THIS PAGE NOT FOR PUBLICATION

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

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

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

PUBLICATION INSTRUCTIONS*

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 This payment is repealed effective September 1, 2009."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 This program has been repealed.**

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

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

STATEMENT OF BASIS AND PURPOSE

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

   This rule is repealed, effective September 1, 2009 in order to help offset the state budget shortfall.

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

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

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

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

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

Initial Review		Final Adoption	
Proposed Effective Date	**9/1/2009**	Emergency Adoption	**8/31/2009**

DOCUMENT # 1

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

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

THIS PAGE NOT FOR PUBLICATION

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

REGULATORY ANALYSIS

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

   The Health Care Services Payment reimburses community clinics and primary care clinics owned and operated by hospitals for primary care services received by low-income and uninsured populations in a primary care setting. To be eligible for this payment, providers must participate in the Colorado Indigent Care Program (CICP).

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

   The elimination of funding for this payment affects CICP providers as follows:

   Community Health Clinics- a decrease of $21,648,000; Primary Health Care Clinics Operated by Hospitals- a decrease of $2,952,000; Denver Health Medical Center- a decrease of $5,400,000.

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

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

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

   There are no costs to the Department or any other agency to implement or enforce this proposed rule.

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

The benefit of the proposed rule revision is a reduction in expenditures for reimbursement to CICP providers for primary care health services offered in an outpatient setting, which will help offset the projected state budget shortfall. The cost is that reimbursements to CICP providers of primary care health services offered in an outpatient setting are eliminated. If the Department does not reduce expenditures and help offset the state budget shortfall, other Medicaid benefits may have to be significantly reduced. There is no ability to continue payments so there are no benefits of inaction.

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

   Since all funding has been eliminated for this payment, there are no other options than to repeal the rule guiding the payment.

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

   None.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

C. Distribution of Available Funds to Providers

14. Colorado Health Care Services Payment. This payment is repealed effective September 1, 2009.~~an allocation of the Colorado Health Care Services Fund and is available to community health clinics and primary care clinics operated by a qualified health care provider that provides primary care services. For this section, primary care services are defined in Section 8.930.1.A of the regulations for the Comprehensive Primary/Preventive Care Grant Program.~~

~~a. For FY 2007-08, 18% of the moneys appropriated from the Colorado Health Care Services Fund shall be allocated to Denver Health Medical Center. After the appropriation to Denver Health Medical Center, 82% of the remaining funds shall be allocated to community health clinics operated by a qualified health care provider and 18% shall be allocated to primary care clinics operated by a qualified health care provider.~~

~~For FY 2008-09, 18% of the moneys appropriated from the Colorado Health Care Services Fund shall be allocated to Denver Health Medical Center. After the appropriation to Denver Health Medical Center, 85% of the remaining funds shall be allocated to community health clinics operated by a qualified health care provider and 15% shall be allocated to primary care clinics operated by a qualified health care provider.~~

~~For FY 2009-10, 18% of the moneys appropriated from the Colorado Health Care Services Fund shall be allocated to Denver Health Medical Center. After the appropriation to Denver Health Medical Center, 88% of the remaining funds shall be allocated to community health clinics operated by a qualified health care provider and 12% shall be allocated to primary care clinics operated by a qualified health care provider.~~

~~b. In order to receive a payment from the Colorado Health Care Services Fund, the qualified health care provider who operates a primary care clinic is required to complete a Colorado Health Care Services Fund Application as issued by the Department. This application for the current state fiscal year shall be submitted to the Department by July 31 of each State fiscal year.~~

~~c. Distribution of available funds for primary care clinics operated by a qualified health care provider shall be based upon historical data for the number of unique low-income clients who received primary care services at a primary care clinic and their number of visits. A qualified health care provider's distribution is calculated based on the average of the dollar amount derived from the provider's number of unique clients who received primary care services at a primary care clinic relative to the total number of clients who received primary care services at a primary care clinic for all qualified health care providers and the dollar amount derived from the provider's number of low-income primary care services visits at a primary care clinic relative to the total number of low-income primary care services visits at a primary care clinic for all qualified health care providers. The historical data will be reported in the Colorado Health Care Services Fund Application and related to the most recently available annual report published by the Colorado Indigent Care Program prior to rate setting by the Department for each upcoming State fiscal year.~~

