THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Pharmaceutical Reimbursement Calculation, Section 8.800.13.
Rule Number:	MSB 11-08-31-A
Division / Contact / Phone:	Pharmacy / Sonia Sandoval / (303) 866-6338

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-08-31-A, Revision to the Medical Assistance Rule Concerning Pharmaceutical Reimbursement Calculation, Section 8.800.13.
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.800.13, 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: 09/23/11
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new text provided from §8.800.13 the unnumbered paragraph through §8.800.13.H the last unnumbered paragraph.
Please make the deletions indicated, additions provided and the re-numbering from §8.800.13.I (formerly §8.800.13.A) through §8.800.13.P (formerly §8.800.13.I. All other text is for clarification only. These changes are effective 09/23/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Pharmaceutical Reimbursement Calculation, Section 8.800.13.
Rule Number:	MSB 11-08-31-A
Division / Contact / Phone:	Pharmacy / Sonia Sandoval / (303) 866-6338

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).

   Historically, pharmacies in Colorado dispensing drugs, on an outpatient basis to fee-for-service Medicaid clients, are reimbursed based on the lowest of five rates calculated by the Department. The purpose of reimbursing pharmacies based on the lowest calculated rate using multiple methodologies is to ensure that the Colorado Medicaid program functions as a prudent purchaser of prescription drugs for Colorado Medicaid clients. Based on changes in the availability of information regarding these rates, the Department is required to develop a new reimbursement methodology. The Department will implement a new reimbursement methodology based on a State Maximum Allowable Cost (MAC) price or Wholesale Acquisition Cost (WAC).

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:

   Due to the change in methodology, if the reimbursement logic is not in the Pharmacy Drug Prescription System (PDCS) for all drugs currently available, client access to medication could be compromised.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Pharmaceutical Reimbursement Calculation, Section 8.800.13.
Rule Number:	MSB 11-08-31-A
Division / Contact / Phone:	Pharmacy / Sonia Sandoval / (303) 866-6338

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.

   Pharmacies that provide services to Medicaid eligible clients will be affected by the proposed rule.

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

   This rule change may increase the pharmacy reimbursement for some drugs and may reduce the reimbursement for others. The Department's goal is to keep this change as cost neutral as possible through use of an expanded State MAC list.

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.

   This is a federally mandated rule change that requires action. The current methodology used for pharmacy reimbursement cannot be used after October 1, 2011. If this action is not taken to change the methodology, client access may become an issue as pharmacy claims may be denied.

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.

   There are no alternative methods for achieving the purpose for the proposed rule due to the federal requirement to change reimbursement methodology.

8.800.13 REIMBURSEMENT CALCULATION

The paragraphs which follow set forth the reimbursement calculation effective September 9, 2011 through September 22, 2011.

8.800.13.A. Covered drugs for all clients except for OAP State Only clients shall be reimbursed at the provider's Usual and Customary Charge minus the client's copayment, as determined according to 10 C.C.R. 2505-10, Section 8.754, or the allowed ingredient cost plus a dispensing fee minus the client's copayment, whichever is less. Covered drugs for the OAP State Only Programs shall be reimbursed according to 10 C.C.R. 2505-10, Section 8.941.

8.800.13.B. The allowed ingredient cost for Retail Pharmacies and Mail Order Pharmacies is the price of the drug calculated according to the applicable pricing methodologies set forth in 10 C.C.R. 2505-10, Section 8.800.13.D, whichever is less

8.800.13.C. The allowed ingredient cost for Institutional and Government Pharmacies is the actual cost of acquisition for the drug dispensed or the price of the drug calculated according to the applicable pricing methodologies set forth in 10 C.C.R. 2505-10, Section 8.800.13.D, whichever is less.

8.800.13.D. The allowed ingredient cost is determined utilizing different methodologies as applicable. The pricing methodologies are:

1. Based on Average Wholesale Price (AWP):

a. AWP less 14.5% for brand name drugs; and

b. AWP less 45% for generic drugs;

2. Direct price plus 18%;

3. State MAC; and

a. The State MAC shall be established as the pharmacy acquisition cost of generic drugs available in the marketplace plus 18%; and

b. The establishment of a State MAC is subject to, but not limited to, the following considerations:

i) Multiple manufacturers;

ii) Broad wholesale price span;

iii) Availability of drugs to retailers at the selected cost;

iv) High volume of Medical Assistance Program client utilization; and

v) Bioequivalence or interchangeability.

