THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Prenatal Plus Program, Section 8.748
Rule Number:	MSB 11-03-08-A
Division / Contact / Phone:	Medicaid Program Division / Ginger Burton / 303-866-2693

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 11-03-08-A, Prenatal Plus Program
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) 8.748, 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*

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Prenatal Plus Program, Section 8.748
Rule Number:	MSB 11-03-08-A
Division / Contact / Phone:	Medicaid Program Division / Ginger Burton / 303-866-2693

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 describes the Prenatal Plus Program which will be solely administered by the Department of Health Care Policy and Financing effective July 1, 2011. Prior to July 1, 2011, CDPHE was responsible for administration of the program. This rule removes reference to administrative functions formerly performed by CDPHE and more clearly outlines and defines program criteria - information that could formerly be found in documents published/provided by CDPHE.

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:

§ 440.210 Required services for the categorically needy.
"(a) A State plan must specify that, at a minimum, categorically needy recipients are furnished the following services:…(2) Pregnancy-related services and services for other conditions that might complicate the pregnancy. (i) Pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services. (ii) Services for other conditions that might complicate the pregnancy include those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus…"

4. State Authority for the Rule:

Initial Review		Final Adoption	**07/08/2011**
Proposed Effective Date	**08/30/2011**	Emergency Adoption	

DOCUMENT #08

25.5-1-301 through 25.5-1-303, C.R.S. (2010);

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Prenatal Plus Program, Section 8.748
Rule Number:	MSB 11-03-08-A
Division / Contact / Phone:	Medicaid Program Division / Ginger Burton / 303-866-2693

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 continues an existing program that provides enhanced services to pregnant Medicaid clients who are determined to be at risk of poor maternal and/or infant health outcomes. Pregnant women and Medicaid providers who serve pregnant women may be affected by the proposed rule to the extent that programmatic and fiscal administration of the program will now be housed at one state department rather than two. This will result in streamlined processes which may attract providers who have not provided services under this program in the past.

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

   To the extent that changes in administration of the program result in additional providers offering services under this program, those providers would be able to be reimbursed for program services. A larger number of eligible women may be able to be served if additional providers join, allowing more women access to program services that may improve maternal and infant health outcomes and could result in cost savings.

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 currently reimburses providers for services provided through this program. As discussed above, to the extent that changes in administration of the program result in additional providers offering services under the program, additional clients may be able to be served and the Department would be responsible for reimbursing qualified providers for those services. This represents an indeterminate impact as it is not clear whether additional providers will begin offering services through this program.

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

   Adopting the proposed rule will allow the Department to be in compliance with SB 11-209 (Long Appropriations Bill) and continue to serve pregnant Medicaid clients who are determined to be at risk of poor maternal and/or infant health outcomes. Inaction would result in noncompliance with state statute.

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

   There are no less costly methods or less intrusive methods for achieving the purpose of the proposed rule. The proposed rule keeps the Department in compliance with state statute.

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.

   Because the existing rule references administrative functions performed by CDPHE, and because CDPHE will no longer be administering any portion of the program as of July 1, 2011, the Department considers revising the current rule to be necessary and the most practical method for achieving its purposes.

8.748.1 DEFINITIONS

Initial Assessment Form means the Prenatal Plus Program risk assessment tool that must be used by all Prenatal Plus Program Providers to further assess and document a client's needs.

Program Eligibility Screening Form means the Prenatal Plus Program eligibility tool that must be used by all Prenatal Plus Program Providers to determine if a client is eligible for Prenatal Plus Program services.

Prenatal Plus Program Provider means an entity or agency that meets the qualifications described in Section 8.748.4 and has been accepted as such by the Department of Health Care Policy and Financing (the Department).

8.748.2 PROGRAM PURPOSE

The purpose of the Prenatal Plus Program is to improve the maternal and infant health outcomes of at-risk Medicaid clients by providing comprehensive and coordinated prenatal and early postpartum support services that complement traditional clinical prenatal care. The primary goal of the program is to reduce the incidence of low birth weight babies while also addressing other lifestyle, behavioral, and non-medical aspects of a woman's life that may affect her and/or her baby's health and well-being. By focusing on case management, nutrition counseling and support, psychosocial counseling and support, client education and health promotion, the Prenatal Plus Program seeks to ensure that women have access to the services and information needed to have healthy pregnancies and healthy babies.