~~d. Distribution of available funds for community health clinics operated by a qualified health care provider shall be based upon historical uncompensated costs for clients who received primary care services at a community health clinic. An individual community health clinic's distribution is calculated based on the community health clinic's historical uncompensated costs for clients who received primary care services at a community health clinic relative to the total historical uncompensated costs for all clients who received primary care services at community health clinics. The historical uncompensated costs shall be that as reported in the most recently available annual report published by the Colorado Indigent Care Program prior to rate setting by the Department for each upcoming State fiscal year.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Outstationing Administrative Costs, § 8.700.8
Rule Number:	MSB 09-08-17-E
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri / X3996

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-17-E, Revision to the Medical Assistance Rule Concerning Reimbursement for Outstationing Administrative Costs, Section 8.700.8
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.700.8 affected, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/1/2009
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.700.8.a and .b with new text provided. This change is effective 9/1/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Outstationing Administrative Costs, § 8.700.8
Rule Number:	MSB 09-08-17-E
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri / X3996

STATEMENT OF BASIS AND PURPOSE

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

   Currently, the Department reimburses federally qualified health centers (FQHCs) for reasonable administrative costs associated with accepting applications to determine Medicaid eligibility. The reimbursement for these activities is commonly referred to as an "outstationing payment". Reimbursement is capped at $60,000 per facility per year. Currently, this maximum payment of $60,000 per facility per year is funded with General Fund and federal funds. However, Denver Health Medical Center presently receives additional federal financial participation for their FQHCs uncompensated costs associated with outstationing activities beyond the $60,000 limit per FQHC by certifying addditional uncompensated costs as recorded in audited cost reports. The certification process is a financing mechanism that allows the Department to receive federal financial participation without contributing General Fund as the state share of the Medicaid payment.

   The proposed rule allows Denver Health Medical Center to certify its uncompensated outstationing costs in lieu of using General Fund to qualify for the matching Medicaid federal financial participation. The rule is structured to accomplish this by (1) declaring that only freestanding FQHCs receive an outstationing payment not to exceed $60,000 per facility (8.700.8.A); and (2) stating that hospital-based FQHCs, which is what Denver Health Medical Center's FQHCs are, shall certify all eligible uncompensated costs associated with accepting applications to determine Medicaid eligibility (8.700.8.B).

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

   The Department may not be able to provide the services necessary to preserve the public health, safety and welfare, if the reimbursement process for outstationing administrative costs is not amended.

Initial Review		Final Adoption	
Proposed Effective Date	**9/1/2009**	Emergency Adoption	**8/31/2009**

DOCUMENT # 2

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   24-2-102(4), C.R.S. (2008)

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Outstationing Administrative Costs, § 8.700.8
Rule Number:	MSB 09-08-17-E
Division / Contact / Phone:	State Programs & Fed Financing Division/Cindy Arcuri / X3996

REGULATORY ANALYSIS

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

   Denver Health Medical Center will be affected by this rule change.

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

   Outstationing payments to Denver Health Medical Center will decrease by approximately $600,000 per year. Presently, Denver Health Medical Center operates 20 FQHCs. The total capped outstationing reimbursement for these facilities if $60,000 x 20 clinics, which computes to $1.2 million. Effective September 1, 2009, the General Fund portion of this $1.2 million, will no longer be available. (General Fund constitutes 50% of the total payment, or $600,000.)

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

   There are no costs to the Department or any other agency to implement or enforce this proposed rule.

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

   This rule must be amended since, after September 1, 2009, the General Fund portion currently used to reimburse outstationing administrative costs will no longer be available.

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

   No less costly or less intrusive methods are available.

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

   None..

