Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health Prior Authorization Correction, Section 8.520.8.C
Rule Number: MSB 22-08-08-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

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

   The original language of Section 8.520.8.C.1 was inadvertently deleted along with the new prior authorization reinstatement language in Sections 8.520.8.C.1.a-j. This emergency rulemaking restores the original Section 8.520.8.C.1 language that preceded the addition of the prior authorization reinstatement language in Sections 8.520.8.C.1.a-j. This does not alter the current Department policy to temporarily pause the pediatric long-term home health prior authorization reinstatement process, effective November 1, 2021 until at least March 2024.

   The Department recently met with Health First Colorado (Colorado's Medicaid program) members and families, providers, and other stakeholders about concerns related to the pediatric long-term home health (LTHH) benefit prior authorization request (PAR) reinstatement process. Based on these conversations, the Department has made the decision to temporarily pause the PAR process effective November 1, 2021 until at least March 2024.

   The pause allows the Department and partners time to robustly engage with stakeholders, train providers on operational changes, evaluate benefit policy, and notify Health First Colorado members before the pause is lifted. This also gives the Department time to ensure full compliance with federal and state policy while keeping Health First Colorado members and their needs front and center.

2. An emergency rule-making is imperatively necessary

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

   Explain:

   The proposed rule is imperatively necessary to address concerns raised by stakeholders concerning the tiered prior authorization reinstatement for long-term home health. The suspension of prior authorization requirements for said services is imperatively necessary for the preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

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REGULATORY ANALYSIS

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

   Members receiving pediatric long-term home health services, and the providers of such services, are impacted by this rule.

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

   The proposed rule maintains the removal of the requirement that pediatric long-term home health services be prior authorized in accordance with the tiered reinstatement of long-term home health prior authorizations established in previous Sections 8.520.8.C.1.a-j, temporarily pausing the pediatric long-term home health prior authorization reinstatement process, effective November 1, 2021 until at least March 2024.

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

   The Department anticipates that expenditure for pediatric long-term home health services would remain in line with spending for the last two years when all prior authorizations for such services were suspended.

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

   The benefit of the proposed rule is providing the Department and stakeholders time to discuss long-term solutions concerning prior authorization of pediatric long-term home health services. The cost of the proposed rule is suspension of prior authorization requirements for such services. The cost of inaction would be continuing the tiered reinstatement of prior authorization of such services while the Department is actively working with stakeholders to discuss the long-term solutions. There are no benefits to inaction.

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

There are no less costly or less intrusive methods for pausing the prior authorization of the services at issue in order to provide the Department and stakeholders time to discuss long-term solutions.

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

   There are no alternative methods for pausing the prior authorization of the services at issue in order to provide the Department and stakeholders time to discuss long-term solutions.

8.520 HOME HEALTH SERVICES

8.520.8.C. Long-Term Home Health

1. Long-term Home Health Services do not require prior authorization under Section 8.017.E. ~~Beginning November 1, 2021, providers must submit a prior authorization request (PAR) for all new long-term pediatric Home Health Services under Section 8.017.E, except for Certified Nurse Assistant services, physical therapy services, occupational therapy services, and speech-language pathology services. For members currently receiving long-term pediatric Home Health Services initiated prior to November 1, 2021, providers must submit a PAR in accordance with the following schedule:~~

   ~~a. Ten percent (10%) of PARs must be submitted by November 30, 2021;~~

   ~~b. An additional 10% of PARs must be submitted by December 31, 2021;~~

   ~~c. An additional 10% of PARs must be submitted by January 31, 2022;~~

   ~~d. An additional 10% of PARs must be submitted by February 28, 2022;~~

   ~~e. An additional 10% of PARs must be submitted by March 31, 2022;~~

   ~~f. An additional 10% of PARs must be submitted by April 30, 2022;~~

   ~~g. An additional 10% of PARs must be submitted by May 31, 2022;~~

   ~~h. An additional 10% of PARs must be submitted by June 30, 2022;~~

   ~~i. An additional 10% of PARs must be submitted by July 31, 2022;~~

   ~~j. The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.~~

2. When an agency accepts an HCBS waiver client to long-term Home Health Services, the Home Health Agency shall contact the client's case management agency to inform the case manager of the client's need for Home Health Services.

3. The complete formal written PAR shall include:

   a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;

   b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits

shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services;

c. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance;

d. Any other medical information which will document the medical necessity for the Home Health Services;

e. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;

f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the client's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and

g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.

h. Long Term Home Health Services for clients 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.

4. Authorization time frames:

a. PARs shall be submitted for, and may be approved for up to a one year period.

b. The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.

c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the CMS-485.

5. The PAR shall not be backdated to a date prior to the 'from' date of the CMS-485.

6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding clients:

a. PAR Approval: If services requested are in compliance with Medicaid rules are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (e.g, the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.

ii) When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client, through August 31, 2022. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

c. Interim Services: Services provided during the period between the provider's submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.