Title of Rule:	Revision to the Medical Assistance Rule Concerning Hospital Services, Section 8.300
Rule Number:	MSB 09-01-20A
Division / Contact / Phone:	Medicaid Program Division / Eric Wolf / 303-866-5963

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-01-20A, Revision to the Medical Assistance Rule Concerning Hospital Services, Section 8.300
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.300, 8.340 and 8.350, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

This is a complete rule re-write. Please delete all text from §8.300 through §8.375.60 and replace with new text from §8.300 through the end of §8.300.12.C. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

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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 purpose of the rule change is to update the rule to be consistent with current practice, which has changed since the rule was last approved. Outdated material has been removed. The rule has been reorganized to make it easier to follow and understand. Enrollment of psychiatric hospitals has been made possible.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 USC Section 1396d

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);

Initial Review	**09/01/2009**	Final Adoption	**10/16/2009**
Proposed Effective Date	**11/30/2009**	Emergency Adoption	

DOCUMENT #17

Title of Rule:	Revision to the Medical Assistance Rule Concerning Hospital Services, Section 8.300
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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.

   Proposed changes will not create changes in who will be affected by the 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.

   There will be no qualitative or quantitative impact upon the affected classes because the proposed changes do not change current practice. The proposed changes will reformat the rule to be consistent with current policy.

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 intent is to revise the rule and to combine three sections (8.300, 8.340 and 8.350) for clarification. There will be no impact on services offered.

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

   Inaction would mean not updating the rule to be consistent with current practice. Failure to do so will place the Medical Assistance Program, which must keep written rules up-to-date with actual practice, at increasing risk of legal challenge.

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

   The rule will not change actual practices. The only costs of implementing rule changes are administrative. Additional revenues will not be required to implement the rule change.

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.

   The only alternative to revising the rule is inaction. In the time since the rule was last revised, some practices have changed. Failure to update the rule places the Medical Assistance Program at risk of legal challenge.

8.300 HOSPITAL SERVICES

8.300.1 Definitions

Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.

Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.

Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.

Department means the Department of Health Care Policy and Financing.

Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.

DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals.

Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.

Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably be expected to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer

limited surgical services and/or obstetrical services including a delivery room and nursery.

A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.

A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.

A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital. In general, Long-Term Care Hospitals have an average length of stay of greater than twenty-five (25) days.

A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.

Inpatient means a person who is receiving professional services at a Hospital; the services include a room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will remain at least overnight and occupy a bed even though it later develops that the client can be discharged or transferred to another Hospital and does not actually use a bed overnight.

Inpatient Hospital Services means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the Hospital by or under the direction of a physician.

Medically Necessary, or Medical Necessity, means a Medicaid service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals are considered Non-DRG Hospitals since their reimbursement is based on a per diem rate.

Observation Stay means a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length.

Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

Outpatient means a client who is receiving professional services at a Hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-a-day basis.

Outpatient Hospital Services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.

Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.

Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his/her best possible functional level.

Relative Weight (DRG weight) means a numerical value which reflects the relative resource consumption for the DRG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost of claims for each DRG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.

Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.

State University Teaching Hospital means a Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education; and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called "swing beds."

Trim Point Day (Outlier Threshold Day) means the day which would occur 1.94 standard deviations above the mean (average) length of stay (ALOS) for each DRG.

Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.

Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

8.300.2 Requirements for Participation

8.300.2.A In-Network Hospitals

1. In order to qualify as an in-network Hospital, a Hospital must:
   a. be located in Colorado
   b. be certified for participation as a Hospital in the Medicare Program;
   c. have an approved Application for Participation with the Department; and
   d. have a fully executed contract with the Department.
2. A border-state Hospital (located outside of Colorado) which is more accessible to clients who require Hospital services than a Hospital located within the state may be an in-network Hospital by meeting the requirements of 10 CCR 2505-10

Section 8.300.2.A.1.b – c. The Department shall make the proximity determination for Hospitals to enroll as a border-state Hospital.

3. In-network and out-of-network Hospitals located in Colorado shall be surveyed by the CDPHE. Failure to satisfy the requirements of CDPHE may cause the Department to institute corrective action as it deems necessary.

8.300.2.B Out-of-Network Hospitals

An out-of-network Hospital, including out-of-state Hospitals, may receive payment for emergency Hospital services if:

1. the services meet the definition of Emergency Care;
2. the services are covered benefits;
3. the Hospital agrees on an individual case basis not to charge the client, or the client's relatives, for items and services which are covered Medicaid benefits, and to return any monies improperly collected for such covered items and services; and
4. the Hospital has an approved Application for Participation with the Department.

8.300.2.C Out-of-State Hospitals

Out-of-state Hospitals may receive reimbursement for non-emergent Hospital services if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4, and the Department has issued a written prior authorization.

8.300.2.D Hospitals with Swing-Bed Designation

1. Hospitals which intend to designate beds as swing beds shall apply to CDPHE for certification of swing beds and to the Department for participation as a Medicaid provider of nursing facility services. The criteria in 10 CCR 2505-10 Section 8.430 must be met in order to become a Medicaid provider.
2. Hospitals providing nursing facility services in swing beds shall furnish within the per diem rate the same services, supplies and equipment which nursing facilities are required to provide.
3. Clients and/or their responsible parties shall not be charged for any of these required items or services as specified in 10 CCR 2505-10 Sections 8.440 and 8.482.
4. Hospitals providing nursing facility services to swing-bed clients shall be in compliance with the following nursing facility requirements.
   a. Client rights: 42 C.F.R. Section 483.10(b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m).
   b. Client Admission, transfer and discharge rights: 42 C.F.R. Section 483.12 (a)(1) through (a)(7).
   c. Client behavior and facility practices: 42 C.F.R. Section 483.13.
   d. Client activities: 42 C.F.R. Section 483.15(f).
   e. Social Services: 42. C.F.R. Section 483.15(g).
   f. Discharge planning: 42 C.F.R. Section 483.20(e)
   g. Specialized rehabilitative services: 42 C.F.R. Section 483.45.
   h. Dental services: 42 C.F.R. Section 483.55.
5. Personal Needs Funds and Patient Payments

   Swing-bed Hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance

with the requirements established for nursing facilities in 10 CCR 2505-10 Section 8.482.

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. Inpatient Hospital services include:
   a. bed and board, including special dietary service, in a semi-private room to the extent available;
   b. professional services of hospital staff;
   c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;
   d. emergency room services;
   e. drugs, blood products;
   f. medical supplies, equipment and appliances as related to care and treatment; and
   g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.
2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.
3. Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.
4. Psychiatric Hospital Services

   Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-network Hospital.
   a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.
   b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:
      i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and
      ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she

attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

5. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-network DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or
b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or
c. placement or repair of the dialysis route ("shunt", "cannula").

8.300.3.B Covered Hospital Services – Outpatient

Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20.

1. Observation Stays

Observation stays are a covered benefit as follows:

a. Clients may be admitted as Outpatients to Observation Stay status.
b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length.
c. A physician's order must be written prior to initiation of the Observation Stay.
d. Observation Stays end when the physician orders either Inpatient admission or discharge from observation.
e. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged.

2. Outpatient Hospital Psychiatric Services

Outpatient psychiatric services, including prevention, diagnosis and treatment of emotional or mental disorders, are Medicaid benefits at DRG Hospitals.

a. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals.

3. Emergency Care

a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral.
b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

8.300.4 Non-Covered Services

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.
2. Inpatient Hospital Services which are not a covered Medicare benefit.
3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department's utilization review vendor or other Department representative.
4. Days awaiting placement or appropriate transfer to a lower level of care are not a covered benefit unless otherwise Medically Necessary.
5. Substance abuse rehabilitation treatment is not covered unless individuals are aged 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement.

8.300.5 Payment for Inpatient Hospital Services

8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services

1. Peer Groups

   For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups:

   a. Pediatric Hospitals
   b. Rehabilitation Hospitals and Long-Term Care Hospitals
   c. Urban Safety Net Hospitals
   d. Rural Hospitals
   e. Urban Hospitals
   f. Hospitals which do not fall into the peer groups described in a through c above shall default to the peer groups described in d and e based on geographic location.

2. Base Payment and Outlier Payment

   DRG Hospitals shall be reimbursed for Inpatient Hospital Services based on a system of DRGs and a hospital-specific Medicaid Inpatient base rate. The reimbursement for Inpatient Hospital Services shall be referred to as the DRG base payment.

   a. The DRG base payment shall be equal to the DRG Relative Weight multiplied by the Medicaid Inpatient base rate as calculated in 10 CCR 2505-10 Section 8.300.5.A.3 – 6.
   b. Outlier days shall be reimbursed at 80% of the DRG per diem rate. The DRG per diem rate shall be the DRG base payment divided by the DRG average length of stay.
   c. The DRG base payment plus any corresponding outlier payment is considered the full reimbursement for an Inpatient Hospital stay where the client was Medicaid-eligible for the entire stay.
   d. When a client was not Medicaid-eligible for an entire Inpatient Hospital stay, reimbursement shall be equal to the DRG per diem rate for every eligible day, with payment up to the full DRG base payment. If applicable, the Hospital shall receive outlier reimbursement.

3. Medicaid Inpatient Base Rate for In-network Colorado DRG Hospitals

   a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate

      i For in-network Colorado DRG Hospitals, excluding Rehabilitation Hospitals, Long-Term Care Hospitals, CAHs, Pediatric Hospitals,

and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the hospital-specific Medicare Federal base rate minus any DSH factors. For the purpose of rate setting effective on July 1 of each fiscal year, the Medicare base rate used shall be the Medicare base rate effective on October 1 of the previous fiscal year.

ii For Pediatric Hospitals, the starting point shall be equal to the cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 for rates effective July 1 of the same calendar year.

iii For Rehabilitation Hospitals and Long-Term Care Hospitals, the starting point shall be set as a cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year.

iv For CAHs and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the average Medicare base rate minus DSH factors for their respective peer group. The average calculation shall exclude CAHs and those Hospitals with less than twenty Medicaid discharges in the previous fiscal year.

b. Application of Adjustment Based on General Assembly Funding

For all in-network, Colorado DRG Hospitals, excluding Urban Safety Net Hospitals, the starting point for the Medicaid Inpatient base rate, as determined in 10 CCR 2505-10 Section 8.300.5.A.3.a, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Urban Safety Net Hospitals' starting point shall be adjusted by the percentage applied to all other Hospitals plus 10 percent. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent.

c. Application of Cost Add-ons to Determine Medicaid Inpatient Base Rate

i The Medicaid Inpatient base rate shall be equal to the rate as calculated in 10 CCR 2505-10 Sections 8.300.5.A.3.a and 8.300.5.A.3.b, plus any Medicaid hospital-specific cost add-ons. The Medicaid hospital-specific cost add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1. Partial year cost reports shall not be used to calculate the cost add-ons.

ii The Medicaid hospital-specific cost add-ons shall be an estimate of the cost per discharge for nursery, neo-natal intensive care units, and Graduate Medical Education (GME). The GME cost add-on information shall be obtained from the audited Medicare/Medicaid cost report, worksheet B, part I; discharges from worksheet S-3, part I, nursery and neo-natal costs, shall be obtained from the audited Medicare/Medicaid cost report, Title XIX in worksheet D-1, part II. The GME cost add-on shall not be applied to the

Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in 10 CCR 2505-10 Section 8.300.9.2.

iii Ten percent of the Medicaid hospital-specific cost add-ons shall be applied.

d. Application of Adjustments for Certain Hospitals
For Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals, the Medicaid Inpatient base rate shall receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.

e. Annual Adjustments
The Medicaid Inpatient base rates are adjusted annually (rebased) and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department.

4. Medicaid Inpatient Base Rate for New In-Network Colorado DRG Hospitals
The Medicaid Inpatient base rate for new in-network Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing period after the Hospital's contract effective date. For the next Inpatient rate rebasing period, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in 10 CCR 2505-10 Section 8.300.5.A.3. If the Hospital does not have a Medicare Inpatient base rate or an audited Medicare/Medicaid cost report to compute a starting point as described in 10 CCR 2505-10 Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals
The Medicaid Inpatient base rate for border-state Hospitals shall be equal to the average Medicaid Inpatient base rate for the corresponding peer group.

6. Medicaid Inpatient Base Rate for Out-of-network Hospitals

a. The Medicaid Inpatient base rate for out of network Hospitals, including out-of-state Hospitals, shall be equal to 90% of the average Medicaid Inpatient base rate for the corresponding peer group.

b. The Department may reimburse an out-of-state Hospital for non-emergent services at an amount higher than the DRG base payment when the needed services are not available in a Colorado Hospital. Reimbursement to the out-of-state Hospital shall be made at a rate mutually agreed upon by the parties involved.

7. Reimbursement for Inpatient Hospital claims that (a) include serious reportable events identified by the Department in the Provider Bulletin with (b) discharge dates on or after October 1, 2009, may be adjusted by the Department.

8.300.5.B Abbreviated Client Stays

1. DRG Hospitals shall receive the DRG base payment and any corresponding outlier payment for Abbreviated Client Stays. The DRG base payment and outlier payment shall be subject to any necessary reduction for ineligible days.

8.300.5.C Transfer Pricing

1. Reimbursement for a client who is transferred from one DRG Hospital to another DRG Hospital is calculated at a DRG per diem rate for each Hospital with payment up to the DRG base payment to each DRG Hospital. If applicable, both Hospitals may receive outlier reimbursement.
2. Reimbursement for a client who is transferred from one DRG Hospital to a Non-DRG Hospital, or the reverse, is calculated at the DRG per diem rate for the DRG Hospital with payment up to the DRG base payment. Reimbursement for the Non-DRG Hospital shall be calculated based on the assigned per diem rate. If applicable, the DRG Hospital may receive outlier reimbursement.
3. For transfers within the DRG Hospital, the Hospital is required to submit one claim for the entire stay, regardless of whether or not the client has been transferred to different parts of the Hospital. Since the Colorado Medicaid program does not recognize distinct part units, Hospitals may not submit two claims for a client who is admitted to the Hospital and then transferred to the distinct part unit or vice versa.
4. Rehabilitation Hospitals and Long-Term Care Hospitals shall not be subject to DRG transfer pricing.

8.300.5.D Payments to Non-DRG Hospitals for Inpatient Services

1. Payments to Psychiatric Hospitals
   a. Inpatient services provided to Medicaid clients in Psychiatric Hospitals shall be reimbursed on a per diem basis. The per diem rates shall follow a step-down methodology. Each step has a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. Criteria for each step are described below:
      i Step 1: day 1 through day 7
      ii Step 2: day 8 through remainder of care at acute level
   b. Hospital rates may be adjusted annually on July 1 to account for changes in funding by the General Assembly and inflationary adjustments as determined by the Medicare Economic Index.
2. Payment to State-Owned Psychiatric Hospitals

   State-owned Psychiatric Hospitals shall receive reimbursement on an interim basis according to a per diem rate. The per diem rate shall be determined based on an estimate of 100% of Medicaid costs from the Hospital's Medicare cost report. A periodic cost audit is conducted and any necessary cost settlement is done to bring reimbursement to 100% of actual audited Medicaid costs.

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

   Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective

adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.
Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

2. Payments to Out-of-Network DRG Hospitals
Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

8.300.7 Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care

GME costs for Medicaid managed care clients shall be paid directly to qualifying Hospitals rather than to managed care organizations (MCOs).

8.300.7.A GME for Medicaid Managed Care – Inpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Medicaid Inpatient GME cost per day for each Hospital that has GME costs in its fee-for-service base rate, excluding State University Teaching Hospitals. Each Hospital's GME cost per day shall be computed when Hospital rates are recalculated each year.
2. MCOs shall provide to the Department Inpatient days by Hospital for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
3. The Medicaid managed care Inpatient days for each Hospital shall be the total of the Inpatient days for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the Inpatient GME reimbursement for each Hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

8.300.7.B GME for Medicaid Managed Care – Outpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's GME cost-to-charge ratio shall be computed when Hospital rates are recalculated each year.
2. MCOs shall provide to the Department Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
3. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per

quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

8.300.8 Disproportionate Share Hospital Adjustment

8.300.8.A Federal regulations require that Hospitals which provide services to a disproportionate share of Medicaid recipients shall receive an additional payment amount to be based upon the following minimum criteria:

1. A Hospital must have a Medicaid Inpatient utilization rate at least one standard deviation above the mean Medicaid Inpatient utilization rate for Hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and
2. A Hospital must have at least two obstetricians with staff privileges at the Hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.
    a. In the case where a Hospital is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the Hospital to perform non-emergency obstetric procedures.
3. Number (2) above does not apply to a Hospital in which:
    a. the Inpatients are predominantly under 18 years of age; or
    b. does not offer non-emergency obstetric services as of December 21, 1987.
4. The Medicaid Inpatient utilization rate for a Hospital shall be computed as the total number of Medicaid Inpatient days for a Hospital in a cost reporting period, divided by the total number of Inpatient days in the same period.
5. The low income utilization rate shall be computed as the sum of:
    a. The fraction (expressed as a percentage),
        i. the numerator of which is the sum (for a period) of
            1) total revenues paid the Hospital for client services under a State Plan under this title and
            2) the amount of the cash subsidies for client services received directly from state and local governments; and
        ii. the denominator of which is the total amount of revenues of the Hospital for client services (including the amount of such cash subsidies) in the period; and
    b. a fraction (expressed as a percentage),
        i. the numerator of which is the total amount of the Hospital's charge for Inpatient Hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (I) (ii) of subparagraph a) of Section 1923 of the Social Security Act, in the period reasonably attributable to Inpatient Hospital services, and
        ii the denominator of which is the total amount of the Hospital's charges for Inpatient Hospital services in the Hospital in the period.
6. The numerator under subparagraph (b)(i) shall not include contractual allowances and discounts.

8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

1. Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a Low Income Payment defined in 10 CCR 2505-10 section 8.903.
2. Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive a Low Income Shortfall payment.
3. The total available funds for the Low Income Shortfall payment equals the percentage of Self Pay Days plus Other Paid Days of those providers who qualify for the Low income Shortfall payment compared to all other Medicaid Inpatient Hospital providers multiplied by the General Fund appropriated by the General Assembly to Safety-Net Provider Payments. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital-specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low-Income Shortfall payment for the specific provider.

8.300.9 Supplemental Inpatient Hospital Payments

8.300.9.A Family Medicine Residency Training Program Payment

A Hospital qualifies for a Family Medicine Residency Training Program payment when it is recognized by the Commission on Family Medicine and has at least 10 residents and interns. The Family Medicine Residency Training Program payment will only be made to Medicaid in-network Hospitals. For each program which qualifies under this section, the additional Inpatient Hospital payment will be calculated based upon historical data and paid in 12 equal monthly installments. The Family Medicine Residency Training Program payment is a fixed amount subject to annual appropriation by the General Assembly.

8.300.9.B State University Teaching Hospital Payment

State University Teaching Hospitals shall receive a supplemental Inpatient Hospital payment for GME costs associated with Inpatient Hospital Services provided to Medicaid fee-for-service and managed care clients. The State University Teaching Hospital payment is calculated based on GME costs and estimated Medicaid discharges using the same methodology as that used to calculate the GME add-on to the Medicaid Inpatient base rate described in 10 CCR 2505-10 Section 8.300.5.A.3.c., and the GME payments to Hospitals for Medicaid managed care described in 10 CCR 2505-10 Section 8.300.7. The State University Teaching Hospital payment is a fixed amount subject to annual appropriation by the General Assembly.

8.300.10 Patient Payment Calculation for Nursing Facility Clients Who are Hospitalized

8.300.10.A When an eligible client is admitted to the Hospital from a nursing facility, the nursing facility shall, at the end of the month, apply all of the available patient payment to the established Medicaid rate for the number of days the client resided in the nursing facility. The nursing facility shall notify the county department of any amount of patient payment that applies, using form AP-5615. An allowed exception to the usual five (5) day completion requirement is that the AP-5615 for

hospitalized clients may be completed at the end of the month. If the nursing facility has calculated an excess amount, the county will notify the Hospital of the amount. If directed by the county department, the nursing facility shall transfer the excess amount to the Hospital and this payment will be shown as a patient payment when the Hospital submits a claim to the Medicaid Program.

8.300.10.B The Hospital is responsible for collecting the correct amount of patient payment due from the client, the client's family, or representatives. Failure to collect patient payment, in whole or in part, does not allow the Hospital to bill Medicaid for the patient payment.

8.300.11. Payment for Hospital Beds Designated as Swing Beds

8.300.11.A Swing Bed Payment Rates

1. Payment for swing-bed services will be made at the average rate per client day paid to Class I nursing facilities for services furnished during the previous calendar year.
2. Oxygen provided to swing-bed clients shall be reimbursed as specified in 10 CCR 2505-10, Sections 8.580 and 8.585.
3. Clients shall be required to contribute their patient payment to the cost of their nursing care. Collection as well as determination of the patient payment amount shall be in accordance with 10 CCR 2505-10, Section 8.482.

8.300.11.B Swing Bed Claim Submission

1. Hospitals shall submit claims for swing-bed routine services as nursing facility claims.
2. Ancillary services (services not required to be provided by nursing facilities participating in the Medicaid program within their per diem rate, but reimbursable under Medicaid, including but not limited to laboratory and radiology) shall be billed separately on the appropriate claim form.

8.300.12 Utilization Management

All participating in-network Hospitals are required to comply with utilization management and review, program integrity and quality improvement activities administered by the Department's utilization review vendor, external quality review organization or other representative.

