DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Healthcare Affordability and Sustainability Fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 18-02-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency / Board: Department of Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-02-01-A, Revision to the Healthcare Affordability and Sustainability Fee Collection and Disbursement, Section 8.3000
3. This action is an adoption of:
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):
   Sections(s) 8.3000, 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: 6/30/18
6. Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.3000 with the proposed text beginning at 8.3001 through the end of 8.300.4.F. This rule is effective July 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Healthcare Affordability and Sustainability Fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 18-02-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

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).

   Make necessary changes for FFY 17-18 time frame. Updates healthcare affordability and sustainability fee amounts and payments amounts in accordance with the CHASE Board's recommendations

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 Healthcare Affordability and Sustainability fee revenue serves as the state share to fund health coverage for more than 500,000 Coloradans currently enrolled in Medicaid and the CHP+. To comply with the State Plan provided to the Centers for Medicare and Medicaid Services, rules must be established on an emergency basis in order to assess fees on hospitals to ensure continuing health care coverage for these Medicaid and CHP+ members and to make required payments to hospitals.

3. Federal authority for the Rule, if any:

   42 CFR 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-4-402.4(4)(g), C.R.S.

Initial Review
Proposed Effective Date **07/30/18**
Final Adoption **06/08/18**
Emergency Adoption

DOCUMENT #02

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Healthcare Affordability and Sustainability Fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 18-02-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 303-866-2456

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.

   Colorado hospitals benefit from increased Medicaid and CICP reimbursement made possible through the healthcare affordability and sustainability fee and matching federal funds and the reduction in the number of uninsured Coloradans from expanded Medicaid and CHP+ eligibility. Low-income persons benefit by having health care coverage through the expanded Medicaid and CHP+ eligibility.

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 healthcare affordability and sustainability fee and matching federal funds will result in more than $2 billion in annual health care expenditures for more than 500,000 Coloradans and will provide more than $200 million in net new federal funds to Colorado hospitals.

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.

   While there are administrative costs associated with CHASE, such costs are funded with fees and federal matching funds and no state general funds are expected to be used.

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

   If no action is taken, CHASE will not have the ability to fund Medicaid and CHP+ expansions, affecting over 500,000 currently enrolled persons. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+ and reduce the federal revenue to hospitals.

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

The State does not have alternative resources to fund hospital payments and health coverage for the populations as provided under CHASE; therefore, no other methods are available to achieve 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.

   The CHASE Act directs the Medical Services Board to promulgate rules for the implementation of the healthcare affordability and sustainability fee; therefore, no alternatives to rule making are available.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

8.3001: DEFINITIONS

"Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.

"CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).

"CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

"CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

"CMS" means the federal Centers for Medicare and Medicaid Services.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.

"Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).

"Essential Access Hospital" means a Critical Access Hospital or General Hospital located in a Rural Area with 25 or fewer licensed beds.

"Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.

"Fund" means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).

"General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

"High Volume Medicaid and CICP Hospital" means a hospital with at least ~~30,000~~27,500 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.

"Health Maintenance Organization" or "HMO" means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.

"Hospital-Specific Disproportionate Share Hospital Limit" or "Hospital-Specific DSH Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

“Inpatient Services Fee” means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

“Inpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

“Long Term Care Hospital” means a General Hospital that is certified as a long term care hospital by the Colorado Department of Public Health and Environment.

“Managed Care Day” means an inpatient hospital day for which the primary payer is a managed care health plan, including a HMO, PPO, POS, and EPO days.

“Medicaid Day” means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

“Medicaid Managed Care Day” means a Managed Care Day for which the primary payer is Medicaid.

“Medicare Cost Report” means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

“MMIS” means the Medicaid Management Information System, the Department’s Medicaid claims payment system.

“MIUR” means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospitals days.

“Non-Managed Care Day” means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.

“Non-State-Owned Government Hospital” means a hospital that is either owned or operated by a local government.