8.748.3 CLIENT ELIGIBILITY

8.748.3.A To be eligible for services provided through the Prenatal Plus Program, a Colorado Medicaid client shall:

1. Be pregnant (self-declared or medically verified) or in the postpartum period (but participated in the Prenatal Plus Program during the prenatal period); and

2. Be determined by a Prenatal Plus Program Provider using the Program Eligibility Screening Form to be at risk of having a negative maternal and/or infant health outcome(s) due to identified risk factors which shall be further assessed and documented using the Initial Assessment Form.

8.748.4 PROVIDER ELIGIBILITY AND QUALIFICATIONS

8.748.4.A Providers wishing to render and be reimbursed for Prenatal Plus Program services, as a condition of being a Prenatal Plus Program Provider, shall:

1. Be a Colorado Medicaid provider enrolled as one of the following Colorado Medicaid Billing Provider Types: Clinic, Federally Qualified Health Center, Rural Health Center, Non-Physician Practitioner Group, Physician, Nurse Practitioner, Certified Nurse-Midwife, or Physician's Assistant;

2. Execute and submit a Prenatal Plus Program addendum to the Colorado Medical Assistance Program Provider Participation Agreement for review and acceptance by the Department; and

3. Manage a Prenatal Plus Program multidisciplinary team(s) of personnel. The multidisciplinary team shall include:

a. A care coordinator(s) who acts as the hub of the multidisciplinary team and is the person primarily responsible for organizing resources and assisting clients in accessing services to meet their individual needs. The care coordinator(s) shall, at minimum, hold a bachelor's degree in a relevant human/social services discipline or be a registered nurse;

b. A registered dietitian(s) who is currently registered with the Commission on Dietetic Registration as a registered dietitian, or a dietetic intern(s) in an internship accredited by the American Dietetic Association and supervised by a registered dietitian who has agreed to serve as a preceptor for the dietetic intern;

c. A mental health professional(s) who, at minimum, is a master's level professional in the field of social work, marriage and family therapy, professional counseling, or other mental health specialty, or an intern(s) in an accredited mental health internship and supervised by a master's level mental health professional; or the Prenatal Plus Program Provider must have a consistent, documented referral relationship with a mental health provider(s) not part of the multidisciplinary team but participating with the Colorado Medicaid Community Mental Health Services Program. Prenatal Plus Program Providers who do not include a mental health professional as part of their multidisciplinary team shall not be eligible for reimbursement of psychosocial counseling and support through the Prenatal Plus Program; and

d. A Colorado Medicaid-enrolled physician, nurse practitioner, certified nurse-midwife, or physician's assistant who is the rendering provider that delegates the provision of Prenatal Plus Program services to the multidisciplinary team.

4. Retain in the record of each client to whom Prenatal Plus Program services are rendered:

a. Identification of qualifying risk factors using the Program Eligibility Screening Form; and

b. A client risk assessment using the Initial Assessment Form.

8.748.5 REIMBURSABLE SERVICES

8.748.5.A Services reimbursable through the Prenatal Plus Program include:

1. Nutrition counseling and support provided by the registered dietitian/dietetic intern consisting of the following components which may be provided on an individual basis or in a group setting based on client need:

a. Nutrition screening;

b. General nutrition education;

c. Comprehensive nutrition status assessment; and

d. Nutrition counseling and targeted nutrition education based on client-specific need. Nutrition counseling shall be considered inclusive of nutrition care-planning, goal-setting, monitoring, follow-up, and nutrition care plan revision.

2. Psychosocial counseling and support provided by the mental health professional consisting of the following components which may be provided on an individual basis or in a group setting based on client need:

a. Psychosocial health screening;

b. Comprehensive psychosocial health assessment; and

c. Psychosocial health counseling and support. Psychosocial counseling and support shall be considered inclusive of psychosocial care-planning, goal-setting, monitoring, follow-up, and psychosocial care plan revision.

i. Psychosocial counseling and support does not include clinical psychotherapy services, traditional medication management, or other clinical services specifically related to treatment of a diagnosed mental health disorder. When clinical mental health disorders are identified, including substance use disorders, clients shall be referred to a provider who participates in the Colorado Medicaid Community Mental Health Services Program or a Medicaid-enrolled substance use disorder treatment provider.

