TITLE OF PROPOSED RULE: Medical Assistance Identification Cards

RULE #: MSB 03-09-05-A

DIVISION/CONTACT PERSON/PHONE: John Wagner, Director, Information Technology Division, x4017

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 Board of Medical Services approved the Medical Identification rule on March 11, 2003. Since then, we have identified several other places in the rules that require adjustments to be in conformity. This rule accomplishes this. Eliminate the guarantee of eligibility associated with the current Medical Assistance Card. Cards will be for identification purposes.

This rule change is necessary because the state is experiencing a severe economic downturn and needs to identify and implement administrative efficiencies. The current monthly production is costly. In addition, presently services could be provided to a person who is no longer eligible. The current policy is to pay claims for any client who presents a valid card for a given month and verify their eligibility card in the middle of the month.

2. If emergency, give reasons.

3. Authority for Rule.

Federal:

State: 26-4-403.7(3), C.R.S. (2002): Automated medical assistance administration

4. Divisions, Boards, Councils, Associations, and other groups who have reviewed this rule.

Attachments:
OP-5 (Regulatory Analysis)
OP-6 (Overview of Proposed Rule)

MSB OP-2 (Rev. 2/97)

Initial Review 12/12/03 Final Adoption 01/09/04

Proposed Effective Date 03/01/04 Emergency Adoption

DOCUMENT #3

TITLE OF PROPOSED RULE: Revisions to language concerning Medical Identification Cards

RULE #: MSB 03-09-05-A

DIVISION/CONTACT PERSON/PHONE John Wagner, Director, Information Technology Division, x4017

REGULATORY ANALYSIS

1. Groups of persons affected (indicate who benefits and who bears the costs of the proposed rule):

Clients will benefit from having one identification card that stays with them for the duration of their eligibility for medical assistance. The State will benefit from the savings inherent from both the cessation of monthly eligibility card production and mailing for each person eligible for Medicaid and, more importantly, from the assurance that claims will only be paid for persons eligible on a given date. At present, if a provider produces a photocopy of a Medical Authorization Card for a given month, even if a person's eligibility ended mid-month, the claim is guaranteed to be paid. Providers are presently instructed that they are to be verifying eligibility by the electronic means presently available. This mechanism ensures that practice. There is an indeterminate savings from converting the cards to identification cards that are issued upon initial eligibility and if a card is lost.

2. Quantitative/qualitative impact, economic or otherwise (include short-term and long-term consequences) and the effect of inaction:

Permanent Identification cards are now in use by 21 other states, and are being implemented by an additional 6 states. There is an administrative savings to the state from the postage and production of monthly paper cards. Some states report a reduction in customer service calls related to timely receipt of cards. All states contacted report that cards are mailed to clients within 24-72 hours of loading an updated eligibility file.

The effect of inaction is to maintain current resource demands ($1.3 million for paper card production and mailing, 1,000 calls per month to the department's customer service line, several days per month of staff time to produce paper cards). This move to an identification card is an efficiency that will generate savings both from card production costs and from payments for services for clients no longer eligible.

The production and mailing of permanent plastic cards is expected to cost about $.88 each. States that now have plastic cards average replacement and new cards at between 1-4.5% per month (or 12-54% per year). This level of replacement is significantly less than replacing every card for every eligible person every month (as in Medicaid today). Costs for producing plastic cards have dropped considerably in recent years, making the proposed option less expensive than previously estimated and less costly than the current paper card.

3. Estimated implementation and enforcement cost(s) and workload impact. If this rule is the result of new legislation, please identify the legislation and its appropriation, and if

the cost analysis indicates a change from the appropriation, state why this has occurred and what action will be taken to mitigate this:

N/A

4. Other options seriously considered and the reason(s) for rejection (include less costly or less intrusive options):

Option 1: Continuing current monthly paper card – discarded because of higher cost, resource demands, and payment inaccuracy implications.