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process ~~accepting applications to determine Medicaid eligibility~~. This outstationing payment shall be made based upon actual cost with a reasonable cost-per-application limit to be established by the Department. The reasonable cost-per application limit shall be based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall the outstationing payment for FQHCs exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities. *[Eff 08/30/2006]*

8.700.8.B Hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting clients in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center clinics shall receive ~~additional~~ federal financial participation for eligible expenditures ~~that are not reimbursed by the outstationing payment methodology under 10 CCR 2505-10, Section 8.700.8.A~~. To receive the federal financial participation, Denver Health Medical Center FQHCs shall provide the State's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid expenditures under 42 C.F.R., Section 433.51. Such certifications shall be sent to the Safety Net Financing Manager. 42 C.F.R., Section 433.51, is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. *[Eff 08/30/2006]*

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Med Assistance Rule Concerning Elimination of the CICP Rural and Public Hospital Payments, §8.903

Rule Number: MSB 09-08-17-F

Division / Contact / Phone: State Programs and Federal Financing / Cindy Arcuri / X3996

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-17-F, Revision to the Medical Assistance Rule Concerning Elimination of the Colorado Indigent Care Program Rural and Public Hospital Payments
3. This action is an adoption of: <Select One>
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.903.C.15 and 16, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/1/2009
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

These programs have been repealed. Please remove all language from §8.903.C.15 and 16 with the exception of the following:

15. Rural Hospital Payment. This payment is repealed effective September 1, 2009.

16. Public Hospital Payment. This payment is repealed effective September 1, 2009.

This chance is effective 09/01/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Med Assistance Rule Concerning Elimination of the CICP Rural and Public Hospital Payments, §8.903
Rule Number:	MSB 09-08-17-F
Division / Contact / Phone:	State Programs and Federal Financing / Cindy Arcuri / X3996

STATEMENT OF BASIS AND PURPOSE

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

   This rule is repealed, effective September 1, 2009 to reduce expenditures to Colorado Indigent Care Program (CICP) rural hospitals with 60 or fewer staffed acute care beds and public-owned CICP hospitals in order to help offset the projected state budget shortfall.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

   The Department may not be able to provide the services necessary to preserve the public health, safety and welfare, if the CICP program expenditures to rural CICP hospitals with 60 or fewer staffed acute care beds are not reduced.

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

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

Initial Review — Final Adoption

Proposed Effective Date **9/1/2009** — Emergency Adoption **8/31/2009**

DOCUMENT # 3

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Med Assistance Rule Concerning Elimination of the CICP Rural and Public Hospital Payments, §8.903
Rule Number:	MSB 09-08-17-F
Division / Contact / Phone:	State Programs and Federal Financing / Cindy Arcuri / X3996

REGULATORY ANALYSIS

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

   The Rural and Public Hospital Payments partially reimburse public-owned hospital providers and rural hospital providers for inpatient hospital services rendered to low-income uninsured populations. To be eligible for these payments, providers must participate in the Colorado Indigent Care Program (CICP).

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

   The elimination of this funding will mean a decrease of $2.5 million that had been appropriated to public-owned CICP hospital providers in FY 2009-10 and a decrease of $2.5 million that had been appropriated for rural CICP hospital providers in FY 2009-10. Other CICP funding for rural and public-owned CICP hospital providers has not been impacted by this rule.

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

   There are no costs to the Department or any other agency to implement or enforce this proposed rule.

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

   The benefit of the proposed rule revision is a reduction in expenditures for CICP rural hospitals with less than 60 beds and public-owned CICP hospitals, which will help offset the projected state budget shortfall. The cost is that these hospitals will no longer receive these supplemental payments to offset costs for CICP clients.

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

   Since all funding has been eliminated for this payment, there are no other options than to repeal the rule guiding these payments.

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

   None.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

C. Distribution of Available Funds to Providers

15. Rural Hospital Payment. This payment is repealed effective September 1, 2009.~~an allocation of the Supplemental Tobacco Litigation Settlement Moneys Account and is available to qualified Rural Hospital providers.~~

~~a. A Rural Hospital provider shall meet the following requirements to qualify for the payment: (1) participate in the Colorado Indigent Care Program; (2) reside outside the boundaries of a federally designated metropolitan statistical area; and (3) have 60 or fewer staffed acute care beds.~~

~~b. Fifty percent of the moneys appropriated to the Supplemental Tobacco Litigation Settlement Moneys Account each fiscal year plus any corresponding available federal financial participation shall be allocated to qualified Rural Hospital providers on a quarterly basis.~~

