Title of Rule:	Revision to the Medical Assistance Rule Concerning Consumer Directed Attendant Support Services (CDASS) Service Definitions
Rule Number:	MSB 12-08-20-A
Division / Contact / Phone:	Long Term Care / Sarah Hoerle / 303-866-2669

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 12-08-20-A, Revision to the Medical Assistance Rule Concerning Consumer Directed Attendant Support Services (CDASS) Service Definitions
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) 8.510.3(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 at §8.510.3.B.2 and §8.510.3.B.3 with the new text provided. All text indicated in blue is for clarification purposes only and should not be revised. This change is effective 01/30/2013.

*to be completed by MSB Board Coordinator

Title of Rule:	Revision to the Medical Assistance Rule Concerning Consumer Directed Attendant Support Services (CDASS) Service Definitions
Rule Number:	MSB 12-08-20-A
Division / Contact / Phone:	Long Term Care / Sarah Hoerle / 303-866-2669

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 proposed rule amends the Home and Community-Based Services (HCBS) Consumer Directed Attendant Support Services (CDASS) definition for Personal Care service and Health Maintenance Activities, 10 CCR 2505-10 8.510.3(B). The proposed change allows for Personal Care service and Health Maintenance Activities in the CDASS delivery system to be offered in both the home and the community. In order for us to provide the Medicaid Buy-In option for working adults, it is required that we offer personal care in the work place 40 hours a week. This proposed rule removes unnecessary barriers to participant access.

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 1915 (C)
   42 C.F.R. 441-300-441.310

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);
   25.5-6-1101, et. seq. C.R.S.

Initial Review	**11/09/2012**	Final Adoption	**12/14/2012**
Proposed Effective Date	**01/30/2013**	Emergency Adoption	

DOCUMENT #02

Title of Rule:	Revision to the Medical Assistance Rule Concerning Consumer Directed Attendant Support Services (CDASS) Service Definitions
Rule Number:	MSB 12-08-20-A
Division / Contact / Phone:	Long Term Care / Sarah Hoerle / 303-866-2669

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 revision will affect clients who receive Personal Care Services and Health Maintenance Activities through the CDASS delivery system and the CDASS attendants who provide these services. The rule clarifies that Personal Care and Health Maintenance Activities can be offered not only in the client's home but also in the community.

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 revision does not change current policy but rather aligns regulation with the current practice; which has been for the participant to receive Personal Care services and Health Maintenance Activities in their home and community for those participating in CDASS.

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 does not anticipate any budgetary impact or effect on state revenues from the proposed rule. Because current practice allows for the participant to receive Personal Care services and Health Maintenance Activities in their home and the community for those participating in CDASS, the Department does not anticipate any increase in clients' allocations or an increase in the proportion of allocations spent.

   It is possible that clients who were previously unaware that these services could be provided in community settings may seek to transition to participant directed programs as a result of this rule change. This may cause changes in client expenditure; however, this is not certain. The Department would account for any observed changes, either positive or negative, through the regular budget process.

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

   In addition to aligning CDASS regulations with current policy, this rule revision will allow the Department to provide the Medicaid Buy-In option for working adults, as allowance of personal care services in the community is a requirement of Colorado HB 08-1072.

The Centers for Medicare & Medicaid Services (CMS) has explained to the Department that the waiver amendment to add the Medicaid Buy-In option will not be approved unless clarification for the allowance for personal care in the work place is also included.

The Department has also received a great deal of Stakeholder feedback advocating for the Department to clarify that Personal Care and Health Maintenance services can be offered in the home and the community. If the Department does not revise the proposed rule, it will increase unnecessary barriers to participant access.

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

   There are no anticipated cost increases to the Department and to any other agency with the implementation and enforcement of the proposed rules. This rule revision does not change current policy but rather aligns regulation with the current practice; which has been for the participant to receive Personal Care services and Health Maintenance Activities in their home and community for those participating in CDASS. There are not less intrusive methods for achieving the purpose of the 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.

   The Department considered not revising the existing rule definition as it does not prohibit clients from receiving these services in the community, though it also does not clearly allow for it. The Department decided that it was in the best interest of all parties to clarify the Personal Care and Health Maintenance Activities service definitions to allow for these services to be offered in both the home and the community.

8.510.3 CDASS SERVICES

8.510.3.A Covered services shall be for the benefit of only the client and not for the benefit of other persons living in the home.

8.510.3.B Services include:

1. Homemaker. General household activities provided by an Attendant in a client's home to maintain a healthy and safe environment for the client. Homemaker activities shall be applied only to the permanent living space of the client and multiple attendants may not be reimbursed for duplicating household tasks. Tasks may include the following activities or teaching the following activities:

    a. Routine light housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas

    b. Meal preparation

    c. Dishwashing

    d. Bed making

    e. Laundry

    f. Shopping for necessary items to meet basic household needs

2. Personal care. Services furnished to an eligible client in the community or in the client's home to meet the client's physical, maintenance, and supportive needs. Including:

    a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as forks, knives, and straws

    b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling the distilled water reservoir, and moving the cannula or mask from the client's face

    c. Skin care preventative in nature when skin is unbroken; including the application of non-medicated/non-prescription lotions and/or sprays and solutions, rubbing of reddened areas, and routine foot checks for people with diabetes

    d. Bladder/Bowel Care:

        i) Assisting client to and from the bathroom

        ii) Assistance with bed pans, urinals, and commodes

        iii) Changing of incontinence clothing or pads

        iv) Emptying Foley or suprapubic catheter bags only if there is no disruption of the closed system

        v) Emptying ostomy bags

    e. Personal hygiene:

i) Bathing including washing, shampooing, and shaving

ii) Grooming

iii) Combing and styling of hair

iv) Trimming, cutting, and soaking of nails

v) Basic oral hygiene and denture care

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings and application of orthopedic devices such as splints and braces or artificial limbs

g. Transferring a client when the client has sufficient balance and strength to assist with and can direct the transfer

h. Assistance with mobility

i. Positioning when the client is able to verbally or non-verbally identify when the position needs to be changed including simple alignment in a bed, wheelchair or other furniture

j. Assistance with self administered medications when the medications have been preselected by the client, a family member, a nurse or a pharmacist and are stored in containers other than the prescription bottles, such as medication minders and medication reminding:

i) Medication minders must be clearly marked as to the day and time of dosage and must be kept in a way as to prevent tampering

ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable

k. Cleaning and basic maintenance of durable medical equipment

l. Protective oversight when the client requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property

m. Accompanying includes going with the client, as necessary on the care plan, to medical appointments, and errands such as banking and household shopping. Accompanying the client to provide one or more personal care services as needed during the trip. Companionship is not a benefit of CDASS

3. Health Maintenance Activities. Routine and repetitive health related tasks furnished to an eligible client in the community or in the client's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include:

a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional

b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation

c. Mouth care performed when:

i) there is injury or disease of the face, mouth, head or neck

ii) in the presence of communicable disease

iii) the client is unconscious

iv) oral suctioning is required

d. Dressing including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary

e. Feeding:

i) When oral suctioning is needed on a stand-by or other basis

ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study

iii) Syringe feeding

iv) Feeding using apparatus

f. Exercise prescribed by a licensed medical professional including passive range of motion

g. Transferring a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed

h. Bowel care provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist

i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters

j. Medical management required by a medical professional to monitor: blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections

k. Respiratory care:

i) Postural drainage

ii) Cupping

iii) Adjusting oxygen flow within established parameters

iv) Suctioning of mouth and nose

v) Nebulizers

vi) Ventilator and tracheostomy care

vii) Prescribed respiratory equipment

Title of Rule:	Revision to the Medical Assistance Rule for Pharmacy Definition, Section 8.800.1 and Reimbursement, Section 8.800.13.
Rule Number:	MSB 12-06-21-A
Division / Contact / Phone:	Rates & Analysis / Jeff Wittreich / 303-866-2456

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 12-06-21-A, Revision to the Medical Assistance Rule for Pharmacy Definition, Section 8.800.1 and Reimbursement, Section 8.800.13.
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):

   Page 1 and Page 2 of Section 8.800.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

   Section 8.800.13 A through 8.800.13 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 at §8.800.1 DEFINITIONS and §8.800.13 REIMBURSEMENT CALCULATIONS with the new text provided. This change is effective 01/30/2013.

*to be completed by MSB Board Coordinator

Title of Rule:	Revision to the Medical Assistance Rule for Pharmacy Definition, Section 8.800.1 and Reimbursement, Section 8.800.13.
Rule Number:	MSB 12-06-21-A
Division / Contact / Phone:	Rates & Analysis / Jeff Wittreich / 303-866-2456

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 proposed rule change is to implement a new pharmacy reimbursement methodology based on actual acquisition costs (AAC) incurred by Colorado pharmacies. The proposed rule change also implements a dispensing fee tiered on total prescription volume.

   It is the Department's desire to better align Medicaid reimbursement to actual costs incurred by Colorado pharmacies. The proposed rule transitions reimbursement from the current methodology based on national pricing sources unrepresentative of Colorado pharmacy costs to a methodology based primarily on Colorado pharmacy costs.

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: Not applicable as this rule is not being presented as an emergency rule.

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).

Initial Review	**11/09/2012**	Final Adoption	**12/14/2012**
Proposed Effective Date	**03/02/2013**	Emergency Adoption	

DOCUMENT # 03

Title of Rule:	Revision to the Medical Assistance Rule for Pharmacy Definition, Section 8.800.1 and Reimbursement, Section 8.800.13.
Rule Number:	MSB 12-06-21-A
Division / Contact / Phone:	Rates & Analysis / Jeff Wittreich / 303-866-2456

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 does not directly affect any classes of persons but instead directly affects Colorado pharmacies. Rural pharmacies, less than 20 pharmacies within the state, will bear the greatest costs of the proposed 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.

   The estimated impact of the proposed rule is a 5.5% reduction in reimbursement to non-rural pharmacies and a 17% reduction in reimbursement to rural pharmacies in Calendar Year (CY) 2013.

   Over the last ten years, Medicaid reimbursement to rural pharmacies has slowly diverged from, and is now greater compared to actual acquisition costs incurred by rural pharmacies. Through the AAC methodology, the Department can realign Medicaid reimbursement to incurred costs for rural pharmacies. This realignment is the reason for the greater decrease in reimbursement to rural pharmacies compared to non-rural pharmacies.

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 benefits of the proposed rule are the increased alignment of Medicaid reimbursement to actual acquisition cost for both rural and non-rural pharmacies, and the increased transparency and understanding of reimbursement to both the state and provider community.

   The cost of not implementing the proposed rule is the continuation of a stopgap reimbursement methodology that becomes more outdated and unrepresentative of cost with time.

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

   The proposed reimbursement methodology is the least costly and least intrusive method for achieving the purpose of the 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 were no alternative methods seriously considered by the Department.

8.800.1 DEFINITIONS

340B Pharmacy means any pharmacy that participates in the Federal Public Health Service's 340B Drug Pricing Program as described in 42 U.S.C. Section 256b (2011). 42 U.S.C. Section 256b (2011) is hereby incorporated by reference into this rule. This rule does not include any later amendments or editions of the code. A copy of the code is available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203 where a copy of the code provision is available for a reasonable charge. A copy is also available, for a reasonable charge from Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-79524. ~~Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.~~

Average Acquisition Cost (AAC) means the average acquisition cost for like drugs grouped by Generic Code Number (GCN). ~~AAC is weighted by Medicaid claims utilization for each drug within a GCN and excludes any drugs with outlier costs.~~ For GCNs with both generic and brand drugs, the Department shall determine two separate AAC rates for the GCN. One AAC rate shall be based on the average acquisition cost for all generic drugs while the other shall be based on the average acquisition cost for all brand drugs.~~all brand drugs will be excluded from the AAC calculation and instead be reimbursed WAC~~

Conflict of Interest means having competing professional or personal obligations or personal or financial interests that would make it difficult to fulfill duties in an objective manner.

Department means the Colorado Department of Health Care Policy and Financing.

Dispensing Fee means the reimbursement amount for costs associated with filling a prescription. Costs include salary costs, pharmacy department costs, facility costs, and other costs.

Dispensing Physician means a licensed physician who prepares, dispenses and instructs clients to self administer medication.

Drug Class means a group of drugs that treat a particular disease or symptom and are in the same therapeutic class.

Emergency Situation means any condition that is life threatening or requires immediate medical intervention as determined in good faith by the pharmacist.

E-prescription means the transmission of a prescription through an electronic application.

Fiscal Agent means a private contractor that supports and operates Colorado's Medicaid Management Information System and performs operational activities that support the administration of the Medical Assistance Program.