Option 2: Laminated card – discarded because it is less durable than the plastic MAC, and less satisfactory as a permanent card.

8.061.2 RESPONSIBILITY FOR SECURING MEDICAL RESOURCE INFORMATION

.21 The county department is required to secure information concerning the health insurance or other medical coverage of an individual at the time that individual applies or is predetermined eligible for public assistance. Such information relates to the name(s) and State I.D. number(s) of the individual(s) covered by the medical coverage, the name of the insurance company, policy number, policy holder, the effective dates of the policy coverage, the address where the medical claim forms must be submitted, and any other information determined necessary for third party liability purposes. This information is to be entered on the State prescribed Client Health Resource Information Form (MS-10). The completed form will be given to the State Department (or its fiscal agent). The information so supplied will be entered into a computerized file and will serve as the basis for claims payment or denial.

.22 The county must enter the required medical resource code for a client on either the AP-800 Financial and Medical Eligibility Reporting Form, FCS 100 or FCS 700, Family and Children Services/Child Welfare Medical Forms. This medical resource indicator will be **available on the eligibility verification.** ~~printed on the Medicaid authorization card supplied to clients. Based on this indicator, m~~**M**edical providers will be required to bill the resource listed (if applicable) before submitting the claim to the Medical Assistance Program for payment.

.23 The individual providers, e.g., hospitals, physicians, home health agencies, etc., are required to make inquiry regarding other medical resources a client has at the time medical services are furnished. If the **eligibility verification** ~~Medicaid authorization card~~ indicates that a resource appropriate to the medical service provided exists, that resource must pay or deny the claim before the Medical Assistance Program can be billed. It is the responsibility of providers to obtain any necessary assignment of benefits from the client.

8.061.3 RIGHT OF RECOVERY IN THIRD PARTY LIABILITY CASES

Section 26-4-403(3), as amended, establishes the State Department's right to recover the cost of medical care provided to an eligible Medicaid client when a third party is liable.

The client has 10 days from the date the notification is mailed to appeal the decision.

8.075.4.C. The client will work in conjunction with the Department to select one physician or managed care organization and one pharmacy in which to receive their care. Clients shall be in the Client Overutilization Program for at least 12 consecutive months.

8.075.4.D. If a client becomes ineligible for Medicaid benefits during the restricted period, restrictions shall automatically commence for 12 consecutive months from the month eligibility is reestablished unless determined otherwise by the Department.

8.075.4.E. The following shall apply when the client has been assigned to the selected physician/MCO and pharmacy:

1. The client shall receive **notification**~~a Medicaid Authorization Card~~ that identifies the program restrictions and providers. It is the responsibility of the client to request services only from the providers identified on the card. Emergency services are available to the client without the need to prior authorize the services.

2. The client shall have the right to a second surgical opinion should surgery be deemed necessary by the designated physician.

8.075.4.F. The designated provider shall serve as the case manager for the client. The physician shall authorize and monitor services rendered to the client by any other provider.

8.075.4.G. A change in designated providers may be granted if any of the following occur:

1. The provider moves, retires, dies, discontinues Medicaid participation or refuses to continue providing care to the client; or

2. The client moves from the physician's service area.

8.075.4.H. Restrictions will be rescinded upon the written recommendations of the client's designated provider and the Department. The Department will notify the client in writing of the decision to rescind restrictions. If, after the case review the decision is not to rescind the restrictions the client shall be afforded the opportunity to appeal in accordance with 8.057.

8.075.5 CLIENT REFUSAL TO COOPERATE

8.075.5.A. If the client refuses to cooperate with the Department and does not appeal the decision to be placed in the program, the Department shall proceed with program placement. The Department shall notify the client of the providers and the effective date of implementation.

