THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule concerning the Colorado Indigent Care Program, Section 8.904.
Rule Number:	MSB 11-07-28-A
Division / Contact / Phone:	Financial and 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 11-07-28-A, Revison to the Medical Assistance Rule concerning the Colorado Indigent Care Program, Section 8.904.
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) 8.904, 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*

Please add new text at §8.904.F.2.d that is provided. All other text is for clarification purposes only. This change is effective 03/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule concerning the Colorado Indigent Care Program, Section 8.904.
Rule Number:	MSB 11-07-28-A
Division / Contact / Phone:	Financial and 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).

   Currently, applicants for the Colorado Indigent Care Program (CICP) who appear to meet Medicaid eligibility requirements must be receive a denial of Medicaid eligibility before being enrolled in the CICP. On March 1, 2012, the Department will implement an expansion of Medicaid to Adults without Dependent Children (AwDC) up to 10% of the federal poverty level (FPL) for 10,000 enrollees. After the first 10,000 enrollees, there will be a waiting list for enrollment in Medicaid. The CICP rules are being revised to clarify that applicants who are on the Medicaid waiting list can be enrolled in CICP.

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:

4. State Authority for the Rule:

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

Initial Review	**12/09/2011**	Final Adoption	**01/13/2012**
Proposed Effective Date	**03/01/2012**	Emergency Adoption	

DOCUMENT # 07

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule concerning the Colorado Indigent Care Program, Section 8.904.
Rule Number:	MSB 11-07-28-A
Division / Contact / Phone:	Financial and 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.

   The CICP provides funding to participating hospitals and community health clinics to partially offset the uncompensated care cost for low-income Coloradans who do not qualify for Medicaid or the Child Health Plan Plus (CHP+). Allowing applicants who are on a waiting list for Medicaid under the AwDC expansion to continue to be enrolled in CICP will prevent the most medically needy from not receiving medical 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.

   These rules will not impact the number of clients participating in the CICP, as clients on the Medicaid waiting list would otherwise be eligible for CICP before the AwDC expansion.

   Funding for CICP providers is limited by the available appropriation. Each provider receives CICP funding in proportion to its write-off costs for services provided to CICP clients compared to all providers' write-off costs. For providers, allowing clients on the Medicaid waiting list to be enrolled in CICP means that providers can submit their write-off costs for waiting list clients to the Department to be used in the calculation of each provider's share of the available appropriation.

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. Available funding for CICP providers is limited by the available appropriation. There are no any additional costs to the Department.

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

   The benefits of the proposed rule are that clients will be able to continue to receive discounted health care services from CICP providers while waiting to be enrolled in Medicaid. CICP providers will continue to be able to submit write-off costs to the Department to be included in the calculation of the distribution of CICP funding. There are no costs to the Department or other agencies to implement the proposed rules. If there is

inaction, individuals who are on a waiting list for Medicaid will not be eligible for discounted health care services through the CICP and will have to forego health care or pay higher out-of-pocket costs.

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 alternatives as there are no anticipated 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.

   The Department does not have an alternative method for achieving the purpose for the proposed rule. Without the rule, clients on a waiting list for Medicaid enrollment will have to wait until they are denied Medicaid eligibility for categorical reasons before being eligible for the CICP.

8.904 PROVISIONS APPLICABLE TO CLIENTS [Eff. 3/30/2008]

F. Applicants Not Eligible

1. The following individuals are not eligible to receive discounted services under available CICP funds:

   a. Individuals for whom lawful presence cannot be verified.

   b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who have not been released on parole, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

   c. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

   d. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

2. Persons who qualify for Medicaid. However, applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:

   a. QMB benefits described at section 10 C.C.R. 2505-10, Section 8.111.1 (2007) of these regulations;

   b. SLMB benefits described at section 10 C.C.R. 2505-10, Section 8.122 (2007), or

   c. The QI1 benefits described at section 10 C.C.R. 2505-10, Section 8.123 (2007).

   d. Applicants who are on a waitlist to become enrolled in Medicaid.