“Outpatient Services Fee” means an assessment on hospitals based on outpatient hospital charges.

“Outpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

“Pediatric Specialty Hospital” means a hospital that provides care exclusively to pediatric populations.

“POS” or “Point of Service” means a type of managed care health plan that charges patients less to receive services from providers in the plan’s network and requires a referral from a primary care provider to receive services from a specialist.

“PPO” or “Preferred Provider Organization” means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.

“Privately-Owned Hospital” means a hospital that is privately owned and operated.

“Psychiatric Hospital” means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

“Rehabilitation Hospital” means an inpatient rehabilitation facility.

"Respiratory Hospital" means a hospital that primarily specializes in respiratory related diseases.

"Rural Area" means a county outside a Metropolitan Statistical Area or an area within an outlying county of a Metropolitan Statistical Area designated by the United States Office of Management and Budget.

"State-Owned Government Hospital" means a hospital that is either owned or operated by the State.

"State University Teaching Hospital" means a High Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

"Supplemental Medicaid Payment" means any of the payments described in 10 CCR 2505-10, Sections 8.3004.B., 8.3004.C., 8.3004.E., and 8.3004.F.

"Uninsured Cost" means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

"Urban Center Safety Net Specialty Hospital" means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days, rounded to the nearest percent, equals or exceeds 65%.

8.3002: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS

8.3002.A. DATA REPORTING

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Enterprise shall distribute a data reporting template to all hospitals ~~no later than April 30 of each year~~. The Enterprise shall include instructions for completing the data reporting template, including definitions and descriptions of each data element to be reported. Hospitals shall submit the requested data to the Enterprise within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Enterprise may estimate any data element not provided directly by the hospital.

2. Hospitals shall submit days and charges for Medicaid Managed Care, out-of-state Medicaid, and uninsured patients, Managed Care Days, and any additional elements requested by the Enterprise.

3. The Enterprise shall distribute a data confirmation report to all hospitals annually. The data confirmation report shall include a listing of relevant data elements used by the Enterprise in calculating the Outpatient Services Fee, the Inpatient Services Fee and the supplemental payments. The data confirmation report shall clearly state the manner and timeline in which hospitals may request revisions to the data elements recorded by the Enterprise. Revisions to the data will not be permitted by a hospital after the dates outlined in the data confirmation report.

4. The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer,

or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.~~,~~

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as ~~1.8208~~2.0208% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $~~86.22~~87.52 per day for Managed Care Days and $~~385.35~~391.15 per day for all Non-Managed Care Days with the following exceptions:

    a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $~~45.02~~45.69 per day for Managed Care Days and $~~201.19~~204.22 per day for all Non-Managed Care Days, and.

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~34.49~~35.01 per day for Managed Care Days and $~~154.14~~156.46 per day for Non-Managed Care Days.

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

   a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) are qualified to receive this payment.

   b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) are qualified to receive this payment.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

   a. Total funds for the Disproportionate Share Hospital payment shall be equal to the Disproportionate Share Hospital allotment as published by CMS during the first quarter of the federal fiscal year.

   b. CICP-participating hospitals with CICP write-off costs, as published in the most recent CICP Annual Report, greater than or equal to a percentage of the statewide average shall receive a payment equal to a proportion of their estimated hospital-specific Disproportionate Share Hospital limit. A Respiratory Hospital shall receive a payment equal to a proportion of their estimated hospital-specific Disproportionate Share Hospital limit.

   c. All remaining qualified hospitals shall receive a payment calculated as their percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining Disproportionate Share Hospital funds.

   d. No hospital shall receive a payment exceeding their hospital-specific Disproportionate Share Hospital limit as specified in federal regulation. If upon review, the Disproportionate Share Hospital Supplemental payment exceeds the hospital-specific Disproportionate Share Hospital limit for any qualified hospital, that hospital's payment shall be reduced to the hospital-specific Disproportionate Share Hospital limit. The reduction shall then be redistributed to the other qualified hospitals not exceeding their hospital-specific Disproportionate Share Hospital limit based on the percentage of uninsured costs to total uninsured costs for all qualified

hospitals not exceeding their hospital-specific Disproportionate Share Hospital Limit.