~~8.180 MEDICAID AUTHORIZATION CARDS AND DURATION OF ELIGIBILITY (Continued)~~

8.183 INSTRUCTIONS FOR HANDLING UNDELIVERED MEDICA**L**~~ID~~ **IDENTIFICATION**~~AUTHORIZATION~~ CARDS

~~.1 Medicaid Authorization Cards are produced by a computer technique in which data mailers contain the card which is printed through the envelope. The envelope is carboned on the inside. Because of this, any marks made (to correct the address, for example) on the envelope will transfer through to the card inside.~~

~~.2~~ The Post Office returns all undelivered Medica**L**~~id~~ **Identification**~~Authorization~~ Cards to the county departments when recipients are deceased, no longer at that address, etc. The following steps will be taken to assure delivery of cards to the recipient.

A. If the address shown ~~o~~**i**n the envelope **window** is incorrect or no longer valid, the county departments are not to make the address change for remailing on the returned envelope. Counties are to open the~~ mailer, separate the card,~~**envelope,** paste a white sticker over the incorrect address, type in the correct address, use a separate envelope with the corrected address, insert the Medical~~id~~ **Identification**~~Authorization~~ Card **Mailer**, and remail the card **and its carrier** to the ~~recip~~**cl**ient's new (correct) address. (This includes out-of-state moves if the ~~recip~~**cl**ient remains eligible.)

B. Counties shall immediately correct the address on the automated system.

C. If the recipient is deceased, the county shall destroy the **identification** ~~authorization~~ card **and make appropriate change in the eligibility system.**~~.~~

8.486.60 CALCULATION OF CLIENT PAYMENT (PETI)

4. Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the client's gross income as follows:

   a. Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS; deductible or co-insurance charges; and

   b. Necessary dental care not to exceed amounts equal to actual expenses incurred; and

   c. Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred; and

   d. Medications, with the following limitations:

      1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the Utilization Review Contractor certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

      2) Medications which may be purchased with the Medical ~~id~~ Identification C~~e~~ard shall not be allowed as deductions.

      3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

      4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

      5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

8.509.31 NEW HCBS-MI CASES (Continued)

E. CALCULATION OF CLIENT PAYMENT (PETI) (Continued)

d) Medications, with the following limitations:

(1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

(2) Medications which may be purchased with the client's Medical~~id~~ **Identification C**~~c~~ard shall not be allowed as deductions.

(3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

(4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

(5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

8.754 CLIENT CO-PAYMENT (Continued)

8.754.11 Exemptions

The following categories of recipients and/or services are exempt from the co-payment requirements:

A. All services to children under the age of 19 (through the entire eligibility cycle month in which they attain the age of 19). ~~The eligibility cycle month is defined as the calendar month for all counties except Denver. For Denver, the eligibility cycle month is designated by the Medicaid eligibility card as either the calendar month or the period of the 16th day of the month to the 15th day of the following month.~~

B. All services to women in the maternity cycle. The maternity cycle is defined as (1) pregnancy (2) labor (3) birth and (4) the immediate postpartum period not to exceed six weeks. The recipient must inform the provider of her pregnancy or postpartum condition at the time of service, and all providers must indicate pregnancy on the claim form in order to claim this exemption. In the case of prescription drugs, the prescribing physician should note pregnancy or postpartum on the prescription. Providers may request oral or written verification of pregnancy or postpartum condition by contacting the physician. If the provider questions the recipient's statement that she is pregnant or postpartum and the provider is unable to obtain verification of the pregnancy or postpartum condition, then the provider may collect the co-payment amount imposed by this regulation from the recipient. If the recipient feels that she has been wrongly denied an exemption due to an unverified pregnancy or postpartum condition, she has the right of appeal through the regular appeals process as outlined under 8.057.

C. All services to institutionalized recipients. Recipients defined as institutionalized include those in skilled nursing facilities (SNF's), intermediate care facilities (ICF's), ICF's for the mentally retarded, recipients under age 21 in inpatient psychiatric hospitals, and recipients 65 and over in institutions for mental diseases.