Federal Upper Limit (FUL) means the upper limit for multiple source drugs as set by the Centers for Medicare and Medicaid Services pursuant to 42 C.F.R. 447. 512 - 447.-516 -(2011). 42 C.F.R. 447.512 - 447.516 (2011[j1]) [j2]~~447. 300-447. 334(2011)~~ is hereby incorporated by reference into this rule. This rule does not include any later amendments or editions of the code. A copy of the code is available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203 where a copy of the code provision is available for a reasonable charge. A copy is also available, for a reasonable charge from U.S. Government Printing Office, P.O. Box 979050, St. Louis, MO 63197-9000. ~~Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.~~

Generic Code Number (GCN) means a standard number to group together drugs that have the same ingredients, route of administration, drug strength, and dosage form.

Good Cause means failing to disclose a Conflict of Interest; participating in wrongdoing or misconduct in the case of serving as a member of a committee or other advisory body for the Department; failing to perform required duties; or missing two scheduled meetings per calendar year.

Government Pharmacy means any pharmacy whose primary function is to provide drugs and services to clients of a facility whose operating funds are appropriated directly from the State of Colorado or the federal government excluding pharmacies funded through Indian Health Services.

Institutional Pharmacy means any pharmacy ~~that participates in the Federal Public Health Services's 340B drug pricing program as described in 42 U.S.C. Section 256b (2008), or~~ whose primary function is to provide drugs and services to hospitalized patients and others receiving health care provided by the facility ~~within which the pharmacy is located~~ with which the pharmacy is associated.

Mail Order Pharmacy means any pharmacy that delivers drugs primarily by mail.

Maintenance Medication means any drug, as determined by the Department, which is used to treat a chronic illness or symptoms of a chronic illness.

Medical Assistance Program shall have the meaning defined in 25.5-1-103(5), C.R.S. (2008).

Medical Assistance Program Allowable Charge means the allowed ingredient cost plus a dispensing fee or the provider's Usual and Customary Charge, whichever is less, minus the client's copayment as determined according to 10 C.C.R. 2505-10, Section 8.754.

Medical Director means the physician or physicians who advise the Department.

Medicare Part D means the drug benefit provided to Part D Eligible Individuals pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Medicare Part D Drugs means drugs defined at 42 U.S.C. Section~~s~~ 1395w-102(e) (2012) and 42 C.F.R. Section 423.100 (2012)~~102 and 141 and 42 C.F.R. Section 423, et seq. (2008)~~. This rule does not include any later amendments ~~are~~ or editions of the code. A copy of the code is available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203 where a copy of the code provision is available for a reasonable charge. A copy is also available, for a reasonable charge from Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-79524. ~~42 U.S.C. Sections 1395w-102 and 141 and 42 C.F.R. Section 423 (2011) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.~~

Non-preferred Drug means a drug that requires a prior authorization as described in 10 C.C.R. 2505-10, Section 8.800.7, before being payable by the Medical Assistance Program.

Old Age Pension Health Care Program and Old Age Pension Health Care Supplemental Program (OAP State Only) means the program established to provide necessary medical care for clients that qualify for Old Age Pension but do not qualify for the Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes.

Over-the-Counter (OTC) means a drug that can be purchased without a physician's prescription.

Part D Eligible Individual has the same meaning as defined in 10 C.C.R. 2505-10, Section 8.1000.1.

Pharmacy and Therapeutics Committee (P&T Committee) means an advisory board that shall perform reviews and make recommendations which facilitate the development and maintenance of the Preferred Drug List as described in 10 C.C.R. 2505-10, Section 8.800.17.

Physical Hardship means any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; or, any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Preferred Drug means a drug that is payable by the Medical Assistance Program without first obtaining a prior authorization unless otherwise required to protect the health and safety of specific clients.

Preferred Drug List (PDL) means a list, applicable only to fee-for-service and primary care physician Medical Assistance Program non-Medicare clients, which identifies the Preferred Drugs and Non-preferred Drugs within a drug class.

Provider Bulletin means a document published and distributed by program and policy staff to communicate information to providers related to the Department.

Retail Pharmacy means any pharmacy that is not a 340B Pharmacy, Government Pharmacy, ~~an~~ Institutional Pharmacy, ~~or a~~ Mail Order Pharmacy, or Rural Pharmacy.

Rural Pharmacy means any pharmacy that is the only pharmacy within a twenty-mile radius.

~~State Maximum Allowable Cost (State MAC) means the maximum ingredient cost allowed by the Department for certain multiple-source drugs.~~

Submitted Ingredient Cost means a pharmacy's calculated ingredient cost. For drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, the Submitted Ingredient Cost means the 340B purchase price.

Total Prescription Volume means all new and refill prescriptions dispensed for all payer types. Payer types include but are not limited to Medicaid, Medicare, commercial, third-party, and uninsured.

Usual and Customary Charge means the reimbursement amount the provider charges the general public to pay for a drug.

Wholesale Acquisition Cost (WAC) means with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. ~~the manufacturer's list price for a drug or biological as described in 42 U.S.C. Section 1395w-3a(c)(6)(B) (2011). 42 U.S.C. Section 1395w-3a(c)(6)(B) (2011) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.~~

8.800.13 REIMBURSEMENT CALCULATION

8.800.13.A. Covered drugs for all clients except for ~~Old Age Pension (~~OAP~~)~~ State Only clients shall be reimbursed the lesser of:

1. ~~t~~The ~~provider's~~ Usual and Customary Charge minus the client's copayment, as determined according to 10 C.C.R. 2505-10, Section 8.754; ~~and~~ or

2. ~~t~~The allowed ingredient cost plus a ~~d~~Dispensing ~~f~~Fee minus the client's copayment, as determined according to 10 C.C.R. 2505-10, Section 8.754.

Covered drugs for the OAP State Only Program~~s~~ shall be reimbursed according to 10 C.C.R. 2505-10, Section 8.941.~~9~~10.

~~.~~ 8.800.13.B. The allowed ingredient cost for Retail Pharmacies, 340B Pharmacies, Institutional Pharmacies, Government Pharmacies and Mail Order Pharmacies shall be the lesser of AAC, or Submitted Ingredient Cost. If AAC is not available, the allowed ingredient cost shall be the lesser of WAC, or Submitted Ingredient Cost. ~~is the price of the drug calculated according to the applicable pricing methodologies set forth in 10 C.C.R. 2505-10, Section 8.800.13.E~~

8.800.13.C. AAC rates shall be rebased monthly using invoices and/or purchase records provided to the Department through a representative group of pharmacies. If the Department cannot establish a process to obtain invoices and/or purchase records on a monthly basis, the Department shall survey one-fourth (1/4) of all Medicaid enrolled pharmacies every quarter to rebase AAC rates. ~~The allowed ingredient cost for Institutional and Government Pharmacies is the lesser of actual cost of acquisition for the drug dispensed or the price of the drug calculated according to the applicable pricing methodologies set forth in 10 C.C.R. 2505-10, Section 8.800.13.E.~~

8.800.13.D. A pharmacy wanting to inquire about a listed AAC rate shall complete the Average Acquisition Cost Inquiry Worksheet posted on the Department's website. The pharmacy shall email the completed worksheet with a copy of the receipt invoice and Medicaid billed claim for the drug in question to Colorado.SMAC@hcpf.state.co.us. The Department shall have five (5) days to provide an inquiry response to the pharmacy. If the AAC rate requires revision, the Department shall then have 5 additional days to update the AAC rate.