8.300.12.A Conduct of Reviews

1. All reviews will be conducted in compliance with 10 CCR 2505-10, Sections 8.076, Program Integrity, and 8.079, Quality Improvement.
2. Reviews will be conducted relying on the professional expertise of health professionals, prior experience and professional literature; and nationally accepted evidence-based utilization review screening criteria whenever possible. These criteria shall be used to determine the quality, Medical Necessity and appropriateness of a health care procedure, treatment or service under review.
3. The types of reviews conducted may include, but are not limited to the following:
    a. Prospective Reviews;
    b. Concurrent Reviews;
    c. Reviews for continued stays and transfers;
    d. Retrospective Reviews.
4. These reviews, for selected Inpatient or Outpatient procedures and/or services, shall include but are not limited to:
    a. Medical Necessity;

b. Appropriateness of care;
c. Service authorizations;
d. Payment reviews;
e. DRG validations;
f. Outlier reviews;
g. Second opinion reviews; and
h. Quality of care reviews.

5. If criteria for Inpatient hospitalization or outpatient Hospital services are not met at any point in a hospitalization (i.e., at the point-of-admission review, Continued Stay Review or Retrospective Review) the provider will be notified of the finding.
   a. When appropriate, payment may be adjusted, denied or recouped.
6. When the justification for services is not found, a written notice of denial shall be issued to the client, attending physician and Hospital. Clients and providers may follow the Department's procedures for appeal. See 10 CCR 2505-10 Sections 8.050, Provider Appeals, and 8.057, Recipient Appeals.

8.300.12.B Corrective Action

1. Corrective action may be recommended when documentation indicates a pattern of inappropriate utilization or questionable quality of care.
2. If corrective action does not resolve the problem, the Department shall initiate sanctions, as set forth in 10 CCR 2505-10, Section 8.076.
3. Retrospective Review may be performed as a type of corrective action for an identified Hospital or client.

8.300.12.C Prior Authorization of Swing-Bed Care

Care for Medicaid clients in hospital beds designated as swing beds shall be prior authorized and subject to the Continued Stay Review process in accordance with the criteria and procedures found in 10 CCR 2505-10, Sections 8.393 and 8.400 through 8.415 . Prior authorization requires a level of care determination using the Uniform Long Term Care 100.2 and a Pre-Admission Screening and Resident Review (PASRR) screening.

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.300

10 CCR 2505-10 8.300

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

8.300 HOSPITAL SERVICES

.10 Hospital services are a benefit of the Medicaid Program and Include those items and services which are ordinarily furnished by a hospital for the care and treatment of inpatients provided under the direction of a physician.

Inpatient hospital services are a benefit under the Modified Medical Program.

.11 Inpatient hospital services which are defined as experimental by the Medicare program are not a benefit of the Medicaid Program.

.12 Inpatient hospital services which are not a covered benefit of the Medicare program are not a benefit of the Medicaid Program.

.13 For Medicaid approved benefits, Medicare patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities.

.14 For Medicaid approved benefits, patients (having Medicaid primary coverage) may receive treatment at any participating Colorado Medicaid hospital facility.

.15 The Peer Review Organization (PRO) may evaluate medical data related to benefit coverage for conformance of benefits to community medical standards. The Department may approve PRO recommendations for modifications to benefit coverage.

.16 The published standards of the Department of Health and Human Services which comprise the Medicare benefits and exclusions described above are based upon 42 USC 1395y, 42 CFR Part 409, and the Medicare Intermediary Manual/Claims Processing/Part 3. No amendments or later additions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Foundation for Medical Care

P.O. Box 173001260 S. Parker Road

Denver, Colorado 80217-0300

or

Manager, Health and Medical Services

Colorado Department of Social Services

1575 Sherman Street

Denver, Colorado 80203

Reimbursement for surgical procedures will be subject to the stipulations set forth in the reimbursement for surgery section.

.20 Acute inpatient hospital psychiatric care is a benefit of the Medicaid Program for eligible

recipients when provided as an integral service of a participating Medicaid general hospital. Acute inpatient hospital psychiatric care is a benefit of the Modified Medical Program.

.30 Psychiatric hospital services are reimbursed by the methodology established in 8.374. Such services, except as described herein, are limited to forty-five (45) days per State fiscal year and include:

A. bed and board, including special dietary service, in a semi-private .room to the extent available;

B. professional services, including those of physicians, physical therapists, either voluntary or paid hospital employees, interns, residents, or other physicians in training in the hospital and general nursing services;

C. laboratory services, therapeutic or diagnostic services involving use of x-ray, radium or radioactive isotopes, emergency room, drugs, whole blood or equivalent quantities of packed red cells, medical supplies, equipment and appliances as related to care and treatment of a psychiatric diagnosis in the hospital.

The forty-five (45) day limit shall not apply to clients who are receiving psychiatric hospital services as a result of a court order requiring the psychiatric hospital services.

8.301 HOSPITAL DEFINITION

A hospital is an institution which:

A. is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the purpose of medical diagnosis, treatment, and care of an injured, disabled, or sick person;

B. is not primarily established for the care and treatment of mental diseases;

C. is licensed by the Colorado Department of Health, and is approved as meeting the standards established for such licensing;

D. is qualified to participate under Title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation.

8.302 MEDICAID PARTICIPATING HOSPITAL: REQUIREMENTS

To be a participating hospital in the Medicaid Program, an institution must:

A. be certified for participation under the Medicare Program;

B. for non-PPS providers, have in effect a negotiated prospective reimbursement rate with the Department, see 8.350, et seq.;

C. have an approved Application for Participation with the Department;

D. a hospital located outside of Colorado which is more accessible to Medicaid clients who require inpatient hospital services than a hospital within the State, can provide services to Colorado Medicaid clients. The Office of Medical Assistance will be free to make the proximity determination. For inpatient services, these hospitals will be paid the average Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services. For outpatient services, these hospitals will be paid 70% of billed charges. Consideration of additional benefit will be made on a case by case basis in accordance with the supporting documentation submitted by the out-of-state hospital; or

E. a Qualified Indian Health Services hospital located outside the State of Colorado may apply for recognition as a provider under Colorado's Medicaid Program. This is pursuant to Public Law No. 94-437, the Indian Health Care Improvement Act, which makes 100% federal financial participation available for payment of inpatient hospital services, outpatient hospital services and emergency transportation to persons who are Indians with a legal tribal affiliation and who are eligible to receive Colorado Medical Assistance benefits. Reimbursement shall be in accordance with the Colorado Title XIX approved State Plan except where insufficient cost data is available in which case payment shall be in accordance with the requirements of the Office of Management and Budget.

Institutions which fail to meet the above requirements shall be eligible to provide emergency hospital services under the Medicaid Program, and shall be classified as non- participating Medicaid Hospitals. Inpatient payment shall be 90% of the Colorado urban or rural DRG payment rate. Outpatient services shall be paid at 60% of billed charges.

8.303 EMERGENCY CARE

Emergency care is defined as a medical condition (including active labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: (a) Placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Emergency care services are exempt from Primary Care Provider referral.

Medical Screening Examination is defined as screening of sick, wounded, or injured persons in the emergency room to determine whether the person has an emergency medical condition. An appropriate medical screening examination (including ancillary services routinely available to an emergency treatment facility) must be available to any individual who comes to the emergency treatment facility for examination or treatment of a medical condition and on whose behalf the examination or treatment is requested.

Disputed Denial: A disputed denial occurs when an authorization for treatment or coordination of care is denied by the primary care provider or a non-physician provider under the PCP's supervision and the emergency physician disagrees with the PCP or non-physician provider's clinical assessment or decision about the recipient's clinical management.

The recipient must return to his/her PCP for further treatment, follow up, referral (if necessary) or other medical services.

Claims submitted for medical screening examination or emergency services, as defined above, do require an emergency indicator code, but do not require a referral from the Primary Care Provider to assure reimbursement.

If an emergency treatment facility or licensed medical professional has made an attempt to contact the primary care provider to coordinate medical care and the primary care provider has not returned the call within 30 minutes, it shall be documented in the patient's medical record, and the Managed Care Hotline shall be notified that the primary care provider failed to return the call.

All claims submitted without the proper primary care physician referral will be denied unless documentation is available demonstrating the primary care physician was unavailable to obtain the proper referral.

Any claim submitted as an emergency care service when non-emergent care was provided is subject to payment recovery.

A claim may be submitted for emergency services when there is a disputed denial. The Managed Care Hotline must be notified when a disputed denial occurs. Any claim submitted as a disputed denial is subject to review by the Department, the Department's peer review organization and may result in payment recovery.

~~8.304 SURGERY BENEFITS~~

~~Reimbursement for surgery will be authorized upon certification by the attending physician that surgical treatment is medically necessary at that time. Surgeries are medically necessary at that time if delay could reasonably result in placing the client's health in jeopardy, deterioration in the person's condition or causing other serious medical consequences and/or serious impairment of bodily functions. This will apply to inpatient and outpatient settings. This regulation is effective for surgeries provided during the time period February 15, through June 30, 1988.~~

~~8.305 NON-PARTICIPATING HOSPITALS~~

~~A non-participating hospital is a hospital which does not meet the requirements of 8.302, above. A non-participating hospital may receive payment for inpatient hospital services if:~~

~~A. the services meet the definition of emergency care;~~

~~B. the services are covered benefits under the Medicaid Program;~~

~~C. the hospital agrees on an individual case basis not to charge the recipient, or the recipient's relatives, for items and services which are covered benefits of the Medicaid Program, and to return any monies improperly collected for such covered items and services.~~

~~8.310 INPATIENT HOSPITAL SERVICES~~

~~8.311 EXTENT OF INPATIENT HOSPITAL SERVICES~~

~~.10 All Medicaid clients admitted to a participating Medicaid hospital pursuant to the provisions of 8.312, et seq., may receive inpatient hospital services (as described in 8.300) for as many days as determined medically necessary by the client's attending physician and by the PRO for the duration of the client's Medicaid eligibility.~~

~~.20 A Colorado non-participating hospital shall be considered a participating hospital only when the services provided to a Medicaid client qualify as emergency services (see 8.303), and they have contacted the Medicaid Program to obtain a provider number.~~

~~.30 Hospitals located outside Colorado shall be deemed participating hospitals for purposes of providing services to eligible clients who require emergency services while temporarily absent from Colorado (or in the case of PRO prior authorization approval per Departmental policy), if said hospital meets the definition of a hospital in 8.301.~~

~~.40 The primary source of payment for a Medicaid client who has health or other insurance covering all or any part of the costs for inpatient hospital services shall be such insurance. In such instances, Medicaid will be the payor of last resort.~~

~~For Medicaid clients who are eligible for Title XVIII (Medicare) benefits, the inpatient hospital services benefit shall run concurrently with Medicare benefits. When Medicare benefits are exhausted and a medical need remains for inpatient hospital services, Medicaid will provide payment for continued inpatient hospital services as a benefit, provided the continuing need for medical services meets criteria for approval.~~

~~8.312 INPATIENT HOSPITAL ADMISSIONS/REVIEW OF MEDICAL NECESSITY OF SERVICES~~

~~.10 To establish administrative controls and procedures on the expenditure of allocated (Medicaid) funds for clients' hospital services, and to meet the requirements of Section 1903(i)(4) of Title XIX of the Social Security Act, the following procedures govern review of medical necessity for hospital services, length of stay for inpatient admissions, and the care delivered in non-hospital settings.~~

.11 All participating hospitals shall participate in the Hospitalization Review Program administered by a Professional Review Organization (PRO).

.12 The Hospitalization Review Program conducted by the PRO may include (but not be limited to):

A. Preadmission review for inpatient admissions selected by frequency and intensity of services;

B. Admission and Continued stay review for selected Non-Prospective-Payment System (Non-PPS) inpatient admissions;

C. Second opinion review for selected inpatient and outpatient procedures;

D. Prior authorization for selected inpatient and outpatient procedures, and elective out-of-state treatment;

E. Retrospective admission and continued stay review of non-PPS admissions. Retrospective admission, DRG validation, and quality of care review of Prospective Payment System (PPS) admission;

F. A random sample of day outliers, readmissions, and transfers on a retrospective basis; and,

G. Quality review for HMO facilities.

8.313 REVIEW OF ADMISSION AND CONTINUED STAY

.10 Effective July 1, 1993, the PRO shall initiate admission and continued stay review in selected non-PPS hospitals subject to departmental approval. The PRO may deny inpatient days, not meeting acute care, rehabilitation care or psychiatric criteria, concurrently or retrospectively.

.11 The hospital, after PRO notification of intent to perform continued stay review, shall be responsible for notifying the PRO of a Medicaid client's admission to the hospital. This notification shall occur on the day of admission, or if the admission is not on a scheduled review day of the PRO, on the first scheduled review day following the client's admission.

.12 The PRO shall examine the medical record and compare the documentation in the record against the appropriate PRO approved hospitalization criteria.

.13 If criteria for hospitalization are not met at any point in the hospitalization (i.e., at the point of admission review or continued stay review) the PRO may cause payment for hospitalization to be denied.

A. When a court-ordered psychiatric inpatient admission does not meet the medical necessity criteria established for Psychiatric Acute Care by the PRO, such stay may be denied by the PRO Physician Advisor (PA).

B. When a court-ordered psychiatric inpatient admission is denied by the PRO PA, the provider shall submit the type of bill as an outpatient claim in order to recover ancillary costs. The billing claim form will reflect the denied admission days as "non-covered days" and will be reimbursed at the prescribed outpatient rate.

.14 During continued stay review prior to issuing a denial of admission or continued hospitalization the PRO shall attempt to contact the attending physician and discuss the need for hospitalization. The PRO decision shall be based on documentation contained in the

medical record.

.15 The documentation shall, at a minimum, meet all guidelines required under 42 C.F.R. Part 466, Part 473 and Part 476 (1992). The Department may fulfill these requirements or parts thereof through contract with the designated professional standards review organization as allowed under 42 C.F.R. 431.630, October 1992 edition. No amendments or later editions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following address, or may be examined at any State Publications Depository Library.

Manager, Office of Medical Assistance Colorado Department of Health Care Policy and Financing 1575 Sherman Street, Denver, Colorado 80203.

Documentation shall be sufficient to substantiate the nature and extent of services provided.

8.314 RETROSPECTIVE REVIEW

.10 Retrospective review will be performed on a sample basis following the client's discharge from the hospital. Retrospective review will determine if the care provided was medically necessary, of adequate medical quality, and if the billing information provided to the fiscal agent was accurate.

Retrospective review may result in all or part of the stay being denied, and/or may affect the DRG assignment for the hospital stay. Retrospective review may result in recovery of all or part of the payment for a hospital stay. At the time of post-payment retrospective denial, the PRO will inform the provider that the Department will make an adjustment to recover the payment.

In the case of outliers (i.e., hospital stays exceeding a predetermined number of days), retrospective review may result in the denial of all or a portion of outlier days.

.11 Retrospective review may be performed for the purpose of monitoring physician or hospital utilization patterns or it may be performed as as type of corrective action for an identified problem provider or client.

8.315 PREADMISSION REVIEW

.10 Preadmission review may be conducted for elective rehabilitation hospital and rehabilitation distinct part unit admissions. The preadmission review process requires that at least 7 days prior to admission to the hospital, the client's attending physician shall contact the PRO and initiate a request for preadmission authorization. The attending physician shall contact the PRO and describe the client's condition. The coordinator shall review the information provided by the attending physician. If criteria for admission are met, the admission shall be approved by the PRO. The PRO shall notify the attending physician, the client, and the hospital in writing regarding the result of the review.

.11 If criteria for hospitalization are not met, the PRO review coordinator shall refer the case to the PRO physician reviewer who shall review the documentation obtained and make a determination as to medical necessity for admission. The physician reviewer may contact the attending physician to discuss the case prior to issuing a denial notification. If an approved PRO preadmission review form is not available in the hospital admission office for any admission requiring preadmission review, and the admission is not specified as an emergency by the attending physician, the client shall be admitted at the financial risk of the hospital and physician.

.12 Preadmission denial, or failure to obtain preadmission approval, may result in recovery of payment(s) made to the hospital and/or physician. Denial of payment may also result if the review did not occur when specified or if the information provided for review was not accurate.

8.316 SECOND OPINION REVIEW

.10 Subject to Departmental approval, the PRO shall provide a second opinion review program for selected procedures. The hospital and/or physician shall be advised in advance of such required review. The second opinion process requires the client's attending physician to obtain a second opinion confirming medical necessity for the selected procedure (on either an inpatient or outpatient basis) in order for payment to be made by Medicaid to the physician and/or the hospital. Providers shall be advised of selected procedures by Medicaid Bulletin. Providers will be notified of changes in selected procedures. Whenever feasible, this notification will occur 60 days prior to the effective date of review.

.11 Second opinion review may be performed in conjunction with preadmission review or independent of preadmission review.

.12 Physicians wishing to schedule one of the selected procedures shall contact the PRO at least 2 weeks prior to the performance of the procedure. A PRO review coordinator shall review documentation from the physician to determine whether criteria for performance of the procedure are met. If criteria are not met then one of the following shall occur:

A. Review coordinator shall contact the client and provide him/her with the name(s) of physicians who shall be willing to provide a second opinion as to the medical necessity of the procedure and shall advise the attending physician of this action; or

B. Review coordinator shall refer the case to a physician reviewer for reviewer for consideration of the medical necessity of the procedure.

.13 If a second confirming opinion is not obtained prior to the procedure being performed, and after review the procedure is found to be medically unnecessary, the Department will recover payment for that procedure and notify the provider. A Notice of Denial shall be provided to the client by PRO.

.14 Documented emergency cases are exempted from this requirement.

8.317 PRIOR AUTHORIZATION REVIEW

.10 Effective March 1, 1992, prior authorization review shall be performed by the PRO for all inpatient elective (non-emergent) care occurring out- of- state, all covered transplants (except corneal or kidney) or when extraordinary elective treatment and/or procedures are identified by the department. Hospital treatment and procedures requiring prior authorization are listed in provider bulletins. All documented emergency cases, regardless of location, are exempt from prior authorization, but are subject to PRO retrospective review.

.11 The provider (not the client) shall contact the PRO by telephone, or in writing, and provide information required by the PRO concerning the patient's medical condition. Subsequent to the initial contact with the PRO, the provider shall also submit any additional information required to complete the prior authorization process.

.12 When a request for prior authorization is received by the PRO, the registered nurse review coordinator (RNRC) shall conduct the prior authorization review, utilizing established PRO review screening criteria described in 8.317.15. The RNRC will have one working day to respond to the provider (physician or hospital) if the screening guidelines are met and the requested treatment/procedure is approved. If screening guidelines are not met, the RNRC must refer the case to a PRO physician reviewer (PR), who will conduct an independent medical evaluation, based on his/her professional medical knowledge and experience, and make a final determination. If PR review is required, the PRO shall have a maximum of five working days to respond to the provider.

.13 When the prior authorization request is for out-of-state elective care or for covered transplants, the PRO shall notify the provider and the client of the determination within the same specifications for timeliness referred to in 8.317.12. For extraordinary elective treatment and/or procedures identified by the Department, the PRO shall send notification to the Department within five working days. The Department will then notify the provider and the client by telephone or by placing written notice in the mail no later than two days after notification is received from the PRO.

.14 The prior authorization reconsideration and formal appeal process for clients is described in 8.318.15. Provider appeals are addressed in 8.318.16 and in 8.050, Provider Appeals.

.15 PRO REVIEW CRITERIA

A state plan for medical assistance shall provide such methods and procedures as are necessary to guard against unnecessary utilization of care. For this purpose, the State is required to contract with a federally approved utilization and quality control peer review organization (PRO). (Stipulations of the Social Security Act - Section 1902(a)(30((A), (B), (C)). No later amendments to or editions of the Social Security Act are incorporated. Copies of these standards or portions thereof are available for public inspection during normal business hours and will be provided at cost from the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

PRO review screening criteria are developed by health professionals relying on professional expertise, prior experience, and the professional literature. These criteria are used to determine the quality, medical necessity, and appropriateness of a health care procedure, treatment or service under review. (Title 42 CFR, Part 466, Subpart A.) No later amendments to or editions of Title 42 CFR are incorporated. Copies of these standards or portions thereof are available for public inspection during normal business hours and will be provided at cost from the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

The PRO shall maintain review criteria development committees for the purpose of revising and/or developing review screening criteria to be utilized for the approval or denial of specific Medicaid benefits. Any new or revised criteria must be approved by the PRO Board of Directors, and shall be reviewed on an approximately yearly basis to assure continuing appropriateness. The Department shall also evaluate and approve all criteria used in the review of Medicaid services.

8.318 ADMINISTRATIVE DENIAL AND APPEAL PROCEDURES

.10 DENIAL AS A RESULT OF PREADMISSION AND PRIOR AUTHORIZATION REVIEW

A denial notification shall be issued by the PRO if justification for admission is not indicated from the documentation provided by the attending physician. A denial notification shall be provided to the attending physician and the client, which shall include the reason for the determination; a statement informing the parties and their representatives of their right to appeal the denial; the location, procedure, and time frame for filing an appeal request; and, a brief statement concerning the duties and functions of the PRO under the act.

.11 DENIAL AS A RESULT OF CONTINUED STAY REVIEW

During continued stay review a denial decision may not be made unless the PRO has made a reasonable attempt to contact the client's attending physician to discuss the review in question. If the PRO makes the decision to deny medical necessity of either admission or continued stay, the PRO shall provide a written notice of denial of Medicaid payment to the client (or next of kin, guardian, or sponsor, if the client is expected to be unable to comprehend the notice) to the

attending physician or other attending health care practitioners, the hospital, and the Department. The notice shall include the reason for the denial, the date after which the stay in the hospital will not be approved as being medically necessary or appropriate, and those items specified under 8.318.10 above.

.12 DENIAL AS A RESULT OF RETROSPECTIVE REVIEW

A. If upon review of the medical record the PRO physician advisor does not find justification for medical necessity for hospitalization, a Notice of Denial shall be issued to the client, attending physician and the hospital. The notice shall include those items specified under 8.318.10 above.

B. The denial of medical necessity may result in denial and recovery of payment to the hospital and/or the physician. In the case of post-payment restrospective denial, the Department will proceed to recover payment upon notification of the denial decision by the PRO. Payment may be denied if review is being performed as a form of corrective action. The hospital and/or the physician shall not pursue collection from the client for the denied payment.

