Public Notice for June 2009 Release

PUBLIC NOTICE
COLORADO MEDICAID
Department of Health Care Policy and Financing

Fee-for-Service Provider Payments

Effective July 1, 2009, in an effort to reduce expenditures for the Colorado Medicaid program, it is the intent of the Department to reduce provider reimbursement rates for most fee-for-service benefits by up to two percent (2.0%). Among the affected benefit categories are: physician and clinic services; Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services; emergency transportation services; non-emergent medical transportation services; dental services; vision services; occupational, physical, and speech therapy services; inpatient hospital services; outpatient hospital services; ambulatory surgery center services; anesthesia services; laboratory and x-ray services; durable medical equipment and supplies; and drugs administered in the office setting. In addition, some medical, durable medical equipment/supply, pathology/laboratory, radiology, and surgery reimbursement rates may receive targeted cuts in addition to the two percent (2.0%) rate cut, if rates for those procedures have fallen out of alignment with current Medicaid pricing standards. Further, some procedure codes in these categories of service that are currently manually priced will be reimbursed based on the Department's fee schedule. An updated fee schedule reflecting these rate changes will be posted on the Department's Web site at www.colorado.gov/hcpf in August 2009.

These changes are expected to result in an annual aggregate decrease in expenditures of $29,000,000. The estimated decreases by service category are as follows:

Estimated Decrease in Expenditure by Service Category	
Physician & EPSDT Services	($5,200,000)
Emergency Transportation Services	($125,000)
Non-emergency Medical Transportation Services	($180,000)
Dental Services	($1,240,000)
Inpatient Hospitals Services	($8,700,000)
Outpatient Hospitals Services	($3,200,000)
Lab & X-Ray Services	($620,000)
Durable Medical Equipment Services	($2,100,000)
Reduce Selected Physician Codes Below 100% of Medicare Rate	($7,400,000)

Home Health, Private Duty Nursing and Home and Community Based Services Provider Payments

Effective July 1, 2009, the Department is planning targeted provider rate cuts, which will represent a rate reduction that will achieve a two percent (2%) reduction in total expenditure for Home Health, Private Duty Nursing and Home and Community Based Services (HCBS) providers. These cuts reduce expenditures by approximately $7.6 million for the upcoming State Fiscal Year. The following program groups will be affected by the two percent (2%) planned cut:

Estimated Decrease in Expenditure by Service Category or HCBS Waiver	
HCBS Waiver for Persons who are Elderly, Blind, and Disabled	($3,150,190)
HCBS Waiver for Persons with Mental Illness	($455,245)
Children's HCBS Waiver	($30,198)
HCBS Waiver for Persons Living with AIDS	($13,281)
HCBS Waiver for Persons with Brain Injury	($240,574)
Children with Autism Waiver	($15,515)
Consumer Directed Attendant Support Services	($314,721)
Home Health	($2,966,267)
Private Duty Nursing	($440,509)

Home and Community Based Services Developmentally Disabled Services, Supported Living Services, Children's Extensive Support (CES), and Children's Habilitation Residential Program Waivers

Effective July 1, 2009, the Home and Community Based Services (HCBS) Developmentally Disabled Services (DD), Supported Living Services (SLS), Children's Extensive Support (CES), and Children's Habilitation Residential Program (CHRP) waivers will implement statewide standardized rates. The new standardized rate structure will mean a specific rate for an ongoing service (e.g., personal care), or specific rates by Levels or settings for a service (e.g., six supported employment group setting rates by Support Level), and in some cases, the rate may still be variable due to the nature of the limited duration service (e.g., home modification is still $1 = 1 unit). Due to the standardization of rates, there will be an impact to the existing individual rates resulting in some increases or decreases. There is no expected change in annual aggregate expenditures.

Hospital Provider Payments

Effective July 1, 2009, it is the intent of the Department to submit a State Plan Amendment to change the methodology for calculating inpatient hospital base rates for providers participating in Medicaid. The Medicaid inpatient hospital base rates will be determined according to budget neutrality as currently defined, but will account for a reduction of $8,700,000 in funding appropriated by the General Assembly for the State's Fiscal Year 2009-10.

Effective October 1, 2009, it is the intent of the Department to submit a State Plan to change inpatient hospital reimbursement for Serious Reportable Events. There is no expected change in annual aggregate expenditures.

Effective July 1, 2009, it is the intent of the Department to submit a State Plan to change the methodology for calculating outpatient hospital reimbursement to out of state hospitals, including those out of state hospitals that are border state hospitals. The expected change in annual aggregate expenditures is approximately $300,000.

Pharmacy Provider Payments

Effective July 1, 2009, it is the intent of the Department to submit a State Plan Amendment changing two pricing methodologies used to determine reimbursement for covered fee-for-service outpatient drugs. The Average Wholesale Price (AWP)-based methodologies will be changed to AWP minus 14% for brand name drugs and AWP minus 40% for generic drugs. These changes are expected to reduce aggregate drug reimbursement by approximately $4,000,000 in State Fiscal Year 2009-10.