3. General client education and health promotion provided by the care coordinator which may be provided on an individual basis or in a group setting based on client need, regarding topics that may include:

a. Basic understanding of the prenatal period

i. Physical and emotional changes related to pregnancy including fetal development;

ii. Healthy and appropriate weight gain during pregnancy;

iii. Healthy prenatal diet and food precautions;

iv. Physical activity precautions and appropriate exercise;

v. Substance use and how it can affect maternal and infant health outcomes;

vi. Sexually transmitted diseases/infections and how they can affect maternal and infant health outcomes;

vii. Bonding with the baby before birth;

viii. Importance of oral hygiene;

ix. Warning signs of preterm labor; and

x. Common terminology;

b. Common concerns related to childbirth and breastfeeding

i. Birth planning, hospital packing/preparation, and attending birth classes;

ii. Pain management options during delivery; and

iii. Benefits of breastfeeding, preparing for breastfeeding and breastfeeding basics;

c. The postpartum period and healthy infancy

i. Postpartum mood disorders (“baby blues” and postpartum depression);

ii. Postpartum recovery issues and adjustment including body changes, self-esteem, and relationship stressors;

iii. Managing stress, day-to-day problem-solving, positive communication techniques, building and using support networks;

iv. Family planning and contraception;

v. Comforting and stimulating infants (including education on shaken baby syndrome risk reduction, recognizing an infant’s distress cues, and bonding/attachment postpartum);

vi. Appropriate expectations for infant behavior, sleeping patterns, teething and crying;

vii. Infant health including newborn feeding, immunizations, pediatrician visits, and car-seat safety; and

viii. Environmental risk factors including violence in the home, smoke, substance use and how they can affect infant health; and

4. Targeted case management provided by the care coordinator. Targeted case management is a service provided to assist clients in gaining access to needed medical, social, educational, and other services, and includes the following components:

a. Comprehensive assessment and periodic reassessment of the client’s needs to determine the necessity for any medical, educational, social, or other services;

b. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that specifies the goals and actions to address the medical, social, educational, and other services needed and identifies a course of action to respond to the assessed needs;

c. Referral and related activities to help the client obtain needed services including activities that help link the client with medical, social, or educational providers, or other programs and services that are capable of providing needed services; and

d. Monitoring and follow-up activities including activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the client’s needs, and which may be with the client, family members, providers, or other entities or individuals.

e. Targeted case management provided by the care coordinator may include, but is not limited to, screening for nutrition and psychosocial risk factors.

f. Note: Targeted case management does not include case management activities that are an integral component of another covered Medicaid service; the direct delivery of an underlying medical, educational, social, or other service to which a client has been referred; activities integral to the administration of foster care programs; or activities for which a client may be eligible that are integral to the administration of another non-medical program.

8.748.6 REIMBURSEMENT

8.748.6.A Reimbursement shall be the lower of:

1. Submitted charges; or

2. Fee schedule for Prenatal Plus Program services as determined by the Department.

THIS PAGE NOT FOR PUBLICATION

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 11-03-22-A, Revision to the Medical Assistance Eligibility Rule Concerning Increase in Resource Limits for Medicare Savings Plan Programs
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) 8.100.5.M, 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 the current text in §8.100.5.M. with the new text provided. This changes only two numbers in paragraph 1. All other text if for clarification purposes only. This change is effective 08/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Increase in Resource Limits for Medicare Savings Plan Programs
Rule Number:	MSB 11-03-22-A
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

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, Section 8.100.5.M to add language to increase the resource limits for Medicare Savings Programs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), P.L. 110-275, amends the resource limit for Qualified Medicare Beneficiaries (QMB), Special Low-Income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI1) to $8,180 for individuals and $13,020 for a couple. This change in resource limit does not apply to Qualified Disabled Working Individuals (QDWI).

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:

   Medicare Improvements for Patients and Providers Act 2008, P.L. 110-275, Section 112

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);

Initial Review	**05/13/2011**	Final Adoption	**07/08/2011**
Proposed Effective Date	**08/30/2011**	Emergency Adoption	

DOCUMENT #10

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 individuals eligible for Medicare Savings Programs.