8.318.13 DENIAL AS A RESULT OF ADMINISTRATIVE ERROR

If a provider does not comply with the PRO request to provide required medical information within 30 calendar days, the claim will be denied and the provider will have an additional 30 calendar days to provide the required information. If after 60 calendar days the required information is not received, the PRO will notify the Department. Upon receiving this notice the Department will initiate recovery of payment and notify the provider.

.14 DENIAL AS A RESULT OF BILLING ERROR

During retrospective review, when the PRO identifies a billing error which has resulted in incorrect payment, the PRO will notify the provider that the Department will correct the billing information and adjust the payment.

.15 APPEALS OF PRO REVIEW DECISIONS

A. PRO Reconsideration Process

1. The reconsideration process available through the PRO is the first step in filing a formal client appeal. The client or his/her representative may initiate the process by contacting the PRO office. The attending physician or the hospital may appeal on the client's behalf. If the request for reconsideration is made within 24 hours or one working day of the issuance of the denial of admission or continued stay, and the client remains hospitalized, the PRO shall complete the reconsideration process within 24 hours of request.

2. The reconsideration process shall consist of an independent review of the medical record by one or more peer physicians who were not involved with the original denial decision.

3. Parties to the denial as stated above shall be notified verbally by PRO of the results of the reconsideration process. This shall be followed by a written notification.

B. Formal Client Appeal

1. A second step is available in the client appeal process, if the patient is dissatisfied with the decision of the PRO reconsideration panel. The patient or his/her

representative may appeal to (the State Department of) General Support Services for a fair hearing before an independent State Administrative Law Judge. Appeals of prior authorization, preadmission or continued stay denials may be filed by the attending physician or the hospital only on behalf of the patient, as formal client appeals, and shall not duplicate appeals filed by the patient. A written request must be made to General Support Services of Administration within 60 calendar days of the date of the PRO reconsideration panel notification. This written request may be filed with either:

a. the PRO following instructions contained in the notification documents; or

b. directly with General Support Services, Division of Administrative Hearings.

The PRO shall forward said appeal to General Support Services, Office of Administrative Courts, for hearing pursuant to Section 24-4-105, C.R.S.

2. The Administrative Law Judge shall conduct the hearing as provided in Section 8.058, STATE HEARINGS. S/he shall prepare and enter an Initial Decision which the State Department shall serve upon each party. The Office of Appeals of the State Department, as designee of the Executive Director, shall review the Initial Decision and enter a Final Agency Decision affirming, modifying, reversing, or remanding the Initial Decision.

If the Final Agency Decision is adverse to the patient, he/she, or his/her representative, shall have a right to judicial review pursuant to Section 24-4-106, C.R.S.

8.318.16 APPEAL OF RETROSPECTIVE DENIALS (PROVIDER APPEALS)

If payment to the provider for covered services rendered to an eligible client is denied due to failure to comply with provisions of the Medical Assistance Program, law and/or appropriate rules, the provider is precluded from collecting payment from the Medicaid client (8.012 Prohibition of Charges to Recipients). Federal regulations at Title 42 CFR Section 447.25, Acceptance of State Payment. No later amendments to or editions of 42 CFR Section 447.25 are included. Copies are available for public inspection during normal business hours and will be provided at cost upon request to the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

.17 DISCHARGE PLANNING

The PRO may perform such services as may be appropriate to assist the attending physician and the participating hospital in identifying, at the earliest reasonable opportunity during the eligible person's hospital stay, situations which may require discharge planning, and in planning for the eligible person's health needs after discharge, including but not limited to the recommendation of appropriate post-hospital accommodations.

.18 SELECTION OF REVIEW METHODOLOGY

The PRO, with Department approval, is responsible for determining the review methodology to be used for specific providers or specific procedures, and shall notify providers accordingly.

8.318.19 CORRECTIVE ACTION

A. Corrective action shall be recommended when documentation is presented which indicates a chronic problem of inappropriate utilization or questionable quality of care. A decision

regarding whether corrective action should be initiated shall then be made.

B. Corrective action may include, but is not limited to: provider education, intensified review, required consultation, mandatory preadmission review, second opinion review, and retrospective review. The provider, and the client, when appropriate, shall be notified when corrective action is to be initiated.

Satisfactory resolution of the identified problem shall result in the corrective action being lifted. If corrective action does not result in resolution of the problem, sanction activity shall be initiated, as defined under the fraud and abuse section of the rules.

.20 AGENCY RECONSIDERATION

The Department may require the PRO to reconsider an initial review decision resulting in either approval or denial. In the case of a request for reconsideration the Department shall communicate the request within 15 working days of the review decision. Upon receipt of the Department's direction to reconsider, the PRO will convene a reconsideration panel to perform an independent review of the medical record by peer physicians who were not involved with the original decision. The PRO will communicate the findings of this reconsideration review to the attending physician, the hospital (if necessary), the client, and the Department within 15 working days of the request.

8.319 HOSPITALIZATION AND EXTENSIONS CONCERNING NEWBORN INFANTS

Medical assistance payments on behalf of the newborn shall extend only for the period of the mother's hospitalization with a single exception; that medical necessity exists for the infant to remain hospitalized. In such cases, the hospitalization for the infant certification and approval for additional days of hospital care, and to the infant's own eligibility for medical assistance following the mother's discharge.

Continued stay of healthy newborns for any other reason after the mother's discharge is not a benefit under the medical assistance program.

8.320 DIALYSIS

The Colorado Medical Assistance Program will provide payment for dialysis treatments to individuals who have established eligibility for public assistance purposes in Colorado. Such individuals must be eligible in all respects under the provisions of 8.100, et seq.

8.321 INPATIENT HOSPITAL (ACUTE DIALYSIS)

Payments may be made to licensed participating hospitals for the provision of dialysis treatments to an eligible recipient who is an inpatient of the hospital only in those cases where hospitalization is required for:

A. An acute medical condition for which dialysis treatments are required; and

B. Any other medical condition for which the Medical Assistance Program provides payment when the eligible recipient receives regular maintenance treatment on an outpatient dialysis program; and

C. Placement or repair of the dialysis route ("shunt", "cannula").

8.322 OUTPATIENT DIALYSIS

Outpatient dialysis treatments are a benefit of the Medical Assistance Program when provided by a separate unit within a hospital or a free standing dialysis treatment center approved for participation by the Colorado State Department of Health Care Policy and Financing. A dialysis treatment center is defined as a health institution or a department of a licensed hospital, which is

planned, organized, operated and maintained to provide outpatient treatment by means of dialysis and/or training for home use of dialysis equipment. Other conditions of participation are those entered into specifically in the agreement with the Department of Health Care Policy and Financing (Department).

.10 AUTHORIZATION FOR OUTPATIENT DIALYSIS

No payments shall be made on behalf of eligible recipients for the provision of outpatient dialysis treatments unless a physician licensed to practice in the State of Colorado certifies the medical need for regular chronic dialysis treatments exists.

Dialysis treatment centers or free-standing dialysis units shall permit the Department to review any records for Medicaid patients upon request.

.11 Payments for Medicaid outpatient dialysis shall continue when documentation certifies that outpatient dialysis treatment must continue because:

A. training of the eligible recipient to perform self-treatment in the home environment is contraindicated; or,

B. the eligible recipient is not a proper candidate for self-treatment in a home environment; or,

C. the home environment of the eligible recipient contraindicates self-treatment; or,

D. the eligible recipient is awaiting a kidney transplant.

8.323 HOME (CHRONIC DIALYSIS)

The high costs of dialysis treatments and the budgetary limitations of the Medicaid program require that all Medicaid patients be considered for the most cost efficient method of dialysis based upon their individual medical diagnosis and condition. Such treatments include home dialysis and peritoneal methods of dialysis.

The participating separate dialysis unit within a hospital or free-standing dialysis treatment center shall be responsible for the maintenance of all equipment and necessary fixtures required for home dialysis and provisions of all supplies.

8.324 PAYMENT FOR DIALYSIS TREATMENTS

.10 INPATIENT HOSPITAL

Payment for inpatient hospital dialysis treatment shall be included as part of the DRG rate.

.20 OUTPATIENT AND HOME TREATMENT

Any facility providing regularly scheduled outpatient or chronic dialysis treatments at a free-standing facility or billing for supplies necessary to perform the various types of home dialysis treatments shall apply for a separate Medicaid provider number from the fiscal agent. Such provider number shall be designated solely for the purpose of claims submission for dialysis services.

The amount of payment for regularly scheduled routine outpatient dialysis or necessary supplies to perform home dialysis treatments, when provided by a separate unit within a hospital or a free standing dialysis treatment center approved for participation by the Colorado State Department of Health Care Policy and Financing, shall be based on the lesser of the unit's specific Medicare rate or the Medicare composite rate ceiling.

The amount of payment for non-routine outpatient dialysis treatments, when provided by a separate unit within a hospital or free-standing dialysis treatment center, shall be based upon the

Medicaid fee schedule.

There is no reimbursement for home dialysis, only for supplies necessary to accomplish home dialysis.

8.325 REIMBURSEMENT FOR ALL ROUTINE AND NON-ROUTINE ANCILLARY DIALYSIS SERVICES

Ancillary services performed as part of the routine dialysis treatment shall be considered as part of the composite rate and billed on the UB-92 claim form.

Non-routine ancillary services performed outside the dialysis treatment shall be reimbursed separately and billed on the Colorado 1500 claim form. This claim form requires the provider use the appropriate HCPCS codes designated for the service provided.

8.325.10 Laboratory Services

All routine laboratory services performed by a dialysis treatment facility, with the designation as a certified clinical laboratory, or as a certified independent laboratory are included as part of the dialysis treatment reimbursement. All routine tests must be performed by the facility, with designation as a certified clinical laboratory, and reimbursed as part of the composite rate or performed by a certified independent outside laboratory and billed to the facility performing the dialysis treatment.

The following required procedures constitute routine laboratory services that are considered medically necessary. These laboratory tests are included as part of the dialysis service reimbursement.

Per Treatment

Hematocrit

Weekly

Prothrombin time for patients on anti-coagulant therapy

Serum Creatinine

BUN

Monthly

HCT

Hgb

Dialysate Protein

Alkaline Phosphatase Magnesium

CBC Sodium

LDH

Potassium

Serum Albumin

CO_2 Serum Bicarbonate

Serum Calcium

~~Serum Chloride~~

~~Specimen Collection~~

~~Serum Phosphorous~~

~~Serum Potassium~~

~~SGOT~~

~~Total Protein~~

~~All Hematocrit and Clotting time tests~~

~~Drugs considered part of the routine dialysis treatment:~~

~~Heparin~~

~~Protamine~~

~~Mannitol~~

~~Glucose~~

~~Saline~~

~~Dextrose~~

~~Pressor Drugs~~

~~Antihistamines~~

~~Antiarrhythmics~~

~~Antihypertensives~~

~~Drugs considered non-routine:~~

~~Antibiotics~~

~~Anabolics~~

~~Hematinics~~

~~Sedatives~~

~~Analgesics~~

~~Tranquilizers~~

~~Muscle Relaxants~~

~~Nonparenteral items may not be billed separately by the dialysis center, but may be billed directly to Medicaid by the supplier. Nonparenteral items administered during the dialysis treatment are reimbursed as part of the composite rate.~~

~~8.330 OUTPATIENT HOSPITAL SERVICES~~

~~Outpatient hospital services are those diagnostic, therapeutic, rehabilitative, preventive, and palliative items and services furnished by or under the direction of a physician to an eligible person who is an outpatient in a participating hospital. Routine and annual physical examinations are not a benefit of the program unless determined necessary based on medical necessity. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals.~~

Outpatient hospital services are a benefit of the Modified Medical Plan.

8.331 DEFINITIONS

"Outpatient" means a patient who is receiving professional services at a participating hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-a-day basis.

"Diagnostic services" means any medical procedures or supplies recommended by a physician within the scope of his/her practice under state law, to enable him/her to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

"Rehabilitative services" mean any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

"Preventive services" mean services provided by a physician within the scope of his/her practice under state law to: (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and, (3) promote physical and mental health and efficiency.

"Palliative services" mean any medical services recommended by a physician within the scope of his/her practice under state law, for the purpose of affording a recipient relief from the symptoms of a condition or disease.

"Therapeutic services" means any medical service provided by a physician within the scope of his/her practice under state law, in the treatment of disease.

8.332 PAYMENT

Outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare charge to cost ratio percent less 28 percent (28%). When the Department determines that the Medicare cost to charge ratio is not representative of a hospital's outpatient costs, the cost to charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Outpatient hospital services which are defined as experimental by the Medicare program are not a benefit of the Medicaid Program. Outpatient hospital services which are not a covered benefit of the Medicare program are not a benefit of the Medicaid program. Extraordinary situations, based upon PRO recommendation and Department approval, will be reviewed for exception to these benefit limitations.

The published standards of the Department of Health and Human Services which comprise the Medicare benefits and exclusions described above are based upon 42 USC 1395y, 42 CFR Part 409, October 1991 edition, and the Medicare Intermediary Manual/Claims Processing/Part 3. No amendments or later editions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Department of Health Care Policy & Financing

1570 Grant St.

Denver, Colorado 80203

OUTPATIENT CLINICAL LABORATORY TESTS

Medicaid reimbursement for clinical diagnostic laboratory tests performed by certified outpatient hospital clinical laboratories may not exceed 60 percent (60%) of the Medicare prevailing charge fee schedule or the Medicaid fee schedule, whichever is lower.

OUTPATIENT ANATOMICAL LABORATORY TESTS

Outpatient anatomical laboratory tests are reimbursed on an interim basis from the Medicaid fee

schedule. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost, or Medicaid fee schedule.

8.332.10 OUTPATIENT PREPROCEDURE AND PRETREATMENT REVIEW

The purpose of preprocedure review and pretreatment review is to confirm the medical necessity and the appropriateness of the selected outpatient procedures and treatments. The PRO shall provide, upon direction from the Department: 1) a preprocedure review program for selected outpatient surgical, medical and radiographic procedures; and 2) a pretreatment review for planned outpatient psychiatric and substance abuse disorder treatments. Physicians and hospitals shall be advised, in advance of selected procedures and treatments requiring PRO review by Medicaid Bulletin.

The purpose of preprocedure review and pretreatment review is to confirm the medical necessity and the appropriateness of the selected outpatient procedures and treatments. The PRO shall provide, upon direction from the Department: 1) a preprocedure review program for selected outpatient surgical, medical and radiographic procedures; and 2) a pretreatment review for planned outpatient psychiatric and substance abuse disorder treatments. Physicians and hospitals shall be advised, in advance of selected procedures and treatments requiring PRO review by Medicaid Bulletin.

.11 OUTPATIENT PREPROCEDURE REVIEW PROCESS

Upon direction from the Department the preprocedure review process shall involve the following procedures: A physician planning to perform one of the selected outpatient surgical medical and radiographic procedures which requires preprocedure review must contact the PRO at least 2 weeks prior to admission and provide the required information relative to the scheduled procedure. A PRO RN Review Coordinator (RNRC) will review the information from the physician to determine whether or not criteria for the procedure are met. If criteria are met, then the RNRC will confirm the procedure. If criteria are not met, then the following will occur:

A. The RNRC will refer the case to a Physician Reviewer (PR) for consideration of the medical necessity and appropriateness of the planned procedure.

B. If the PR does not confirm the plan of care, then the RNRC will contact the patient and provide him/her with the names of two physicians who are willing to provide a second opinion as to the medical necessity and appropriateness of the planned procedure. If the second opinion physician confirms the procedure, then the review process is complete. The PRO will notify the patient, the attending physician, and the hospital of the outcome of this action.

C. If the second opinion does not confirm the planned procedure, then the patient may request a third opinion. When the request is received, the RNRC facilitates the third opinion as described in the preceding paragraph.

D. If the third opinion confirms the procedure, then the review process is complete. The PRO will notify the patient, attending physician, and the hospital as above. If the third opinion physician does not confirm the procedure, then the review process is complete and the procedure is not confirmed. The PRO will notify the patient, the attending physician, and the hospital.

8.332.12 OUTPATIENT PRETREATMENT REVIEW PROCESS

Upon direction from the Department, the pretreatment review process shall involve the following procedures: A physician planning to treat one of the selected psychiatric or substance abuse disorders in an outpatient setting must contact the PRO within 2 weeks for

approval of the treatment plan and to provide the PRO the required information relative to the current patient status. A PRO RN Review Coordinator (RNRC) will review the information provided to determine whether or not criteria for the planned treatment are met. If criteria are met, then the RNRC confirms the plan for care. If the criteria are not met, then the RNRC will refer the case to a PRO Physician Reviewer who will use his/her best medical judgement to decide whether or not the plan of care is appropriate and demonstrates medical necessity. If he/she agrees with the plan of care, then he/she will approve the planned treatment. If he/she does not agree with the plan of care, then the treatment is denied. The PRO will notify the patient and attending physician of the denial, including the procedure for appeal.

.13 Denial and appeal as a result of outpatient pretreatment review shall be processed as described in 8.318.10 through 8.318.18.

.14 It is assumed that emergency care for the selected psychiatric/substance abuse disorders would be treated in the acute care setting.

.15 OUTPATIENT PREPROCEDURE AND PRETREATMENT REVIEW PAYMENT

Unless specifically approved by the Department, providers will receive NO reimbursement for outpatient claims submitted for payment where appropriate PRO review is not obtained by the facility or when the required PRO review is not documented appropriately.

Documented emergency care is exempt from the second opinion and pretreatment review process. All emergency care may be reviewed retrospectively by the PRO to validate the medical necessity and appropriateness of the procedures or the treatments performed.

8.333 OUTPATIENT PSYCHIATRIC SERVICES

8.333.10 DEFINITION OF OUTPATIENT AND CLINICS

1. Outpatient Psychiatric hospital services mean preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

(a) Are furnished to outpatients;

(b) Are furnished by or under the direction of a physician; and

(c) Are furnished by an institution that:

(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

(ii) Meets the requirements for participation in Medicare.

2. Clinic outpatient psychiatric services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

(a) Are provided to outpatients;

(b) Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

(c) Are furnished by or under the direction of a physician.

8.333.20 EVALUATION

1. Effective September 13, 2002, 10 C.C.R. 2505-10, Section 8.333.10 shall not apply to recipients enrolled in and receiving mental health services through the Mental Health Capitation Program.

2. An intake evaluation for any recipient entering an organized program or course of psychiatric treatment shall be completed. Evaluation is defined as a written assessment that evaluated the recipient's mental condition, and based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate. The evaluation team shall include a physician and an individual experienced in diagnoses and treatment of mental illness. The evaluation team shall certify that the program is appropriate to meet the recipient's treatment needs and shall be made part of the medical records.

3. The evaluation team shall periodically review and update the recipient's Plan of Care (PoC) (as defined in 8.333.30) in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team shall perform such reviews every 90 days and the reviews shall be documented in detail in the patient records, kept on file and made available as requested for State or Federal audit purposes.

   Audits for the purpose of medical necessity for the services rendered shall be conducted by the Department of Health Care Policy and Financing or its designee.

8.333.30 DOCUMENTATION

1. Each recipient receiving outpatient psychiatric services in an outpatient or clinic setting shall have an individual, written, Plan of Care (PoC), designed to improve the patient's condition to the point that participation in the program is no longer necessary. Treatment objectives must be included in the PoC and a description of:

   a. The treatment regimen: The specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives;

   b. A projected schedule for service delivery: This includes the expected frequency and duration of each type of planned therapeutic session or encounter; the type of personnel that shall be furnishing the services; and a projected schedule for completing re-evaluations of the patient's condition and updating the PoC;

   c. Re-evaluations of treatment objectives that shall be scheduled no less than once every six months; and

   d. The written PoC which shall be developed and be entered into the patient's record prior to any billings for service being submitted for reimbursement.

2. The outpatient program shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, shall consist of material which includes:

   a. the specific services rendered;

   b. the date and actual time the services were rendered;

   c. who rendered the services;

d. the setting in which the services were rendered;

e. the amount of time it took to deliver the services;

f. the relationship of the services to the treatment regimen described in the PoC;

g. updates describing the patient's progress.

Clinics that are licensed by Department of Human Services, Mental Health Services are exempt from the above specific documentation standards and shall be required to adhere to the documentation standards required by the licensing authority. But deviations shall be documented in the medical record. For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC shall be documented in the patient's record. Similarly, a detailed explanation, shall be documented for a medical or remedial therapy session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

If the documentation standards required above are not met, that service is subject to recoupment and/or State and Federal administrative or civil action.

8.333.40 REIMBURSEMENT

Outpatient hospitals and clinics shall bill on the appropriate claim forms to receive reimbursement.

8.340 GRADUATE MEDICAL EDUCATION (GME) AND DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS TO HOSPITALS FOR MEDICAID MANAGED CARE

Effective for inpatient discharges and outpatient dates of service after October 1, 1997. graduate medical education (GME) costs for Medicaid managed care clients shall be paid directly to qualifying hospitals. rather than to managed care organizations (MCOs).

8.341 GME for Medicaid Managed Care - Inpatient Services

.10 The hospital cost report used for the most recent rebasing shall be used to determine the Medicaid inpatient GME cost per day for each hospital that has graduate medical education costs in its fee-for-service base rate. Each hospital's GME cost per day shall be computed when hospital rates are recalculated each year.

.20 MCOs shall provide to the Department inpatient days. by hospital. for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

.30 The Medicaid managed care inpatient days for each hospital shall be the total of the inpatient days for each hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the inpatient GME reimbursement for each hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each hospital by June 30th of each year.