~~a. Qualified hospitals will receive a DSH Payment calculated as the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all remaining qualified hospitals multiplied by the state's total annual Disproportionate Share Hospital allotment to not exceed the estimated Hospital-Specific Disproportionate Share Hospital Limit.~~

~~b. DSH Payments to a Respiratory Hospital shall be limited to 60% of its estimated Hospital Specific Disproportionate Share Hospital Limit. DSH Payments to a hospital that opened within the last two state fiscal years shall be limited to 20% of its estimated Hospital Specific Disproportionate Share Hospital Limit.~~

8.3004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. General Hospitals and Critical Access Hospitals shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. A qualified Essential Access Hospital shall receive a payment based on their percentage of beds to total beds for all qualified Essential Access Hospitals. A qualified non-Essential Access Hospital shall receive a payment based on their percentage of Uninsured Costs to total Uninsured Costs for all qualified non-Essential Access hospitals.

8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. General Hospitals and Critical Access Hospitals are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals are not qualified are not qualified to receive this payment.

3. Measures. Quality incentive payment measures include ~~five~~ seven ~~base~~ measures ~~and three optional measures. Hospitals can report data on up to five measures annually.~~ Qualified hospitals must report the first and second measures. A hospital must then report the remaining measures in sequential order. If a hospital is not eligible for a measure, then the next measure is reported.~~all the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed.~~

   a. The ~~base~~ measures for the quality incentive payment are:

      i. Culture of safety,~~Emergency department process measure, which includes communicating information about the Medicaid nurse advice line, primary care providers, and Regional Care Collaborative Organizations (RCCO) to Medicaid clients when they are seen in the emergency department and establishing emergency department policies or guidelines for prescribing opioids,~~

      ii. Active participation in the Regional Care Collaborative Organizations (RCCO), ~~Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,~~

      iii. Rate of Cesarean section,~~Rate of thirty (30) day all-cause hospital readmissions,~~

      iv. Percentage of patients who gave the hospital an overall rate of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey,~~ and~~

~~v. Culture of safety.~~

~~b. The optional measures for the quality incentive payment are:~~

      v~~i~~. Emergency department process,~~Active participation in the RCCO,~~

      v~~i~~i. Advance care planning, and

      v~~ii~~i. ~~Screening and intervention for tobacco use~~Tobacco Screening and Follow-up.

4. The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.~~,~~

5. Calculation methodology for payment.

   a. Determine available points by hospital to a maximum of 10 points per measure.

      i. Available points are defined as the number of measures for which a hospital qualifies multiplied by the number of points designated for the measure.

   b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department.

   c. Normalize the total points awarded by dividing total points earned by total points eligible, multiplied by 50.

   d. Calculate adjusted Medicaid discharges by hospital.

      i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by gross Medicaid billed charges divided by gross inpatient Medicaid billed charges.

      ii. For hospitals with fewer than 200 annual Medicaid discharges, the total number of discharges is multiplied by 125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare prospective payment system calculation.

   e. Calculate total adjusted discharge points

      i. Adjusted discharge points are defined as the total number of points earned for all measures multiplied by the number of adjusted Medicaid discharges.

   f. Determine the dollars per discharge point.

      i. Dollars per discharge point are tiered such that hospitals with higher quality point<u>s</u> ~~scores~~ <u>earned</u> receive ~~higher~~ <u>more dollars per discharge</u> point~~s per discharge~~<u>than hospitals with lower quality points earned</u>. <u>There are five tiers delineating the dollar value of a discharge point with each tier assigned at ten quality point increments. For each tier increase, the dollars per discharge point increase by a multiplier.</u>

The multiplier for the five tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Multiplier ~~Dollars per Discharge Point~~
1	1-10	1x~~$5.95~~
2	11-20	1.5x~~$8.93~~
3	21-30	2x~~$11.90~~
4	31-40	2.5x~~$14.88~~
5	41-50	3x~~$17.85~~

g. Calculate payment by hospital by multiplying the adjusted discharge points for that hospital by the dollars per discharge point.