Nursing facility Provider Payments

Effective July 1, 2009 it is the intent of the Department to submit a State Plan Amendment to adjust the method of reimbursing nursing facilities under the Colorado Medicaid program as directed by Senate Bill 09-263. This change reinstates the 8% per year limitation on growth for allowable health care services costs for nursing facility reimbursement. In addition, supplemental payments shall be made to nursing facilities based on quality performance criteria, to nursing facilities who serve residents with severe cognitive dementia or acquired brain injury and/or to nursing facilities who serve residents with severe mental health conditions or developmental disabilities. A supplemental payment shall be made to nursing facilities for care and services rendered to Medicaid residents to offset payment of the provider fee assessed under 25.5-6-203 C.C.R. (2008). The aggregate statewide average per diem rate for administrative and general costs, health care costs and capital costs that exceed the general fund expenditures growth limitation shall be paid as a supplemental Medicaid payment using the provider fee subject to the priority of uses of the provider fee noted above. If the provider fee is insufficient to fully fund the supplemental Medicaid payment, the supplemental payment shall be reduced to all providers proportionately. For the fiscal year 7/1/2009 through 6/30/2010 the general fund shall be limited to the prior fiscal year, and for the fiscal year 7/1/2010 through 6/30/2011, the general fund shall be limited to a five percent increase from the prior year. For the fiscal year beginning 7/1/2009 the provider fee shall not exceed $7.50. For the fiscal year beginning 7/1/2010 and each fiscal year thereafter the provider fee shall not exceed $7.50 per non-Medicare resident day plus inflation based on the national skilled nursing facility market basket index.

Supplemental Medicaid Payments to Rural and Public Hospitals

Effective June 15, 2009 it is the intent of the Department to submit a State Plan Amendment to modify the supplemental Medicaid payment to qualified rural hospital providers and to qualified hospital providers that provide services to low-income populations. These payments are commonly known as the Rural Hospital payment and the Public Hospital payment. The payments are based on the number of clients served and costs related to providing services. A change in annual aggregate expenditures will occur because of a change in total funds appropriated for these payments.

In State Fiscal Year 2008-09 (July 1, 2008 – June 30, 2009) total available funds for the Rural Hospital payment will be approximately $2.5 million. In State Fiscal Year 2009-10 (July 1, 2009 – June 30, 2010) total funds available for the Rural Hospital payment will be approximately $3.0 million.

In State Fiscal Year 2008-09 (July 1, 2008 – June 30, 2009) total available funds for the Public Hospital payment will be approximately $2.5 million. In State Fiscal Year 2009-10 (July 1, 2009 – June 30, 2010) total funds available for the Public Hospital payment will be approximately $3.0 million.

Supplemental Medicaid Payments and Disproportionate Share Hospital Payments for Providers who Participate in the Colorado Indigent Care Program

Effective June 15, 2009 the Department proposes to submit a State Plan Amendment (SPA) to adjust the FY 2008-09 annual total expenditures, and if necessary, any prior fiscal year amounts, for the Disproportionate Share Hospital (DSH) payment known as the Low-Income payment; the Supplemental Medicaid payment known as the High-Volume payment; the DSH payment known as the Bad Debt payment; the Supplemental Medicaid payment known as the Pediatric Major Teaching Hospital payment; and the Supplemental Medicaid payment known as the Family Medicine Residency Program payments and the State University Teaching Hospital payment. The adjustments to annual total expenditures will include an increase in the federal Disproportionate Share Hospital allotment of 2.5% related to the American Recovery and Reinvestment Act.

Effective July 1, 2009 the Department proposes to submit a State Plan Amendment (SPA) to adjust the FY 2009-10 annual total expenditures for the Disproportionate Share Hospital (DSH) payment known as the Low-Income payment, the Supplemental Medicaid payment known as the High-Volume payment, the DSH payment known as the Bad Debt payment, the Supplemental Medicaid payment known as the Pediatric Major Teaching Hospital payment, and the Supplemental Medicaid payment known as the Family Medicine Residency Program payments and the State University Teaching Hospital payment. The adjustments to annual total expenditures will include an increase in the federal Disproportionate Share Hospital allotment of 2.5% related to the American Recovery and Reinvestment Act.

Effective July 1, 2009 the Department proposes to submit three State Plan Amendments (SPA) to modify the Supplemental Medicaid payments for Outpatient Hospital, Nursing Facility and Home Health Agency services. These payments will be modified so the distribution of funds is made based on provider uncompensated Medicaid costs, such that the payments cannot exceed the federal upper payment limit. Further, based on pending federal regulations, these payments may be required to be reconciled to actual costs once final audited costs become available. The Supplemental Medicaid payment for Nursing Facility providers may need to be adjusted to account for increased Medicaid payments, which may eliminate the ability for the Department to continue this payment. There is no expected change in annual aggregate expenditures since the upper payment limit (UPL) calculated is a fixed amount set by federal regulations.