.40 MCOs other than Mental Health Assessment and Services Agencies (MHASAs) shall provide to the Department inpatient days, by hospital, for discharges from October 1, 1997 through December 31, 1997. This data shall be used for the purpose of calculating the GME reimbursement for the first partial year covered under this new methodology. (MHASA days

are not included for this partial period since GME was still included in the payment to MHASAs.) If the MCOs are unable to provide this data by April 30, 1998, the reimbursement will be calculated using one quarter of the MCO inpatient hospital days at each hospital for the 1997 calendar year. This initial inpatient GME payment to hospitals shall be made by June 30, 1998.

8.342 GME for Medicaid Managed Care - Outpatient Services

.10 The hospital cost report used for the most recent rebasing shall be used to determine the outpatient GME cost to charge ratio for each hospital that has a graduate medical education program. Each hospital's GME cost per day shall be computed when hospital rates are recalculated each year.

.20 MCOs shall provide to the Department outpatient charges for Medicaid clients. by hospital. for outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

.30 The Medicaid managed care outpatient charges for each hospital shall be the total of the outpatient charges for each hospital received from the MCOs for each quarter. That total shall be multiplied by 72 percent of outpatient charges to determine the outpatient GME reimbursement for each hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each hospital by June 30th of each year.

.40 MCOs other than MHASAs shall provide to the Department outpatient charges. by hospital. for outpatient dates of service from October 1, 1997 through December 31, 1997. This data shall be used for the purpose of calculating the GME reimbursement for the first partial year covered under this new methodology. (MHASA charges are not included for this partial period since GME was still included in the payment to MHASAs.) If the MCOs are unable to provide this data by April 30, 1998. the reimbursement shall be calculated using one quarter of the outpatient hospital charges at each hospital for the 1997 calendar year. This initial inpatient GME payment to hospitals shall be made by June 30, 1998.

8.350 PAYMENT OF HOSPITAL COSTS FOR NON-PPS PROVIDERS AND UNITS

This section provides the method by which the payment rate for costs of medical care provided by exempt providers to eligible clients shall be determined. This method shall be referred to as "The Hospital Rate System."

In summary, these rules provide that:

a. For exempt (non-PPS) providers, the rate of payment for services rendered during the twelve month period corresponding with the State's fiscal year (7/1 ? 6/30) shall be determined and agreed upon by both the provider and the Department of Health Care Policy and Financing.

b. For exempt (non-PPS) providers, the prospective rates may be established in accordance with the established accounting principles and regulations utilized for the determination of reimbursement to providers as provided for by Title XVIII, with the exception that prospective rather than historic expenses will provide the basis for payment. Title XVIII regulations shall be utilized as guidelines. This method of payment will not exceed that produced under available Title XVIII methods of apportionment of such costs.

c. The establishment of prospective rates shall be supported by current and predicted costs derived through an appropriate budget and accounting system.

d. Absolute and comparative performance measurements shall be based upon the direct costs of patient care which shall include approved research projects and educational activities only. In addition, any comparative evaluations shall reflect the provider's size, geographic location,

and scope of services.

e. In order to provide incentives for the efficient and economical utilization of provider resources, the payment rate agreed upon by provider and the Department of Health Care Policy and Financing shall be neither retroactively increased to reflect unforeseen patient costs nor retroactively decreased as a result of efficient provider operation. However, gains accruing to the provider as a result of a suspension of those patient services which were included in the setting of the prospective rate may be subject to a reduced adjustment.

f. Provision is made for the Department to consider establishing a mechanism for determining emergency adjustments of prospectively determined rates.

g. Provision is made for the Department to consider establishing a mechanism of administrative review of any prospective rate which cannot be agreed upon by the Department of Health Care Policy and Financing and provider.

8.351 METHODS FOR DETERMINING RATES FOR EXEMPT PROVIDERS

.10 As used in this section, 8.351, unless the context otherwise requires, the following definitions shall apply:

(1) "Add-ons" - This consists of a significant increase in a budgeted departmental cost that exceeds the consumer price index (CPI) and which can be justified on the basis of being a new or expanded service, a price increase, or case mix change. It is understood that rate modifiers, as described in the consent decree, are considered to be synonymous with add-ons. Further details regarding add-ons are found in the consent decree.

(2) "Consent Decree" - Settlement of Colorado Hospital Association, et al. v. State of Colorado, et al., D.C. Colorado, 76-F, 140, December 13, 1977. These rules, as modified by the consent decree, are applied in determining rates for Medicaid provider hospital.

(3) "Retroactive" - Increases incurred in years prior to the budget year. Exception: the Department may consider add-ons incurred in the current (most recent contract) year if such expenses were unforeseen and therefore not budgeted. Increases which were budgeted but not requested will not be considered as retrospective add-ons.

(4) "Significant Increase" - An increase in he cost of goods and services over the CPI which results in a minimum increase of $.20 per diem or $2,000 per year in total inpatient Medicaid payment, based on the most recent annual Medicaid days.

.20 The provider shall submit an approved budget which provides the basis for any add-ons requested prior to the submission of same to the Department of Health Care Policy and Financing. All information supplied by provider is deemed to be confidential.

a. The provider's proposed budget shall be submitted 60 days prior to the beginning of the State's fiscal year and shall be accompanied by the add-on request, where applicable. If an approved budget is not available May 1, the provider shall not submit an interim budget. No penalty is imposed for late budget submittal other than a possible delay in the effective date of a new rate. No per diem can be offered until an approved budget is received. The add-on request shall be accompanied by all required documentation. Documentation shall be sufficient to prove the merits of the add-on, including its relation to patient care as defined by Medicare. The Department reserves the right to request any additional information considered necessary to justify the add-on request. Provider shall propose a prospective payment rate for the next operating period. No add-ons requests shall be accepted after August 1.

b. If no add-on requests accompany the approved budget, the Department shall offer the hospital a rate computed by applying the appropriate CPI to the provider's previous contract rate.

The participation agreement shall become effective on the date of receipt by the Department or the beginning of the State's fiscal year, whichever is later.

c. The CPI used shall be the CPI W-U.S. for the 12 month period ending 90 days prior to the beginning of the State's new fiscal year.

d. If add-ons are requested, the two parties can begin negotiations. Should it appear that no agreement can be reached before the beginning of the State's fiscal year, the CPI rate will be offered. When accepted, then a participation agreement for the CPI increase only shall be signed to become effective on the date of signature or the State's fiscal year, whichever is later, and shall remain effective until such time as it is replaced by a participation agreement for a final rate based upon approved add-on requests.

e. Negotiations with respect to add-ons may continue as follows: If there is no agreement with respect to the add-ons within 60 days from the beginning of the State's fiscal year (July 1), the provider shall receive written notice from the Department that it is required to proceed within the scope of the following four options.

(1) Sign a participation agreement for the Department's offer;

(2) File a request for a rate review board hearing. Whatever rate is then decided upon would become effective the date the contract is signed, or such other date, as recommended by the rate review board and approved by the Executive Director.

(3) Continue to negotiate for an additional 20 days (to Sept. 18). A final offer shall be issued by the Department on or before 10 days (to September 28). The provider shall either sign a contract or request rate review. Rate review shall be requested within fifteen (15) days (to October 13). If rate review is requested after October 13 it shall be denied; or

(4) Withdraw from participation in the Medicaid Program.

f. A provider and/or the Department of Health Care Policy and Financing shall be able to request changes in rates when major events that have a fiscal impact occur which were unpredictable or were uncontrollable by the provider and which would require a rate change to meet the financial requirements of the provider.

The Department of Health Care Policy and Financing shall act upon such a request within a thirty-day period after receipt of the request.

g. A possible basis for denial of add-ons includes, but is not limited to: projects which do not foster cost containment and which do not improve patient care, in accordance with Medicare regulations, or projects which would significantly increase a hospital's per diem in excess of that of its peers, or projects which are not required as a medical necessity. Return on equity and increases in hospital property costs caused by re-evaluation of assets are not allowable add-ons. Retroactive issues shall not be considered for add-ons in the prospective budget year.

8.352 REVIEW PROCEDURES CARRIED OUT BY THE DEPARTMENT

Upon receipt of materials from providers, the Department of Health Care Policy and Financing shall:

Review submitted material for completeness and request additional information if necessary.

Review cost components of the rate to determine significant changes, i.e., addition or deletion of departments determine changes in rates resulting from such additions or deletions.

Equate the proposed expenses/rate with prior rate by removing or adding the expenses of the departments in question.

Review the components of the proposed rate. Salary, other supplies and expense, professional fees shall be evaluated for their change as related to appropriate wage and price indices.

Approve the rate if the changes fall within limits defined above.

Review additional information as provided. Approve as a result of extenuating circumstances or disapprove request.

Calculate a counter proposed rate on all rates which are disapproved.

8.353 RATE REVIEW BOARD

.10 The Rate Review Board shall consist of six (6) members who shall be appointed by the Executive Director, Department of Health Care Policy and Financing, and shall serve thereon at the pleasure of said Executive Director. Three of the said six (and three alternate members) members shall be members of the staff of the Department of Health Care Policy and Financing. Three of the said six (and three alternate members) members shall be selected from the membership of the Colorado Hospital Association. The total membership of the Board shall be seven (7) members. Such seventh member (and one alternate for said seventh member) shall be selected by the six above said and duly appointed members from candidates submitted by any such member or any other person making known his desire for such membership.

.20 The principle function of the Rate Review Board shall be to assist the Department of Health Care Policy and Financing in determination of rates to be paid individual hospitals as described and set forth in these rules.

.30 The board also shall function in performing administrative reviews as set forth in 8.354.

8.354 ADMINISTRATIVE REVIEW

A request for rate review board hearing (see 8.351.20) shall necessitate the following steps:

a. The Department of Health Care Policy and Financing shall designate, within a period of thirty (30) days, a date upon which provider may appear before the Department of Health Care Policy and Financing Hospital Rate Administrative Review Board. Such appearance date shall not be later than sixty (60) days following the request for hearing unless otherwise agreed to by the hospital and the Department.

b. The Board shall not consider any evidence of add-on requests that were denied because of noncompliance with the rules of the Department. The Board shall be bound by the rules and regulations of the Department in its deliberations and recommendations to the Executive Director.

c. Provider shall place before the Board evidence it deems to be good and sufficient to warrant purchaser's acceptance of the proposed rate. Department of Health Care Policy and Financing shall, at the same time, state evidence it deems good and sufficient to warrant acceptance of the counter proposal. All review shall be open to the public and shall be conducted informally insofar as an orderly presentation will permit. The Board shall only consider evidence presented or introduced at the review which is within the scope of the rules of the Department. A full and complete record shall be kept of the proceedings. Cost of

attendance shall be borne by the provider.

d. For purposes of conducting reviews, five (5) members of the Board constitute a quorum, one of whom must be the chairman or vice chairman. No Board member shall hear any matter in which he has an interest, nor shall he represent either party at the review. Either Department of Health Care Policy and Financing or the subject provider may challenge any Board member in writing, served upon the Board Chairman five (5) days in advance of any schedule review, and if the Board shall find merit in the challenge, it shall excuse the challenged member.

e. Within hirty (30) days after the review, the Review Board shall render its decision, in writing, to both parties. The rate designated by the Review Board shall be recommended to the Executive Director for his consideration. The Executive Director shall issue a final decision to the provider within thirty (30) days after receiving the Rate Review Board's recommendations. A final offer based on this decision shall be made to the provider within seven (7) days after the decision has been issued. Copies of such decision shall be kept on file by the Board.

f. Department has exclusive right to set rates for hospital vendors. Department may allow vendors to request adjustments in rates as provided herein. The Medical Services Board may, in its discretion, review rates. A vendor has no vested right to participate in the Medicaid program. Any vendor by applying to participate agrees to accept the rate determined after the procedures set out herein, and should he not be able to accept the rates so determined, shall withdraw from participating.. In such an event, if the negotiations have extended into the vendor's new fiscal period, final settlement for services provided during such new fiscal period shall be on the basis of 90 percent of allowed charges.

8.355 FORMS TO BE USED CONCERNING THE PAYMENT RATE FOR HOSPITALS

The instructions set forth in 8.350 - 8.355.10 et seq. are designed to allow Colorado hospitals to prepare an estimate of per diem patient costs in their next fiscal year in accordance with Section 8.351 through 8.355.80.

These instructions are designed to be used by those hospitals which currently do not prepare budgets. They are not complete, in the sense that they do not provide for the budgeting of either patient revenue or capital expenditures, but instead concentrate only upon hospital expenses and adjustment to expenses.

.10 PATIENT DAY STATISTICS

.11 The purpose of this form is to establish a level of service for the hospital's budget year. Specifically, the level of service shall be considered as the number of patient days that are anticipated in the next year.

.12 The form provides for the patient days by month for the current and budget years for up to seven patient categories and nursery. The categories of patient type are neither meant to be all inclusive nor are they meant to be mandatory. No doubt many hospitals do not have their patient statistics kept in this manner. A minimum breakdown of patient days, however, shall be by Nursery and Other.

.13 In the space provided in "Current Year", enter by month the patient days, broken down into as many categories as possible. This information should be available from medical records for the current year through the end of last month. Then, using knowledge of existing medical trends, and both recent and anticipated changes in the community, changes in the hospital facilities, or other items which would affect the level of hospital service, such as seasonal trends, predict by month the number of patient days for the remainder of the current year and for the budget year. The estimate shall be broken into

the same categories as the existing statistics.

.14 Total each column and row ("foot" and "crossfoot").

8.355.20 PAYROLL BUDGET WORKSHEET

.21 This form may be used, if desired, to estimate the amount of the salaries to be paid in the budget year. This form need not be returned to the Department. By Department, list each full-time employee and then each part-time employee. Leave several spaces after each department.

.22 From each employee's earnings record, enter in column 4 the earnings paid to date. From the number of pay periods remaining in the year, estimate each employee's earnings for the rest of the year and enter this in column 5. Be certain to reflect that each employee may have been given a raise or will soon receive one in the calculation of the remaining wages.

.23 If additional employees are to be added before year end, enter their position description in column 2, and in column 3 enter their start date, the number of pay periods they are expected to be employed through the rest of the year, and their expected annual earnings. In column 4, enter the wages to be paid that employee. Place an asterisk by those positions which are new. The cross total of columns 4 and 5 should be placed in column 6.

.24 Total columns 4, 5 and 6.

.25 For each position listed at year end, determine the increases, if any, that will be paid in the budget year. For example, recognize that a $100 merit increase which is due halfway through the year will only cause a $50 increase in earnings. For all positions which have not been newly created this year, add columns 6, 7 and 8 across to determine the budget year wages (column 9). For those positions which have been added this year (not new employees filling existing positions), add the estimated annual wages entered in column 3 to columns 7 and 8 to obtain budget year wages.

.26 For each new position, if any, to be created in the budget year, enter the position description in column 2, and in column 3, enter the start date, number of pay periods, and estimated annual earnings for the position. Enter the anticipated wages to be paid the employee in column 9.

.27 Total columns 7, 8 and 9.

.28 In columns 10 and 11 respectively, enter 5.2% of column 9 not to exceed $468, and enter 3.1% of column 9 not to exceed $130. Total columns 10 and 11.

8.355.30 PAYROLL SUMMARY

From the Payroll Budget Worksheet, enter the estimated wages to be paid in the current year and the wages expected in the budget year. Also enter the number of employees expected at the end of both the current and budget year.

Total columns 2 through 5.

8.355.40 SUPPLIES AND SERVICES

.41 This form shall be used for all expenses other than payroll and payroll taxes, and medical professional fees.

.42 In column 2, enter the expenses corresponding to the description in column 1 for the year to date. In column 3, estimate the expenses for the remainder of the year. This may be done in either of two ways. If the first portion of the year has been representative of the year's activity, annualize the rest of the year, i.e., if nine months of actual expenses have been recorded, place the figure 1.33 (12/9) in column 3 and multiply column 2 by 3 to obtain the year's expense (column 4). If activity in the first portion of the year has not been representative, either because expenses have been too high or there is an unusual expense still to be incurred, estimate the remaining expense based upon the particular situation. Add columns 2 and 3 for those expenses which were not annualized and place the total in column 4.

.43 Based upon historic trends and upon the forecast of patient days, estimate the expenses for the budget year, and place them in column 5.

8.355.50 MEDICAL PROFESSIONAL FEES

Procedures for completion of this form should correspond to those for completing Worksheet C - Supplies and Services.

8.355.60 ADJUSTMENTS TO EXPENSES

The captions and the intent of this form correspond to the captions and the intent of schedules A-5 of Form SSA-1562. The procedure for completing this form is the same procedure used in Worksheet C and Worksheet D.

8.355.70 YEAR EXPENSE SUMMARY

Two forms should be submitted, one for the current year, and one for the budget year, identify by lining out "budget" or "current" as applicable. Enter by department, in Columns 2 through 5, the expenses calculated for the applicable year. These expenses come forward from Schedules B-1, C, and D. Enter the total of Columns 2 through 5 in Column 6. Enter the adjustments from Worksheet E in Column 7 and subtract Column 7 from Column 6 to obtain net expenses.

8.355.80 HOSPITAL EXPENSE SUMMARY

Figures for the current year and the budget year carry forward from Columns 8 of Schedules F.

8.355.90 Modification of payment to exempt non-prospective payment (non-PPS) hospitals (including free-standing psychiatric hospitals) effective with dates of services on or after December 15, 1989.

1. For purposes of payment, exempt hospitals will not be considered to be in any of the peer group categories developed for prospective payment system (PPS) hospitals. Exempt hospitals (including free standing psychiatric hospitals) will be paid a per diem for inpatient hospital services. Exempt hospitals and exempt units are also eligible for the major teaching hospital and disproportionate share payments as described in 8.356.20.

2. Effective for dates of service on or after July 1, 1991, exempt hospitals will receive modifications to per diem rates via the add-on development process described in 8.351 through 8.355. The maximum amount of any rate increase granted to a facility's per diem rate shall be a 7% annual limit.

3. In July 1993, the maximum amount of any add-on granted to a facility's per diem rate shall be no more than the weighted average increase in the base rates of participating PPS hospitals. This exemption from the 7% annual limit shall be in effect only for state fiscal

year 1994 and for every third year thereafter when PPS base rates are recalculated.

4. An exempt hospital advisory committee will be convened by the department, consisting of representatives of the department and the hospital industry, to include but not be limited to:

a. representatives of psychiatric facilities,

b. representatives of state facilities,

c. the Colorado Hospital Association.

The purpose of this committee is to advise the department on issues related to future modification to the rate structure and other issues of relevance to non-PPS inpatient hospital financing and delivery of health care services. The department will attempt to assure statewide geographic representation in the selection of committee members.

8.356 PAYMENTS FOR INPATIENT HOSPITAL SERVICES

.10 General Provisions

The payment method described in this section will apply to all Colorado participating hospitals, effective with dates of service on or after December 15,1989 (unless otherwise specified).

.20 Definitions

1. Diagnosis Related Group (DRG): A patient classification that reflects clinically cohesive groupings of inpatient hospitalizations that utilize similar amounts of hospital resources. The Medicare grouping methodology will be used as a base for the DRG payment system. The Department has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid.

2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the client's admission to the hospital.

3. Relative Weight: A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases: Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The Department shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.

4. Base Rate:

An estimated cost per Medicaid discharge.

For PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by reducing the Medicare base rate by a set percentage equally to all PPS Hospitals. This percentage will be determined by the Department based on the

available funds appropriated by the General Assembly.

For the purpose of rate setting effective on July 1 of each fiscal year, the Medicare base rate used will be the Medicare base rate effective on October 1 of the previous fiscal year adjusted for inflation. For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty Medicaid discharges in the previous fiscal year, the Medicare base rate used will be the average Medicare base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty Medicaid discharges in the previous fiscal year. The inflation factor will be the CMS hospital market basket index used to inflate the Medicare base rates relative to the fiscal year for which the Medicaid base rates are effective.

Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge for Nursery, Neo-Natal Intensive Care Units, and Graduate Medical Education.

Urban Center Safety Net Specialty Hospitals may receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process. To qualify as an Urban Center Safety Net Specialty Hospital, the urban hospital's Medicaid days plus Colorado Indigent Care Program (CICP) days relative to total days, rounded to the nearest percent, shall be equal to or exceed sixty-seven percent. Medicaid and total days shall be Medicaid eligible inpatient days and total inpatient days from the most recent survey requested by the Department prior to March 1 of each year for July 1 rates. If the provider fails to report the requested days, the days used shall be collected from data published by the Colorado Hospital Association in its most recent annual report available on March 1 of each year. The CICP days shall be those reported in the most recently available CICP Annual Report as of March 1 of each year.

Pediatric Specialty Hospitals may receive an additional adjustment factor to account for the specialty care provided. This adjustment factor will be determined by the Department during the rate setting process.

For PPS Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate will be set as a cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. This Medicaid base rate may be adjusted by an equal percent for all hospitals within the peer group. This percentage will be determined by the Department as required by the available funds appropriated by the General Assembly.

Beginning April 1, 2004, acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries shall receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.

5. Exempt Providers and Units: Those hospitals and units within hospitals which are designated by the Department to be exempt from the DRG-based prospective payment system (PPS).

The Department may designate facilities as exempt or non-exempt providers. . Non-exempt providers shall be reimbursed using the DRG-based prospective payment system (PPS).

6. Hospital Peer Groups: The grouping of hospitals for the purpose of cost comparison and

determination of efficiency and economy. The peer groups are defined as follows:

a. Pediatric Specialty Hospitals: All hospitals providing care exclusively to pediatric populations.

b. Rehabilitation and Specialty-Acute Hospitals: All hospitals providing rehabilitation or specialty-acute care (hospitals with average lengths of stay greater than 25 days).

c. Rural Hospitals: Colorado hospitals not located within a federally designated metropolitan statistical area (MSA).

d. Urban Hospitals: All Colorado hospitals in MSAs, including those in the Denver MSA. Also included would be the rural referral centers in Colorado, as defined by HCFA. 42 U.S.C. Section 1395 WW(D)(5)(C)(I), 42 C.F.R. Sections 412.90(C) and 412.96.