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 positively impacts individuals with higher resources. The proposed rule allows for an increase in the resource limit for Medicare Savings Programs to account for Consumer Price Inflation (CPI) to ensure that individuals do not lose eligibility for the Medicare Savings Programs due to inflationary increases in the value of resources.

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 would be no costs or savings to the Department. The proposed rule would apply an inflationary increase to the resource limits for Medicare Savings Programs and does not change the relative asset limits.

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

   Not applicable. The rules are necessary to be in conformity with current federal law.

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

   Not applicable. The rules are necessary to be in conformity with current federal law.

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. The rules are necessary to be in conformity with current federal law.

8.100.5.M. Resource Requirements

1. Consideration of resources: Resources are defined as cash or other assets or any real or personal property that an individual or spouse owns. The resource limit for an individual is $2000. For a married couple, the resource limit is $3000. The resource limits for the QMB, SLMB, and QI programs are ~~$8,100~~ $8,180 for a single individual and ~~$12,910~~ $13,020 for a married individual living with a spouse and no other dependents. If one spouse is institutionalized, refer to Spousal Protection-Treatment of Income and Resources for Institutionalized Spouses.

2. The following resources are exempt in determining eligibility:

    a. The principal place of residence, which is owned by the applicant or applicant's spouse, including the home in which the individual resides, the land on which the home is located and related out-buildings.

    b. If an individual or spouse moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence.

    c. If an individual leaves his or her home to live in an institution, the home will still be considered the principal place of residence, irrespective of the individual's intent to return as long as the individual's spouse or dependent relative continues to live there. Dependent relative is defined as one who is claimed as a dependent for federal income tax purposes.

    d. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Interfaces for Citizenship and/or Identity for Medicaid eligibility. Section 8.100.3.H.
Rule Number:	MSB 11-03-22-B
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

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 11-03-22-B, Revision to the Medical Assistance Rule Concerning Interfaces for Citizenship and/or Identity for Medicaid eligibility. Section 8.100.3.H.
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.H, 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 from section 8.100.3.H. through section 8.100.3.H.1.G with new text provided from section 8.100.3.H through section 8.100.3.H.2.b.vii. This change is effective 08/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Interfaces for Citizenship and/or Identity for Medicaid eligibility. Section 8.100.3.H.
Rule Number:	MSB 11-03-22-B
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

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).

   Interfaces are needed to ease the administrative burden of the paper verification process for citizenship and/or identity for eligibility sites and clients. Eligibility sites will have the authority to accept the interface and process cases without further documentation.

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:

   Children's Health Insurance Program Reauthorization Act of 2009, Pub.L. 111-3, section 211 (2009)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);

Initial Review — Final Adoption **07/08/2011**

Proposed Effective Date **08/30/2011** — Emergency Adoption

DOCUMENT #09

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Interfaces for Citizenship and/or Identity for Medicaid eligibility. Section 8.100.3.H.
Rule Number:	MSB 11-03-22-B
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

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 that have their data matched through the various interfaces will benefit from this proposed rule because they will have their citizenship and/or identity verified without having to provide documents. The interface will also ease administrative burdens for eligibility workers at counties and eligibility sites.

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

   Interfaces are needed to ease the administrative burden of the paper verification process for citizenship and/or identity for eligibility sites and clients. Eligibility sites will have the authority to accept the interface and process cases without further documentation.

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 cost of the SSA electronic interface being implemented into the Colorado Benefits Management System is $254,488. These costs are being funded through the State Health Access Program grant to support Colorado's health care expansion efforts.

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

   Without the proposed rule, Medicaid clients would have to continue to provide paper documentation to prove citizenship and identity, which is a barrier to enrollment for individuals that do not have immediate access to a birth certificate and/or a state issued identification card. In addition, eligibility workers at counties and eligibility sites would have to continue the paper verification process for citizenship and/or identity, which currently causes an administrative burden and delays in application processing for clients that do not have immediate access to the required documentation. The proposed rule would cost $254,488, funded through the federal State Health Access Program grant, and would alleviate these burdens on clients and eligibility sites.

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

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

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

   There are no alternative methods to the interface in this proposed rule.