3. Individuals who are eligible for the Children's Basic Health Plan. However, individuals who are waiting to become an enrollee in the Children's Basic Health Plan and/or have incurred charges at a participating qualified health care provider in the 90 days prior to the application date shall not be excluded from consideration for eligibility on a temporary basis. Once the applicant becomes enrolled in the Children's Basic Health Plan, the applicant is no longer eligible to receive discounted health care services under available CICP funding.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Retroactive Eligibility for the Aged, Blind or Disabled categories,§8.100.5.C.2
Rule Number:	MSB 11-10-27-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 11-10-27-A, Revision to the Medical Assistance Rule Concerning Retroactive Eligibility for the Aged, Blind or Disabled categories,§8.100.5.C.2
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) 8.100.5.C.2, 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*

Please delete current text at §8.100.5.C.2.a & b as identified and replace with new text provided at §8.100.5.C.2.a, b, i & ii and c. All other text is for clarification purposes only. This change is effective 03/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Retroactive Eligibility for the Aged, Blind or Disabled categories,§8.100.5.C.2
Rule Number:	MSB 11-10-27-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 purpose of this rule revision is to clarify the criteria for granting retroactive eligibility to aged, blind,or disabled individuals who are found to be SSI eligible. The federal authority for this rule is located at 42 CFR §435.914 and 42 USC §1396a(a)(34). The authority for this rule is contained in 25.5-1-301 through 25.5-1-303, C.R.S. (2011); 25.5-4-101(1), C.R.S. (2011).

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:

   42 CFR §435.914 and 42 USC §1396a(a)(34)

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. (2011)

Initial Review	**12/09/2011**	Final Adoption	**01/13/2012**
Proposed Effective Date	**03/01/2012**	Emergency Adoption	

DOCUMENT # 06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Retroactive Eligibility for the Aged, Blind or Disabled categories,§8.100.5.C.2
Rule Number:	MSB 11-10-27-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 rule changes will affect aged, blind, or disabled individuals who are eligible for or who receive SSI benefits and request retroactive coverage.

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 would clarify that the effective date for Medicaid eligibility for individuals eligible for or receiving SSI benefits may include retroactive coverage up to 90 days prior to the application date if the individual otherwise meets the SSI financial and disability criteria.

   The proposed rule change will eliminate gaps in Medicaid coverage experienced by some disabled individuals who are eligible for or who receive SSI. These gaps in coverage result in medical bills that may go unpaid, unless the SSI individual's Medicaid eligibility is backdated 90 days. The proposed regulation alleviates 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 retroactive Medicaid eligibility for individuals who are eligible for or who are receiving SSI benefits, if they meet the SSI financial and disability criteria for the three months preceding the date of application. This rule clarifies retroactive Medicaid eligibility for individuals eligible for SSI benefits.

   The proposed rule is intended to clarify retroactive eligibility. There may be a fiscal impact to the Department in providing that coverage to additional individuals. The Department is required to provide this mandatory coverage. The Department does not have data at this time with which to quantify this potential mandatory 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.

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

8.100.5.C. Effective Date Of Eligibility

1. Medical Assistance shall be approved effective as of the date of application for Medical Assistance, or as of the date the person becomes eligible for Medical Assistance, whichever is later. Individuals held in correctional facilities or who are held in community corrections programs that are determined eligible for Medical Assistance shall be approved effective as of the individual's date of release.

2. Clients applying for Medical Assistance under the Aged, Blind and Disabled category shall be reviewed for retroactive eligibility as described at 8.100.3.E. When reviewing for retroactive eligibility for an individual who is SSI eligible or applied and became SSI eligible in each of the retroactive months, the applicant must:

   a. Be aged at least 65 years, or;

   b. Meet the Social Security Administration definition of disability by;

      i. approved as eligible to receive either SSI or SSDI, on or prior to the date of a medical service, or

      ii. having a disability onset date determined on or prior to the date of a medical service,

   c. and meet the financial requirements as described at 8.100.5.E.

~~To be eligible for retroactive Medical Assistance, the categorically needy disabled or blind person shall either:~~

~~a. have received SSI money payment or Social Security disability insurance (DIB) for that month, or~~

~~b. be determined to have met the SSI definition of disability or blindness at that month through the procedure for processing applicant/client determinations as described in the chapter on AID TO NEEDY DISABLED OR BLIND PERSONS in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1).~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, Section 8.765.12.B
Rule Number:	MSB 11-11-11-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles / 303-866-2830

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 11-11-11-A, Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, Section 8.765.12.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) 8.765.12.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). <Select One>

PUBLICATION INSTRUCTIONS*

Please delete text indicated at §8.765.12.B. All other text is for clarification purposes only. This change is effective 03/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, Section 8.765.12.B
Rule Number:	MSB 11-11-11-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles / 303-866-2830

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).