8.800.13.E. To address weekly fluctuations in drug prices, the Department shall apply a percent adjustment to existing AAC rates for drugs experiencing significant changes in price. The percent adjustment shall be determined using weekly changes in price based on national pricing benchmarks. Every week, the Department shall post an updated AAC price list, with the adjusted AAC rates, on the Department's website (www.colorado.gov/hcpf). A percent adjustment shall only be applied to an AAC rate until the Department can rebase the rate through the process discussed in 10 C.C.R. 2505-10, 8.800.13.C.

~~8.800.13.D. The State Maximum Allowable Cost (MAC) price shall be established as:~~

~~1. The Average Acquisition Cost (AAC) plus fifty one and one-tenths percent (51.1%) for non-rural pharmacies; and~~

~~2. The AAC plus two hundred and thirty-three percent (233%) for rural pharmacies as defined in 8.800.13.G.~~

~~a. The establishment of the AAC is subject to, but not limited to, the following considerations:~~

~~i) A minimum of two readily available manufacturers in the United States;~~

~~ii) An Orange Book (bio-equivalency) rating of "A";~~

~~iii) The most popular / practical package sizes are used in the review process;~~

~~iv) AAC limits are continually reviewed for additions, deletions, increases, decreases and FUL comparison.~~

~~8.800.13.E. The allowed ingredient cost is determined utilizing different methodologies as applicable.~~

~~The allowed ingredient cost will be the lesser of the MAC price as defined in10 C.C.R. 2505-10, Section 8.800.13. D or submitted ingredient cost. If no MAC price is available, the allowed ingredient cost will be the lesser of:~~

~~a. Wholesale Acquisition Cost (WAC);~~

~~i) WAC plus two and six-tenths percent (2.6%) for brand drugs; and~~

~~ii) WAC minus one-tenths percent (0.1%) for generic drugs;~~

~~b. Submitted ingredient cost.~~8.800.13.F. ~~The MAC Price List is posted on the Department's web site (www.colorado.gov/hcpf) on a weekly basis.~~

8.800.13.~~G~~F. Any pharmacy, except a Mail Order Pharmacy, that is the only pharmacy within a twenty mile radius may submit a letter to the Department requesting the designation ~~of~~ as a rural pharmacy~~to become a Rural Pharmacy~~. If the designation is approved by the Department, ~~as a Rural Pharmacy~~ the ~~reimbursement~~ allowed ingredient cost shall be AAC. If AAC is not available, the allowed ingredient cost shall be WAC.

1. To reduce the burden of transitioning to an AAC reimbursement methodology for rural pharmacies, and to ensure guaranteed Medicaid access in rural communities, the Department shall include a percent increase to AAC and phase the percent increase out over a one-year period. The effective dates and corresponding percent increases shall be:

a. February 1, 2013 to May 31, 2013 – AAC+60%

b. June 1, 2013 to September 30, 2013 – AAC+40%

c. October 1, 2013 to January 31, 2014 – AAC+20%

d. February 1, 2014 forward – AAC+0%

2. ~~be calculated according to the following pricing methodologies:~~

~~Rural pharmacies will be reimbursed using the MAC price as defined in 10 C.C.R. 2505-10, Section 8.800.13. E. If no MAC price is available, the WAC price plus thirty and four-tenths percent (30.4%) will be the allowed ingredient cost.~~

In cases where WAC applies, the Department shall also include a percent increase to WAC and phase the percent increase out over a one-year period. The effective dates and corresponding percent increases shall be:

a. February 1, 2013 to May 31, 2013 – WAC+60%

b. June 1, 2013 to September 30, 2013 – WAC+40%

c. October 1, 2013 to January 31, 2014 – WAC+20%

d. February 1, 2014 forward – WAC+0%

8.800.13.G. Dispensing Fees shall be determined based upon reported dispensing costs provided through a Cost of Dispensing (COD) survey completed every two fiscal years. The Dispensing Fees for Retail Pharmacies, 340B Pharmacies, Institutional Pharmacies and Mail Order Pharmacies shall be tiered based upon annual Total Prescription Volume. The Dispensing Fees shall be tiered at:

1. Less than 60,000 total prescriptions filled per year = $13.40

2. Between 60,000 and 90,000 total prescriptions filled per year = $11.49

~~3. Greater than 90,000 total prescriptions filled per year = $9.67~~3. Between 90,000 and 110,000 total prescriptions filled per year = $10.25

4. Greater than 110,000 total prescriptions filled per year = $9.31

8.800.13.H. The designation of a pharmacy's Dispensing Fee shall be updated annually. Every October, the Department shall contact a pharmacy requesting the completion of an attestation letter stating the pharmacy's Total Prescription Volume for the period September 1 to August 31. A pharmacy shall have until October 31 to provide the completed attestation letter to the Department. Using the attestation letter, the Department shall update a pharmacy's Dispensing Fee effective January 1. A pharmacy failing to provide the Department an attestation letter on

or before October 31, regardless of their previous Dispensing Fee, shall be reimbursed the $9.6731 Dispensing Fee.

8.800.13.I. The Department shall determine the Dispensing Fee for a pharmacy enrolling as a Medicaid provider based on the pharmacy's Total Prescription Volume. During the enrollment process, a pharmacy shall provide the Department an attestation letter stating their Total Prescription Volume for the previous twelve (12) months. Using the attestation letter, the Department shall determine the pharmacy's Dispensing Fee effective upon approval of enrollment. If a pharmacy has been open for less than 12 months, the Department shall annualize the Total Prescription Volume to determine the pharmacy's Dispensing Fee. A pharmacy failing to provide the Department an attestation letter during the enrollment process shall be reimbursed the $9.6731 Dispensing Fee. The Dispensing Fee shall be used until it can be updated the following year in accordance with 10 C.C.R. 2505-10, 8.800.13.H.