~~c. The Rural Hospital payment to a qualified provider shall be calculated as the individual provider's Weighted Medically Indigent Costs relative to the sum of total Weighted Medically Indigent Costs for all qualified hospital providers multiplied by the allocation available to Rural Hospital providers. Weighted Medically Indigent Costs shall be as defined in Section 8.903.C.10 and the allocation available to Rural Hospital providers shall be as specified in Section 8.903.C.15.b.~~

16. Public Hospital Payment. This payment is repealed effective September 1, 2009.~~an allocation of the Supplemental Tobacco Litigation Settlement Moneys Account and is available to qualified Public Hospital providers. [Eff. 10/30/07]~~

~~a. A Public Hospital provider shall meet the following requirements to qualify for the payment: (1) participate in the Colorado Indigent Care Program; and (2) be either a State-owned or Local-owned hospital provider. [Eff. 10/30/07]~~

~~b. Fifty percent of the moneys appropriated to the Supplemental Tobacco Litigation Settlement Moneys Account each fiscal year, plus all interest and income earned on the deposit and investment of moneys in the Account, plus any corresponding available federal financial participation shall be allocated to qualified Public Hospital providers on a quarterly basis. [Eff. 10/30/07]~~

~~c. The Public Hospital payment to a qualified provider shall be calculated as the individual hospital provider's Weighted Medically Indigent Costs relative to the sum of total Weighted Medically Indigent Costs for all qualified hospital providers multiplied by the allocation available to Public Hospital providers. Weighted Medically Indigent Costs shall be as defined in Section 8.903.C.10 and the allocation available to Public Hospital providers shall be as specified in Section 8.903.C.16.b. [Eff. 10/30/07]~~

THIS PAGE NOT FOR PUBLICATION

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

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

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

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.800.13.D.1.a. and b. with the new text provided. This change is effective 09/01/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

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

STATEMENT OF BASIS AND PURPOSE

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

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

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

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

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

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

Initial Review — Final Adoption

Proposed Effective Date **09/01/2009** — Emergency Adoption **08/31/2009**

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

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

REGULATORY ANALYSIS

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

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

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

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

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

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

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

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

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

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

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

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

8.800.13 REIMBURSEMENT CALCULATION

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

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

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

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

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reduction to FQHC Reimbursement, §8.700
Rule Number:	MSB 09-08-20-B
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-20-B, Revision to the Medical Assistance Rule Concerning Reduction to FQHC Reimbursement, §8.700
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.700.7, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.700.7.A through §8.700.7.D with the new text provided. This change is effective 09/01/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reduction to FQHC Reimbursement, §8.700
Rule Number:	MSB 09-08-20-B
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule will reduce the FQHC encounter rate to a rate that is halfway between the alternative rate and the BIPA (PPS) rate.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

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

3. Federal authority for the Rule, if any:

   Social Security Act, Section 1902(aa)

4. State Authority for the Rule:

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

Initial Review — Final Adoption

Proposed Effective Date **09/01/2009** — Emergency Adoption **08/31/2009**

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reduction to FQHC Reimbursement, §8.700
Rule Number:	MSB 09-08-20-B
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

REGULATORY ANALYSIS

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

   Federally Qualified Health Centers (FQHCs) will receive reduced reimbursement for services provided.

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

   Reimbursement to FQHCs is estimated to be reduced by $3,915,491 for FY 09-10.

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

   None.

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

   The benefit of the proposed rule revision is a reduction in FQHC expenditures, which will help offset the projected state budget shortfall and allow the Department to provide FQHC benefits without significant changes in coverage. The cost is that FQHCs may receive less reimbursement for the services they provide. If the Department does not reduce expenditures and help offset the state budget shortfall, the FQHC benefit and/or other Medicaid benefits may have to be significantly reduced.

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

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

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

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

8.700.7 REIMBURSEMENT

8.700.7.A FQHCs shall be reimbursed a per visit encounter rate based on 100% of reasonable cost. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. A medical encounter and a dental encounter on the same day and at the same location shall count as two separate visits. *[Eff 08/30/2006]*

8.700.7.B ~~The encounter rate shall be the higher of:~~Encounter rate calculation *[Eff 0~~9~~8/01~~30~~/200~~96~~]*

Effective September 1, 2009, the encounter rate shall be the average of the Prospective Payment System (PPS) rate and the alternative rate.