8.100.3.H. Citizenship and Identity Documentation Requirements

1. For determinations of initial eligibility and redeterminations of eligibility for Medical Assistance made on or after July 1, 2006, ~~applicants/clients shall provide satisfactory documentary evidence of~~ citizenship or nationality and identity status must be verified unless such satisfactory documentary evidence has already been provided, as described in 8.100.3.H.4.b. This requirement applies to an individual who declares or who has previously declared that he or she is a citizen or national of the United States.

   a. The following electronic interfaces shall be accepted as proof of citizenship and/or identity as listed and should be used prior to requesting documentary evidence from applicants/clients:

      i) SSA Interface is an acceptable interface to verify citizenship and identity. An automated response from SSA that confirms that the data submitted is consistent with SSA data, including citizenship or nationality, meets citizenship and identity verification requirements. No further action is required for the individual and no additional documentation of either citizenship or identity is required.

   b.This requirement does not apply to the following groups:

      i)~~a~~. Individuals who are entitled to or who are enrolled in any part of Medicare.

      ii)~~b~~. Individuals who receive Supplemental Security Income (SSI).

      iii)~~c~~. Individuals who receive child welfare services under Title IV-B of the Social Security Act on the basis of being a child in foster care.

      iv)~~d~~. Individuals who receive adoption or foster care assistance under Title IV-E of the Social Security Act.

      v)~~e~~. Individuals who receive Social Security Disability Insurance (SSDI).

      vi)~~f~~. Children born to a woman who has applied for, has been determined eligible, and is receiving Medical Assistance on the date of the child's birth, as described in 8.100.4.G.5. This includes instances where the labor and delivery services were provided before the date of application and were covered by the Medical Assistance Program as an emergency service based on retroactive eligibility.

         ~~i~~1) A child meeting the criteria described in 8.100.3.H.1.f. shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence at any time in the future, regardless of any subsequent changes in the child's eligibility for Medical Assistance.

         ~~ii~~2) Special Provisions for Retroactive Reversal of a Previous Denial

            ~~1~~a) If a child described at 8.100.3.H.1.f. was previously determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial shall be reversed. Eligibility shall be effective retroactively to the date of the child's birth provided all of the following criteria are met:

~~a~~(1) The child was determined to be ineligible for Medical Assistance during the period between July 1, 2006 and October 1, 2009 solely for failure to meet the citizenship and identity documentation requirements as they existed during that period;

~~b~~(2) The child would have been determined to be eligible for Medical Assistance had 8.100.3.H.1.f. and/or 8.100.3.H.1.f.ii.1) been in effect during the period from July 1, 2006 through October 1, 2009; and

~~c~~(3) The child's parent, caretaker relative, or legally appointed guardian or conservator requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

~~2~~~~3~~b) A child for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.Q.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed pursuant to this subsection 1.

~~3~~(4c) A child granted retroactive eligibility for Medical Assistance shall be subject to the requirements described at 8.100.4.G.5. for continued eligibility.

~~G~~vii). Individuals receiving Medical Assistance during a period of presumptive eligibility.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to Medical Assistance Rule Concerning Home Health Special Reimbursement of Non-Homebound Dually Eligible clients
Rule Number:	MSB 11-04-01-A
Division / Contact / Phone:	Medicaid/Benefit Management / Guinevere Blodgett / 5927

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 11-04-01-A, Home Health Special Reimbursement of Non-Homebound Dually Eligible clients
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) 8.520 Home Health Services, 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 from §8.528.15.A through §8.528.15.C with new text provided from §8.528.14.D through §8.528.14.F.2. All other text has been provided for reference purposes only. This change is effective 05/13/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to Medical Assistance Rule Concerning Home Health Special Reimbursement of Non-Homebound Dually Eligible clients
Rule Number:	MSB 11-04-01-A
Division / Contact / Phone:	Medicaid/Benefit Management / Guinevere Blodgett / 5927

STATEMENT OF BASIS AND PURPOSE

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

   At the present time, home health agencies are required to bill Medicare, and must then wait for partial payment, or a denial, to get payment from Medicaid, the payor of last resort. However, Medicare does not cover services for clients who do not meet the home bound status requirement for home health benefits, and submitting claims to Medicare for these services does not result in any payment. Colorado Medicaid allows home health care to be delivered to clients who are not home bound, but in accordance with the current rule, home health agencies must wait for the Medicare denials to get the claims paid. This can create an unduly burdensome delay in payment for the home health agencies. The proposed rule change will allow home health agencies to bill Medicaid at the time of services for dual eligible clients who are not homebound, which will resolve the payment delay issue. Home health agencies will still be required to obtain a Medicare denial for the client records to ensure that Medicaid is the payor of last resort. This rule revision also includes the deletion of obsolete cost reporting requirements.