   Section 8.765.12.B states, "If the Referral Agency (defined as the Division of Youth Corrections, County Departments of Human/Social Services who have legal custody of a client, Behavioral Healthcare Organization or Community Mental Health Center that refers the client to a PRTF or RCCF providing mental health services for the purpose of the placement through the Child Mental Health Treatment Act) disagrees with the Multidisciplinary Team's Assessment and the client is denied admission, the client has the right to appeal pursuant to 10 C.C.R. 2505-10, Section 8.057."

   The Department of Health Care Policy and Financing is not the managing authority over RCCFs, the Department of Human Services is. Therefore, if a client would like to appeal denied admission to an RCCF, they need to appeal to the Department of Human Services. Clients cannot appeal denied admission to an RCCF under our appeal rules because we are not the managing authority, thus it is not our decision.

   Coinciding with that, if section 8.765.12.B is not deleted, it would actually contradict Volume 7 by giving our department authority over a client appeal process that the Department of Human Services actually has the authority over as defined in their Volume 7.

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:

42 CFR 44O.130(d)
42 CFR 440.160

Initial Review	**12/09/2011**	Final Adoption	**01/13/2012**
Proposed Effective Date	**03/01/2012**	Emergency Adoption	

DOCUMENT # 03

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, Section 8.765.12.B
Rule Number:	MSB 11-11-11-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles / 303-866-2830

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 classes of persons who will be affected by the proposed deletion of section 8.765.12.B, include the Department of Health Care Policy and Financing, the Department of Human Services, RCCFs, and clients who are denied admission to RCCFs.

   If this deletion does not occur, the Department of Health Care Policy and Financing will have contradicting rules with the Department of Human Services in regard to appeal rules. This would negatively affect all RCCFs and clients who are denied admission to RCCFs who want to 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 probable quantitative and qualitative impact of not deleting section 8.765.12.B, as previously stated would be that if this deletion does not occur, the Department of Health Care Policy and Financing will have contradicting rules with the Department of Human Services in regard to appeal rules. This would negatively affect all RCCFs and clients who are denied admission to RCCFs who want to appeal.

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.

   We do not anticipate that this proposed rule change will increase the utilization or costs to the Department or to any agency associated with this rule change. Nor do we anticipate that this rule change will affect state revenues.

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

   The probable cost of not deleting section 8.765.12.B as previously states would be that the Department of Health Care Policy and Financing would have contradicting rules with the Department of Human Services in regard to appeal rules.

The probable benefit of deleting this section, would be that our Volume 8 rules and the Department of Human Services Volume 7 rules would not be contradictory.

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

   We see the process of simply deleting this section as the least costly and least intrusive method for achieving non-contradictory rules between Volume 7 and Volume 8.

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.

   We do not foresee any alternative methods for achieving the purpose.

8.765.12 RCCF RESPONSIBLITIES

8.765.12.A. The RCCF shall include the following in the client's record:

1. Results from the Multidisciplinary Team's Assessment;

2. Client's Medicaid Eligibility Determination Form; and

3. Client's diagnoses, characteristics and presenting problem.

8.765.12.B. The RCCF shall transmit the items listed in 8.765.12.A. to the Referral Agency. ~~If the Referral Agency disagrees with the Multidisciplinary Team's Assessment and the client is denied admission, the client has the right appeal pursuant to 10 C.C.R. 2505-10, Section 8.057.~~

8.765.12.C. The RCCF shall designate a Licensed Mental Health Professional to act as a case manager for mental health services for each client.

8.765.12.D. The Licensed Mental Health Professional shall maintain an organized, legible, chronological, current record on each client.

8.765.12.E. The client's Plan of Treatment for mental health services shall be integrated into the agency's comprehensive Plan of Care reviewed by the Multidisciplinary Team. The Plan of Care shall:

1. Be signed and dated by the client, the Referral Agency and the Licensed Mental Health Professional and the parent/guardian.

2. Include an initial plan developed prior to the onset of mental health services that needs of the client.

3. Address mental health and other needs including the client's presenting problems, physical health, emotional status, behavior, support system in the community, available resources and discharge plan.