8.800.13.J. In November of each year, the Department shall compare a pharmacy's Total Prescription Volume and Medicaid percent provided with the attestation letter to their Medicaid claims data. If the Department identifies any inconsistencies, the Department shall request a pharmacy to provide documentation that substantiates their Total Prescription Volume for the period September 1 to August 31 within thirty (30) days. If the Department determines that the pharmacy incorrectly reported their Total Prescription Volume, the pharmacy shall be reimbursed at the correct tier based on their actual Total Prescription Volume. If a pharmacy does not provide the documentation to the Department within the 30 days, the pharmacy shall be reimbursed the $9.6731 Dispensing Fee.

8.800.13.K. The tiered Dispensing Fee shall not apply to Government Pharmacies which shall instead be reimbursed a $0.00 Dispensing Fee.

8.800.13.L. The tiered Dispensing Fee shall not apply to Rural Pharmacies which shall instead be reimbursed a $14.14 Dispensing Fee.

~~2. Retail Pharmacies shall receive a dispensing fee of $4.00.~~

~~3. Institutional Pharmacies shall receive a dispensing fee of $1.89.~~

~~4. The dispensing fee for a Maintenance Medication delivered via mail by a Mail Order Pharmacy shall be $4.00.~~

~~5. Government Pharmacies shall receive no dispensing fee.~~

8.800.13.M ~~6.~~ Dispensing Physicians shall not receive a ~~d~~Dispensing ~~f~~Fee unless their offices or sites of practice are located more than 25 miles from the nearest participating pharmacy. In that case, the Dispensing Physician shall ~~receive~~ instead be reimbursed a ~~dispensing fee of~~ $1.89 Dispensing Fee.

Title of Rule:	Revision to the Medical Assistance Rules Concerning the Hospital Provider Fee Collection and Disbursement, § 8.2003 and 8.2004
Rule Number:	MSB 12-09-18-A
Division / Contact / Phone:	Finance Office / Matt Haynes / 6305

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 12-09-18-A, Revision to the Medical Assistance Rules Concerning the Hospital Provider Fee Collection and Disbursement, § 8.2003 and 8.2004
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) 8.2003 and 8.2004, 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*

Various text throughout §8.2003 and §8.2004 has been revised, amended and/or added or deleted. Other text has been provided for clarification only. The text for clarification only that should not be revised, amended, and/or added or deleted is indicated in the filing in blue. All text in black is revised, amended and/or added or deleted. This change is effective 01/30/2013.

*to be completed by MSB Board Coordinator

Title of Rule:	Revision to the Medical Assistance Rules Concerning the Hospital Provider Fee Collection and Disbursement, § 8.2003 and 8.2004
Rule Number:	MSB 12-09-18-A
Division / Contact / Phone:	Finance Office / Matt Haynes / 6305

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).

Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers.

The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2012), and implements the Hospital Quality Incentive Payment (HQIP), as required by the act. HQIP links supplemental payments to measures of quality of care, process, and health outcomes.

The proposed rule increases the fees assessed on hospital providers to fund these payments, and to fund expansions of Medicaid and Child Health Plan Plus (CHP+) eligibility authorized under the Act.

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 Section 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);
   25.5-4-402.3, C.R.S. (2012)

Initial Review	**11/09/2012**	Final Adoption	**12/14/2012**
Proposed Effective Date	**01/30/2012**	Emergency Adoption	

DOCUMENT #04

Title of Rule:	Revision to the Medical Assistance Rules Concerning the Hospital Provider Fee Collection and Disbursement, § 8.2003 and 8.2004
Rule Number:	MSB 12-09-18-A
Division / Contact / Phone:	Finance Office / Matt Haynes / 6305

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.

Colorado hospitals benefit from increased Medicaid and Colorado Indigent Care Program (CICP) reimbursements made possible through provider fee funding. Low-income persons benefit from the expanded Medicaid and Child Health Plan Plus (CHP+) eligibility.

In regard to the Hospital Quality Incentive Payment, Colorado hospitals will benefit from the receipt of supplemental provider fee payments based on performance on measures related to the quality of care provided. Medicaid clients benefit to the extent that the supplemental payments, as well as quality measurement and reporting activities, lead to improved quality of care and health outcomes. Additionally, Colorado hospitals may be required to manually submit data to the Department via an electronic survey mechanism.

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

From October 2012 through September 2013, the provider fee will generate approximately $644 million in federal funds to Colorado. Hospitals will have an estimated net benefit of $158 million.

The total funds available annually for the inpatient quality incentive supplemental payment pool shall be equal to up to five percent (5%) of the sum of total inpatient and outpatient acute care expenditures from the prior State Fiscal Year as established in the Department's annual budget request. For the 2012-13 model year, the HQIP payments will be $32 million.

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.

While there are administrative costs associated with implementation of the Colorado Health Care Affordability Act, all such costs are covered by provider fees collected; no state General Fund is used.

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

If no action is taken, the Department will not have the ability to fully fund Medicaid and CHP+ expansions, affecting over 60,000 currently enrolled persons and up to 100,000 persons in the long run. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+. Inaction would also mean that $25 million in General Fund relief for the Medicaid program in FY 2012-13 would not be realized, which could result in greater provider rate cuts or other budget actions.

For the Hospital Quality Incentive Payment, this rule will fulfill the legislative mandate to tie supplemental provider fee payments to measures of care quality and health outcomes as required by the Colorado Health Care Affordability Act. Quality measurement and reporting activities, combined with supplemental provider fee payments based on these activities, should lead to improvements in the quality of care delivered and health outcomes for Medicaid clients. If no action is taken, the requirement as described in the Colorado Health Care Affordability Act will not be fulfilled.

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

The state does not currently have the resources to fund the hospital payments and coverage expansions under the hospital provider fee. The Department began collecting fees from hospitals in April 2010, after the rules were established and federal approval was obtained.

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 continues to meet regularly with stakeholders and the Hospital Provider Fee Oversight and Advisory Board and seeks their input and recommendations to maximize the benefit to the state from the Colorado Health Care Affordability Act. The first hospital provider fee expansions have been implemented and increased reimbursement has been made to hospitals. The proposed rules continue to fund the implementation of the Act to increase health care coverage and reduce uncompensated hospital costs for Medicaid and uninsured persons.

8.2003: Hospital Provider Fee

8.2003.A. Outpatient Services Fee

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.865~~0.535~~% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.2003.B. Inpatient Services Fee

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $82.44~~116.07~~ per day for Managed Care Days and $368.45~~515.69~~ per day for all other Days as reported to the Department by each hospital by April 30 with the following exceptions:

   a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $43.04~~60.60~~ per day for Managed Care Days and $192.37~~269.24~~ per day for all other Days.