4. FUL

a. When FUL rates are announced, the Department shall adopt them; and

b. A drug that is subject to FUL may be reimbursed at a rate greater than FUL if the prescriber certifies that the brand name drug is medically necessary for the client. The prescriber

must make such certification through the prior authorization process or other procedures established by the Department.

8.800.13.E. A drug-pricing file containing all of the pricing methodologies shall be maintained and updated at least monthly by the Department.

8.800.13.F. Any pharmacy, except a Mail Order Pharmacy, that is the only pharmacy within a twenty-mile radius may submit a letter to the Department requesting to become a Rural Pharmacy. If approved as a Rural Pharmacy, the modified estimated acquisition cost shall be AWP minus 12% for brand name and generic drugs instead of the amount set forth in 10 C.C.R. 2505-10, Section 8.800.13.D.1.

8.800.13.G. Information on current pricing may be obtained by contacting the Department's Pharmacy Section.

8.800.13.H. Dispensing Fee

1. The dispensing fee is a pre-determined amount paid to a pharmacy for dispensing a prescription. It is established and periodically adjusted based upon the results of a cost survey which is designed to measure actual costs of filling prescriptions. The results of any such survey shall be reported to the Medical Services Board at the next regular meeting following delivery of the report to the Department.

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

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

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

5. Government Pharmacies shall receive no dispensing fee.

6. Dispensing Physicians shall not receive a dispensing fee unless their offices or sites of practice are located more than 25 miles from the nearest participating pharmacy. In that case, the Dispensing Physician shall receive a dispensing fee of $1.89.

The paragraphs which follow set forth the reimbursement calculation effective September 23, 2011 unless otherwise noted in the paragraph.

8.800.13.I~~A~~. Covered drugs for all clients except for Old Age Pension (OAP) State Only clients shall be reimbursed the lesser the provider's Usual and Customary Charge minus the client's copayment, as determined according to 10 C.C.R. 2505-10, Section 8.754,and the allowed ingredient cost plus a dispensing fee minus the client's copayment. Covered drugs for the OAP State Only Programs shall be reimbursed according to 10 C.C.R. 2505-10, Section 8.941.9.

8.800.13.J~~B~~. The allowed ingredient cost for Retail Pharmacies and Mail Order Pharmacies is the price of the drug calculated according to the applicable pricing methodologies set forth in 10 C.C.R. 2505-10, Section 8.800.13.M~~E~~.

8.800.13.K~~C~~. The allowed ingredient cost for Institutional and Government Pharmacies is the lesser of actual cost of acquisition for the drug dispensed or the price of the drug calculated according to the applicable pricing methodologies set forth in 10 C.C.R. 2505-10, Section 8.800.13.M~~E~~.

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

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

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

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

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

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

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

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

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

1. Effective September 239, 2011 through September 30, 2011, the allowed ingredient cost will be the lesser of the MAC price as defined in10 C.C.R. 2505-10, Section 8.800.13. LD, or submitted ingredient cost. If no MAC price is available, the allowed ingredient cost will be the less of:-

a. Wholesale Acquisition Cost (WAC);

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

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

b. Average Wholesale Price (AWP);

i) AWP less fourteen and five-tenths percent (14.5%) for brand drugs; and

ii) AWP less forty five percent (45%) for generic drugs;

c. Submitted ingredient cost;

d. Federal Upper Limit (FUL) rates.

2. Effective October 1, 2011, the allowed ingredient cost will be the lesser of the MAC price as defined in10 C.C.R. 2505-10, Section 8.800.13. LD, or submitted ingredient cost. If no MAC price is available, the allowed ingredient cost will be the lesser of:

a. Wholesale Acquisition Cost (WAC);

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

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

b. Submitted ingredient cost.

8.800.13.NF. The MAC Price List will be posted on the Department's web site (www.colorado.gov/hcpf) on a weekly basis beginning September 923, 2011.