4. Include specific goals and measurable objectives, expected dates of achievement and specific discharge criteria to be met for termination of treatment. Criteria for discharge shall include provisions for follow-up services.

5. Specify all mental health services necessary to meet the needs of the client and to treat the client's current diagnosis while the client is in the RCCF.

6. Identify the provision of or the referral for services other than mental health services.

7. Be readily identifiable and be maintained in the client's record.

8. Document any court-ordered mental health services including identifying the agency responsible for providing the court-ordered treatment.

9. Be reviewed by the Multidisciplinary Team monthly and revised as needed.

8.765.12.F. Except in cases of emergency, all mental health services indicated in the Plan of Care shall be provided.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Buy-In Program for Working Adults with Disabilities §8.100.
Rule Number:	MSB 11-10-06-A
Division / Contact / Phone:	Eligibility / Marivel Guadarrama / 3926

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 11-10-06-A, Revision to the Medical Assistance Rule Concerning Medicaid Buy-In Program for Working Adults with Disabilities §8.100.
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) 8.100.1, 8.100.3, 8.100.5, and 8.100.6, 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*

Please make changes to current rule as follows:

§8.100.1 Definitions: insert new definitions for "**Employed means that an individual** . . ."; "**Limited disability for the Medicaid Buy-In** . . ."; "**Premium means the monthly amount** . . ."; and "**SGA Substantial Gainful Activity is defined** . . ." at the appropriate place as provided.

§8.100.3.F Groups Assisted Under the Program: at §8.100.3.F.l please add new paragraph provided.

§8.100.3.H. Citizenship and Identity Documentation Requirements: at §8.100.3.H.9.c please add an additional line to the table for "Medicaid Buy-In Program for Working Adults with Disabilities" as provided.

§8.100.3.M. Consideration of Resources: please add the text provided to this paragraph.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

§8.100.3.N. Federal Financial Participation (FFP): please add new paragraph at §8.100.3.N.2.e. that will immediately follow the new paragraph d. that was added from MSB 11-10-25-A.

§8.100.5.A Application Requirements: Please add new text provided at §8.100.5.A.1.a through §8.100.5.A.1.c; delete the current text at §8.100.5.A.2; and renumber §8.100.5.A.3 to §8.100.5.A.2.

§8.100.5.F. Income Requirements: Please add new text provided to paragraph §8.100.5.F.1.

§8.100.5.H. Income Disregards: Please add new text provided at §8.100.5.H.1.; §8.100.5.H.2.c.

§8.100.5.M. Resource Requirements: Please add new text provided to §8.100.5.M.1.

§8.100.6.O Medicaid Buy-In Program for Working Adults with Disabilities: Please add new text provided from §8.100.6.O through §8.100.6.O.2 as a new subsection to the rule.

All other text is provided for clarification purposes only. Any text not specifically identified to delete should remain in the rule. This change is effective 03/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Buy-In Program for Working Adults with Disabilities §8.100.
Rule Number:	MSB 11-10-06-A
Division / Contact / Phone:	Eligibility / Marivel Guadarrama / 3926

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 rules amend 10 CCR 2505-10, sections 8.100.1, 8.100.3, 8.100.5, and 8.100.6 to allow adults between the ages of 16 through 64, who earn too much income or have too many resources to qualify for other Medicaid programs, to receive Medicaid by paying a monthly premium based on their income. These individuals must have a qualifying disability as determined using Social Security Administration medical criteria, be ineligible for other Medicaid programs, and have income less than or equal to 450% of the Federal Poverty Level (FPL).

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:

   The federal authority for this rule is located in Section 201 of the Ticket to Work and Work Incentive Improvement Act of 1999, Public Law 106-170.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-6-1401 through 25.5-6-1406, C.R.S. (2011)

Initial Review	**12/09/2011**	Final Adoption	**01/13/2012**
Proposed Effective Date	**03/01/2012**	Emergency Adoption	

DOCUMENT # 06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Medicaid Buy-In Program for Working Adults with Disabilities §8.100.
Rule Number:	MSB 11-10-06-A
Division / Contact / Phone:	Eligibility / Marivel Guadarrama / 3926

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 rule will affect working adults with disabilities who are at least 16 but less than 65 years of age with income less than or equal to 450% of FPL regardless of resources.

