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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 08-12-04-A,Data Provision and Claims Requirements, Section 8.064
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) 8.064, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new section 8.064 attached after existing text at §8.063.20 and before §8.065.

This change is effective 1/9/2009.

*to be completed by MSB Board Coordinator

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Title of Rule: Data Provision and Claims Requirements, Section 8.064

Rule Number: MSB 08-12-04-A

Division / Contact / Phone: Legal/Gary Ashby/X 3947

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).

   New legislation passed this past year requires that rules be implemented to provide guidelines on what is required from insurers and other responsible third parties to do proper data matching and claims recovery.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal regulation and/or

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

   Explain:

   These rules are necessary to implement the requirements of HB-1409 and the federal Deficit Reduction Act of 2005.

3. Federal authority for the Rule, if any:

   The Deficit Reduction Act of 2005 - 42 U.S.C. 1396a(a)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-4-209, C.R.S. (2008)

Initial Review — Final Adoption **02/13/2009**

Proposed Effective Date **01/09/2009** — Emergency Adoption **01/09/2009**

DOCUMENT #

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Data Provision and Claims Requirements, Section 8.064

Rule Number: MSB 08-12-04-A

Division / Contact / Phone: Legal/Gary Ashby/X 3947

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 insurers, pharmacy benefit managers and other responsible third parties as defined in 25.5-4-209 C.R.S. (2008) who are legally responsible for the payment of a health claim. The rule also affects the Department's vendor responsible for collecting overpayments where someone other than Medicaid was primarily responsible for the health claim.

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 rule by itself will not have much of an impact on others. It simply defines what data elements are required for eligibility data matches and reiterates the claims requirements. In combination with the new legislation, this rule will have the following impact. Insurers and other responsible third parties as defined in 25.5-4-209 C.R.S (2008) are required to provide their eligibility files to the Department or its business associate for eligibility data matching with Medicaid's eligibility files. Where matches are found, the responsible third party will be required to pay any health claims it should be paying first. The Department or its business associate will pay any reasonable costs of the responsible third party to provide the eligibility files. This rule states what minimum data elements are required to be sent in the eligibility file to the Department or its business associate.

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 by itself does not provide any additional costs to the Department or other agencies. In combination with the new legislation, this rule should help increase recoveries for the Department. The Department pays a contingency fee to its vendor (referred to in the statute as its business associate).

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

   This rule and the recently approved state legislation are required under federal law. First, if the rule is not approved, the Department would not be in compliance with state law (the new legislation). Second, if the rule is not approved, the Department would not be in compliance with federal law and the Department could lose federal financial participation funds. State expenditures for the Department are expected to decrease $300,000 in fiscal year 2008-09

and $400,000 in fiscal year 2009-10. Savings are split equally between the State general fund and the federal government.

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 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 for achieving the purpose of the proposed rule since the new legislation specifically requires a rule.

8.064 Data Provision and Claims Requirements

8.064.1 Data Provision from Third Parties

8.064.1.A. All third parties, as a condition of doing business in the state, shall provide on a monthly basis, and within 60 days of request, to the Department or its Business Associate or designee, including Medicaid MCO plans, an electronic file from the third party's database containing eligibility records of all persons covered by the third party containing the minimum necessary data elements to enable the Department or its Business Associate or designee to achieve a satisfactory data match. The Department or its Business Associate or designee has the right, in their sole discretion, to request additional data from any third party if the file provided does not result in a satisfactory data match that enables the Department or its Business Associate to determine which persons are dually eligible for medical assistance and the coverage provided by the third party necessary to prepare HIPAA compliant bills and for the purpose of cost avoidance. Such request will be cumulative and the third party will be required to submit monthly eligibility records with all requested data elements.

8.064.1.B Third parties are encouraged to work with the Department or its Business Associate or designee to enter into Data Use Agreements on a case by case basis. Execution of a Data Use Agreement with the Department or its Business Associate shall satisfy the Minimum Necessary requirement.

8.064.1.C. "Satisfactory Data Match" means obtaining results from the data match that enable the Department to achieve cost avoidance and that will provide medical providers with adequate information to bill the third party and have their claims adjudicated without request for further information from the third party and that enables the Department or its Business Associate or designee to bill previously paid claims to the third party resulting in proper adjudication without requests for further information from the third party to proceed with adjudication.