1. The ~~Prospective Payment System (PPS),~~PPS rate ~~a~~is~~s~~ defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554~~.~~, BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library. ~~The Acute Care Benefits Section Manager at the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of BIPA, or the materials may be examined at any publications depository library.~~ *[Eff 09/01/2009]~~08/30/2006]~~*

2. ~~The alternative rate calculated by the Department. *[Eff 08/30/2006]*~~The alternative rate shall be the lower of the annual rate or the base rate. The annual rate and the base rate shall be calculated as follows:

~~8.700.7.C The alternative rate shall be the lower of the annual or the base rate. The annual and base rates shall be calculated as follows: *[Eff 08/30/2006]*~~

~~1~~a~~).~~ Annual rates shall be the FQHCs current year's calculated inflated rate, after audit. *[Eff 08/30/2006]*

b) ~~2. Base rates shall be recalculated (rebased) every three years.~~ The new base rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years. Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs. Base rates shall be recalculated (rebased) every three years. *[Eff 08/30/2006]*

3. If the PPS rate is higher than the alternative rate, the FQHC encounter rate shall be the PPS rate.

4. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement base rate for the first year. The base rate shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. This shall be the FQHCs base rate until the next rebasing period. *[Eff 08/30/2006]*

New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates. *[Eff 08/30/2006]*

5~~3~~. ~~-~~The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate. *[Eff 08/30/2006]*

Freestanding FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. Freestanding FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments. *[Eff 08/30/2006]*

The new reimbursement rate for freestanding FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement rate (if less than the new audited rate) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120th day after the freestanding FQHCs fiscal year end. *[Eff 08/30/2006]*

The new reimbursement rate for hospital-based FQHCs shall be effective January 1 of each year. *[Eff 08/30/2006]*

If a hospital-based FQHC fails to provide the requested documentation, the costs associated with those activities shall be presumed to be non-primary care services and shall be settled using the Outpatient Hospital reimbursement rate. *[Eff 08/30/2006]*

All hospital-based FQHCs shall submit separate cost centers and settlement worksheets for primary care services and non-primary care services on the Medicare Cost Report for their facilities. Non-primary care services shall be reimbursed according to Section 8.332. *[Eff 08/30/2006]*

6~~4~~. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If a FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation. *[Eff 08/30/2006]*

8.700.7.C~~D~~ The Department shall notify the FQHC of its rate. *[Eff 08/30/2006]*

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, §8.332
Rule Number:	MSB 09-08-20-C
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-20-C , Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.332, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new paragraph text at paragraph 2 under §8.332 between first paragraph:

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

And second paragraph:

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

This change is effective 09/01/2009

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, §8.332
Rule Number:	MSB 09-08-20-C
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule change will reduce reimbursement to hospitals for outpatient services from 72 percent of cost to 70.9 percent of cost.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

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

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

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

Initial Review — Final Adoption

Proposed Effective Date **09/01/2009** — Emergency Adoption **08/31/2009**

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule for Outpatient Hospital Reimbursement, §8.332
Rule Number:	MSB 09-08-20-C
Division / Contact / Phone:	Rates Section / Jessica McKeen / 3858

REGULATORY ANALYSIS

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

   Hospitals in Colorado will receive reduced reimbursement for outpatient hospital services.

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

   Reimbursement to hospitals for outpatient services is estimated to be reduced by $1,742,068 for FY 09-10.

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

   None.

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

   The benefit of the proposed rule revision is a reduction in outpatient hospital expenditures, which will help offset the projected state budget shortfall and allow the Department to provide outpatient hospital benefits without significant changes in coverage. The cost is that hospitals may receive less reimbursement for outpatient treatment. If the Department does not reduce expenditures and help offset the state budget shortfall, the outpatient hospital benefit and/or other Medicaid benefits may have to be reduced significantly.

