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

Rule Number: MSB 06-07-25-A

Division / Contact / Phone: Safety Net Financing / Sonya Guram / 6198

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 implements reductions in the provider rates to allow the Old Age Pension Health and Medical Care Program to operate within statutory spending limits. Program expenditures at current provider rates are forecasted to exceed the program's FY 06-07 spending authority. To remain within the constitutional expenditure limitation of the Old Age Pension Health and Medical Care Program and to remain within the appropriation from the General Assembly concerning the Supplemental Old Age Pension Health and Medical Care Program provider rates are adjusted.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal regulation and/or

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

   Explain:

   Emergency rule-making is imperatively necessary in order to be in compliance with Colorado state law. Forecasted program expenditures exceed the program's FY 06-07 spending authority by $9.9 million. Proposed provider rate reductions are expected to allow the Department to stay within the $14,262,663 appropriation to the Old Age Pension Health and Medical Care Program for FY 06-07.

3. Federal authority for the Rule, if any:

   N/A. This is a state-only program.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2005);
   26-2-117 C.R.S. (2005)

Initial Review | Final Adoption **10/13/05**

Proposed Effective Date **09/01/06** | Emergency Adoption **08/11/06**

DOCUMENT #01

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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.

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

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

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

Service Type	Current Rate	New Rate
Pharmacy	100%	70%
Inpatient Hospital	10%	10%
Outpatient Services	62%	40%
Practitioner/Physician	100%	40%
Emergency Dental	100%	40%
Independent Laboratory and X-ray	100%	40%
Medical Supply	100%	40%
Hospice and Home Health	100%	40%
Emergency Transportation	100%	40%

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

   The Department is implementing these rate reductions in order to manage the Old Age Pension Health and Medical Care Program expenditures and maintain these expenditures within the statutory and constitutional spending authority of the program. If these rates are not reduced, the Department will exceed its appropriation and create a statutory violation.

   It is expected that there will be a cost to the Department for the programming required to change reimbursement rates in the Medicaid Management Information System for pharmaceutical services, but the work will be done within the Department's contracted maintenance hours.

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

   Inaction would result in program expenditures exceeding its appropriation and create a statutory violation.

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

   There are no known less costly methods for achieving this purpose. The Department is not allowed to cap enrollment. The Department is researching options to redesign the program so that it can meet client need without constant rate revisions.

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.

   Various rate change scenarios for service categories were considered that would bring total program expenditures to budget. The proposed rate structure is intended to ensure that necessary services are available to clients while keeping program costs within its appropriation.

8.941.6 GENERAL EXCLUSIONS

In addition to any specific exclusion defined in this manual, the general exclusions from coverage of the Old Pension Health Care Program and the Old Age Pension Health Care Supplemental Program defined by the rules of the Department of Human Services (9 CCR 2503-1) are also excluded.

8.941.7 OUT-OF-STATE MEDICAL CARE

All requirements for out of state medical care as defined by the rules in this manual apply to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program for covered services with the exception that any reduction, suspension or elimination of benefits must be applied.

8.941.8 SUBMISSION OF CLAIMS

Rules governing the submission or payment of claims, provider or recipient appeals, third party liability, overpayment, fraud and abuse, and State identification numbers as defined in this manual apply to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program for covered services with the exception that any reduction, suspension or elimination of benefits provided must also be applied.

8.941.9 REIMBURSEMENT TO PROVIDERS

As of October 15, 2004, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program will reimburse inpatient hospital services, which are only a covered benefit at those hospitals that participate under the Colorado Indigent Care Program, at 10% of the appropriate Medicaid reimbursement.

~~For dates of service from May 1 through June 30, 2006 providers of physician and practitioner services will be reimbursed at 70% of the appropriate Medicaid reimbursement. Reimbursement for outpatient services; emergency transportation services; medical supply services; hospice and home health services; lab and x-ray services; and emergency dental services shall be at 53% of the appropriate Medicaid reimbursement for dates of service within this same time period.~~

~~As of July 1 2006, reimbursement rates will return to pre-May 2006 levels, and providers shall be reimbursed at 100% of the appropriate Medicaid reimbursement for physician and practitioner services; emergency transportation services; medical supply services; hospice and home health services; lab and x-ray services; and emergency dental services.~~

~~As of July 1, 2006, providers shall be reimbursed at 62% of the appropriate Medicaid reimbursement for outpatient services (including outpatient hospitals,~~

~~federal qualified health centers, rural health centers and dialysis centers).~~

~~Pharmacy services are paid at 100% of the appropriate Medicaid reimbursement.~~

As of September 1, 2006, providers of physician and practitioner services; outpatient services (including outpatient hospitals, federal qualified health centers, rural health centers and dialysis centers); emergency dental services; independent laboratory and x-ray services; medical supply services; hospice and home health services; and emergency transportation services will be reimbursed at 40% of the appropriate Medicaid reimbursement.

As of November 1, 2006, pharmacy claims are reimbursed at 70% of the appropriate Medicaid reimbursement.

In accordance with 8.941.1(E), the Executive Director may alter the reimbursement for any service with the condition that expenditures remain within the constitutional and statutory limits.

8.941.10 CLIENT CO-PAYMENT

Recipients of benefits under the OAP Health Care Program or Old Age Pension Health Care Supplemental Program shall be responsible for paying directly to providers a set portion of the cost of services according to the regulations and fee schedule as defined for the Medical Assistance and described in section 8.754 of this manual. This charge to the recipient will be called co-payment.

Those recipients whose co-payments reach a limit of $300.00 within a January 1 through December 31 calendar year will be exempted from further co-payments during that year. The exemption will begin on the date of payment for the claim, which indicates that the cumulative maximum has been reached.

It will be a recipient responsibility to present the Medical ID Card to the provider at the time a service is rendered in order to claim exemption from copayment for that service.

8.942 CHANGE OF SUPPLEMENTAL INCOME STATUS CODE (SISC) TO MEDICAID

8.942.1 MEDICAID QUALIFICATION

When a recipient of OAP-A or OAP-B and the OAP Health Care Program or Old Age Pension Health Care Supplemental Program subsequently qualifies for Medicaid, his/her SISC code must be changed to indicate Medicaid benefits. Additionally, the county must backdate the Medicaid benefits to the date the individual became eligible for Medicaid even if the recipient was eligible for the OAP Health Care Program or the Old Age Pension Health Care Supplemental Program at the time. Some reasons for Medicaid eligibility are: receipt of

Supplemental Security Income, receipt of Social Security disability benefits, attainment of age 65, changes in alien status or reduction of resources that caused the individual to be ineligible for Medicaid.