8.800.13.OG. Any pharmacy, except a Mail Order Pharmacy, that is the only pharmacy within a twenty-mile radius may submit a letter to the Department requesting to become a Rural Pharmacy. If approved as a Rural Pharmacy, the reimbursement shall be calculated according to the following pricing methodologies:

Effective September 923, 2011 through September 30, 2011, a rural pharmacy will be reimbursed the MAC price as defined in 10 C.C.R. 2505-10, Section 8.800.13. LD. If no MAC price is available, the allowed ingredient cost will be AWP minus twelve percent (12.0%).

Effective October 1, 2011, a rural pharmacy will be reimbursed using the MAC price as defined in 10 C.C.R. 2505-10, Section 8.800.13. LD. If no MAC price is available, the WAC price plus thirty and four-tenths percent (30.4%) will be the allowed ingredient cost.

~~8.800.13.H. Information on current pricing may be obtained by contacting the Department's Pharmacy Section.~~

8.800.13.PI. Dispensing Fee

1. The dispensing fee is a pre-determined amount paid to a pharmacy for dispensing a prescription. It is established and periodically adjusted based upon the results of a cost survey which is designed to measure actual costs of filling prescriptions. The results of any such survey shall be reported to the Medical Services Board at the next regular meeting following delivery of the report to the Department.

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

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

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

5. Government Pharmacies shall receive no dispensing fee.

6. Dispensing Physicians shall not receive a dispensing fee unless their offices or sites of practice are located more than 25 miles from the nearest participating pharmacy. In that case, the Dispensing Physician shall receive a dispensing fee of $1.89.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.100.6.C.10
Rule Number:	MSB 11-08-24-A
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-08-24-A, Revision to the Medical Assistance Rule Concerning SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.100.6.C.10
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) 8.100.6.C.10, 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: 9/9/2011
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please add new text provided beginning at §8.100.6.C.10 through §8.100.6.C.10.a.1.c). The new text will immediately follow §8.100.6.C.9. All other text is for clarification purposes only. This change is effective 09/09/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.100.6.C.10
Rule Number:	MSB 11-08-24-A
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

STATEMENT OF BASIS AND PURPOSE

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

   The proposed language was approved for publication effective September 1,2008. However, it was subsequently deleted through administrative error effective April 1, 2009. The proposed rule is being presented in order to reestablish the previously approved language. The purpose of this rule change is to revise the Supplemental Security Income (SSI) Medicaid eligibility requirements to incorporate changes in federal law governing the effective date of eligibility for individuals under 21 and to provide criteria for granting eligibility to infants who are found to be disabled shortly after birth.

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 proposed language was approved for publication effective September 1, 2008. However, it was subsequently deleted through administrative error effective April 1, 2009. The proposed rule is being presented in order to reestablish the previously approved language. The purpose of this rule change is to revise the Supplemental Security Income (SSI) Medicaid eligibility requirements to incorporate changes in federal law governing the effective date of eligibility for individuals under 21 and to provide criteria for granting eligibility to infants who are found to be disabled shortly after birth.

3. Federal authority for the Rule, if any:

   42 CFR §435.120, 42 CFR §435.909(b)(1), 42 CFR §435.914, 42 USC §1396a(a)(10)(A)(i)(II)(cc)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-4-104(1), C.R.S. (2007)

Initial Review		Final Adoption	
Proposed Effective Date	**09/09/2011**	Emergency Adoption	**09/09/2011**

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.100.6.C.10
Rule Number:	MSB 11-08-24-A
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

REGULATORY ANALYSIS

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

   The proposed language was approved for publication effective September 1, 2008. However, it was subsequently deleted through an administrative error effective April 1, 2009. The proposed rule is being presented in order to reestablish the previously approved language.

   The proposed rule changes will affect children under the age of 21 who are eligible for or who are receiving SSI benefits and infants found to be disabled at or shortly after birth who are eligible for or receiving SSI. Under the current rules, Medicaid eligibility for these infants does not begin until the date on which they are found eligible for SSI, and this sometimes does not occur until days or weeks after the child was born. As a result, some disabled children do not have insurance coverage to cover the cost of their birth and first few days or weeks of hospitalization. Current Department policy allows the effective date for Medicaid eligibility for individuals eligible for or receiving SSI benefits to be backdated up to 90 days, if the individual otherwise meets the SSI financial and disability criteria, and this policy has been employed to provide coverage for some infants in these situations. The proposed rule change would clarify that Medicaid coverage is available for SSI-eligible infants found to be disabled shortly after birth by providing for automatic coverage back to the date of birth if certain criteria are met.