Facilities which do not fall into the peer groups described in a will default to the peer groups described in b. through d. based on geographic location.

7. Outlier Days: The days in a hospital stay which occur after the trim point day. The trim point day is that day which would occur 1.94 standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations will be adjusted to maintain budget neutrality when changes are made to the DRG payment system. Trim points shall be periodically adjusted when the Department determines it is necessary to ensure that payments reasonably reflect the average cost of claims for each DRG. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.

8. Major Teaching Hospital Allocations: Effective October 1, 1993, hospitals shall qualify for additional payment when they meet the criteria for being a major teaching hospital, and when their Medicaid days combined with indigent care days (days of care provided under Colorado's indigent care program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available.

a. Criteria

A major teaching hospital is defined as a Colorado hospital which meets the following criteria:

1. maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s.

2. maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed.

3. meets the department's eligibility requirement for disproportionate share payment.

b. Payment Formula

The additional major teaching payment rate is calculated as follows:

MTHR = ((ICD + MD)/TPD) X MIAF

where:

MTHR = major teaching hospital rate

ICD = indigent care days

MD = Medicaid days

MIAF = medically indigent adjustment factor

I/R FTE's (7/1/91 to 6/30/92)	MIAF
110 to 150	1.1590
151 to 190	1.4909

Payment calculation for hospitals which qualify for the additional major teaching hospital payment shall be as follows:

a. Based upon data available at the beginning of each fiscal year, Colorado shall determine each hospital's ICD, MD and TPD. ICD will be extracted from the most recent available Colorado Indigent Care Program interim report to the Colorado General Assembly, submitted by the University of Colorado Health Sciences Center. MD and TPD will be extracted from the most recently available Colorado Acute and Rehabilitation Hospital Utilization Data Report of the Colorado Hospital Association. In addition, each hospital's Medicaid payment for the previous fiscal year shall be estimated.

b. Multiply the Medicaid payment by the calculated MTHR to determine the additional major teaching hospital payment.

c. Payment shall be made monthly.

9. Disproportionate Share Hospital Adjustment:

a. Federal regulations require that hospitals which provide services to a disproportionate share of Medicaid recipients shall receive an additional payment amount to be based upon the following minimum criteria:

1) Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and

2) A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.

In the case where a hospital is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

3) Number 2) above does not apply to a hospital in which:

a) the inpatients are predominantly under 18 years of age; or

b) does not offer non-emergency obstetric services as of December 21, 1987.

The Medicaid inpatient utilization rate for a hospital shall be computed as the

~~total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.~~

~~The low income utilization rate shall be computed as follows:~~

~~a) The fraction (expressed as a percentage)~~

~~(I) the numerator of which is the sum (for a period) of (i) total revenues paid the hospital for patient services under a State Plan under this title and (ii) the amount of the cash subsidies for patient services received directly from state and local governments, and (II) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and~~

~~b) A fraction (expressed as a percentage)~~

~~(I) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (I) (ii) of subparagraph a) (of Section 1923 of the Social Security Act) in the period reasonably attributable to inpatient hospital services, and (II) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.~~

~~The numerator under subparagraph (b)(I) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a state plan approach under this title).~~

~~b. Colorado Determination of Individual Hospital Disproportionate Payment Adjustment~~

~~Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a Low Income Payment defined in section 8.903 of these regulations.~~

~~Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive a Low Income Shortfall payment.~~

~~The total available funds for the Low Income Shortfall payment equals the percentage of Self Pay Days plus Other Paid Days of those providers who qualify for the Low income Shortfall payment compared to all other Medicaid Inpatient Hospital providers multiplied by the General Fund appropriated by the General Assembly to Safety-Net Provider Payments. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low Income Shortfall payment for the specific provider.~~

~~c. Disproportionate share amounts shall be based upon the recalculated base rate for affected facilities (prospectively determined annually in conjunction with base rate changes). The percentage of Medicaid patients in each facility used to calculate the appropriate disproportionate share payments (if any) shall be based upon the most recent Colorado Hospital Association Data Bank information available, information from hospitals not participating in the Data Bank, and from Health Maintenance Organizations and/or Prepaid Health Plans describing total patient days and Medicaid days. Data will be subject to validation through the use of data from the~~

Department and the Colorado Foundation for Medical Care.

d. Effective January 1, 1991, an additional Disproportionate Share Adjustment payment method shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share Hospital criterion of Medicaid inpatient hospital services utilization rate of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for third party payments), less Colorado Indigent Care Programs patient payments and Colorado Indigent Care Programs reimbursements.

For each hospital which qualifies under this section D, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. The basis for this calculation will be information published by the Colorado Indigent Care Programs in its most recent annual report available before rate setting by the Department for each upcoming state fiscal year. The Colorado Indigent Care Programs costs, patient payments, and program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Programs, subject to validation through the use of data from the Department, the Colorado Foundation for Medical Care, and/or independent audit.

Effective July 1, 1993. Component 1 shall be superseded by a Disproportionate Share Adjustment payment method (herein described as Component Ia) under which the above cost data will be inflated forward from the year of the most recent available Colorado Indigent Care Program report available before rate setting (using the CPI-W. Medical Care for Denver) through June 30 of the fiscal year payment period.

Effective for the period from June 1, 1994 to June 30, 1994, each facility will receive a Component Ia payment proportional to the level of low income care services provided, as measured by the percent of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements, that will allow the State to approach but not exceed the State's Federal Fiscal Year 1994 Disproportionate Share Hospital allotment as published in the May 2, 1994 Federal Register. If these reimbursements exceed the federal allotment limits, they will be recovered proportionately from all participating hospitals.

Effective for the period from July 1, 1994 to June 30, 1995, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by 200% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

Effective June 1 through June 30, 1995, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 200% of the hospital's reported Colorado Hospital

~~Association bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report available before rate setting by the Department, inflated from the year of the annual report to June, 1995 using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, and reduced by estimated patient payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.~~

~~Effective from July 1, 1998, through September 30, 1998, and from October 1, 1998 through September 30, 1999, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of $93 million in Federal Fiscal Year 1998, and $85 million in Federal Fiscal Year 1999. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.~~

~~Effective from September 1, 2000, through September 30, 2000, each government hospital will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. These payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of $79 million in Federal Fiscal Year 2000. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share payments. This payment will apply to any government disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State. Effective June 1, 2001, this bad debt Disproportionate Share Adjustment payment to government hospitals is extended to an annual basis, and is subject to the Federal Funds limits of the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The limit for 2001 is $81.765 million. These payments are subject to approval and appropriation by the General Assembly.~~

~~Effective July 1, 1995, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by up to 100% of the~~

hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department.

This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

e. Effective retroactively to July 1, 1991, the department will reimburse disproportionate share hospitals for the reasonable costs associated with administrative outstationing eligibility functions. The reimbursement will occur in the following manner:

Disproportionate share hospitals will submit on an extra line on the Medicaid Cost Report (related to Worksheet A - Trial Balance) the Administrative and General pass through direct costs associated with outstationing activities. This additional retrospective reimbursement will be separately identified on the Medicaid Settlement Sheet.

Payment, for taking of the initial applications and initiating the process of determining Medicaid eligibility, shall be made to recognize these provider administrative costs. This outstationing payment shall be made based upon actual cost with a reasonable cost per application limit to be established by the Department, based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall reimbursement exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities.

f. Effective October 1, 1991 through September 30, 1992, a separate separate Component 2 Disproportionate Share Adjustment payment method shall apply for all hospitals eligible to receive reimbursement for services provided to Colorado Medicaid patients. These payments shall be made in addition to all other Medicaid payments. Hospitals which serve a higher proportion of low income care will receive a higher disproportionate share adjustment. The additional disproportionate share payments are based upon and are proportional to historical Medicaid Program payments and Colorado Indigent Program payments. The calculation shall be based upon the most recent Colorado Hospital Association Data Bank information available regarding the amount of uncompensated care provided, excluding discounts for contractual allowances made to third party payers, and the most recently published Colorado Indigent Care Program Annual Report.

To provide funding for this payment adjustment, all Colorado hospitals will be assessed 10% of their own specific Medicaid revenues for the previous state fiscal year. Failure of the provider to pay the assessment shall result in the Department withholding Component 2 disproportionate share payment. The disproportionate share payment for Component 2 is based upon the amount of previous year's historical Medicaid and Medically Indigent payment. This is expressed in the following formula and payment schedule:

Uncompensated Inpatient Care Ratio = UICR

Uncompensated I/P care revenue* . .

~~———————————————~~	~~=~~	~~UICR~~
~~Total I/P care revenue~~	~~.~~	~~.~~

~~* The total of bad debt and charity care revenue~~

~~The UICR is used to array facilities to determine the level of uncompensated care. Based upon the level of uncompensated care, facilities will receive from 10% to 60% of their uncompensated care historical cost base (which is defined as .50 of Medically Indigent payment and .10 of Medicaid payment for the previous fiscal year).~~

~~Increased Historical~~	~~.~~	~~.~~
~~UICR~~	~~.~~	~~Cost Base (HCB)~~
~~0.00 - 0.029~~	~~Level 1~~	~~10%~~
~~0.30 - 0.049~~	~~Level 2~~	~~10%~~
~~0.050 - 0.079~~	~~Level 3~~	~~30%~~
~~0.080 - 0.109~~	~~Level 4~~	~~40%~~
~~0.110 - 0.169~~	~~Level 5~~	~~50%~~
~~0.170+~~	~~Level 6~~	~~60%~~

~~Component 2 Payment is determined as follows:~~

~~HCB = Increased Historical Cost Base~~

~~X = .10 x Medicaid Payment~~

~~Y = .50 x Medically Indigent Payment~~

~~Component 2 Payment = HCB x X + Y~~

~~Hospitals qualifying under both the Component 1 and Component 2 disproportionate share methodology, as described in Sections D and # above, may receive only the greater of the Component 1 or Component 2 payment adjustments.~~

~~g. Based upon historical data for the period July 1, 1986 through June 30, 1989, an additional Disproportionate Share Adjustment payment (herein described as Component 3) will be made effective on October 1, 1991, to any disproportionate share hospitals meeting the current Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share Hospital criterion of Medicaid inpatient hospital services utilization rate of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the state (as described above in this subsection.~~

Disproportionate Share Hospital Adjustment, paragraph (A)). Hospitals meeting this criterion shall be eligible for an additional Disproportionate Share payment adjustment as follows:

Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for third party payments), less Colorado Indigent Care Programs patient payments and Colorado Indigent Care Programs reimbursements.

For each hospital which qualifies under Component 3, these amounts will be calculated based upon historical data (for the period July 1, 1986 to June 30, 1989) and paid in a single payment. The basis for this calculation will be information published by the Colorado Indigent Care Programs in its annual reports, which would have been available before each applicable state fiscal year period. The Colorado Indigent Care Programs costs, patient payments, and program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Programs, subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care, and/or independent audit.

h. Effective July 1, 1994, an additional disproportionate share payment adjustment method will apply to any outstate disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula.

1) Eligibility for Outstate Disproportionate Share Hospital Payments.

These hospitals are defined as those hospitals which meet the disproportionate share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one percent of total patient days. Providers who are not participating in the Colorado Indigent Care Program are excluded from receiving this adjustment. Also excluded are Specialty Indigent Care Program providers, which are defined by the Colorado Indigent Care Program as those providers which either offer unique specialized services or serve a unique population. Outstate hospitals are defined by the Colorado Indigent Care Program as those Colorado hospitals that are outside the City and County of Denver, and who participate in the Colorado Indigent Care Program.

Effective July 1, 2001, Outstate Disproportionate Share hospitals which do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition will be separated into the Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals. Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are owned by a state, county or local government entity. Non-Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are not owned by a state, county or local government entity.

These hospitals must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The obstetrics requirement does not apply to a hospital in

which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.

Hospitals must participate in the Colorado Indigent Care Program, and must meet the separate annual audit requirements of the Colorado Indigent Care Program; and must supply data per the Colorado Indigent Care Program guidelines on total charges, total third party collections, total patient liability, and write-off charges to the Colorado Indigent Care Program. Hospitals meeting these criteria shall be eligible for an additional disproportionate share payment adjustment as follows:

2) Reimbursement.

a) Percent of Uncompensated Care.

Each facility will receive a payment proportional to its uncompensated medically indigent costs, as calculated by the Colorado Indigent Care Program. The percent of uncompensated care that will be reimbursed depends on the annual amount appropriated by the State Legislature to the Colorado Medically Indigent Program for Outstate hospitals. Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals may have a different calculated total reimbursement percentage of uncompensated costs.

b) Calculation of Uncompensated Costs.

These uncompensated costs will be calculated by taking total medically indigent charges, subtracting total third party collections and total patient liability to obtain write-off charges, and then multiplying write-off charges by the cost-to-charge ratio as defined by the Colorado Indigent Care Program, to calculate medically indigent write-off costs. The cost-to-charge ratio is defined by the Colorado Indigent Care Program as that cost-to-charge ratio calculated using the most recently submitted Medicare Cost Report for each hospital.

3) Method of Payment.

a) Basis of Payment.

For each hospital which qualifies under this section, these payments for indigent care costs will be calculated based upon prospective data provided by the Colorado Indigent Care Program. The basis for this calculation will be the projected reimbursement for the current fiscal year as calculated by the Colorado Indigent Care Program.

b) Payment Limits

The DSH payment will not exceed uncompensated costs as defined in the Social Security Act, Section 1923(g)(1)(A). Adjustments will be made to the monthly payments based on interim recalculations performed by the Colorado Indigent Care Program.

c) Frequency of Payment.

Payment will be made on a monthly basis.

11. Family Medicine Residency Training Program: A hospital qualifies as a teaching hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Commission on

Family Medicine and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the major teaching hospital program, it is not eligible for this program, unless the facility is a university hospital. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Training Program will be $213,195. Effective July 1, 1999, the annual payment for each Family Medicine Residency Training Program will be $228,379. The annual payment will change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

8.356.30 Subject to the fiscal agent's implementation of the DRG payment system, PPS hospitals will receive DRG-based payment for inpatient hospital stays no sooner than April 1, 1988.

.31 The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the client was treated, surgical procedures involved, and complication of the illness. Every DRG is assigned a relative weight, average length of stay, and trim point, based upon data obtained from states operating Medicaid DRG systems and upon Colorado-specific data as they become available. The DRG relative weight will be multiplied by the base rate for the each hospital to generate the base payment amount.

.32 Abbreviated patient stays will be paid as follows:

A. The hospital will receive the full DRG payment for all patient deaths and cases in which the patient left against medical advice.

B. Subject to Department approval, in cases involving transfers to, from or between PPS hospitals, PPS facilities excluding rehabilitation and specialty-acute hospitals will be paid a DRG per diem for each day based upon the full DRG payment, divided by the average length of stay for the DRG (up to a maximum of the full DRG payment). These discharges may also qualify for outlier payment when the length of stay exceeds the DRG trim point.

C. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility.

8.356.40 ADJUSTMENTS FOR OUT OF STATE PROVIDERS

A. Payment for out-of-state and non-participating Colorado hospital inpatient services shall be at a rate equal to 90% of the average Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services.

B. The state agency may reimburse a higher payment rate (than 90% of the average Colorado other urban or rural DRG payment rate) for non-emergent services when needed services are not available in Colorado hospitals. Non-emergent inpatient medical care rendered at an out-of-state hospital to a Colorado Medicaid client must be prior

authorized by the State Department of Health Care Policy and Financing, based upon review and recommendation by the PRO. For non-DRG payment, the out-of-state hospital will be paid at a rate mutually agreed upon by the parties involved.

Payment shall in no case exceed 100% audited Medicaid costs as determined by the Department and/or its agent.

In no case shall payment exceed $1,000,000 per admission.

Prior to authorization for payment, the PRO will review to determine the medical necessity of the treatment. Payment will be made only for the specific treatment(s) approved by the PRO as medically necessary and for complications occurring during the hospital stay which are directly related to the illness under treatment. All subsequent readmissions must be independently reviewed by the PRO and receive separate authorization for payment. The out-of-state hospital will be responsible for providing the PRO (on a bimonthly basis) medical records necessary for PRO review. Non-compliance with a PRO request for medical records will result in denial of reimbursement.

8.356.50 BASE RATES FOR NEW PPS FACILITIES

A. Beginning July 1, 1996, claims for clients admitted to pediatric specialty hospitals will be reimbursed under the DRG payment system.

B. Claims for clients admitted to rehabilitation and specialty-acute hospitals which are designated as non-exempt providers beginning July 1, 1997 shall be reimbursed using the DRG payment system.

C. The Department shall assign any new PPS facilities which become providers during the year to the appropriate peer group. The new facility shall submit budgeted cost data to the Department for consideration. The Department shall consider this data and/or cost and rate data for similar facilities in determining the initial reimbursement rate for new PPS facilities. If a new facility does not submit adequate budgeted cost data, the Department may assign a new PPS facility a rate equal to the lowest rate in the peer group to which the facility is assigned.

D. When changes occur at a Medicaid provider which affect the health facility license or scope of operations attributed to that provider number, the Department shall determine whether a rate adjustment is necessary based on the resulting impact on costs. Examples of such changes include but are not limited to mergers and consolidations, acquisitions, expansions of services to existing facilities, and changes in ownership involving multi-campus hospitals. The Department may use hospital cost report data and may require the provider to submit additional historical and/or budgeted costs for the operating locations involved in order to determine the rate adjustment. If the provider does not submit adequate historical or budgeted cost data, the Department may adjust the rate to the lowest rate in the peer group to which the provider is assigned.

The Department shall adjust rates for the changes described in this section only to the extent that such changes improve efficiency. The rate resulting from the changes shall be no higher than the rate paid prior to the change. The Department may reflect anticipated efficiencies of changes by discounting existing rates for the cost savings.

Changes which are limited to inpatient hospital services shall not be considered significant if the change in total beds is less than 5 (five) percent of the facility's certified beds prior to the change. If the change involved outpatient hospital services, the provider shall submit budgeted cost information for the Department to use in determining whether the change will significantly impact costs. The Department will determine the necessary rate adjustment for significant changes based on this data.

8.356.60 MEDICAID DATA

All hospitals participating in the Medicaid program will submit Medicaid and total hospital utilization, statistical and financial data to the Colorado Hospital Association Data Bank Program. If a hospital does not report to the Colorado Hospital Association data base, the Department will send the required format for reporting this data.

8.356.70 DRG ADVISORY COMMITTEE

The DRG Advisory Committee shall meet periodically, but no less frequently than annually, to provide advisory input to the department on the DRG payment system. This input shall include, but not be limited to:

1. Base Rate Determination

2. Relative weight adjustment

3. Changes in basic grouping methodology

4. Other aspects of the DRG payment system.

8.358 PATIENT PAYMENT CALCULATION FOR NURSING FACILITY CLIENTS WHO ARE HOSPITALIZED

When an eligible client is admitted to the hospital from a nursing facility, the nursing facility shall, at the end of the month, apply all of the available patient payment to the established Medicaid rate for the number of days the client resided in the nursing facility. The nursing facility shall notify the county department of any amount of patient payment that applies. Form AP-5615 shall be used to notify the county. An allowed exception to the usual five (5) day completion requirement is that the AP-5615 for hospitalized clients may be completed at the end of the month. If the nursing facility has calculated an excess amount, the county will notify the hospital and the State Department of Health Care Policy and Financing of the amount. The nursing facility shall transfer the excess amount to the hospital and this payment will be shown as a patient payment when the hospital submits a claim to the Medicaid Program.

.10 When a patient, who is not a transfer from a nursing facility, is admitted to the hospital and it appears the patient may be eligible for medical assistance, the hospital shall notify the county department. If the patient subsequently qualifies for assistance on the basis of institutionalization (see 8.110.31(B)) the county department will compute the income available to the individual. Except for deductions as allowed under the section Nursing Facility/Hospitalized Recipient Income, all income available to the individual must be applied to the cost of medical care. The hospital will show this as third party payment when submitting a claim to the Medicaid Program.

.20 The hospital is responsible for collecting the correct amount of patient payment due from the client, his family, or representatives. Failure to collect patient pay, in whole or in part, does not allow the hospital to bill the Medical Assistance Program.

.30 The hospital shall advise the responsible county department when the client is ready for discharge.

8.373 INPATIENT PSYCHIATRIC CARE FOR INDIVIDUALS UNDER THE AGE OF 21

Inpatient psychiatric care is a benefit of the Medicaid Program for individuals eligible for Medicaid benefits under the age of 21 only when (A) provided in an institution which is accredited as a

psychiatric hospital by the Joint Commission on Accreditation of Hospitals, or in a facility or program accredited by the Joint Commission of Accreditation of Hospitals; (B) services are provided under the direction of a physician and involve active treatment which a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, or prevent further regression so that the services will no longer be needed; and (C) are provided prior to the date such individual attains age 21, or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, (i) the date such individual no longer requires such services or (ii) if earlier, the date such individual attains 22.

In addition to these requirements, these facilities shall comply with all the federal federal requirements for inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs as specified in 42 C.F.R. 441.150, et seq., October 1992 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Manager, Health and Medical Services, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, CO 80203-1714. The Department may fulfill these requirements or parts thereof through contract with the designated professional standards review organization as allowed under 42 C.F.R. 431.630, October 1992 edition. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Foundation for Medical Care

P.O. Box 173001260 So. Parker Road

Denver, CO 80217-0300

or

Manager, Health and Medical Services

Colorado Department of Health Care Policy and Financing

1575 Sherman Street

Denver, CO 80203

8.373.05 COMMUNITY MENTAL HEALTH SYSTEM REFERRAL FOR INPATIENT PSYCHIATRIC CARE RENDERED TO PATIENTS UNDER AGE 21

When inpatient psychiatric care is provided to Medicaid clients under age 21 at a hospital (other than a state institution) reimbursed by per-diem rates, the Community Mental Health Center (CMHC) referral system shall apply:

A. Admission Notification Assessment

When a Medicaid enrolled individual under age 21 is admitted to an inpatient hospital for psychiatric care, the hospital shall notify the PRO, by telephone, of the admission within 24 hours. The PRO shall notify the CMHC in the patient's service area of responsibility by telephone and writing within 48 hours of notification.