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to $32.98~~46.43~~ per day for Managed Care Days and $147.38~~206.27~~ per day for all other Days.

8.2003.C. Assessment of Fee

1. The Department shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Oversight and Advisory Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Department shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed.

2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Department will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2003.D. Refund of Excess Fees

1. If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Department shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Department shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.2002.B.

2. After the close of each State fiscal year and no later than the following August 31, the Department shall present a summary of fees collected, expenditures made or encumbered, and interest earned in the Fund during the State fiscal year to the Oversight and Advisory Board.

    a. If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Department has not expended or encumbered those fees at the close of each State fiscal year:

        i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less four percent of the estimated expenditures for health coverage expansions authorized by the Act for the subsequent State fiscal year as most recently published by the Department.

        ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the State fiscal year.

        iii. The Department shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.2002.B.

        iv. For State fiscal year ending June 30, 2011 only, the Department shall not refund unencumbered and unexpended fees for which the intended expenditure had received approval for federal Medicaid matching funds by CMS. Unencumbered and unexpended fees in the Fund shall remain in the Fund to be used for allowable expenditures in State fiscal year 2011-12.

        v. For State fiscal year ending June 30, 2012 only, the Department shall not refund unencumbered and unexpended fees for which the intended expenditure had received approval for federal Medicaid matching funds by CMS. Unencumbered and unexpended fees in the Fund shall remain in the Fund to be used for allowable expenditures in State fiscal year 2012-13.

8.2004: Supplemental Medicaid and Disproportionate Share Hospital Payments

8.2004.A. Conditions applicable to all supplemental payments

1. All supplemental payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Department.

2. No hospital shall receive a payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the CICP Disproportionate Share Hospital payment or the Uninsured Disproportionate Share Hospital payment exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, that hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction for the CICP Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated CICP Costs, relative to the aggregate of Uncompensated CICP Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit. The amount of the retroactive reduction for the Uninsured Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated Charity Care Costs relative to the aggregate of Uncompensated Charity Care Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit.

3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2004.B. Outpatient Hospital Supplemental Medicaid Payment

1. Qualified hospitals. ~~General Hospitals, Rehabilitation Hospitals and Critical Access Hospitals shall receive this payment.~~Licensed or certified as a General Hospital by the Colorado Department of Public Health and Environment and provides outpatient hospital services to Medicaid clients.

~~2. Excluded hospitals. Psychiatric Hospitals and Long Term Care Hospitals shall not receive this payment.~~

~~3~~2. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado Medicaid Management Information System (MMIS) are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-specific outpatient billed

costs. For each qualified hospital, the annual Outpatient Hospital ~~Payment~~ Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. ~~31.50%.~~ The percentage adjustment factor may vary for state-owned, non-state government owned, and private hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin and reported annually to the Medical Services Board.

~~The percentage adjustment factors for each qualified hospital are:~~

~~Provider Name~~	~~FFY 11-12 OP Percentage Adjustment Factor~~	~~FFY 12-13 OP Percentage Adjustment Factor~~
~~Animas Surgical Hospital~~	~~141.39%~~	~~155.18%~~
~~Arkansas Valley Regional Medical Center~~	~~31.55%~~	~~31.67%~~
~~Aspen Valley Hospital~~	~~57.45%~~	~~63.94%~~
~~Boulder Community Hospital~~	~~48.60%~~	~~63.92%~~
~~Centura Health - Avista Adventist Hospital~~	~~38.57%~~	~~44.33%~~
~~Centura Health - Littleton Adventist Hospital~~	~~25.76%~~	~~25.66%~~
~~Centura Health - Mercy Regional Medical Center~~	~~48.91%~~	~~50.85%~~
~~Centura Health - Parker Adventist Hospital~~	~~55.89%~~	~~46.20%~~
~~Centura Health - Penrose -St. Francis Health Services~~	~~27.22%~~	~~24.88%~~
~~Centura Health - Porter Adventist Hospital~~	~~44.95%~~	~~44.50%~~
~~Centura Health - Saint Anthony Central Hospital~~	~~5.65%~~	~~5.68%~~
~~Centura Health - Saint Anthony North Hospital~~	~~35.57%~~	~~44.22%~~
~~Centura Health - Saint Anthony Summit Hospital~~	~~57.59%~~	~~61.01%~~
~~Centura Health - St. Mary-Corwin Medical Center~~	~~52.83%~~	~~64.10%~~
~~Centura Health - St. Thomas More Hospital~~	~~96.34%~~	~~117.04%~~
~~Children's Hospital Colorado~~	~~25.61%~~	~~28.20%~~
~~Colorado Plains Medical Center~~	~~9.46%~~	~~8.96%~~
~~Community Hospital~~	~~33.81%~~	~~45.53%~~
~~Conejos County Hospital~~	~~216.33%~~	~~193.27%~~
~~Craig Hospital~~	~~196.20%~~	~~339.46%~~
~~Delta County Memorial Hospital~~	~~99.65%~~	~~147.11%~~
~~Denver Health Medical Center~~	~~18.32%~~	~~21.59%~~
~~East Morgan County Hospital~~	~~68.40%~~	~~65.95%~~
~~Estes Park Medical Center~~	~~12.28%~~	~~11.94%~~
~~Exempla Good Samaritan Medical Center~~	~~49.39%~~	~~54.62%~~
~~Exempla Lutheran Medical Center~~	~~17.55%~~	~~17.95%~~