8.064.1.D. "Third Party" means a health insurer, self-insured plan, group health plan as defined in 29 U.S.C. Sec 1167(1), service benefit plan, managed care organization, pharmacy benefit manager, or other party, that is by statute, contract, or agreement legally responsible for payment of a claim for a health care item or service, such as third party administrators.

8.064.1.E. "Minimum Necessary" is defined as those data elements necessary to achieve a satisfactory match, and includes, but is not limited to the following:

1. First name, Middle initial, and Last name;
2. Date of Birth;
3. Sex code (M or F);
4. Social Security number or policy number if a crosswalk to actual social security numbers is provided contemporaneously, or the last 4 digits of the SSN;
5. Policy and Group number;
6. Group Name/Employer Name;
7. Begin and end dates of coverage;
8. Coverage types provided to each member and dependent;

9. Pharmacy Indicator and PBM information including a crosswalk to PBMs if multiple PBMs;

10. Subscriber Full address;

11. Dependent(s) First name, Middle Initial, and Last name;

12. Dependent(s) DOB;

13. Dependent(s) SSN or last 4 digits of SSN;

14. Dependent(s) Sex Code.

8.064.1.F. "Business Associate" shall have the same meaning as provided in 45 CFR 160.103.

8.064.1.G. Third parties shall accept and respond to inquiries and contact, either in writing or telephonically for verification purposes or otherwise, regarding members and coverage from the Department or its Business Associate or its designee including the provision of applicable NPI numbers.

8.064.2 Claims Requirement

8.064.2.A. Third parties shall accept the Department's right of recovery and assignment of benefits from any individual or entity to the extent that such item or service is covered by the third party.

8.064.2.B. Claims shall not be denied for lack of preauthorization.

8.064.2.C. Claims shall not be denied for the type of format of the claim form.

8.064.2.D. Claims shall not be denied for a failure to present proper documentation at the point-of-sale that is the basis for the claim if the claim is presented within three years of the date that the item or service is furnished, and any action by the Department to enforce its right is commenced within six years after the Department's submission of the claim.

8.064.2.E. Third parties are required to accept and adjudicate claims submitted by the Department or its Business Associate and it is the duty of the third party to inform its clients that they intend to accept and adjudicate claims with or without specific authorization from its clients.

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 08-11-21-B, Changes to Provider Reimbursement Rates for the Old Age Pension Health and Medical Care 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) 8.941.9, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM beginning at §8.941.1 through the end of §8.941.1.G with the new text attached.

Also, please replace current text in §8.941.9 with the attached new text.

This change is effective 01/09/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Changes to Provider Reimbursement Rates for the Old Age Pension Health and Medical Care Program
Rule Number:	MSB 08-11-21-B
Division / Contact / Phone:	Safety Net Programs / Cindy Arcuri / 3996

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).

   Effective January 9, 2009, this rule implements increases for specific provider rates so that the Old Age Pension Health and Medical Care Program can reimburse providers closer to the program's statutory spending limits. Program expenditures at the current provider rates are forecast to fall below the program's estimated spending authority for FY 2008-09. The proposed increased provider rates may be sustained throughout FY 2009-10 by using reserve funds in the Supplemental Old Age Pension Health and Medical Care Fund if such additional funding is approved by the General Assembly.

   The Board last addressed reimbursement rates for this program in April 2007. In June 2007 the process for determining eligibility for financial and medical assistance services for all non-citizen residents changed. One change was made so that non-citizens who have been in the United States at least five years may be found eligible for Medicaid on a timely basis in accordance with federal law. The other change related to the process for verification of lawful presence. Between these two changes, caseload in the OAP Health and Medical Care Program dropped significantly from July 2007 through January 2008. This unexpected drop in caseload has been the primary reason that expenditures for this program have been much lower than forecasted in April 2007.

   The Safety Net Programs section has worked closely with the Eligibility Systems staff to understand the effects of these eligibility systems changes and some modifications to the verification of lawful presence process have occurred as a result of ongoing analysis. Caseload has now stabilized and is now growing at an expected rate. The Department will continue to monitor the program.