1. The CMHC will determine if the client's condition warrants assessment, and what alternative services are available. If, after notification, the CMHC staff determines an assessment is necessary, such assessment shall occur within 10 working days from the date of notification. The CMHC staff will assess the client's medical condition/service needs, document the assessment in the hospital medical record, and participate in

development of the disposition plan.

2. Exception: If the Medicaid client admitted to the hospital is enrolled in the Mental Health Assessment and Service Agency (MHASA) program, procedures established by that program for notification and coordination of care shall be followed.

B. In hospitals where inpatient psychiatric care is provided to Medicaid clients under age 21 at a hospital (other than a state institution) reimbursed by per-diem rates, PRO retrospective review shall assess the medical necessity for admission and for the number of paid days, in accordance with 8.314.10.

C. In the event of denial of any or all of the client's stay, the appeal process for clients and/or providers is described at 8.318.12.

8.373.20 ELIGIBILITY

With the exception of determination that a child is deprived of parental support or care and school attendance, a person's eligibility for this program shall be determined under AFDC rules. See the Medical Assistance Eligibility section regarding needy persons under 21.

Determining eligibility for the "Under 21 Psychiatric Program" must include a determination of whether the person, individually or through his family, is covered by medical insurance or has other "third party" medical resources which must be used prior to benefit coverage under Medicaid. Except for an amount reserved for personal needs, all income available to the individual must be applied to the costs of medical care. When such individual has no income, a personal needs payment may be made if the individual is eligible as an eligible member of an AFDC household.

8.373.30 ELIGIBILITY AND INITIAL CERTIFICATION PROCESS

1. The admitting facility shall refer those persons deemed potentially eligible for benefits to the county department of social services of the county in which the facility is located or the county of jurisdiction for the client if different and known to the facility. The referral shall include medical data: diagnosis, prognosis, treatment plan, and long and short-range treatment goals. Such referral should contain as much personal and financial data as possible to enable the county department quickly to undertake and complete eligibility determination.

2. The referral information concerning medical data shall immediately be forwarded by the county department to the Peer Review Organization for purposes of securing certification of the need for inpatient psychiatric care.

3. At the time of such submittal, the county department shall initiate application and eligibility determination process. County departments shall work cooperatively with the facility concerning the securing of application.

4. The State Department promptly shall furnish the county department with the result of its review, certifying, as applicable, the child's need for care. See Section - Extension Certification concerning extensions.

5. The county department shall complete its eligibility determination process and notify the applicant, in accordance with standard procedures therefor (Form PA-75 or PA-78). If the Peer Review Organization fails to certify the child as requiring inpatient care, this reason shall be set forth as the primary reason for denial in the recipient notice.

6. The facility shall advise the responsible county department of any changes in income or

circumstances affecting eligibility or payment by the individual client in care. The client (parent or guardian if client is a minor) also has responsibility to provide such information to the county department.

7. Procedures and entries concerning reporting are set forth in the Financial and Medical Eligibility Reporting Manual.

8.373.40 EXTENSION CERTIFICATION

Such individuals admitted to a long - term inpatient psychiatric facility with a psychiatric diagnosis are limited to an initial length of stay of up to 30 days. The attending physician (psychiatrist) may request authorization for additional inpatient treatment if, in his opinion, additional active psychiatric treatment in a long-term inpatient psychiatric facility can be expected to result in amelioration of the diagnosed condition.

Such extensions beyond the initial 30 days must be certified by the Office of Medical Assistance, Department of Social Services. Signature is required on each Extension Form MED-177 which states the current medical records have been reviewed and the client's psychiatric condition warrants continued inpatient active treatment. Certification shall be made on the 25th day of care and every 30 days thereafter. Extensions of psychiatric diagnosis(es) beyond the initial 30 days shall be granted only in those cases where the attending physician (psychiatrist) determines that the client can be expected to make a satisfactory recovery through the application of active treatment. Failure to maintain properly signed Certification Form MED-177 for current period of care on client's chart will result in recovery of Medicaid funds.

Medicaid records are subject to audit by staff of the Department of Health Care Policy and Financing or its authorized representative.

Extension certification shall be made before the patient enters into each succeeding period of inpatient care. This applies to all persons eligible for Medicaid regardless of status of application until eligibility is denied or the client is discharged, whichever occurs first. Appropriate prior notice rules are applicable.

8.373.50 INSPECTION OF CARE

These facilities shall be surveyed under the Colorado Department of Public Health and Environment's Inspection of Care Program. Failure to satisfy the Inspection of Care requirements shall cause the Department to institute corrective action as it deems necessary.

8.373.60 BILLING PROCEDURES

Billing procedures for the Under 21 Psychiatric Program shall be issued by the Medicaid Fiscal Agent. Such billing procedures shall be approved by the Office of Medical Assistance and, as a minimum, shall include the following provisions:

1. All necessary client identification and statistical data as required to maintain necessary and proper medical records.

2. The billing form shall certify that extension certification was made as described under Extension Certification above.

3. Any income the client receives while an inpatient in a long-term care psychiatric facility shall be shown as another resource. Such income shall be applied toward the payment of the client's hospital care.

4. For a facility licensed as a psychiatric hospital, the rate of payment shall be that rate as

determined in accordance with procedures contained in the PAYMENT OF HOSPITAL COSTS Section of this staff manual less any third-party resources, including patient payments.

5. For facilities not licensed as a psychiatric hospital, the initial payment shall be $2710, until such time as a Medicaid cost report is filed according to procedures defined in FORM MED-13: GENERAL INFORMATION, MED-13: DEPARTMENT RESPONSIBILITIES AND FORM MED-13: NURSING FACILITY RESPONSIBILITIES.

Reimbursement for subsequent periods shall be determined according to procedures described in Computation of Individual Reimbursement Rate and Determination of Maximum Reimbursement Rate of the LONG TERM CARE - REIMBURSEMENT Section of these regulations. For purposes of reimbursement, all psychiatric facilities included under the Under 21 Psychiatric Program which are not licensed as hospitals shall constitute a single class of facilities.

6. Third-party payments are made first. Medicaid payment is made after other resources are exhausted.

Modification to billing procedures necessitated by new or additional requirements of the Medicaid Program shall be authorized by the Office of Medical Assistance of the Department of Health Care Policy and Financing.

8.374 PAYMENT FOR INPATIENT SERVICES AT FREE STANDING PSYCHIATRIC HOSPITALS

.10 Payment for inpatient care provided to Medicaid clients under age 21 in free standing psychiatric hospitals (excluding state institutions) shall be limited to the following institutions:

Centennial Peaks Hospital

Cleo Wallace Center

La Plata Psychiatric Hospital

This limitation applies to the licensed beds available at each institution as of October 10, 1988. Effective June 1, 1991, for the facilities listed in this section, the Department may impose contractual limits on beds by means of the hospital participation agreements subject to the provisions of 8.374.30.

.20 Effective October 10, 1988, payment rates for these institutions have been established by the Department on the basis of historical Medicaid payment rates and Medicaid payment rates and evaluation of hospital information concerning the relationship between hospital costs and patient length of stay. The following per diem rates will be in effect as of October 10, 1988:

Day 1 through Day 7:	$330
Day 8 through remainder of care at acute level:	$239
Days certified awaiting appropriate transfer:	$ 67

These rates will be increased initially on July 1, 1989, by the CPI-W. However, when the weighted average of base rates for participating prospective payment system (PPS) hospitals decreases due to a decrease in appropriations available to the Department, the rates for free-standing psychiatric hospitals shall not be increased by an inflation factor and shall be decreased by the same percentage as the base rates for the PPS hospitals. Effective

December 15, 1989, these free standing psychiatric hospital rates will be updated annually by the methodology described in 8.355.90. The annual inflator may be adjusted by the Department.

.30 The Department shall conduct an annual assessment to include:

A. The appropriateness of the geographic location of these beds relative to patient needs for access.

B. The appropriateness of the number of beds available, relative to patient needs and accessibility.

Based upon results of this annual assessment the Department shall determine the appropriateness of maintaining the contractual relationships in effect 10/30/88 with psychiatric hospitals (excluding state institutions) providing care for persons under 21 years of age, and if necessary, modify these contractual relationships relative to the number of beds eligible for reimbursement.

Based upon results of this assessment the Department may also issue a Request for Proposal in order to obtain provider contracts for the number and geographic location of beds deemed appropriate.

.31 Federal statute requires that Certification of Need (CON) be performed for all hospital inpatient care provided to Medicaid clients in Colorado Free Standing Psychiatric Hospitals. Payment for inpatient claims submitted by Free Standing Psychiatric Hospitals will be denied if the Colorado Foundation for Medical Care (CFMC) determines that the facility has not complied with Departmental CON documentation.

The CON is performed by the hospital's internal review team. The CFMC denial will be administrative and not subject to appeal.

8.375 SWING-BED HOSPITALS

.10 DEFINITIONS

"Swing-Bed Hospital" is a hospital participating in Medicare and Medicaid that has an approval from the federal government to provide skilled and/or intermediate care services.

"Routine SNF Services" and "Routine ICF Services" are those services required to be provided by nursing facilities participating in the Medicaid program as part of their per diem rate.

"Ancillary Services" are services which are not required to be provided by nursing facilities participating in the Medicaid program within their per diem rate, but which are reimbursable services under the Medicaid program. These include but are not limited to: laboratory and x-ray services, and prescription drugs.

.20 APPLICATION PROCESS

Hospitals which intend to designate swing-beds for the Medicaid program must program must apply to the Colorado Department of Public Health and Environment for certification of swing-beds and to the Colorado Department of Health Care Policy and Financing for participation as a provider of skilled and/or intermediate nursing facility services.

The following requirements must be met for participation as a swing-bed hospital:

1. Hospitals must meet state regulations with respect to certificates of need.

2. Hospitals must have fewer than 50 inpatient acute care beds excluding newborn bassinets and beds in special care units: i.e., ICU, CCU, EDRD, etc. (does not apply to hospitals

approved on a demonstration basis by the U.S. Department of Health and Human Services.)

3. Hospitals are not located in an area of the state designated as "urbanized" by the most recent official census published by the Federal Bureau of the Census. (Does not apply to hospitals approved on a demonstration basis by the U.S. Department of Health and Human Services.)

4. Hospitals must have a current valid Medicare agreement. Hospitals on "deferred termination" status are not eligible nor are hospitals with a waiver of 24-hour RN coverage.

8.375.30 PAYMENT RATES

Payment for swing-bed services will be made at the average rate per patient day paid to Class I nursing facilities for services furnished during the previous calendar year.

Payment for routine skilled nursing facility and intermediate care facility services may not exceed the rates charged for the same services to private pay residents or residents with other sources of income.

Oxygen provided to swing-bed patients will be paid at the same rate currently paid to skilled nursing facilities and intermediate care facilities in addition to payments made for routine services.

Clients shall be required to contribute all patient income minus the personal needs amount to the cost of their skilled or intermediate nursing care. Collection as well as determination of the patient income amount shall be in accordance with the section of this manual entitled "Patient Income and Possessions."

.40 CLAIM SUBMISSION

Hospitals shall submit claims for swing-bed routine services and oxygen on nursing facility claim forms provided by the fiscal agent.

Ancillary services shall be billed separately on the appropriate claim form.

.50 SERVICES FURNISHED WITHIN THE PER DIEM RATE

Hospitals providing skilled nursing facility and/or intermediate care facility services in swing-beds must furnish the same services, supplies and equipment within the per diem rate which skilled nursing facilities and intermediate care facilities, excluding intermediate care facilities/mentally retarded, are required to provide.

Clients and/or their families or guardians shall not be charged for any of these required items or services.

8.375.60 PATIENTS' RIGHTS

Hospitals providing skilled nursing facility or intermediate care facility services to swing-bed patients shall adhere to the patient's rights requirements for skilled nursing facilities and intermediate care facilities contained in the Department of Public Health and Environment regulations including:

The right to be transferred or discharged only for medical reasons or his/her welfare, or that of other patients, or for nonpayment for his/her stay and the right to be given reasonable advance notice of any transfer or discharge, except in the case of an emergency as determined by professional staff.

However, if the hospital wishes to establish limited lengths of stay in its swing-beds, it will be considered to have protected this patient right if the patient signs a notice of the conditions of

such stay at the onset of his/her intermediate care facility or skilled nursing facility care.

.70 PERSONAL NEEDS FUNDS AND PATIENT PAYMENTS

Swing-bed hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance with the requirements established for nursing facilities in the section entitled "Patient Income and Possessions."

.80 PRIOR AUTHORIZATION OF SWING-BED CARE BY THE PEER REVIEW ORGANIZATION

All Medicaid patients shall be prior authorized and subject to the continued stay review processes of the Peer Review Organization in accordance with the criteria and procedures found in the section of this manual entitled "Long Term Care - General."

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule for the Exemption of the American Recovery and Reinvestment Act of 2009 Unemployment Benefit Increase. 8.100.3.L
Rule Number:	MSB 09-04-16-A
Division / Contact / Phone:	Eligibility / Eric Stricca / 303-866-4475

ECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-04-16-A, Revision to the Medical Assistance Eligibility Rule for the Exemption of the American Recovery and Reinvestment Act of 2009 Unemployment Benefit Increase. 8.100.3.L
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.3.L, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new text provided at §8.100.3.L.1.ee which immediately follows current text at §8.100.3.L.1.dd. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule for the Exemption of the American Recovery and Reinvestment Act of 2009 Unemployment Benefit Increase. 8.100.3.L
Rule Number:	MSB 09-04-16-A
Division / Contact / Phone:	Eligibility / Eric Stricca / 303-866-4475

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 purpose of this rule change is to exempt the increase of $25 a week in unemployment compensation benefits required under the American Recovery and Reinvestment Act of 2009. The proposed rule will ensure that the amount of the increase will not impact the income eligibility of Medicaid recepients or applicants.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   American Recovery and Reinvestment Act of 2009 section 2002(h)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);

Initial Review	**09/11/2009**	Final Adoption	**10/16/2009**
Proposed Effective Date	**11/30/2009**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule for the Exemption of the American Recovery and Reinvestment Act of 2009 Unemployment Benefit Increase. 8.100.3.L
Rule Number:	MSB 09-04-16-A
Division / Contact / Phone:	Eligibility / Eric Stricca / 303-866-4475

REGULATORY ANALYSIS

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

   The proposed rule will affect any individual who is currently eligible for Medicaid or who will be applying for Medicaid and who is receiving Unemployment Benefits.

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 qualitative impact is that individuals can retain or gain Medicaid income eligibility and still receive the increase in unemployment compensation to help meet their living expenses.

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 exemption of the increase in unemployment compensation will have no fiscal impact.

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

   Inaction would cause the Medicaid program to be out of compliance with federal law which would jeopardize the Federal Financial Participation of the Medicaid program.

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

   N/A

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.

   None

8.100.3.L. General Income Exemptions

1. For the purpose of determining eligibility for Medical Assistance the following shall be exempt from consideration as either income or resources:

cc. Any portion of educational loans and grants obtained and used under conditions that preclude their use for current living cost (need-based).

dd. Financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act that is made available for attendance cost shall not be considered as income or resources. Attendance cost includes tuition, fees, rental or purchase of equipment, materials or supplies required of all students in the same course of study, books, supplies, transportation, dependent care and miscellaneous personal expenses of students attending the institution on at least a half-time basis, as determined by the institution.

ee. The additional unemployment compensation of $25 a week enacted through the American Recovery and Reinvestment Act of 2009.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Mail Order Pharmacy, Section 8.800
Rule Number:	MSB 09-07-06-A
Division / Contact / Phone:	Pharmacy Benefits Section / Tom Leahey / 303-866-2519

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 09-07-06-A, Revision to the Medical Assistance Rule Concerning Mail Order Pharmacy, Section 8.800

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.800, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.800.3.A.2.b with the new text attached. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Mail Order Pharmacy, Section 8.800
Rule Number:	MSB 09-07-06-A
Division / Contact / Phone:	Pharmacy Benefits Section / Tom Leahey / 303-866-2519

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 proposed rule revision would permit Medicaid clients to use mail order pharmacies if they have third party insurance which allows the use of mail order pharmacies. This rule revision is required pursuant to Senate Bill 09-252.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-5-505 C.R.S. (2008)

Initial Review	**09/11/2009**	Final Adoption	**10/16/2009**
Proposed Effective Date	**11/30/2009**	Emergency Adoption	

DOCUMENT #01

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Mail Order Pharmacy, Section 8.800
Rule Number:	MSB 09-07-06-A
Division / Contact / Phone:	Pharmacy Benefits Section / Tom Leahey / 303-866-2519

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.

   Medicaid clients who meet the requirement of the proposed rule revision will benefit by having access to mail order delivery of maintenance medications. Mail order pharmacies may benefit from an increase in dispensed drugs for the qualifying clients. Pharmacies that do not provide a mail order service may see a corresponding decline in drugs dispensed for qualifying clients.

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

   Currently, the Department is aware of only one mail order pharmacy (Kaiser Permanente) which is enrolled as a Medicaid provider. The Department assumes that most of the clients who would utilize mail order delivery pursuant to SB 09-252 are clients who have Kaiser Permanente as their third party insurance. The Department also assumes that there would be minimal interest among other mail order pharmacies to enroll as Medicaid providers. As a result, the Department assumes that there would be a nominal number of new clients who would receive mail order delivery of maintenance medications under SB 09-252. In addition, the Department assumes it could absorb the costs associated with manually enrolling these clients in the optional benefit and updating its rules.

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.

   Since the proposed rule is a relatively modest revision to an existing program, the Department expects to implement and enforce the proposed rule using existing resources. The Department does not anticipate a significant effect on state revenues.

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

   The proposed rule revision facilitates access to drugs for qualifying Medicaid clients and ensures the Department is compliant with state law. Failure to implement the proposed rule revision would cause the Department to be noncompliant with state law and may adversely impact access to drugs for a nominal number of clients with third party insurance that allows the use of mail order pharmacies.

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

   Not applicable.

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.

   Not applicable.

8.800.3 MAIL ORDER

8.800.3.A. Mail order delivery of a Maintenance Medication by a Mail Order Pharmacy is a pharmacy benefit when:

1. A client has been informed that a local pharmacy may be able to provide the same services as a Mail Order Pharmacy; and

2. A client, or a client's physician, declares in writing that the client has:

    a. A Physical Hardship that prohibits the client from obtaining a Maintenance Medication from a local pharmacy; or

    b. Third-party insurance that ~~requires~~allows the client to obtain a Maintenance Medication from a Mail Order Pharmacy.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Eligibility Rules Concerning the State-Only Prenatal Program 8.100.1; 8.100.4
Rule Number:	MSB 09-07-17-A
Division / Contact / Phone:	Client and Community Relations / Ann Clemens / 6115

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-07-17-A, Revisions to the Medicaid Eligibility Rules Concerning the State-Only Prenatal Program 8.100.1; 8.100.4
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.1; 8.100.4, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at 8.100.1 with the new text provided:
Insert new paragraph in definitions between §8.100.1 paragraph 58:

Legal Immigrant is an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the immigration and naturalization service as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by the immigration and naturalization service.

And paragraph 59:

Long Term Care is a Medical Assistance category that provides nursing-home care, home-health care, personal or adult day care for individuals above the age of 65 or with a chronic or disabling condition that needs constant supervision.

Please delete current paragraph 90: "State-Only Prenatal is a state funded. . ."

Please replace existing language at §8.100.4.G.10 with new text provided. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Eligibility Rules Concerning the State-Only Prenatal Program 8.100.1; 8.100.4
Rule Number:	MSB 09-07-17-A
Division / Contact / Phone:	Client and Community Relations / Ann Clemens / 6115

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 proposed rule amends 10 CCR 2505-10, Sections 8.100.1 and 8.100.4 to remove language regarding the use of state-only funds and change the name of the program to Legal Immigrant Prenatal. The Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3, section 214 (2009) allows states to request federal financial participation for pregnant legal immigrants within their first five years in the United States. Colorado Revised Statute directs the Department to seek federal financial participation for this population.

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:

   C.R.S. 25.5-5-201(4) directs the Department to seek federal financial participation for this population. Pub. L. 111-3, section 214 (2009) allows federal financial participation for this population. The Department must seek federal financial participation for this optional group or the program could be subject to closure due to state funding limitations.

3. Federal authority for the Rule, if any:

   Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3, section 214 (2009)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-5-201(4) C.R.S. (2008)

Initial Review		Final Adoption	**10/16/2009**
Proposed Effective Date	**11/30/2009**	Emergency Adoption	

DOCUMENT #18

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Eligibility Rules Concerning the State-Only Prenatal Program 8.100.1; 8.100.4
Rule Number:	MSB 09-07-17-A
Division / Contact / Phone:	Client and Community Relations / Ann Clemens / 6115

REGULATORY ANALYSIS

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

   The proposed rule will not affect any classes of persons. The current program will remain the same. The proposed rule will remove language regarding the use of state-only funds and change the name of the program.

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 will not affect any classes of persons. The current program will remain the same. The proposed rule will remove language regarding the use of state-only funds and change the name of the program.

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 proposed rule will result in a General Fund cost savings of $1.3 million annually because the Department will seek federal financial participation for this population.

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

   C.R.S. 25.5-5-201(4) directs the Department to seek federal financial participation for this population. Pub. L. 111-3, section 214 (2009) allows federal financial participation for this population. The Department must seek federal financial participation for this optional group or the program could be subject to closure due to state funding limitations.

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

   N/A

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.