~~Exempla Saint Joseph Hospital~~	~~39.43%~~	~~44.77%~~
~~Family Health West Hospital~~	~~139.02%~~	~~154.85%~~
~~Grand River Medical Center~~	~~41.05%~~	~~38.63%~~
~~Gunnison Valley Hospital~~	~~9.34%~~	~~9.63%~~
~~Haxtun Hospital~~	~~57.35%~~	~~74.61%~~
~~HealthOne Medical Center of Aurora~~	~~29.10%~~	~~39.96%~~
~~HealthOne North Suburban Medical Center~~	~~23.02%~~	~~32.52%~~
~~HealthOne Presbyterian/St. Luke's Medical Center~~	~~8.94%~~	~~7.61%~~
~~HealthOne Rose Medical Center~~	~~49.52%~~	~~60.85%~~
~~HealthOne Sky Ridge Medical Center~~	~~69.35%~~	~~74.97%~~
~~HealthOne Spalding Rehabilitation Hospital~~	~~5.91%~~	~~42.97%~~
~~HealthOne Swedish Medical Center~~	~~30.44%~~	~~35.94%~~
~~HealthSouth Rehabilitation Hospital~~	~~208.96%~~	~~298.04%~~
~~Heart of the Rockies Regional Medical Center~~	~~27.56%~~	~~22.85%~~
~~Keefe Memorial Hospital~~	~~102.55%~~	~~89.19%~~
~~Kit Carson County Memorial Hospital~~	~~51.56%~~	~~62.07%~~
~~Kremmling Memorial Hospital~~	~~36.14%~~	~~32.08%~~
~~Lincoln Community Hospital and Nursing Home~~	~~152.37%~~	~~165.25%~~
~~Longmont United Hospital~~	~~6.44%~~	~~7.44%~~
~~McKee Medical Center~~	~~46.96%~~	~~59.20%~~
~~Medical Center of the Rockies~~	~~19.82%~~	~~17.88%~~
~~Melissa Memorial Hospital~~	~~268.09%~~	~~384.80%~~
~~Memorial Hospital~~	~~33.00%~~	~~36.37%~~
~~Montrose Memorial Hospital~~	~~13.77%~~	~~16.03%~~
~~Mount San Rafael Hospital~~	~~50.09%~~	~~44.48%~~
~~National Jewish Health~~	~~75.49%~~	~~90.04%~~
~~North Colorado Medical Center~~	~~14.57%~~	~~17.23%~~
~~Northern Colorado Rehabilitation Hospital~~	~~143.06%~~	~~465.18%~~

~~Pagosa Mountain Hospital~~	~~140.61%~~	~~100.56%~~
~~Parkview Medical Center~~	~~24.75%~~	~~24.11%~~
~~Pikes Peak Regional Hospital~~	~~138.50%~~	~~124.31%~~
~~Pioneers Hospital~~	~~124.87%~~	~~144.40%~~
~~Platte Valley Medical Center~~	~~29.63%~~	~~34.86%~~
~~Poudre Valley Hospital~~	~~21.94%~~	~~23.03%~~
~~Prowers Medical Center~~	~~51.40%~~	~~61.56%~~
~~Rangely District Hospital~~	~~36.71%~~	~~55.81%~~
~~Rio Grande Hospital~~	~~206.37%~~	~~219.71%~~
~~San Luis Valley Regional Medical Center~~	~~15.13%~~	~~16.55%~~
~~Sedgwick County Memorial Hospital~~	~~111.09%~~	~~111.81%~~
~~Southeast Colorado Hospital~~	~~176.46%~~	~~198.63%~~
~~Southwest Memorial Hospital~~	~~31.94%~~	~~35.67%~~
~~Spanish Peaks Regional Health Center~~	~~66.00%~~	~~88.70%~~
~~St. Mary's Hospital and Medical Center~~	~~15.14%~~	~~25.33%~~
~~St. Vincent General Hospital District~~	~~41.86%~~	~~50.76%~~
~~Sterling Regional MedCenter~~	~~29.81%~~	~~35.22%~~
~~The Memorial Hosptial~~	~~31.28%~~	~~30.30%~~
~~University of Colorado Hospital~~	~~32.77%~~	~~36.66%~~
~~Vail Valley Medical Center~~	~~59.79%~~	~~50.58%~~
~~Valley View Hospital~~	~~9.46%~~	~~13.10%~~
~~Vibra Long Term Acute Care Hospital~~	~~2358.41%~~	~~0.00%~~
~~Weisbrod Memorial County Hospital~~	~~243.12%~~	~~234.54%~~
~~Wray Community District Hospital~~	~~76.53%~~	~~68.58%~~
~~Yampa Valley Medical Center~~	~~12.57%~~	~~13.49%~~
~~Yuma District Hospital~~	~~74.84%~~	~~71.76%~~

~~If the hospital qualifies as a Pediatric Specialty Hospital this payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by 27.45%. For State Teaching Hospitals, this payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by 25%.~~

~~8.2004.C. Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment~~

~~1. Qualified hospitals. General Hospitals and Critical Access Hospitals located in a Rural Area, with 20 or fewer licensed beds, where at least 80% of total Medicaid payments are for outpatient hospital services shall receive this payment.~~

~~2. Excluded hospitals. Psychiatric Hospitals and Long Term Care Hospitals shall not receive this payment.~~

~~3. Calculation methodology for payment. This payment shall equal 70% of inflated annual hospital-specific Medicaid outpatient billed costs.~~

8.2004.C~~D~~. CICP Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. There will be three categories for qualified hospitals: State-Owned Government Hospitals, Non-State-Owned Government Hospitals, and Private-Owned Hospitals. State-Owned Government Hospitals shall receive 20.47~~15.00~~% of the State's annual Disproportionate Share Hospital Allotment, Non-State-Owned Government Hospitals shall receive 32.28~~42.50~~% and Private-Owned Hospitals shall receive 25.98~~22.50~~%.

   A qualified hospital's annual payment shall equal its share of the percent of Uncompensated CICP Costs of all qualified hospitals in the category divided by the State's annual Disproportionate Share Hospital allotment allocated to the category.

8.2004.D~~E~~. Uninsured Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that report charges for services provided to low-income uninsured persons to the Department in a manner as prescribed by the Department shall receive this payment.

2. Excluded hospitals. Hospitals that participate in the CICP, Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. Twenty-one and twenty eight hundredths percent (21.28~~0.00~~%) of the State's annual Disproportionate Share Hospital allotment shall be allocated to the Uninsured Disproportionate Share Hospital Payment. A qualified hospital's annual payment shall equal its share of the percent of Uncompensated Charity Care Costs of all qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital Payment.

8.2004.E~~F~~. CICP Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals and hospitals that do not participate in the CICP shall not receive this payment.

3. Calculation methodology for payment.

a. Qualified hospitals shall receive an annual payment, such that, when combined with the CICP Disproportionate Share Hospital Payment, shall total to a percentage of Weighted Uncompensated CICP Costs. The percentage applied to Weighted Uncompensated CICP Costs shall be:

i. Fifty-three~~wo and five-tenths~~ percent (53.0~~2.5~~%) for High Volume Medicaid and CICP Hospitals,

ii. Seventy~~-five~~ percent (705%) for Rural Hospitals, or

iii. Fifty-four~~Sixty~~ percent (54~~60~~%) for all other qualified hospitals.