   The proposed rule also adds in clarifying language under Section 8.941.1(E) relating to the authority of the Executive Director of the Department to increase reimbursement rates to providers within constitutional and statutory limits.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

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

Initial Review		Final Adoption	**02/13/2009**
Proposed Effective Date	**01/09/2009**	Emergency Adoption	**01/09/2009**

DOCUMENT #04

Explain:

Increasing provider reimbursement rates as soon as possible ensures clients will have continued access to health care services, despite the current economic downturn. The rate increase can be supported within existing funding.

3. Federal authority for the Rule, if any:

   Not applicable. This is a state-only program.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-2-101, C.R.S. (2008)

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Changes to Provider Reimbursement Rates for the Old Age Pension Health and Medical Care Program

Rule Number: MSB 08-11-21-B

Division / Contact / Phone: Safety Net Programs / Cindy Arcuri / 3996

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 persons affected by the proposed rules are the recipients and providers of medical care for the Old Age Pension Health and Medical Care Program. Rate increases directly impact providers and may indirectly improve client access to care.

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 rule will adjust payment rates based on the Medicaid reimbursement as follows:

Service Type	Current Rate	Proposed Rate Effective January 9, 2009
Pharmacy	70%	75%
Inpatient Hospital	10%	10%
Outpatient Services	60%	65%
Practitioner/Physician	60%	65%
Emergency Dental	60%	65%
Independent Laboratory and X-Ray	60%	65%
Medical Supply	60%	65%
Hospice and Home Health	60%	65%
Emergency Transportation	60%	65%

Under this proposed rate structure, expenditures within FY 2008-09 will be approximately $2.5 million less than allowed under the current appropriation. Unexpended appropriations remain in the Supplemental Old Age Pension Health and Medical Care Fund in accordance with 26-2-117(3), C.R.S. (2008). Funds from this Supplemental Fund are subject to

appropriation by the General Assembly. Through the usual budget process, the Department intends to request an appropriation from the Supplemental Old Age Pension Health and Medical Care Fund in FY 2009-10 to support the higher provider reimbursement rates under this proposal. Under this proposal, the remaining reserve balance in this Supplemental Fund at the end of FY 2009-10 is projected to be roughly $3.4 million. Thus, the Department believes that this proposed rate increase is prudent and beneficial to providers and clients.

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 is implementing these rate changes in order to better manage the Old Age Pension Health and Medical Care Program's expenditures within statutory and constitutional spending authority limits. No administrative costs are anticipated to program changes in reimbursement rates in the Medicaid Management Information System. These changes will not affect state revenues as the legislative intent of the Supplemental Old Age Pension Health and Medical Care Fund is to fund the Old Age Pension Health and Medical Care Program and unexpended moneys from the program revert to the Supplemental Fund rather than the General Fund.

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

   Inaction would result in needlessly low reimbursement rates to providers, which in turn could negatively affect participation in the program and potentially limit client access to health care services. Inaction would also result in noncompliance with the intent of the Long Bill appropriations for FY 2008-09.

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

   The Department is researching options to redesign the program so that client needs can be met without frequent revisions to provider reimbursement rates. The Department consults with the provider community and stakeholders to identify long-term solutions for this program. However, it would be premature to present options to the Board at this time.

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 has modeled numerous rate change and expenditure scenarios. The Department believes the proposal provides an equitable benefit to providers, is simple to understand, and conservatively uses funds within the Supplemental Old Age Pension Health and Medical Care Fund to finance the program's expenditures.

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

In accordance with the Constitution of Colorado, Title XXIV, Section 7, and the Colorado Social Services Act, an Old Age Pension Health Care Program is established to provide necessary medical care for the Old Age Pension recipients who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. The State Department is designated as the single State agency to administer the program.

The Old Age Pension Health Care Supplemental Program is authorized by Colorado Revised Statues, Section 26-2-117, C.R.S. The funding for this program cannot be accessed until all funds in the Old Age Pension Health Care Program are exhausted.

A. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program provide optional benefits to clients who qualify for (State only) OAP-A and (State only) OAP-B pensions who do not qualify for Federal Financial Participation in the Colorado Medicaid Program. These cases are coded with Supplemental Income Status Code (SISC) C.