   N/A

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

58Legal Immigrant is an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the immigration and naturalization service as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by the immigration and naturalization service.

Legal Immigrant Prenatal is a medical program that provides medical coverage for pregnant legal immigrants who have been legal immigrants for less than five years.

59Long Term Care is a Medical Assistance category that provides nursing-home care, home-health care, personal or adult day care for individuals above the age of 65 or with a chronic or disabling condition that needs constant supervision.

89SSI eligible means eligible to receive Supplemental Security Income under Title XVI of the Social Security Act, and may or may not be receiving the monetary payment.

90~~State Only Prenatal is a state funded medical program that provides prenatal and post-partum medical coverage for pregnant legal immigrants who have been legal immigrants for less than five years.~~

91TANF - Temporary assistance to needy families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. The program began on July 1, 1997, and succeeded the Aid to Families with Dependent Children program. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

8.100.4.G. Family and Children's Covered Groups

10. A pregnant legal ~~alien~~immigrant who has been a legal immigrant for less than five years is eligible for ~~state-funded prenatal and post-partum~~ medical care if she meets the eligibility requirements for expectant mothers listed in 8.100.4.G.9. This population is referenced as ~~State-Only~~ Legal Immigrant Prenatal.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Eligibility Rule Concerning the Exemption of Decennial Census Income

Rule Number: MSB 09-08-04-A

Division / Contact / Phone: Client & Community Relations Office/Corinne Lamberson/6587

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-04-A, A Revision to the Medical Assistance Eligibility Rule Concerning the Exemption of Decennial Census Income
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.3.L, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please delete current text at §8.100.3.L.1.aa and replace with new text provided. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning the Exemption of Decennial Census Income
Rule Number:	MSB 09-08-04-A
Division / Contact / Phone:	Client & Community Relations Office/Corinne Lamberson/6587

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 purpose of this rule is to exempt all wages paid by the Census Bureau for temporary employment related to decennial census activities. The proposed rule allows Medicaid recipients to accept temporary employment and maintain their medical coverage. By consolidating this rule, it will eliminate the administrative burden to complete future State Plan Amendments and rule changes associated with the decennial census.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. 1396a (a) (17)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);

Initial Review	**9/11/2009**	Final Adoption	**10/16/2009**
Proposed Effective Date	**11/30/2009**	Emergency Adoption	

DOCUMENT # 10

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning the Exemption of Decennial Census Income
Rule Number:	MSB 09-08-04-A
Division / Contact / Phone:	Client & Community Relations Office/Corinne Lamberson/6587

REGULATORY ANALYSIS

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

   The proposed rule will allow parents who are eligible for Medicaid and/or have a Medicaid child to accept the decennial census employment and maintain medical coverage. Consolidating this rule will remove the administrative burden to complete future rule changes associated with the decennial census.

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 qualitative impact is that the parent can accept the temporary decennial census employment and maintain medical coverage for their family without having to make a choice between employment or health care. Consolidating this rule will remove the administrative burden to complete future rule changes associated with the decennial census.

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 exemption of decennial census income will have no fiscal impact.

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

   Consolidating this rule will remove the administrative burden to complete future rule changes associated with the decennial census.

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

   N/A

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.

None

8.100.3.L. General Income Exemptions [Eff. 05/30/2009]

1. For the purpose of determining eligibility for Medical Assistance the following shall be exempt from consideration as either income or resources: *[Eff. 05/30/2009]*

    a. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a repayment agreement. Declaration of such loans is sufficient verification. *[Eff. 05/30/2009]*

    b. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act. *[Eff. 05/30/2009]*

    c. Title XVI (SSI) or Title II (Retirement Survivors or Disability Insurance) retroactive payments (lump sum) for nine months following receipt and the remainder countable as a resource thereafter. *[Eff. 05/30/2009]*

    d. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for women, infants and children (WIC). *[Eff. 05/30/2009]*

    e. Home produce utilized for personal consumption. *[Eff. 05/30/2009]*

    f. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act; relocation payments to a displaced homeowner toward the purchase of a replacement dwelling are considered exempt for up to 6 months. *[Eff. 05/30/2009]*

    g. Experimental Housing Allowance Program (EHAP) payments made by HUD under section 23 of the U.S. Housing Act. *[Eff. 05/30/2009]*

    h. Payments made from Indian judgment funds and tribal funds held in trust by the Secretary of the Interior and/or distributed per capita; and initial purchases made with such funds. (Public Law No 98-64 and Public Law No. 97-458). *[Eff. 05/30/2009]*

    i. Distributions from a native corporation formed pursuant to the Alaska Native Claims Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to exceed $ 2000 per individual per calendar year; stock; a partnership interest; or an interest in a settlement trust. Cash payments, up to $ 2000, received by a client in one calendar year which is retained into subsequent years is excluded as income and resources; however, cash payments up to $ 2000 received in the subsequent year would be excluded from income in the month(s) received but counted as a resource if retained beyond that month(s). *[Eff. 05/30/2009]*

    j. Assistance from other agencies and organizations. *[Eff. 05/30/2009]*

    k. Major disaster and emergency assistance provided to individuals and families, and comparable disaster assistance provided to states, local governments and disaster assistance organizations shall be exempt as income and resources in determining eligibility for Medical Assistance. *[Eff. 05/30/2009]*

    l. Payments received for providing foster care. *[Eff. 05/30/2009]*

m. Payments to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than the minimum wage, and Title II and Title III of the Domestic Volunteer Services Act. *[Eff. 05/30/2009]*

o. The benefits provided to eligible persons or households through the Low Income Energy Assistance (LEAP) Program. *[Eff. 05/30/2009]*

p. Training allowances granted by the Workforce Investment Act (WIA) to enable any individual whether dependent child or caretaker relative, to participate in a training program *[Eff. 05/30/2009]*

q. Payments received from the youth incentive entitlement pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs under the Youth Employment and Demonstration Project Act. *[Eff. 05/30/2009]*

r. Social Security benefit payments and the accrued amount thereof to a client when an individual plan for self-care and/or self-support has been developed. In order to disregard such income and resources, it shall be determined that (1) SSI permits such disregard under such developed plan for self-care-support goal, and (2) assurance exists that the funds involved will not be for purposes other than those intended. *[Eff. 05/30/2009]*

s. Monies received pursuant to the "Civil Liberties Act of 1988" P.L. No. 100-383, (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts). *[Eff. 05/30/2009]*

t. Effective January 1, 1989, payments made from the Agent Orange Settlement Fund or any fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No 381 (E.D.N.Y). *[Eff. 05/30/2009]*

u. A child receiving subsidized adoption funds shall be excluded from the Medical Assistance budget unit and his income shall be exempt from consideration in determining eligibility, unless such exclusion results in ineligibility for the other members of the household. *[Eff. 05/30/2009]*

v. Effective January 1, 1991, the Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month. *[Eff. 05/30/2009]*

w. Any money received from the Radiation Exposure Compensation Trust Fund, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510. *[Eff. 05/30/2009]*

x. Reimbursement or restoration of out-of-pocket expenses. Out-of-pocket expenses are actual expenses for food, housing, medical items, clothing, transportation, or personal needs items. *[Eff. 05/30/2009]*

y. Effective 8/1/1994, payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286. *[Eff. 05/30/2009]*

z. General Assistance, SSI, OAP-A and cash assistance under the Temporary Assistance to Needy Families (TANF) funds. *[Eff. 05/30/2009]*

aa. ~~Effective March 1, 2000, all wages paid by the United States Census Bureau for temporary employment related to U.S. Census 2000 activities. *[Eff. 05/30/2009]*~~

THIS PAGE NOT FOR PUBLICATION

~~All wages paid by the United States Census Bureau for temporary employment related to U.S. Census 2010 activities. [Eff. 05/30/2009]~~

All wages paid by the United States Census Bureau for temporary employment related to the decennial Census.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: **Error! Reference source not found.**, §8.100.3.G

Rule Number: MSB **Error! Reference source not found.**

Division / Contact / Phone: **Error! Reference source not found.** / **Error! Reference source not found.** / **Error! Reference source not found.**

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-07-A, Revision to the Medical Assistance Eligibility Rule Concerning Afghan Special Immigrants
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.3.G, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.100.3.G.1.g.7.l (delete 6 and insert 8 *months*) with new text provided. This change is effective 11/30/2009.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Afghan Special Immigrants, §8.100.3.G
Rule Number:	MSB 09-08-07-A
Division / Contact / Phone:	Client and Community Relations / Corinne Lamberson / x6587

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 purpose of this rule is to extend medical benefits from up to 6 months to a maximum of 8 months for the Afghan Special Immigrant population. The Department must implement the proposed rule to comply with P.L. No. 111-08 Omnibus Appropriations Act of 2009.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   P.L. No. 111-08 Omnibus Appropriations Act of 2009

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);

Initial Review	**09/11/2009**	Final Adoption	**10/16/2009**
Proposed Effective Date	**11/30/2009**	Emergency Adoption	

DOCUMENT # 05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Afghan Special Immigrants, §8.100.3.G
Rule Number:	MSB 09-08-07-A
Division / Contact / Phone:	Client and Community Relations / Corinne Lamberson / x6587

REGULATORY ANALYSIS

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

   The proposed rule will affect Afghan Special Immigrants who may receive up to 8 months of medical benefits from their date of entry into the United States. The proposed rule will provide 2 additional months of coverage.

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 qualitative impact of the proposed rule will allow Afghan Special Immigrants to receive 2 additional months of medical coverage.

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 extension of medical benefits will have an indeterminate fiscal impact. It is difficult to ascertain the number of Afghan Special Immigrant's that will reside in Colorado given that the overall number of special immigrant statuses issued is limited. Based on this information, we can estimate that the number of Afghan Special Immigrants receiving the time limited benefits will be relatively small and the cost will be nominal.

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

   The Department must implement the proposed rule pursuant to P.L. No. 111-08 Omnibus Appropriations Act of 2009.

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

   N/A

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.

   None

8.100.3.G. General and Citizenship Eligibility Requirements

1. To be eligible to receive Medical Assistance, an eligible person shall:

    a. Be a resident of Colorado;

    b. Not be an inmate of a public institution, except as a patient in a public medical institution or as a resident of an Long Term Care Institution or as a resident of a publicly operated community residence which serves no more than 16 residents;

    c. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. See section 8.100.4.H for special provisions extending Medical Assistance coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

    d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;

    e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;

    f. Meet all other requirements of the Medical Assistance Program for which application is being made; and

    g. Fall into one of the following categories:

        i) Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or

        ii) Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

        iii) Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance benefits to begin no earlier than five years after the non-citizen's date of entry into the United States who falls into one of the following categories:

            1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");

            2) paroled into the United States for at least one year under section 212(d)(5) of the INA; or

            3) granted conditional entry under section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

            4) determined by the eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. sec. 1641, has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Medicaid); or

5) lawfully admitted for permanent residence under the INA with 40 qualifying quarters as defined under Title II of the Social Security Act. The 40 quarters is counted based on a combination of the quarters worked by the individual, the individual's spouse as long as they remain married or spouse is deceased, and/or the individual's parent while the individual is under age 18; or

6) The statutes and acts listed at 8.100.3.G.1.g.iii.1 through 8.100.3.G.1.g.iii.5 are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

7) Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

   a) lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children); or

   b) lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried, dependent children); or

   c) granted asylum under section 208 of the INA for seven years after the date of entry into the United States; or

   d) refugee under section 207 of the INA for seven years after the date of entry into the United States; or

   e) deportation withheld under section 243(h) (as in effect prior to September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208) of the INA for seven years after the date of entry into the United States; or

   f) Cuban or Haitian entrant, as defined in section 501(e)(2) of the Refugee Education Assistance Act of 1980 for seven years after the date of entry into the United States; or

   g) an individual who (1) was born in Canada and possesses at least 50 percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 450b(e); or

   h) admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461) for seven years after the date of entry into the United States; or

   i) lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict; or

j) a victim of a severe form of trafficking in persons, as defined in section 103 of the Trafficking Victims Act of 2000, 22 U.S.C. 7102; or

k) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA within the initial 8 months of special immigrant status; or

l) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA within the initial ~~6~~ 8 months of special immigrant status.

m) The statutes and acts listed at 8.100.3.G.1.g.iii.7.c through 8.100.3.G.1.g.iii.7.l are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Rule for Determining Reimbursement Rates of Pharmaceuticals, §8.800
Rule Number:	MSB 09-08-17-C
Division / Contact / Phone:	Pharmacy Benefits Section/ Tom Leahey/x2519

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-17-C, Revision to the Medical Assistance Pharmacy Rule for Determining Reimbursement Rates of Pharmaceuticals, §8.800
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.800, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.800.13.D.1.a. and b. with the new text provided. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Rule for Determining Reimbursement Rates of Pharmaceuticals, §8.800
Rule Number:	MSB 09-08-17-C
Division / Contact / Phone:	Pharmacy Benefits Section/ Tom Leahey/x2519

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 proposed rule revision is a targeted reduction in selected reimbursement rates for covered fee-for-service outpatient drugs. The proposed outpatient drug rate reduction is a component of the overall Medicaid provider rate reductions being implemented to offset the state budget shortfall.

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 Department may not be able to provide the services necessary to preserve the public health, safety and welfare, if the provider rate reductions are not implemented.

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(a)(30)(A)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   24-4-103(6), C.R.S. (2008)

Initial Review — Final Adoption **10/16/2009**

Proposed Effective Date **11/30/2009** — Emergency Adoption

DOCUMENT #11

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Rule for Determining Reimbursement Rates of Pharmaceuticals, §8.800
Rule Number:	MSB 09-08-17-C
Division / Contact / Phone:	Pharmacy Benefits Section/ Tom Leahey/x2519

REGULATORY ANALYSIS

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

   The providers affected by the proposed rule revision are pharmacies (not including qualifying rural pharmacies) that bill Medicaid for covered fee-for-service outpatient drugs. Medicaid clients will benefit from the proposed rule because the rate reduction will help the Department maintain current outpatient drug benefits.

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 Department anticipates that the aggregate outpatient drug reimbursement to pharmacies will be reduced by about $3.5 million for Fiscal Year 2009-10.

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 can implement and enforce the proposed rule revision with existing resources. The Department anticipates that the rule revision will reduce aggregate outpatient drug expenditures for Fiscal Year 2009-10, thereby requiring less state revenue to provide drug benefits at the anticipated level of utilization.

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 revision is a reduction in aggregate drug expenditures, which will help offset the projected state budget shortfall and allow the Department to provide outpatient drug benefits without significant changes in coverage. The cost is that pharmacies may receive less reimbursement for drugs, depending on which drugs are billed to Medicaid. If the Department does not reduce expenditures and help offset the state budget shortfall, the outpatient drug benefit and/or other Medicaid benefits may have to be significantly reduced.

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

The targeted reduction of provider reimbursement rates, including those for outpatient drugs, is one of the most effective means to reduce expenditures, given the size of the forecasted state budget shortfall and the urgency in which the shortfall must be offset.

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.

   The Department is taking many steps to reduce expenditures, including other targeted provider rate reductions.

8.800.13 REIMBURSEMENT CALCULATION

8.800.13.D. The allowed ingredient cost is determined utilizing different methodologies as applicable. The pricing methodologies are: *[Emer. Rule eff. 07/01/2009]*

1. Based on Average Wholesale Price (AWP): *[Emer. Rule eff. 07/01/2009]*

    a. AWP less 14.5%~~14%~~ for brand name drugs; and *[Emer. Rule eff. 07/01/2009]*

    b. AWP less 45%~~40%~~ for generic drugs; *[Emer. Rule eff. 07/01/2009]*

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Elimination of the CICP HCS, Section 8.903.C.
Rule Number:	MSB 09-08-17-D
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri/X3996

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-17-D, Revision to the Medical Assistance Rule Concerning Elimination of the Colorado Indigent Care Program Health Care Services Payment, Section 8.903.C.
3. This action is an adoption of: a repeal of existing rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.903.C.14, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/1/2009
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please delete text from §8.903.C.14 through the end of §8.903.C.14.d leaving only the text that reads "Colorado Health Care Services Payment. This payment is repealed effective September 1, 2009." **effective 09/01/2009. This program has been repealed. This permanent change is effective 11/30/2009.**

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Elimination of the CICP HCS, Section 8.903.C.
Rule Number:	MSB 09-08-17-D
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri/X3996

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).

   This rule is repealed, effective September 1, 2009 in order to help offset the state budget shortfall.

   Currently, the Health Care Services Payment is funded through a $15 million General Fund appropriation matched by $15 million in federal Medicaid funds (federal financial participation calculated at 50%) for a total of $30 million.

   The Colorado Health Care Services Fund was a temporary fund created pursuant to Senate Bill 06-044 and became effective July 1, 2006. The Health Care Services Fund was created through the availability of excess General Fund made possible by the voter-approved "Referendum C". The exemptions of Referendum C and the enabling legislation for the Health Care Services Payments were scheduled to expire in FY 2010-11. These exemptions will expire this fiscal year, FY 2009-10, as part of the governor's budget-balancing responsibilities.

   The early elimination of this funding source does not eliminate all payments to CICP clinics. The appropriation of $6.1 million to reimburse CICP clinics is not impacted by this rule change.

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 Department may not be able to provide the services necessary to preserve the public health, safety and welfare, if termination of the Health Care Services Fund payments to CICP providers for primary care health services offered in an outpatient setting is not implemented.

Initial Review		Final Adoption	**10/16/2009**
Proposed Effective Date	**11/30/2009**	Emergency Adoption	

DOCUMENT # 08

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(a)(30)(A).

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   24-4-103(6), C.R.S. (2008)

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Elimination of the CICP HCS, Section 8.903.C.
Rule Number:	MSB 09-08-17-D
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri/X3996

REGULATORY ANALYSIS

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

   The Health Care Services Payment reimburses community clinics and primary care clinics owned and operated by hospitals for primary care services received by low-income and uninsured populations in a primary care setting. To be eligible for this payment, providers must participate in the Colorado Indigent Care Program (CICP).

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 elimination of funding for this payment affects CICP providers as follows:

   Community Health Clinics- a decrease of $21,648,000; Primary Health Care Clinics Operated by Hospitals- a decrease of $2,952,000; Denver Health Medical Center- a decrease of $5,400,000.

   The Colorado Health Care Services Fund was a temporary fund created pursuant to Senate Bill 06-044 and became effective July 1, 2006. The Health Care Services Fund was created through the availability of excess General Fund made possible by the voter-approved "Referendum C". The exemptions of Referendum C and the enabling legislation for the Health Care Services Payments were scheduled to expire in FY 2010-11. These exemptions will expire this fiscal year, FY 2009-10, as part of the Governor's budget-balancing responsibilities.

   The early elimination of the Health Care Services funding source does not eliminate all payments to CICP clinics. The appropriation of $6.1 million to reimburse CICP clinics is not impacted by this.

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.

   There are no costs to the Department or any other agency to implement or enforce this proposed rule.

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 revision is a reduction in expenditures for reimbursement to CICP providers for primary care health services offered in an outpatient setting, which will help offset the projected state budget shortfall. The cost is that reimbursements to CICP providers of primary care health services offered in an outpatient setting are eliminated. If the Department does not reduce expenditures and help offset the state budget shortfall, other Medicaid benefits may have to be significantly reduced. There is no ability to continue payments so there are no benefits of inaction.

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

   Since all funding has been eliminated for this payment, there are no other options than to repeal the rule guiding the payment.

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.

   None.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

C. Distribution of Available Funds to Providers

14. Colorado Health Care Services Payment. This payment is repealed effective September 1, 2009.~~an allocation of the Colorado Health Care Services Fund and is available to community health clinics and primary care clinics operated by a qualified health care provider that provides primary care services. For this section, primary care services are defined in Section 8.930.1.A of the regulations for the Comprehensive Primary/Preventive Care Grant Program.~~

~~a. For FY 2007-08, 18% of the moneys appropriated from the Colorado Health Care Services Fund shall be allocated to Denver Health Medical Center. After the appropriation to Denver Health Medical Center, 82% of the remaining funds shall be allocated to community health clinics operated by a qualified health care provider and 18% shall be allocated to primary care clinics operated by a qualified health care provider.~~

~~For FY 2008-09, 18% of the moneys appropriated from the Colorado Health Care Services Fund shall be allocated to Denver Health Medical Center. After the appropriation to Denver Health Medical Center, 85% of the remaining funds shall be allocated to community health clinics operated by a qualified health care provider and 15% shall be allocated to primary care clinics operated by a qualified health care provider.~~

~~For FY 2009-10, 18% of the moneys appropriated from the Colorado Health Care Services Fund shall be allocated to Denver Health Medical Center. After the appropriation to Denver Health Medical Center, 88% of the remaining funds shall be allocated to community health clinics operated by a qualified health care provider and 12% shall be allocated to primary care clinics operated by a qualified health care provider.~~

~~b. In order to receive a payment from the Colorado Health Care Services Fund, the qualified health care provider who operates a primary care clinic is required to complete a Colorado Health Care Services Fund Application as issued by the Department. This application for the current state fiscal year shall be submitted to the Department by July 31 of each State fiscal year.~~

~~c. Distribution of available funds for primary care clinics operated by a qualified health care provider shall be based upon historical data for the number of unique low-income clients who received primary care services at a primary care clinic and their number of visits. A qualified health care provider's distribution is calculated based on the average of the dollar amount derived from the provider's number of unique clients who received primary care services at a primary care clinic relative to the total number of clients who received primary care services at a primary care clinic for all qualified health care providers and the dollar amount derived from the provider's number of low-income primary care services visits at a primary care clinic relative to the total number of low-income primary care services visits at a primary care clinic for all qualified health care providers. The historical data will be reported in the Colorado Health Care Services Fund Application and related to the most recently available annual report published by the Colorado Indigent Care Program prior to rate setting by the Department for each upcoming State fiscal year.~~

~~d. Distribution of available funds for community health clinics operated by a qualified health care provider shall be based upon historical uncompensated costs for clients who received primary care services at a community health clinic. An individual community health clinic's distribution is calculated based on the community health clinic's historical uncompensated costs for clients who received primary care services at a community health clinic relative to the total historical uncompensated costs for all clients who received primary care services at community health clinics. The historical uncompensated costs shall be that as reported in the most recently available annual report published by the Colorado Indigent Care Program prior to rate setting by the Department for each upcoming State fiscal year.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Outstationing Administrative Costs, § 8.700.8
Rule Number:	MSB 09-08-17-E
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri / X3996

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-17-E, Revision to the Medical Assistance Rule Concerning Reimbursement for Outstationing Administrative Costs, Section 8.700.8
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.700.8 affected, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/1/2009
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.700.8.a and .b with new text provided. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Outstationing Administrative Costs, § 8.700.8
Rule Number:	MSB 09-08-17-E
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri / X3996

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).