   The proposed rule changes will also affect caseworkers at the county departments of social/human services and medical assistance sites who make determinations of Medicaid eligibility. These individuals will need to become familiar with the new rules and with procedures for implementing them.

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 change will eliminate gaps in insurance coverage experienced by some disabled infants who are eligible for or who receive SSI. These gaps in coverage result in medical bills that become the responsibility of the infant's parents, counties, or other parties, and often end up unpaid, unless the infant's Medicaid eligibility is backdated 90 days. While the Department's policy has been to backdate Medicaid eligibility for up to 90 days for these

infants if they otherwise meet the SSI financial criteria, this has not been done consistently or expeditiously in all cases. The proposed regulations should help alleviate this problem.

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.

   Current Department policy already allows for backdating Medicaid eligibility for individuals who are eligible for or who are receiving SSI benefits up to 90 days, if they meet the SSI financial and disability criteria. This policy has not been consistently applied in all cases in which it could have been invoked and has resulted in some individuals who may have been eligible for Medicaid coverage of their medical bills not receiving that coverage. The proposed rule change is intended to help reduce the prevalence of this problem among infants, and , to the extent that it is successful, there may be a fiscal impact to the Department in providing that coverage. The Department does not have data at this time with which to quantify this potential fiscal impact.

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

   Inaction would result in the department being out of compliance with federal statue. It would also result in some SSI eligible disabled infants continuing to experience difficulties in obtaining Medicaid coverage for bills incurred from date of birth until the date on which SSI eligibility is established. The proposed rule would alleviate this problem.

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 are no effective alternative methods for achieving the purpose of the proposed rule.

8.100.6.C. SSI Eligibles

1. Benefits of the Colorado Medical Assistance Program must be provided to the following:

    a. persons receiving financial assistance under SSI;

    b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;

    c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.

2. The Department has entered into an agreement with SSA in which SSA shall determine Medical Assistance for all SSI applicants. Medical Assistance shall be provided to all individuals receiving SSI benefits as determined by SSA to be eligible for Medical Assistance.

3. The eligibility sites shall have access to a weekly unmatched listing of all individuals newly approved and a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the eligibility site to authorize Medical Assistance.

4. Medical Assistance shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.

5. Notification shall be sent to the SSI recipient advising him/her of the approval of Medical Assistance.

6. The SISC Code for this type of assistance is B.

7. Denied or terminated Medical Assistance based on a denial or termination of SSI which is later overturned, must be approved from the original SSI eligibility date.

8. Individuals who remain eligible as SSI recipients but are not receiving SSI payments shall receive Medical Assistance benefits. This group includes persons whose SSI payments are being withheld as a means of recovering an overpayment, whose checks are undeliverable due to change of address or representative payee, and persons who lost SSI financial assistance due to earned income.

9. If the eligibility site obtains information affecting the eligibility of these SSI recipients, they shall forward such information to the local Social Security office.

10. For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on which the individual became eligible for SSI, whichever is later.

    a. Special Provisions for Infants

        1. For an infant who is eligible for or who is receiving SSI, the effective date of Medicaid eligibility shall be the infant's date of birth if:

            a) the infant was born in a hospital;

            b) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and

c) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning the Nursing Facility Provider Fees and Reimbursement, Sections 8.443.11, 8.443.12 and 8.443.17.
Rule Number:	MSB 11-08-15-A
Division / Contact / Phone:	Financial & Administrative Services Office / Nancy Dolson / 303.866.3698