Effective July 1, 2009 the Department proposes to submit a SPA to modify the supplemental Medicaid payment to Denver Health Medical Center and other qualified hospital providers that operate primary care clinics and provide primary care services to low-income populations. This payment is commonly known as the Colorado Health Care Services payment. These payments may be converted from a Supplemental Medicaid payment to a Disproportionate Share Hospital (DSH) payment to eliminate the impact on the federal upper payment limit. There is no expected change in annual aggregate expenditures since the UPL calculated and DSH allocation are fixed amounts set by federal regulations.

Effective July 1, 2009 the Department proposes to submit a SPA to modify the supplemental Medicaid payment to qualified rural hospital providers and to qualified hospital providers that provide services to low-income populations. These payments are commonly known as the Rural Hospital payment and the Public Hospital payment. These payments may be converted from a Supplemental Medicaid payment to a DSH payment to eliminate the impact on the federal upper payment limit. There is no expected change in annual aggregate expenditures since the UPL calculated and DSH allocation are fixed amounts set by federal regulations.

Effective July 1, 2009 the Department, for the purpose of additional reimbursement, proposes to submit a SPA to receive a federal match under the DSH allocation for the Primary Care Fund payment to Denver Health Medical Center. The payment will be based on the number of low-income, uninsured clients served in the primary care setting. The proposed payment is $13.2 million. There is no expected change in annual aggregate federal expenditures as the DSH allocation is a fixed amount set by federal regulations.

Payments to School Health Service Providers

Effective July 1, 2009 the Department proposes to submit a SPA or a proposal to the federal Division of Cost Allocation to allow Medicaid School Based Administrative Claiming. The Medicaid program will leverage federal funds to reimburse administrative activities necessary for the proper and efficient administration of the state Medicaid plan. The Medicaid School Based Administrative Claiming program would reimburse school districts for the time employees spend in administrative activities that directly support efforts to identify and enroll potentially eligible children and their families into Medicaid. Expected allowable activities include the following: Medicaid Outreach; Facilitating Medicaid Eligibility Determination;

Transportation-Related Activities in Support of Medicaid Covered Services; Translation Related to Medicaid Services; Program Planning, Policy Development, and Interagency Coordination Related to Medical Services; Medical/Medicaid Related Training; Referral, Coordination, and Monitoring of Medicaid Services; General Administration. The expected aggregate increase in reimbursement to School Health Service Providers is $1,000,000.

Hospital Provider Fee and Resulting Provider Payments

Effective July 1, 2009 the Department proposes to submit a SPA to implement portions of the Health Care Affordability Act of 2009, House Bill 09-1293. The Department is authorized to collect inpatient and an outpatient hospital provider fees for the purpose of obtaining federal financial participation for the state's medical assistance programs. Provider fees shall be used to increase reimbursements to hospitals; to increase the number of people covered by medical assistance programs; and to pay for administrative costs related to the fee and program expansions. Subject to the receipt of federal authorization, state payments to hospitals will increase through (1) maximizing inpatient and outpatient hospital provider payments based on federal regulations, (2) increasing payments under the Colorado Indigent Care Program (CICP) up to 100 percent of cost, and (3) paying a new quality incentive payment. If sufficient fees and federal funding are available, the bill allows the Department to expand medical assistance programs.

It is the intent of the Department to submit a SPA that will include changes to the Disproportionate Share Hospital (DSH) payment known as the Low-Income payment, the Medicaid payment known as the High-Volume payment, the DSH payment known as the Bad Debt payment, the Medicaid payment known as the Supplemental UPL payment. All of these payments may be suspended and replaced with a new payment methodology. It is the intent to increase Supplemental Medicaid payments and DSH payments so hospital providers will receive up to 100 percent of costs for provider services under the CICP.

It is the intent of the Department to submit SPAs that will include changes to Medicaid inpatient hospital payments and outpatient hospital payments. The inpatient hospital payments may be modified to impact the Medicaid Base Rate or Base Rate calculation; the Budget Neutrality calculation; and the DRG Method of Payment. Such changes will impact reimbursement methodologies to all inpatient hospitals paid through the prospective payment system, including: Critical Access Hospitals, Rehabilitation and Specialty-Acute Hospitals. Further, the reimbursement methodology for the hospital specific Medicaid cost add-ons for Nursery, Neo-Natal Intensive Care Units, and Graduate Medical Education will be modified. Also, additional Supplemental Medicaid payments or cost add-ons may be implemented for inpatient hospital services.

The outpatient hospital payments may be modified to cover up to 100% of provider costs, through a change to outpatient hospital payments, changes to Supplemental Medicaid payments, or a combination of these payments.

The expected increases in hospital reimbursements are as follows:

- Inpatient Hospital Payments: $75,800,000
- Outpatient Hospital Payments: $68,200,000
- Supplemental Medicaid and DSH payments: $322,200,000

Aggregate payments to hospitals will not exceed federal upper payment limits for inpatient and outpatient hospital services.

General Information

Details regarding specific cuts will be published in a Colorado Medicaid Provider Bulletin. A link to this notice will be posted on the Department's web site (www.colorado.gov/hcpf) starting on June 15, 2009. Written comments may be addressed to: Director, Medical and CHP+ Program Administration Office, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203.