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

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

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

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

8.332 PAYMENT

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

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

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning on-Medical Transportation, §8.494
Rule Number:	MSB 09-08-20-F
Division / Contact / Phone:	Longterm Care / Michelle Halvorson / 3832

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-20-F, Revision to the Medical Assistance Rule Concerning on-Medical Transportation, §8.494
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) 8.494.50 affected, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.494.50 through §8.494.54 with the new text provided from §84.49.50 through §8.494.55. This change is effective 09/01/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning on-Medical Transportation, §8.494
Rule Number:	MSB 09-08-20-F
Division / Contact / Phone:	Longterm Care / Michelle Halvorson / 3832

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).

   For the preservation of public health, safety and welfare.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

   The Department may not be able to provide the services necessary to preserve the public health, safety and welfare if the non-medical transportation reductions are not put in place.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

Initial Review — Final Adoption

Proposed Effective Date **09/01/2009** — Emergency Adoption **08/31/2009**

DOCUMENT #07

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning on-Medical Transportation, §8.494
Rule Number:	MSB 09-08-20-F
Division / Contact / Phone:	Longterm Care / Michelle Halvorson / 3832

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.

   Home and Community Based clients obtaining services from Waiver programs utilizing Non-Medical Transportation in excess of two (2) round trips per week. .

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 limits Non-Medical Transportation to two round-trips per week per person not including HCBS Adult Day transportation.

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 decrease in services to HCBS clients will create a savings of approximately 1% of General Fund Revenue for the Department and State.

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

   If this limitation is not put into effect the potential 1% savings to the General Fund Revenue will not occur.

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

   There are not less costly methods.

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

   None

8.494 NON-MEDICAL TRANSPORTATION

8.494.50 LIMITATIONS AND REIMBURSEMENT

.51 Reimbursement for non-medical transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services.

.52 A provider's submitted charges shall not exceed those normally charged to 'the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities.

.53 No payment shall be made for charges when the recipient is not actually in the vehicle.

.54 Effective 2/1/99, there shall be no reimbursement under this section for non-medical transportation services provided to clients residing in uncertified congregate facilities. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued.

.55 Effective 09/01/2009, excluding transportation to HCBS Adult Day facilities, a client may not receive more than two (2) round trip services per week utilizing NMT.

THIS PAGE NOT FOR PUBLICATION

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

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

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

PUBLICATION INSTRUCTIONS*

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

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

And paragraph 59:

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

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

Please replace existing language at §8.100.4.G.10 with new text provided. This change is effective 09/01/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

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

STATEMENT OF BASIS AND PURPOSE

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

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

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

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

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

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

Initial Review — Final Adoption

Proposed Effective Date **09/01/2009** — Emergency Adoption **08/31/2009**

DOCUMENT #08

THIS PAGE NOT FOR PUBLICATION

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

REGULATORY ANALYSIS

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

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

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

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

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

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

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

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

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

   N/A

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

   N/A

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

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

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

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

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

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

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

8.100.4.G. Family and Children's Covered Groups

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

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Ambulatory Surgery Centers, Section 8.570

Rule Number: MSB 09-08-26A

Division / Contact / Phone: Medicaid Program Division / Eric Wolf / 303-866-5963

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-26A, Ambulatory Surgery Centers, Section 8.570
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 8.570, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/1/2009
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.570.6.A and B. with the next text provided. This change is effective 09/01/2009.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Ambulatory Surgery Centers, Section 8.570

Rule Number: MSB 09-08-26A

Division / Contact / Phone: Medicaid Program Division / Eric Wolf / 303-866-5963

STATEMENT OF BASIS AND PURPOSE

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

   Specifies changes in reimbursement rates.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

   If the Department does not reduce expenditures and help offset the state budget shortfall, the ambulatory surgery benefit or other benefits may have to be reduced significantly, which will interfere with the health and safety of Medicaid clients throughout Colorado.

3. Federal authority for the Rule, if any:

   Social Security Act Section 1902 (a) 30 (A) and 42 CFR Section 416.125

4. State Authority for the Rule:

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

Initial Review — Final Adoption

Proposed Effective Date **09/01/2009** — Emergency Adoption **08/31/2009**

DOCUMENT #09

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Ambulatory Surgery Centers, Section 8.570

Rule Number: MSB 09-08-26A

Division / Contact / Phone: Medicaid Program Division / Eric Wolf / 303-866-5963

REGULATORY ANALYSIS

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

Ambulatory surgical centers will receive lowered reimbursement from the Medicaid program.