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. (2010);

Initial Review — Final Adoption

Proposed Effective Date **05/13/2011** — Emergency Adoption **05/13/2011**

DOCUMENT #01

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to Medical Assistance Rule Concerning Home Health Special Reimbursement of Non-Homebound Dually Eligible clients
Rule Number:	MSB 11-04-01-A
Division / Contact / Phone:	Medicaid/Benefit Management / Guinevere Blodgett / 5927

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.

   All Medicare/Medicaid dually eligible clients receiving home health services will be affected by the proposed 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.

   Home health agencies will receive more timely payment for this client population. The amount of reimbursement will remain the same.

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.

   This rule has the potential to make Medicaid claims pay more quickly after the service is rendered. The Department believes that should this result in costs shifting, the impact would be minimal. Many providers are currently compliant with the rule change and the dollar amount of claims that could be impacted is relatively low. Should the Department find the cost shift to be higher than expected it will account for the change through the regular budget process.4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   This rule change will allow home health agencies to receive payment for services without waiting for a Medicare denial, which will benefit our home health provider network.

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

   This rule will allow for timely billing of services for this population, but will not affect the cost of these services.

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.

8.528 REIMBURSEMENT

.14 SPECIAL REIMBURSEMENT CONDITIONS

A. Reimbursement for third party resource and Medicare crossover claims shall not exceed Medicaid costs.

B. When Home Health agencies provide Home Health services, in accordance with these regulations, to clients who receive Home and Community Based Services for the Developmentally Disabled (HCBS-DD), the Home Health agency shall be reimbursed:

1. Under normal procedures for Home Health reimbursement, if the client resides in an Intensive Adult Residential Service group home, a personal care host home, or personal care alternatives home; or

2. By the group home provider, if the client resides in a Moderate Supervision Group Home, or Specialized Group Home, because the group home has already received Medicaid funding for the home health services and is responsible for payment to the Home Health agency.

C. Acute Home Health services provided to Medicaid HMO clients, including Medicaid HMO clients who are also HCBS recipients, shall not be reimbursed under the Medicaid Home Health program, but shall be reimbursed under Medicaid HMO rules. If a client's Home Health service need exceeds 60 days, the Home Health Agency shall submit a Prior Authorization for Long Term: Home Health to the Single Entry Point agency, if the client is 18 years old: or more; or to the Medicaid fiscal agent if the client is less than 18 years old.

D. All Medicare requirements shall be met and exhausted prior to any dual eligible client's claims being billed to Medicaid, as demonstrated by a Medicare denial of benefits, except in the specific cases listed at 8.528.14[JLD1].D.1 and 8.525.14.D.2.

1. A Home Health Agency may bill Medicaid without billing Medicare if the services below are the only services on the claim:

a. Pre-pouring of medications;

b. Certified Home Health Aide services;

c. Occupational Therapy services when provided as the sole skilled service; or

d. Routine Laboratory Draw services.

2. A Home Health Agency may bill Medicaid at the time of services, if the conditions below apply. The claim must also be submitted to Medicare so that the denial, when received, is part of the client's file.

a. The client is stable;

b. The client is not experiencing an acute episode; and

c. The client routinely leaves the home without taxing effort and unassisted for social, recreational, educational, or employment purposes.

3. The Home Health Agency shall maintain clear documentation in the client's record of the conditions and services that are billed to Medicaid without billing Medicare.

4. A Home Health Advance Beneficiary Notice (HHABN) shall be filled out as prescribed by Medicare.

E. A dual eligible Long Term Home Health Care client who has an Acute Episode shall be switched from Medicaid to Medicare reimbursement. Medicaid resumes as the payer of record when Medicare denies payment as a non-covered benefit and the service is a Medicaid benefit, or when the service consists of those listed in 8.528.14.D.2.