B. Under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program, only the following State funded benefits are provided: physician and practitioner services, inpatient hospital, outpatient services, lab and x-ray, emergency transportation, emergency dental, pharmacy, home health services and supplies, and Medicare cost sharing. As of January 1, 2004 the inpatient hospital benefit is suspended until October 15, 2004.

   Effective October 15, 2004, the inpatient hospital benefit is restored at those hospitals which participate under the Colorado Indigent Care Program. Services to the clients covered under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program are limited to those inpatient services available under the Colorado Indigent Care Program.

   Effective January 1, 2006, Medicare Part D prescription drugs provided pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (defined at 42 U.S.C. Sections 1395w-102 and 141 and 42 C.F.R. Section 423, et seq.) shall not be a benefit for those individuals who are eligible for both Medicare and the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program. The pharmacy drug benefit under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program shall follow Medicaid regulations, as specified under 8.830.

   For the benefits listed above, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program shall only be used to provide clients with health care services determined to be medically necessary by the health care provider.

C. All other medical benefits not listed in paragraph B are excluded under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program. Inpatient care in an institution for tuberculosis or mental diseases, skilled and intermediate nursing facility services, and home and community based services are also excluded.

D. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program eligibility shall not be retroactive. Eligibility shall begin with the date of application or date eligibility is established, whichever is later.

E. The Executive Director of the Department of Health Care Policy and Financing, under the direction of the State Medical Services Board, shall manage the Old Age Pension Health and Medical Care fund and the supplemental Old Age Pension Health and Medical Care fund to assure that

utilization controls and other mechanisms are in place in order to hold expenditures within the constitutional and statutory limits.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will exceed the available funds, he/she shall take action to reduce expenditures as needed by reducing, suspending, or eliminating payments for covered benefits.

The Executive Director shall consider reducing, suspending or eliminating benefits, individually or in any combination, based upon the shortest duration of time and considering the least impact on the client. The Executive Director shall report to the Board whenever such action is required, specifying the dollar impact, length of time for the reduction, and the number of clients and providers affected. In addition, the Executive Director shall report to the Board on the feasibility of other cost reduction options.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will be less than the available funds, he/she may take action to increase expenditures up to constitutional and statutory limits by modifying the reimbursement methodology for covered benefits. In addition, the Executive Director shall report to the Board whenever such action is taken.

F. Counties shall provide information to Old Age Pension Health Care Program clients regarding the disposal of excess resources in order to qualify for the Medicaid program. Such information shall include advisements concerning the prohibition of transfer of assets without fair consideration.

G. If Medicare pays for a medical service that is a non-benefit for this group, the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program.

8.941.9 REIMBURSEMENT TO PROVIDERS

~~From May 1, 2007 through June 30, 2007, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program will reimburse inpatient hospital services at 50% of the appropriate Medicaid reimbursement. [Eff 07/30/2007]~~

As of July 1, 2007, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program will reimburse inpatient hospital services at 10% of the appropriate Medicaid reimbursement. [Eff 07/30/2007]

~~From May 1, 2007 through June 30, 2007, providers of physician and practitioner services; outpatient services (including outpatient hospitals, federal qualified health centers, rural health centers and dialysis centers); emergency dental services; independent laboratory and x-ray services; medical supply services; hospice and home health services; and emergency transportation services will be reimbursed at 70% of the appropriate Medicaid reimbursement. [Eff 07/30/2007]~~

As of ~~July 1, 2007~~ January 9, 2009, providers of physician and practitioner services; outpatient services (including outpatient hospitals, federal qualified health centers, rural health centers and dialysis centers); emergency dental services, independent laboratory and x-ray services; medical supply services; hospice and home health services; and emergency transportation services will be reimbursed at ~~60~~65% of the appropriate Medicaid reimbursement. ~~[Eff 07/30/2007]~~

As of ~~November 1, 2006~~ January 9, 2009, pharmacy claims are reimbursed at ~~70~~75% of the appropriate Medicaid reimbursement. ~~[Eff 07/30/2007]~~

In accordance with 8.941.1(E), the Executive Director may alter the reimbursement for any service with the condition that expenditures remain within the constitutional and statutory limits. [Eff 07/30/2007]