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

   The savings from this change are part of the estimated $1,742,068 reduction to outpatient hospital services.

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

   None.

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

   The cost of this proposed rule revision is that ambulatory surgical centers will receive less reimbursement for their services. The benefit of the proposed rule revision is a reduction in ambulatory surgical center expenditures, which will help offset the projected state budget shortfall and allow the Department to provide ambulatory surgical benefits without significant changes in coverage. If the Department does not reduce expenditures and help offset the state budget shortfall, the ambulatory surgery benefit or other benefits may have to be reduced significantly.

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

   The targeted reduction of provider reimbursement rates, including those for ambulatory surgical centers, is one of the most effective means of reducing expenditures given the size of the forecasted state budget shortfall and the urgency with which it must be offset.

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

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

8.570 AMBULATORY SURGERY CENTERS

8.570.6 REIMBURSEMENT

8.570.6.A For payment purposes, ASC surgical procedures are grouped into nine categories ~~corresponding to CMS defined groups~~. The Health Care Procedural Coding System (HCPCS) is used to identify surgical services.

8.570.6.B Reimbursement for approved surgical procedures shall be allowed only for the primary or most complex procedure. No reimbursement is allowed for multiple or subsequent procedures. Approved surgical procedures identified in one of the nine ASC groupers ~~groupers~~ shall be reimbursed a facility fee at the lower of billed charges or ~~or 80% of the Medicare assigned rate~~ 77.22% of the 2007 Medicare-assigned rate. No reimbursement shall be allowed for services not included on the Department ~~-~~approved list for covered services.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Durable Medical Equipment and Medical Supplies

Rule Number: MSB 09-08-26-B.

Division / Contact / Phone: Medicaid Program / Doug van Hee / 4986

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 09-08-26-B., Durable Medical Equipment and Medical Supplies
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.590, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.590.7.I.1. through 3. with the new text provided. This change is effective 09/01/2009

*to be completed by MSB Board Coordinator

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Title of Rule: Durable Medical Equipment and Medical Supplies

Rule Number: MSB 09-08-26-B.

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STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule change will reduce reimbursement rates for durable medical equipment and supplies that are paid from fee schedule, invoiced costs or from manufacture suggegested retail prices.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

   The Department may be unable to continue to provide the some medical services necessary to preserve the public health, safety and welfare, if the rate reductions are not implemented.

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2008);
   25.5-5-102 (F) C.R.S. (2008)

Initial Review — Final Adoption

Proposed Effective Date **09/01/2009** — Emergency Adoption **08/31/2009**

DOCUMENT #10

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REGULATORY ANALYSIS

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

   Durable medical equipment and disposable medical supply providers will receive less reimbursement for services provided.

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

   Total fund reduction for durable medical equipment and supplies for FY 2009-10 is $875,318.

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

   None

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

The benefit of the proposed rule revision is a reduction in durable medical equipment and supply expenditure, which will help offset the projected state budget shortfall and allow the Department to provide benefits without significant change in coverage. The cost is that providers will receive less reimbursement. If the Department does not reduce expenditures and help offset the state budget shortfall, the durable medical equipment and supply benefit and/or other Medicaid benefits may have to be reduced significantly.

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

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

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

The Department is taking many steps to achieve program efficiencies to reduce expenditures, including other targeted provider rate reductions and defining benefits to identify the amount, scope and duration of the each benefit.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.590.7.I. Reimbursement rate for a purchased item shall be as follows: *[Eff 12/31/2006]2*

1. Fee Schedule items, with a HCPC or CPT code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the department fee schedule. *[Eff 12/31/2006]*

2. Manually priced items that have no maximum allowable reimbursement rate assigned, but have a Manufacture Suggested Retail Price (MSRP) shall be reimbursed the MSRP less 22.67 percent. (Eff 08/31/2009)

3.~~2~~. Manually priced items that have no maximum allowable reimbursement rate assigned ,nor a MSRP shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturers invoice cost, plus 15.87 ~~twenty~~ percent. *[Eff 08~~12~~/31/200~~96~~]*