F. If both Medicare and Medicaid reimburse for the same visit or service provided to a client in the same episode, the reimbursement shall be considered a duplication of payment and the Medicaid reimbursement shall be returned to the Department.

1. Upon receiving a duplicate payment, Home Health agencies shall return the payment to Medicaid within sixty (60) calendar days of final Medicare payment.

2. Failure to return the Medicaid payment to the Department shall be deemed a false claim and subject to the provisions set forth in 25.5-4-303.5, C.R.S., et seq. and referred to the Medicaid Fraud Control Unit in the Colorado Department of Law for criminal investigation.

~~.15 COST REPORTING~~

~~A. All Home Health agencies shall report and submit to the Department cost report information on a Department prescribed form for home health aides, nurses, occupational, physical and speech therapists.~~

~~B. By dates set forth by the Department, home health providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or State fiscal year.~~

~~C. Providers that do not comply with Section 8.528.15 shall have their Medicaid provider agreement terminated.~~

8.529 POST-PAYMENT REVIEW

.10 The Medicaid Quality Assurance Unit shall periodically conduct post-payment reviews of selected Home Health services.

.11 Home Health agencies shall submit or produce requested documentation of services to the Medicaid Quality Assurance Unit in accordance with rules at 8.079.62. Such documentation shall include, at a minimum:

A. Physician-signed plans of care, which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client. The plan of care must be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services provided must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.

B. Records documenting the nature and extent of the care actually provided such as, but not limited to, nursing notes.

.12 The Medicaid Quality Assurance Unit shall review all information available from any source, shall contact clients, and may conduct on-site visits to Home Health agencies and/or clients.

.13 The Medicaid Quality Assurance Unit shall initiate appropriate administrative, civil, or criminal investigations and/or sanctions for all services which:

A. Are found to be out of compliance with all applicable regulations;

B. Are not consistent with the client's documented medical needs and functional capacity,

C. Are not reasonable in amount, frequency, and duration;

D. Are duplicative of any other services that the client received or that the client received funds to purchase;

E. Total more than twenty-four hours per day of paid care, regardless of funding source (An example of care totaling more than 24 hours per day would be 5 home health visits plus 12 hours of personal care);

F. Consist of visits or contiguous units which are shorter or longer than the length of time required to perform all the tasks prescribed on the care plan.

.14 Clients and families of clients shall not be billed by home health agencies for any services for which Medicaid reimbursement is recovered as a result of post-payment review.

.15 Providers may appeal post-pay sanctions in accordance with Section 8.050, PROVIDER APPEALS AND HEARINGS.

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies, Section 8.590.7.I
Rule Number:	MSB 11-04-14-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

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 11-04-14-A, Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies, Section 8.590.7.I
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) 8.590.7.I, 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 Section 8.590.7.I.2 and Section 8.590.7.I.3 with new text provided. All other text is for reference only. This change is effective 08/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies, Section 8.590.7.I
Rule Number:	MSB 11-04-14-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

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 rule gives the reimbursement rates for durable medical equipment and supplies. To address the state budget shortfall, the proposed rule change reduces reimbursement rates for durable medical equipment and supplies from the fee schedule, or calculated using invoiced costs or manufacturer suggested 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:

3. Federal authority for the Rule, if any:

Social Security Act, Section 1902(a)(30)(A)
42 CFR 440.70
42 CFR 447.15

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-5-4-416 C.R.S.

Initial Review — Final Adoption **07/08/2011**

Proposed Effective Date **08/30/2011** — Emergency Adoption

DOCUMENT #06

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies, Section 8.590.7.I
Rule Number:	MSB 11-04-14-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / x5942

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 a lower 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.

This rule will reduce by .75% the amount that durable medical equipment and supply providers are reimbursed.

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 proposed rule change will help offset the projected state budget shortfall and allow the Department to provide benefits without any significant changes in coverage. The cost of this rule change is that providers will receive a lower reimbursement. If the Department does not make this reduction, the durable medical equipment and supply benefit, and other Medicaid benefits, may have to be reduced.

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

A reduction of provider reimbursement is an effective way to reduce expenditures, given the size of the forecasted state budget shortfall and the urgent need to offset it.