~~5~~6. The dollars per discharge point for tier 1 will be set to an amount so that the total quality incentive payments made to all qualified hospitals will equal seven percent of the total reimbursement made to hospitals in the previous state fiscal year.~~The total funds for the quality incentive payment for the year ending September 30, 2017 is eighty-nine million six hundred sixty-nine thousand five hundred two dollars ($89,669,502).~~

8.3004.G. REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENT AND DISPROPORTIONATE SHARE HOSPITAL PAYMENT

1. The Enterprise shall calculate the Supplemental Medicaid Payment and Disproportionate Share Hospital Payment under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Supplemental Medicaid Payment and Disproportionate Share Hospital Payment shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual payment made each year, the methodology to calculate such payment, and the payment reimbursement schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Supplemental Medicaid Payment or the Disproportionate Share Hospital Payment to be reimbursed.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Pharmacy Prior Authorization Timeline, Section 8.800.7.B
Rule Number: MSB 18-03-01-B
Division / Contact / Phone: Client and Clinical Care Office / January Montano / 303-866-6977

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency / Board: Department of Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-03-01-B, Revision to the Medical Assistance Rule concerning the Pharmacy Prior Authorization Timeline, Section 8.800.7.B
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) 8.800.7.B, 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)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.800.7.B with the proposed language beginning at 8.800.7.B through the end of 8.800.7.B. This rule is effective July 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Pharmacy Prior Authorization Timeline, Section 8.800.7.B
Rule Number: MSB 18-03-01-B
Division / Contact / Phone: Client and Clinical Care Office / January Montano / 303-866-6977

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 rules at 10 CCR 2505-10, Section 8.800.7.B., outline the timeline and process requirements for pharmaceutical prior-authorization requests. The requirements of this section create an unrealistic timeline for prescribers and Department staff to process pharmaceutical prior-authorization requests that require additional information.

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:

3. Federal authority for the Rule, if any:

   Section 1927(d)(2) of the Social Security Act

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-5-506, C.R.S. (2017)

Initial Review **05/11/18** Final Adoption **06/08/18**
Proposed Effective Date **07/30/18** Emergency Adoption

DOCUMENT #10

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Pharmacy Prior Authorization Timeline, Section 8.800.7.B
Rule Number: MSB 18-03-01-B
Division / Contact / Phone: Client and Clinical Care Office / January Montano / 303-866-6977

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.

   Prescribers and Department staff will benefit from the proposed rule as they will have additional time to process pharmaceutical prior-authorization requests (PAR) that require additional information from the prescriber to review. Prescribers that previously only had 24 hours to respond to the Department's request for additional information concerning incomplete prior authorization requests, now have 72 hours.

   Currently, the Department sends requests for additional information to the prescriber, pends the PAR, and will then deny the PAR after 24 hours if no response is received. The prescriber then files an appeal with the Office of Administrative Courts (OAC) AND submits a new PAR which may be approved, resulting in an unnecessary appeal; or the PAR is denied. The 24-hour limitation in rule has created a back-log of unnecessary Appeals for the Office of Administrative Courts and the Office of Appeals has reached out to the Department to address the issue.

   The proposed rule revisions do not increase the number of PARs pending at a given time, it decreases it, as it allows prescribers more time to respond which means they are less likely to send in a duplicative PAR submission, or file an appeal.

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 quality of information received by Department staff from prescribers may improve due to the additional time provided as a result of the rule change. Prescribers would have more time to address Department requests for additional information in support of pharmaceutical prior authorization requests.