4. Calculation methodology for weighting CICP uncompensated costs

a. Hospitals can qualify for up to two increases to weight their inflated CICP costs. Weighted CICP costs are calculated separately for hospitals within a Rural Area and hospitals not within a Rural Area. Qualifying for, and weighting inflated CICP costs are determined and calculated as follows:

i. CICP Cost as a percentage of total cost

a. Hospitals not within a Rural Area whose CICP costs as a percentage of total costs is greater than the mean plus one standard deviation percentage for all hospitals not within a Rural Area will have their inflated CICP costs increased by 2% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

b. Hospitals within a Rural Area whose CICP costs as a percentage of total costs is greater than the mean plus one standard deviation percentage for all hospitals within a Rural Area will have their inflated CICP costs increased by 2% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

ii. Medicaid and CICP Days as a percentage of total days

a. Hospitals not within a Rural Area whose combined Medicaid and CICP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all hospitals not within a Rural Area will have their inflated CICP costs increased by 5% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

b. Hospitals within a Rural Area whose combined Medicaid and CICP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all hospitals

within a Rural Area will have their inflated CICP costs increased by 5% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

c. For those facilities that qualify for both CICP Inflated Cost weightings, the inflated CICP cost will be increased by 2% first, and the resulting weighted CICP costs will then be increased by 5%.

8.2004.FG. Inpatient Hospital Base Rate Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Long Term Care Hospitals and Critical Access Hospitals with an established Medicaid inpatient base rate shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this annual payment equals the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate with increases as follows:

   a. Pediatric Specialty Hospitals shall have a 16.020.0% increase.

   b. State UniversityTeaching Hospitals shall have a 23.031.3% increase.

   c. Long Term Care Hospitals and Rehabilitation Hospitals shall have a 1025.0% increase.

   d. Hospitals located in Rural Areas and Critical Access Hospitals shall have a 7560.0% increase.

   e. Urban Safety Net Hospitals shall have a 15.00% increase.

   fe. Other General Hospitals and Critical Access Hospitals shall have an 45.051.3% increase.

8.2004.GH. High Level Neo-natal Intensive Care Unit (NICU) Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals certified level IIIb or IIIc neo-natal intensive care unit (NICU) shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals, and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $2,500 per Medicaid NICU Day.

8.2004.HI. State Teaching Hospital Supplemental Medicaid Payment

1. Qualified hospitals. State Teaching Hospitals shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $100 per Medicaid Day.

3. Effective October 1, 2012 the State Teaching Hospital Supplemental Medicaid Payment is suspended.

8.2004.IJ. Acute Care Psychiatric Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals with licensed distinct-part psychiatric units shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $200 per Medicaid Psychiatric Day.

8.2004.JK. Large Rural Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in a Rural Area with 26 or more licensed beds shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $750 per Medicaid Day, and qQualified hospitals who participate in the CICP, and whose percentage of Medicaid Days plus CICP Days to total days is in the top 25% of all providers will receive an additional $100 per Medicaid Day.

8.2004.KL. Denver Metro Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County or Douglas County shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment.

    a. For each qualified hospital located in Adams County or Arapahoe County, this payment is calculated on an annual basis at $800 per Medicaid Day, and qQualified hospitals who participate in the CICP, and whose percentage of

Medicaid Days plus CICP Days to total days is in the top 25% of all providers will receive an additional $100 per Medicaid Day.~~.~~

b. For each qualified hospital located in Denver County, this payment is calculated as $865~~900~~ per Medicaid Day~~, and q~~Qualified hospitals who participate in the CICP, and whose percentage of Medicaid Days plus CICP Days to total days is in the top 25% of all providers will receive an additional $100 per Medicaid Day.~~.~~

c. For each qualified hospital located in Boulder County, Broomfield County, or Jefferson County, this payment is calculated as $1075~~100~~ per Medicaid Day~~, and q~~Qualified hospitals who participate in the CICP, and whose percentage of Medicaid Days plus CICP Days to Total Days is in the top 25% of all providers will receive an additional $100 per Medicaid Day.~~.~~

8.2004.L~~M~~. Metropolitan Statistical Area Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in El Paso County, Larimer County, Mesa County, Pueblo County or Weld County shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital this payment is calculated on an annual basis at $650 per Medicaid Day.

8.2004.M~~N~~. Pediatric Specialty Hospital Provider Fee Payment

1. Qualified hospitals. Hospitals qualified to receive the Pediatric Major Teaching Hospital Payment in 10 CCR 2505-10 Section 8.903.C.6 shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis and shall equal $1~~2~~ million.

8.2004.N. Hospital Quality Incentive Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Pediatric Hospitals, Long Term Acute Care Hospitals and Critical Access Hospitals with an established Medicaid inpatient base rate, and that meet the minimum criteria for no less than two of the selected measures, may qualify to receive this payment.

2. Excluded hospitals. Psychiatric Hospitals and Out-of-State Hospitals in both bordering and non-bordering states.

3. Measures. The measures for the Hospital Quality Incentive Payment are:

a. Rate of Central Line-Associated Blood Stream Infections (CLABSI)

b. Rate of elective deliveries between 37 and 39 weeks gestation

c. Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT)

d. Structured efforts to reduce readmissions and improve care transitions

4. Calculation methodology for payment. Payments shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments. For each qualified hospital, this payment will be calculated as follows:

a. Determine Available Points by hospital, subject to a maximum of 10 points per measure

i. Available Points are defined as the number of measures for which a hospital qualifies multiplied by 10

b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department

c. Normalize the total points earned per measure to total possible points for all measures by hospital

d. Calculate Adjusted Medicaid Discharges by hospital

i. Adjusted Medicaid Discharges are calculated by multiplying the number of Medicaid inpatient discharges by the Adjusted Discharge Factor

ii. The Adjusted Discharge Factor is defined as the most recently available annual total gross Medicaid billed charges divided by the inpatient gross Medicaid billed charges

iii. The Adjusted Discharge Factor shall be no greater than 5

e. Calculate Total Discharge Points

i. Discharge Points are defined as the number of points earned per measure multiplied by the number of Adjusted Medicaid Discharges

f. Calculate the Dollars per Discharge Point

i. Dollars per Discharge Point will be calculated by dividing the total HQIP funds available under the inpatient UPL by the total number of Discharge Points across qualified hospitals

g. Determine HQIP payout by hospital by multiplying the total Discharge Points for that hospital by the Dollars per Discharge Point.

5. The total funds for the Hospital Quality Incentive Payment for the Federal Fiscal Year beginning October 1, 2012 will be $32,000,000.