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

There are no alternative methods for achieving the purpose for the proposed rule because the rate cut was decided by the Legislature. The Department continually looks for other ways (besides rate reductions) to make the Medicaid program more efficient and reduce expenditures, and recommends these to the Legislature.

8.590.7 REIMBURSEMENT

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 ~~22.39~~22.97 percent.

3. 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 ~~13.56~~12.71 percent.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Ambulatory Surgery Centers, Section 8.570.6.B
Rule Number:	MSB 11-04-14-B
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / 5942

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 11-04-14-B, Revision to the Medical Assistance Rule Concerning Ambulatory Surgery Centers, Section 8.570.6.B
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) 8.570.6.B, 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 from Section 8.570.6.B through Section 8.570.6.B.2 with new text provided. All other text is for reference only. This change is effective 08/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Ambulatory Surgery Centers, Section 8.570.6.B
Rule Number:	MSB 11-04-14-B
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / 5942

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 rule describes the reimbursement methodology for Ambulatory Surgery Centers. Unlike most service reimbursement rules, this rule includes a specific number - a percentage of the Medicare rate. The Department proposes to align this rule with other reimbursement rules by removing the specific number and referencing the Department's fee schedule.

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:

42 CFR 447.201(b)
Attachment 4.19-B of the Colorado Medicaid State Plan

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-4-401, C.R.S

Initial Review		Final Adoption	**07/08/2011**
Proposed Effective Date	**08/30/2011**	Emergency Adoption	

DOCUMENT #07

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Ambulatory Surgery Centers, Section 8.570.6.B
Rule Number:	MSB 11-04-14-B
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / 5942

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 surgery centers will need to reference the Department's fee schedule rather than the rule to get their rates. These providers are already rely on the fee schedule; therefore, there will be no impact on these providers.

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

   This rule change will not have an impact on ambulatory surgery centers or any other stakeholders.

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 will be no effect on state revenues. The Department will reduce the administrative burden on the Department and the Medical Services Board by eliminating rule changes that are currently necessary every time the fee schedule changes for these services. In addition, it is easier for providers to read and understand the reimbursement fees on the fee schedule, rather than the way it is currently stated in rule.

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

   There are no costs associated with this rule change. It does not change the transparency of the Department's reimbursement process or rates.

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.

The reimbursement amount could be left in the rule, but the way it is written is confusing to providers and creates unnecessary rule changes every time the rate changes. Therefore, the Department recommends removing this information from the rule and, instead, referencing the fee schedule. This is how the majority of the Department's reimbursement rules are currently written.

8.570.6 REIMBURSEMENT

8.570.6.A For payment purposes, ASC surgical procedures are grouped into nine categories. 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. No reimbursement shall be allowed for services not included on the Department approved list for covered services. Approved surgical procedures identified in one of the nine ASC groupers shall be reimbursed a facility fee at the lower of the following:

1. ~~billed~~Submitted charges; or

2. Fee schedule as determined by the Department. ~~75.69% 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: Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6

Rule Number: MSB 11- 05 -10 -A

Division / Contact / Phone: Rates and Analysis / Elizabeth Lopez / 6018

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 11- 05 -10 -A, Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
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) 8.300.6.A, 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*

At Section 8.300.6.A.1, unnumbered paragraph 5, please insert new text provided. All other text is for reference only. This change is effective 08/30/2011.

*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, Section 8.300.6
Rule Number:	MSB 11- 05 -10 -A
Division / Contact / Phone:	Rates and Analysis / Elizabeth Lopez / 6018

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 69.3% of cost to 68.8% 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:

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. (2010);
   24-4-103(6), C.R.S., (2010)
   SB 11-209

Initial Review — Final Adoption **07/08/2011**

Proposed Effective Date **08/30/2011** — Emergency Adoption

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number:	MSB 11- 05 -10 -A
Division / Contact / Phone:	Rates and Analysis / Elizabeth Lopez / 6018

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 $ 1,218,987 for FY 11-12 as a result of the 0.75% reduction.

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 will generally receive less reimbursement for outpatient treatment.

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.

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.

   Senate Bill 11-209 mandates across-the-board rate reductions for most Medicaid providers effective 7/1/2011.

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%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). 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 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). 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 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). 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 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

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.