015	N/A	N/A	This rule is still accurate and consistent with the Federal and State requirements related to these provisions.

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8.800.12	Basis for Reimbursement	This rule summarizes and clarifies the requirements for a claim to be reimbursed by Medicaid. The requirements are based on federal and state laws including Medicaid requirements, Board of Pharmacy Requirements, tamper-resistant prescription pad requirements and any other governing laws and regulations.	August 2015	N/A	N/A	This rule is still accurate and consistent with the Federal and State requirements related to these provisions.

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8.800.13	Reimbursement Calculation	This rule establishes the reimbursement methodology for the drug benefit and provides related details. This is in compliance with Federal laws and regulations including 42 USC 1396r-8, 42 CFR 447.500 et seq., 42 CFR 447.332 and 333. CMS is pushing states toward using AAC and/or NADAC as a reimbursement methodology so Colorado is already in compliance with this request. The rule is in compliance with the State Plan Amendment that CMS approved	August 2015	Rev	Pending	

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark “Pending”	If rule will remain as is, provide explanation
8.800.14	Prescription Quantities	This rule implements the minimum and maximum prescription quantities that are allowed pursuant to Federal law, 42 USC § 1396r-8(d).	August 2015	N/A	N/A	This rule is up to date and accurate.
8.800.15	Reimbursement from Pharmacies Redispensing Unused Medication	This rule was implemented pursuant to a Colorado statute, CRS 25.5-5-502.	August 2015	Rev	Pending	

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8.800.16	Preferred Drug List	This rule implements the Governor's Executive Order, D 004 07, that established a Medicaid Preferred Drug List. A preferred drug list is allowed under Federal law (42 USC § 1396r-8(d)).	August 2015	Rev	Pending	
8.800.17	Pharmacy and Therapeutics Committee	This rule implements the Governor's Executive Order, D 004 07, that established a Medicaid Preferred Drug List. A preferred drug list is allowed under Federal law (42 USC § 1396r-8(d)).	August 2015	N/A	N/A	This rule is consistent with Federal requirements and the Executive Order. Nothing has changed regarding the Committee so this rule is up to date.

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
8.800.18	Prescription Drug Consumer Information and Technical Assistance Program	This rule was implemented pursuant to a Colorado statute, CRS 25.5-5-507. The Department filed a State Plan Amendment (SPA) to implement this program and revise this program and the rule reflects what was approved by CMS in the SPA.	August 2015	N/A	N/A	This rule is still consistent with the Colorado statute as well as the SPA that approved this program. There are no out of date items or confusing items related to this rule.

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8.300.1	Definitions	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	Revision: • Citing to the Medical Necessity Definition	Pending	N/A

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
8.300.2	Requirements for Participation	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	Revision: • Updating In-network/out-of-network language • Adding language regarding Change of Ownership • Removing contract requirement for In-network hospitals – according to federal updates	Pending	

CCR and Section Number	Regulation Title	Statutory Basis (Authority)	Month Review was Completed	Will the Review Result in a Rule Revision (Rev) or Repeal (Rep)	Date Rulemaking Action was taken If not completed mark "Pending"	If rule will remain as is, provide explanation
8.300.3	Covered Hospital Services	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	Revision: • Moving Prior Authorization Requirements for Bariatric Services to a more appropriate section of the Rule	Pending	
8.300.4	Non-Covered Services	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	Revision: • Rewording for clarity	Pending	
8.300.5	Payment for Inpatient Hospital Services	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	Revision: • Specifying the wording on DRG base rate • Clarifying the wording for new DRG hospitals base rate	Pending	

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8.300.6	Payments For Outpatient Hospital Services	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	As is	No change required	Rule section is explained efficiently
8.300.7	Graduate Medical Education (GME)	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	Revision: • Change GME percentage to cite outpatient percentage reimbursement that can change from year to year	Pending	N/A
8.300.8	Disproportionate Share Hospital Adjustment	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	As is	No change required	Rule section is explained efficiently

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8.300.9	Supplemental Inpatient Hospital Payments	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	As is	No change required	Rule section is explained efficiently
8.300.10	Patient Payment Calculation for Nursing Facility Clients Who are Hospitalized	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	As is	No change required	Rule section is explained efficiently
8.300.11	Payment for Hospital Beds Designated as Swing Beds	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	As is	No change required	Rule section is explained efficiently
8.300.12	Utilization Management	Federal: 42 USCS 1396 (d) (1) and 42 USCS 1396 (d) (2) State: CRS 25.5.-4-402	September, 2015	Revision: Moving Prior Authorization Requirements for Bariatric Services to a more appropriate section of the Rule	Pending	N/A