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-08-15-A, Revisions to the Medical Assistance Rule Concerning the Nursing Facility Provider Fees and Reimbursement, Sections 8.443.11, 8.443.12 and 8.443.17.
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) 8.443.11, 8.443.12 and 8.443.17, 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: 9/9/11
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please delete old text as indicated and insert new text provided at §8.443.11.6. Please delete indicated text in the first unnumbered paragraph at §8.443.12 and at §8.443.12.6 please delete text indicated and add new text provided. Please add new text provided at §8.443.4.a. (vii) All other text is provided for clarity only. These changes are effective 09/09/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning the Nursing Facility Provider Fees and Reimbursement, Sections 8.443.11, 8.443.12 and 8.443.17.
Rule Number:	MSB 11-08-15-A
Division / Contact / Phone:	Financial & Administrative Services Office / Nancy Dolson / 303.866.3698

STATEMENT OF BASIS AND PURPOSE

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

   The rule is being updated to change the hierarchy of nursing provider fee-funded supplemental payments consistent with statute, to change the pay for performance component of nursing facility reimbursement to a $1 to $4 per day add-on scale consistent with the SB 06-131 committee's recommendations, and to add a supplemental payment for the acuity or case-mix of Medicaid residents to the list of components funded by nursing facility provider fees.

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:

   Senate Bill 11-125, signed into law by Governor Hickenlooper on May 23, 2011, increased the maximum fee to be assessed on Class I nursing facilities and re-ordered the hierarchy of supplemental payments funded by nursing facility provider fees, and is effective July 1, 2011. The rule change aligns the funding hierarchy with the revised statute. The new hierarchy and higher fee rate means that the pay-for-performance component will be fully funded and paid before the cost per diem growth over the General Fund limit. As funding is now available for pay-for-performance, this rule amendment changes the scale to a $1 to $4 per day add-on consistent with the recommendations of the SB 06-131 committee.

   SB 11-125 also added a supplemental payment component for acuity or case-mix of Medicaid residents effective July 1, 2011. This rule change adds the acuity or case-mix supplemental payment to the list of components funded by nursing facility provider fees to comply with state law.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-6-202, C.R.S. (2010)

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning the Nursing Facility Provider Fees and Reimbursement, Sections 8.443.11, 8.443.12 and 8.443.17.
Rule Number:	MSB 11-08-15-A
Division / Contact / Phone:	Financial & Administrative Services Office / Nancy Dolson / 303.866.3698

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.

   Class I nursing facility providers in the state are affected by the proposed rule. The proposed rule changes the pay-for-performance add-on from $1 to $3 per Medicaid day, depending on points earned, to $1 to $4 per Medicaid day. This proposed rule change means that more of the funding generated by nursing facility fees will be directed to nursing facilities that provide services that result in better care and higher quality of life for their residents. The pay-for-performance portion of nursing facility fee-funded payments increases approximately $1.6 million.

   In addition and as required by SB 11-125, the proposed rule re-orders the hierarchy of supplemental payments funded by nursing facility provider fees and adds a supplemental payment for the acuity or case-mix of Medicaid residents. The addition of an acuity or case-mix payment benefits class I nursing facilities that provide services to Medicaid residents by providing reimbursement for the resource utilization of their Medicaid residents.

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

   Under the fee limit per SB 11-125, total nursing facility fee-funded supplemental payments total $83.6 million. The proposed rule change directs $4.2 million toward pay-for-performance ($1.6 million more than under existing rule) and directs $3.9 million toward reimbursement for the acuity or case-mix of Medicaid residents.

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 proposed rule has no costs for the Department or other agencies.

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 is that it directs more reimbursement for nursing facilities toward higher quality care and toward the resource utilization of Medicaid residents based on

acuity or case-mix. There is no cost to implement the proposed rule as it makes changes within an existing reimbursement structure.

The amount of funds available for nursing facility reimbursement is fixed. If there is inaction, the rule would be inconsistent with statutory requirements. There is no benefit to inaction.

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

   There are no increased costs associated with 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.

   No alternatives exist. Without the proposed rule, the pay-for-performance will not be fully funded as intended by the SB 06-131 committee. Also, without the proposed rule, the funding hierarchy would be inconsistent with statute and the acuity or case-mix component would not be described rule.