   There quantitative impact of the rule change is that it will decrease the number of unnecessary PARs prescribers submit. It will also reduce the number of unnecessary appeals the Office of Administrative Courts, the Office of Appeals and Department staff have to respond to.

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 anticipated costs to the Department or any other agency due to the implementation and enforcement of the proposed rule.

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

   The cost of action: no costs of action exist.

   The cost of inaction: pharmaceutical prior-authorization requests would continue to be denied for members whose prescribers were unable to respond to Department requests within 24 hours. Unnecessary appeals would continue to cause a backlog in the Office of Administrative Courts and the Office of Appeals, blocking other cases more urgently needed to be heard from scheduling in a timely manner.

   Benefits of action: Increased time for prescriber-staff to respond to Department requests for additional information in support of pharmacy prior authorization. Reduction in the number of duplicative prior authorization requests and unnecessary appeals received by Department staff; ultimately reducing the amount of time a member has to wait to receive a medication if approvable.

   Benefits of inaction: there are no benefits of inaction. The 24-hour processing window has not been demonstrated in the data analyzed by the Departments Pharmacy PAR vendor to incentivize providers, but rather causes an increase in duplicative PAR requests, a backlog in appeals cases and an increase in the amount of time the member may be without the prescribed medication. Furthermore, the increase to 72 hours may reduce the amount of time a member will wait to receive a medication if the prescriber does not submit a complete PAR.

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, however, there are no anticipated costs due to implementation of the 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 alternative methods for achieving the purpose of the proposed rule.

8.800.7 PRIOR AUTHORIZATION REQUIREMENTS

8.800.7.A. Prior authorization shall be obtained before drugs that are subject to prior authorization restrictions may be provided as a benefit. Prior authorization requests may be made by the member's physician, any other health care provider who has authority under Colorado law to prescribe the medication being requested or any long-term-care pharmacy or infusion pharmacy that fills prescriptions on behalf of the member and is acting as the agent of the prescriber. The prior authorization request shall be made to the Fiscal Agent. The prescriber shall provide any information requested by the Fiscal Agent including, but not limited to, the following:

1. Member name, Medical Assistance Program state identification number, and birth date;

2. Name of the drug(s) requested;

3. Strength and quantity of drug(s) requested; and

4. Prescriber's name and medical license number, Drug Enforcement Administration number, or National Provider Identifier.

8.800.7.B. When the prior authorization request is received, it shall be reviewed to determine if the request is complete. If it is complete, the requesting provider shall be notified of the approval or denial of the prior authorization request via telephone and/or facsimile at the time the request is made, if possible, but in no case later than 24 hours after the request is made. If the prior authorization request is incomplete or additional information is needed, an inquiry to the party requesting the prior authorization shall be initiated within one working day from the day the request was received. If no response is received from that party within ~~24~~72 hours of the Department's inquiry, the prior authorization shall be denied.

8.800.7.C. In an emergency situation, the pharmacy may dispense up to a 72-hour supply of a covered drug that requires a prior authorization if it is not reasonably possible to request a prior authorization for the drug before it must be dispensed to the member for proper treatment. The pharmacist may call the prior authorization help desk to receive override approval. Prescriptions dispensed under the override approval are eligible for reimbursement.

8.800.7.D. The Department shall solicit and maintain a list of any interested parties who wish to comment on any proposed additions to the drugs that are subject to prior authorization. The list of interested parties shall be notified of any proposal and shall be given reasonable time, not to exceed 30 days, to comment or recommend changes before any drugs become subject to prior authorization. Notwithstanding the foregoing, if a new drug is approved by the FDA and that drug is in a class of drugs already subject to prior authorization, the new drug shall also be subject to prior authorization without any comment period.

8.800.7.E. Any changes to the drugs that are subject to prior authorization or any documentation required to obtain a prior authorization shall be published in the Provider Bulletin. Notification in the Provider Bulletin shall satisfy any notification requirements of any such changes.