   Currently, the Department reimburses federally qualified health centers (FQHCs) for reasonable administrative costs associated with accepting applications to determine Medicaid eligibility. The reimbursement for these activities is commonly referred to as an "outstationing payment". Reimbursement is capped at $60,000 per facility per year. Currently, this maximum payment of $60,000 per facility per year is funded with General Fund and federal funds. However, Denver Health Medical Center presently receives additional federal financial participation for their FQHCs uncompensated costs associated with outstationing activities beyond the $60,000 limit per FQHC by certifying addditional uncompensated costs as recorded in audited cost reports. The certification process is a financing mechanism that allows the Department to receive federal financial participation without contributing General Fund as the state share of the Medicaid payment.

   The proposed rule allows Denver Health Medical Center to certify its uncompensated outstationing costs in lieu of using General Fund to qualify for the matching Medicaid federal financial participation. The rule is structured to accomplish this by (1) declaring that only freestanding FQHCs receive an outstationing payment not to exceed $60,000 per facility (8.700.8.A); and (2) stating that hospital-based FQHCs, which is what Denver Health Medical Center's FQHCs are, shall certify all eligible uncompensated costs associated with accepting applications to determine Medicaid eligibility (8.700.8.B).

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 Department may not be able to provide the services necessary to preserve the public health, safety and welfare, if the reimbursement process for outstationing administrative costs is not amended.

Initial Review		Final Adoption	**10/16/2009**
Proposed Effective Date	**11/30/2009**	Emergency Adoption	

DOCUMENT # 09

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   24-2-102(4), C.R.S. (2008)

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Outstationing Administrative Costs, § 8.700.8
Rule Number:	MSB 09-08-17-E
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri / X3996

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.

   Denver Health Medical Center will be affected by this rule change.

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

   Outstationing payments to Denver Health Medical Center will decrease by approximately $600,000 per year. Presently, Denver Health Medical Center operates 20 FQHCs. The total capped outstationing reimbursement for these facilities if $60,000 x 20 clinics, which computes to $1.2 million. Effective September 1, 2009, the General Fund portion of this $1.2 million, will no longer be available. (General Fund constitutes 50% of the total payment, or $600,000.)

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.

   There are no costs to the Department or any other agency to implement or enforce this proposed rule.

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

   This rule must be amended since, after September 1, 2009, the General Fund portion currently used to reimburse outstationing administrative costs will no longer be available.

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

   No less costly or less intrusive methods are available.

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.

   None..

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process ~~accepting applications to determine Medicaid eligibility~~. This outstationing payment shall be made based upon actual cost with a reasonable cost-per-application limit to be established by the Department. The reasonable cost-per application limit shall be based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall the outstationing payment for FQHCs exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities. *[Eff 08/30/2006]*

8.700.8.B Hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting clients in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center clinics shall receive ~~additional~~ federal financial participation for eligible expenditures ~~that are not reimbursed by the outstationing payment methodology under 10 CCR 2505-10, Section 8.700.8.A~~. To receive the federal financial participation, Denver Health Medical Center FQHCs shall provide the State's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid expenditures under 42 C.F.R., Section 433.51. Such certifications shall be sent to the Safety Net Financing Manager. 42 C.F.R., Section 433.51, is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. *[Eff 08/30/2006]*

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Med Assistance Rule Concerning Elimination of the CICP Rural and Public Hospital Payments, §8.903
Rule Number:	MSB 09-08-17-F
Division / Contact / Phone:	State Programs and Federal Financing / Cindy Arcuri / X3996

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-17-F, Revision to the Medical Assistance Rule Concerning Elimination of the Colorado Indigent Care Program Rural and Public Hospital Payments
3. This action is an adoption of: <Select One>
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.903.C.15 and 16, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/1/2009
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

These programs have been repealed. Please remove all language from §8.903.C.15 and 16 with the exception of the following:

15. Rural Hospital Payment. This payment is repealed effective September 1, 2009.

16. Public Hospital Payment. This payment is repealed effective September 1, 2009.

This chance is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Med Assistance Rule Concerning Elimination of the CICP Rural and Public Hospital Payments, §8.903
Rule Number:	MSB 09-08-17-F
Division / Contact / Phone:	State Programs and Federal Financing / Cindy Arcuri / X3996

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).

   This rule is repealed, effective September 1, 2009 to reduce expenditures to Colorado Indigent Care Program (CICP) rural hospitals with 60 or fewer staffed acute care beds and public-owned CICP hospitals in order to help offset the projected state budget shortfall.

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 Department may not be able to provide the services necessary to preserve the public health, safety and welfare, if the CICP program expenditures to rural CICP hospitals with 60 or fewer staffed acute care beds are not reduced.

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(a)(30)(A).

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   24-4-103(6), C.R.S. (2008)

Initial Review — Final Adoption **10/16/2009**

Proposed Effective Date **11/30/2009** — Emergency Adoption

DOCUMENT # 10

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Med Assistance Rule Concerning Elimination of the CICP Rural and Public Hospital Payments, §8.903
Rule Number:	MSB 09-08-17-F
Division / Contact / Phone:	State Programs and Federal Financing / Cindy Arcuri / X3996

REGULATORY ANALYSIS

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

   The Rural and Public Hospital Payments partially reimburse public-owned hospital providers and rural hospital providers for inpatient hospital services rendered to low-income uninsured populations. To be eligible for these payments, providers must participate in the Colorado Indigent Care Program (CICP).

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 elimination of this funding will mean a decrease of $2.5 million that had been appropriated to public-owned CICP hospital providers in FY 2009-10 and a decrease of $2.5 million that had been appropriated for rural CICP hospital providers in FY 2009-10. Other CICP funding for rural and public-owned CICP hospital providers has not been impacted by this rule.

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.

   There are no costs to the Department or any other agency to implement or enforce this proposed rule.

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 revision is a reduction in expenditures for CICP rural hospitals with less than 60 beds and public-owned CICP hospitals, which will help offset the projected state budget shortfall. The cost is that these hospitals will no longer receive these supplemental payments to offset costs for CICP clients.

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

   Since all funding has been eliminated for this payment, there are no other options than to repeal the rule guiding these payments.

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.

   None.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

C. Distribution of Available Funds to Providers

15. Rural Hospital Payment. This payment is repealed effective September 1, 2009.~~an allocation of the Supplemental Tobacco Litigation Settlement Moneys Account and is available to qualified Rural Hospital providers.~~

~~a. A Rural Hospital provider shall meet the following requirements to qualify for the payment: (1) participate in the Colorado Indigent Care Program; (2) reside outside the boundaries of a federally designated metropolitan statistical area; and (3) have 60 or fewer staffed acute care beds.~~

~~b. Fifty percent of the moneys appropriated to the Supplemental Tobacco Litigation Settlement Moneys Account each fiscal year plus any corresponding available federal financial participation shall be allocated to qualified Rural Hospital providers on a quarterly basis.~~

~~c. The Rural Hospital payment to a qualified provider shall be calculated as the individual provider's Weighted Medically Indigent Costs relative to the sum of total Weighted Medically Indigent Costs for all qualified hospital providers multiplied by the allocation available to Rural Hospital providers. Weighted Medically Indigent Costs shall be as defined in Section 8.903.C.10 and the allocation available to Rural Hospital providers shall be as specified in Section 8.903.C.15.b.~~

16. Public Hospital Payment. This payment is repealed effective September 1, 2009.~~an allocation of the Supplemental Tobacco Litigation Settlement Moneys Account and is available to qualified Public Hospital providers. [Eff. 10/30/07]~~

~~a. A Public Hospital provider shall meet the following requirements to qualify for the payment: (1) participate in the Colorado Indigent Care Program; and (2) be either a State-owned or Local-owned hospital provider. [Eff. 10/30/07]~~

~~b. Fifty percent of the moneys appropriated to the Supplemental Tobacco Litigation Settlement Moneys Account each fiscal year, plus all interest and income earned on the deposit and investment of moneys in the Account, plus any corresponding available federal financial participation shall be allocated to qualified Public Hospital providers on a quarterly basis. [Eff. 10/30/07]~~

~~c. The Public Hospital payment to a qualified provider shall be calculated as the individual hospital provider's Weighted Medically Indigent Costs relative to the sum of total Weighted Medically Indigent Costs for all qualified hospital providers multiplied by the allocation available to Public Hospital providers. Weighted Medically Indigent Costs shall be as defined in Section 8.903.C.10 and the allocation available to Public Hospital providers shall be as specified in Section 8.903.C.16.b. [Eff. 10/30/07]~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reduction to FQHC Reimbursement, §8.700
Rule Number:	MSB 09-08-20-B
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-20-B, Revision to the Medical Assistance Rule Concerning Reduction to FQHC Reimbursement, §8.700
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.700.7, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.700.7.A through §8.700.7.D with the new text provided. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reduction to FQHC Reimbursement, §8.700
Rule Number:	MSB 09-08-20-B
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

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 proposed rule will reduce the FQHC encounter rate to a rate that is halfway between the alternative rate and the BIPA (PPS) rate.

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 Department may not be able to provide the services necessary to preserve the public health, safety, and welfare if FQHC rate reductions are not implemented.

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(aa)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);

Initial Review — Final Adoption **10/16/2009**

Proposed Effective Date **11/30/2009** — Emergency Adoption

DOCUMENT #12

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reduction to FQHC Reimbursement, §8.700
Rule Number:	MSB 09-08-20-B
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

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.

   Federally Qualified Health Centers (FQHCs) will receive reduced reimbursement for services provided.

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

   Reimbursement to FQHCs is estimated to be reduced by $3,915,491 for FY 09-10.

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.

   None.

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 revision is a reduction in FQHC expenditures, which will help offset the projected state budget shortfall and allow the Department to provide FQHC benefits without significant changes in coverage. The cost is that FQHCs may receive less reimbursement for the services they provide. If the Department does not reduce expenditures and help offset the state budget shortfall, the FQHC benefit and/or other Medicaid benefits may have to be significantly reduced.

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

The targeted reduction of provider reimbursement rates, including those for FQHC services, is one of the most effective means to reduce expenditures, given the size of the forecasted state budget shortfall and the urgency in which the shortfall must be offset.

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.

The Department is taking many steps to reduce expenditures, including other targeted provider rate reductions.

8.700.7 REIMBURSEMENT

8.700.7.A FQHCs shall be reimbursed a per visit encounter rate based on 100% of reasonable cost. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. A medical encounter and a dental encounter on the same day and at the same location shall count as two separate visits. *[Eff 08/30/2006]*

8.700.7.B ~~The encounter rate shall be the higher of:~~Encounter rate calculation *[Eff 0~~9~~8/01~~30~~/200~~96~~]*

Effective September 1, 2009, the encounter rate shall be the average of the Prospective Payment System (PPS) rate and the alternative rate.

1. The ~~Prospective Payment System (PPS),~~PPS rate ~~a~~is~~s~~ defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554~~.~~, BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library. ~~The Acute Care Benefits Section Manager at the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of BIPA, or the materials may be examined at any publications depository library.~~ *[Eff 09/01/2009]~~08/30/2006]~~*

2. ~~The alternative rate calculated by the Department. *[Eff 08/30/2006]*~~The alternative rate shall be the lower of the annual rate or the base rate. The annual rate and the base rate shall be calculated as follows:

~~8.700.7.C The alternative rate shall be the lower of the annual or the base rate. The annual and base rates shall be calculated as follows: *[Eff 08/30/2006]*~~

~~1~~a~~).~~ Annual rates shall be the FQHCs current year's calculated inflated rate, after audit. *[Eff 08/30/2006]*

b) ~~2. Base rates shall be recalculated (rebased) every three years.~~ The new base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years. *[Eff 08/30/2006]*

3. If the PPS rate is higher than the alternative rate, the FQHC encounter rate shall be the PPS rate.

4. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement base rate for the first year. The base rate shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. This shall be the FQHCs base rate until the next rebasing period. *[Eff 08/30/2006]*

New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates. *[Eff 08/30/2006]*

5~~3~~. ~~-~~The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate. *[Eff 08/30/2006]*

Freestanding FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. Freestanding FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments. *[Eff 08/30/2006]*

The new reimbursement rate for freestanding FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement rate (if less than the new audited rate) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120th day after the freestanding FQHCs fiscal year end. *[Eff 08/30/2006]*

The new reimbursement rate for hospital-based FQHCs shall be effective January 1 of each year. *[Eff 08/30/2006]*

If a hospital-based FQHC fails to provide the requested documentation, the costs associated with those activities shall be presumed to be non-primary care services and shall be settled using the Outpatient Hospital reimbursement rate. *[Eff 08/30/2006]*

All hospital-based FQHCs shall submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities. Non-primary care services shall be reimbursed according to Section 8.332. *[Eff 08/30/2006]*

6~~4~~. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If a FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation. *[Eff 08/30/2006]*

8.700.7.C~~D~~ The Department shall notify the FQHC of its rate. *[Eff 08/30/2006]*

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, §8.332
Rule Number:	MSB 09-08-20-C
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-20-C , Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.332, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new paragraph text at paragraph 2 under §8.332 between first paragraph:

"Outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare charge to cost ratio percent less 28 percent (28%). When the Department determines that the Medicare cost to charge ratio is not representative of a hospital's outpatient costs, the cost to charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%)."

And second paragraph:

"Outpatient hospital services which are defined as experimental by the Medicare program are not a benefit of the Medicaid Program. Outpatient hospital services which are not a covered benefit of the Medicare program are not a benefit of the Medicaid program. Extraordinary situations, based upon PRO recommendation and Department approval, will be reviewed for exception to these benefit limitations."

This change is effective 11/30/2009

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, §8.332
Rule Number:	MSB 09-08-20-C
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

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 proposed rule change will reduce reimbursement to hospitals for outpatient services from 72 percent of cost to 70.9 percent of cost.

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 Department may not be able to provide rate the services necessary to preserve the public health, safety and welfare, if the provider rate reductions are not implemented.

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(a)(30)(A)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   24-4-103(6), C.R.S., (2008)

Initial Review — Final Adoption **10/16/2009**

Proposed Effective Date **11/30/2009** — Emergency Adoption

DOCUMENT #13

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, §8.332
Rule Number:	MSB 09-08-20-C
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

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.

   Hospitals in Colorado will receive reduced reimbursement for outpatient hospital services.

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

   Reimbursement to hospitals for outpatient services is estimated to be reduced by $1,742,068 for FY 09-10.

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.

   None.

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 revision is a reduction in outpatient hospital expenditures, which will help offset the projected state budget shortfall and allow the Department to provide outpatient hospital benefits without significant changes in coverage. The cost is that hospitals may receive less reimbursement for outpatient treatment. If the Department does not reduce expenditures and help offset the state budget shortfall, the outpatient hospital benefit and/or other Medicaid benefits may have to be reduced significantly.

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

The targeted reduction of provider reimbursement rates, including those for outpatient hospital services, is one of the most effective means to reduce expenditures given the size of the forecasted state budget shortfall and the urgency in which the shortfall must be offset.

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.

The Department is taking many steps to reduce expenditures, including other targeted provider rate reductions.

8.332 PAYMENT

Outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare charge to cost ratio percent less 28 percent (28%). When the Department determines that the Medicare cost to charge ratio is not representative of a hospital's outpatient costs, the cost to charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Effective September 1, 2009, outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare charge to cost ratio percent less 29.1 percent (29.1%). When the Department determines that the Medicare cost to charge ratio is not representative of a hospital's outpatient costs, the cost to charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Ambulatory Surgery Centers, Section 8.570

Rule Number: MSB 09-08-26A

Division / Contact / Phone: Medicaid Program Division / Eric Wolf / 303-866-5963

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-26A, Ambulatory Surgery Centers, Section 8.570
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 8.570, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/1/2009
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.570.6.A and B. with the next text provided. This change is effective 11/30/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Ambulatory Surgery Centers, Section 8.570

Rule Number: MSB 09-08-26A

Division / Contact / Phone: Medicaid Program Division / Eric Wolf / 303-866-5963

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).

   Specifies changes in reimbursement rates.

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:

   If the Department does not reduce expenditures and help offset the state budget shortfall, the ambulatory surgery benefit or other benefits may have to be reduced significantly, which will interfere with the health and safety of Medicaid clients throughout Colorado.

3. Federal authority for the Rule, if any:

   Social Security Act Section 1902 (a) 30 (A) and 42 CFR Section 416.125

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);

Initial Review — Final Adoption **10/16/2009**

Proposed Effective Date **11/30/2009** — Emergency Adoption

DOCUMENT #16

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Ambulatory Surgery Centers, Section 8.570

Rule Number: MSB 09-08-26A

Division / Contact / Phone: Medicaid Program Division / Eric Wolf / 303-866-5963

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.

Ambulatory surgical centers will receive lowered reimbursement from the Medicaid program.

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 savings from this change are part of the estimated $1,742,068 reduction to outpatient hospital services.

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.

   None.

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

   The cost of this proposed rule revision is that ambulatory surgical centers will receive less reimbursement for their services. The benefit of the proposed rule revision is a reduction in ambulatory surgical center expenditures, which will help offset the projected state budget shortfall and allow the Department to provide ambulatory surgical benefits without significant changes in coverage. If the Department does not reduce expenditures and help offset the state budget shortfall, the ambulatory surgery benefit or other benefits may have to be reduced significantly.

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

   The targeted reduction of provider reimbursement rates, including those for ambulatory surgical centers, is one of the most effective means of reducing expenditures given the size of the forecasted state budget shortfall and the urgency with which it must be offset.

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.

   The Department is taking many steps to reduce expenditures, including other targeted provider rate reductions.

8.570 AMBULATORY SURGERY CENTERS

8.570.6 REIMBURSEMENT

8.570.6.A For payment purposes, ASC surgical procedures are grouped into nine categories ~~corresponding to CMS defined groups~~. The Health Care Procedural Coding System (HCPCS) is used to identify surgical services.

8.570.6.B Reimbursement for approved surgical procedures shall be allowed only for the primary or most complex procedure. No reimbursement is allowed for multiple or subsequent procedures. Approved surgical procedures identified in one of the nine ASC groupers ~~groupers~~ shall be reimbursed a facility fee at the lower of billed charges or ~~or 80% of the Medicare assigned rate~~ 77.22% of the 2007 Medicare-assigned rate. No reimbursement shall be allowed for services not included on the Department ~~-~~approved list for covered services.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Durable Medical Equipment and Medical Supplies

Rule Number: MSB 09-08-26-B.

Division / Contact / Phone: Medicaid Program / Doug van Hee / 4986

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-26-B., Durable Medical Equipment and Medical Supplies
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.590, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.590.7.I.1. through 3. with the new text provided. This change is effective 11/30/2009

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Durable Medical Equipment and Medical Supplies

Rule Number: MSB 09-08-26-B.

Division / Contact / Phone: Medicaid Program / Doug van Hee / 4986

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 proposed rule change will reduce reimbursement rates for durable medical equipment and supplies that are paid from fee schedule, invoiced costs or from manufacture suggegested retail prices.

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 Department may be unable to continue to provide the some medical services necessary to preserve the public health, safety and welfare, if the rate reductions are not implemented.

3. Federal authority for the Rule, if any:

   Social Security Act, Section, 1902(a)(30)(A)
   42 CFR 440.70

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-5-102 (F) C.R.S. (2008)

Initial Review — Final Adoption **10/16/2009**

Proposed Effective Date **11/30/2009** — Emergency Adoption

DOCUMENT #15

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Durable Medical Equipment and Medical Supplies

Rule Number: MSB 09-08-26-B.

Division / Contact / Phone: Medicaid Program / Doug van Hee / 4986

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.

   Durable medical equipment and disposable medical supply providers will receive less reimbursement for services provided.

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

   Total fund reduction for durable medical equipment and supplies for FY 2009-10 is $875,318.

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.

   None

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 revision is a reduction in durable medical equipment and supply expenditure, which will help offset the projected state budget shortfall and allow the Department to provide benefits without significant change in coverage. The cost is that providers will receive less reimbursement. If the Department does not reduce expenditures and help offset the state budget shortfall, the durable medical equipment and supply benefit and/or other Medicaid benefits may have to be reduced significantly.

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

   The targeted reduction of provider reimbursement rates is one of the most effective means to reduce expenditures given the size of the forecasted state budget shortfall and the urgency in which the shortfall must be offset.

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.

The Department is taking many steps to achieve program efficiencies to reduce expenditures, including other targeted provider rate reductions and defining benefits to identify the amount, scope and duration of the each benefit.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.590.7.I. Reimbursement rate for a purchased item shall be as follows:

1. Fee Schedule items, with a HCPC or CPT code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the department fee schedule.

2. Manually priced items that have no maximum allowable reimbursement rate assigned, but have a Manufacture Suggested Retail Price (MSRP) shall be reimbursed the MSRP less 20.82 percent.

3.~~2~~. Manually priced items that have no maximum allowable reimbursement rate assigned ,nor a MSRP shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturers invoice cost, plus 15.87 ~~twenty~~ percent.