8.443.11 FUNDING SPECIFICATIONS

The general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets) shall be limited by statute. . Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation. In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers exceeding the statutory limitation on annual growth in the general fund share of the aggregate statewide average of the per diem rate net of patient payment, proportional decreases will be made to the rates so that anticipated payments will equal the statutory growth limitation in the general fund share of the per diem rate. The percentage will be determined in accordance with the following fraction: Legislative appropriations / The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for all class I Nursing Facilities.

1. Non-state and federal payment percent: Annually the Department will determine the percent of nursing facility per diem rates paid by non-state and non-federal fund sources. This determination will be based on an analysis of Medicaid nursing facility class I paid claims. A sample period of claims may be used to perform this analysis. The analysis will be prepared prior to the annual July 1st rate setting.

2. Legislative appropriation base year amount: The base year will be the state fiscal year (SFY) ending June 30, 2008. The legislative appropriation for the base year will be determined by multiplying each nursing facility's time weighted average Medicaid per diem rate during the base year by their expected Medicaid case load (Medicaid patient days) for the base year. This amount will be reduced by the non-state and non-federal payment percentage, and then the residual will be split between state and federal sources using the time weighted Federal Medical Assistance Percentage (FMAP) during the base year.

3. Medicaid case load for each facility will be determined using Medicaid paid claims data for the calendar year ending prior to the July 1st rate setting. Providers with less than a full year of paid claims data will have their case load annualized.

4. Preliminary state share: Effective July 1, 2009 and each succeeding year the Department shall calculate a preliminary state share commitment towards the class I Medicaid nursing facility reimbursement system. The preliminary state share shall be calculated using the same methodology used to calculate the legislative appropriation base year amount. The Medicaid per diem rates used in this calculation are the preliminary rates that would be effective July 1st prior to any rate reduction provided for within this section of the rule.

5. For SFY 2009 and each succeeding year the final state share of Medicaid per diem rates will be limited to the legislative appropriation amount from the base year increased by the statutory growth limitation over the prior SFY. These determinations will be made during the July 1st rate setting process each year. If the preliminary state share (less the amount applicable to provider fees) is greater than the indexed legislative base year amount, proportional reductions will be made to the preliminary nursing facility rates to reduce the state share to the indexed legislative appropriation base year amount.

6. Provider fee revenue will first be used to pay the provider fee offset payment, then the payment for acuity or case-mix of residents, ~~then the state's share of the per diem rate over the general fund cap,~~ then the Pay-for-Performance program, ~~and~~ then payments for residents who have moderately to severe mental health conditions, cognitive dementia ~~and~~ or acquired brain injury, and then the supplemental Medicaid payments for the amount by which the average statewide per diem rate exceeds the general fund share established under Section 25.5-6-202(9)(b)(II), C.R.S.~~.~~. Any difference between

the amount of provider fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share above.

7. The following calculation illustrates the above and, for illustration purposes, assumes the statutory limit on general fund is 3%:

8.443.12 PAY-FOR-PERFORMANCE COMPONENT

Starting July 1, 2009, the Department shall make a ~~a~~ supplemental payment based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents (pay-for-performance). The payment will be based on a nursing facility's performance in the domains of quality of life, quality of care and facility management.

1. The application for the additional quality performance payment includes specific performance measures in each of the domains, quality of life, quality of care and facility management. The application includes the following:

    a. The number of points associated with each performance measure;

    b. The criteria the facility must meet or exceed to qualify for the points associated with each performance measure.

2. The prerequisites for participating in the program are as follows:

    a. No facility with substandard deficiencies on a regular annual, complaint, or any other Colorado Department of Public Health and Environment survey will be considered for pay for performance.

    b. The facility must perform a resident/family satisfaction survey. The survey must (a) be developed, recognized, and standardized by an entity external to the facility; and, (b) be administered on an annual basis with results tabulated by an agency external to the facility. The facility must report their response rate, and a summary report must be made publically available along with the facility's State's survey results.

3. To apply the facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The facility must maintain documentation supporting its representations for each performance measure the facility represents it meets or exceeds the specified criteria. The required documentation for each performance measure is identified on the application and must be submitted with the application. In addition, the facility must include a written narrative for each sub- category to be considered that describes the process used to achieve and sustain each measure.

4. The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions. Facilities will be selected for onsite verification of performance measures representations based on risk.

5. A nursing facility will accumulate a maximum of 100 points by meeting or exceeding all performance measures indicated on the matrix.

6. The per diem rate add-on will be calculated according to the following table:

    0 –~~45~~20 points = No add-on

    21-45 points = $1.00 per day add-on

    46 – 60 points = $~~1~~2.00 per day add-on

    61 – 79 points = $~~2~~3.00 per day add-on

    80 – 100 points = $~~4~~3.00 per day add-on

If the expected average payment for those facilities receiving a supplemental payment is less than twenty-five hundredths of one percent of the statewide average per diem base rate, the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid add-on payment equal to twenty-five hundredths of one percent of the average nursing facility base rate.

7. These calculations will be performed annually to coincide with the July 1st rate setting process.

8.443.17 PROVIDER FEES

8.443.17.A The state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

1. Each class I nursing facility that is licensed in this State shall pay a fee assessed by the state department.

2. The following nursing facility providers are excluded from the provider fee:

   a. A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services and skilled nursing care on a single, contiguous campus. Assisted living services include assisted living residences as defined in Section 25-27-102 (1.3), C.R.S., or that provide assisted living services on-site, twenty-four hours per day, seven days per week;

   b. A skilled nursing facility owned and operated by the state;

   c. A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and

   d. A facility that has forty-five or fewer licensed beds.

3. To determine the amount of the fee to assess pursuant to this section, the state department shall establish a rate per non-Medicare patient day that is equivalent to a percentage of accrual basis gross revenue (net of contractual allowances) for services provided to patients of all class I nursing facilities licensed in this State. The percentage used to establish the rate must not exceed that allowed by federal law. For the purposes of this section, total annual accrual basis gross revenue does not include charitable contributions or revenues received by a nursing facility that are not related to services provided to nursing facility residents (for example, outpatient revenue).

4. The state department shall calculate the fee to collect from each nursing facility during the July 1 rate-setting process.

   a. Each July 1, the state department will determine the aggregate dollar amount of provider fee funds necessary to pay for the following:

      (i) State department's administrative cost pursuant to 8.443.17.B.1

      (ii) CPS pursuant to 8.443.10.A

      (iii) PASRR pursuant to 8.443.10.B

      (iv) Pay for Performance pursuant to 8.443.12

      (v) Provider Fee Offset Payment pursuant to 8.443.10.C

      (vi) Excess of the statutory limited growth in the general fund pursuant to 8.443.11

(vii) Acuity or case-mix of residents pursuant to 8.443.7.D

b. This calculation will be based on the most current information available at the time of the July 1 rate-setting process.

c. The aggregate dollar amount of provider fee funds necessary will be divided by non-Medicare patient days for all class I nursing facilities to obtain a per day provider fee assessment amount for each of the two following categories:

(i) nursing facilities with 55,000 total patient days or more;

(ii) nursing facilities with less than 55,000 total patient days.

The state department will lower the amount of the provider fee charged to nursing facility providers with 55,000 total patient days or more to meet the requirements of 42 CFR 433.68 (e). In addition, the 55,000 total patient day threshold can be modified to meet the requirements of 42 CFR 433.68 (e).

d. Each facility's annual provider fee amount will be determined by taking the per day provider fee calculated above times the facility's reported annual non-Medicare patient days.

e. Each nursing facility will report monthly its total number of days of care provided to non-Medicare residents to the Department of Health Care Policy & Financing. Non-Medicare patient days reported in the year prior to the July 1 rate-setting process will be used as the facility's annual non-Medicare patient days for the provider fee calculation.

f. If a facility's actual non-Medicare patient days differ by more than 5% from the prior year reported non-Medicare patient days used to determine the provider's fee payment, the facility can request the state department, in writing, to review the facility's provider fee calculation. If the state department determines that the facility's actual non-Medicare patient days differ by more than 5% from the facility's non-Medicare patient days used to determine the facility's provider fee, an adjustment to the facility's annual provider fee payment will be made. The facility's annual provider fee will be based on actual non-Medicare patient days rather than reported days in the prior year.

g. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed the state department.

h. The state department shall assess the provider fee on a monthly basis.

i. The fee assessed pursuant to this section is due 30 days after the end of the month for which the fee was assessed.