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 impacts working adults with disabilities who have income or resources above the amounts allowable for other Medicaid programs. The rule will allow these persons to buy-in to the Medicaid Buy-In program for Working Adults with Disabilities and receive Medicaid benefits. Anticipated caseload is 57 for fiscal year 2011-2012 and 1,695 for fiscal year 2012-2013.

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.

   Probable costs to the Department and other agencies due to the implementation and enforcement of the proposed rule are approximately $2,219,000 in fiscal year 2011-2012 and $22,803,000 in fiscal year 2012-2013. These are total fund costs, and will be paid for exclusively from cash funds collected from hospital provider fees and federal matching funds. No General Fund will be required.

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

   The Department must implement the proposed rule pursuant to the Colorado Health Care Affordability Act (HB 09-1293).

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.

   None

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

Common Law Marriage is legally recognized as a marriage in the State of Colorado under certain circumstances even though no legally recognized marriage ceremony is performed or civil marriage contract is executed. Individuals declaring or publicly holding themselves out as a married couple through verbal or written methods may be recognized as legally married under state law. C.R.S. 14-2-104(3)

Community Spouse is a person who is legally married to an institutionalized spouse and is not in a medical institution or nursing facility. The community spouse remains in the community.

Community Spouse Resource Allowance is the amount of resources that the Medical Assistance regulations permit the spouse staying at home to retain.

Complete application means an application in which all questions have been answered, which is signed, and for which all required verifications have been submitted.

The Department is defined in this volume as the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Child Health Plan Plus programs as well as other State-funded health care programs.

Dependent child is defined in this volume as a child residing in the home under the age of 18 or between the ages of 18 and 19 who is a full time student in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19.

Dependent relative for purposes of this rule is defined as one who is claimed as a dependent by an applicant for federal income tax purposes.

Disability means the inability to do any substantial gainful activity (or, in the case of a child, having marked and severe functional limitations) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of l2 months or more.

Dual eligible clients are Medicare recipients who are also eligible for Medical Assistance.

Earned Income is defined for purposes of this volume as any compensation from participation in a business, including wages, salary, tips, commissions and bonuses.

Earned Income Disregards are the allowable deductions and exclusions subtracted from the gross earnings. Income disregards vary in amount and type, depending on the category of assistance.

Eligibility site is defined in this volume as a location outside of the Department that has been deemed by the Department as eligible to accept applications and determine eligibility for applicants.

Employed means that an individual has earned income and is working part time, full time or is self-employed, and has proof of employment. Volunteer or in-kind work is not considered employment.

EPSDT- Early Periodic Screening, Diagnosis and Treatment is the child health component of the Medical Assistance Program. It is required in every state and is designed to improve the health of low-income children by financing appropriate, medically necessary services and providing outreach and case management services for all eligible individuals.

Equity value is the fair market value of land or other asset less any encumbrances.

Legal Immigrant Prenatal is a medical program that provides medical coverage for pregnant legal immigrants who have been legal immigrants for less than five years.

Limited Disability for the Medicaid Buy-In Program for Working Adults with Disabilities means that an individual has a disability that would meet the definition of disability under SSA without regard to Substantial Gainful Activity (SGA).

Long-Term Care is a Medical Assistance category that provides nursing-home care, home-health care, personal or adult day care for individuals above the age of 65 or with a chronic or disabling condition that needs constant supervision.

Long-Term Care institution means class I nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR) and swing bed facilities. Long-Term Care institutions can include hospitals.

Managed care system is a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care.

Medical Assistance is defined as all medical programs administered by the Department of Health Care Policy and Financing. Medical Assistance/Medicaid joint state/federal health benefits program for individuals and families with low income and resources. It is an entitlement program that is jointly funded by the states and federal government and administered by the state. This program provides for payment of all or part of the cost of care for medical services.

Medical Assistance Required Household is defined for purposes of this volume as all parents or caretaker relatives, spouses, and dependent children residing in the same home.

Minimal verification is defined in this volume as the minimum amount of information needed to process an application for benefits. No other verification can be requested from clients unless the information provided is questionable or inconsistent.

MMMNA - Minimum Monthly Maintenance Needs Allowance is the calculation used to determine the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MIA - Monthly Income Allowance is the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MSP - Medicare Savings Program is a Medical Assistance Program to assist in the payment of Medicare premium, coinsurance and deductible amounts. There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLIMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals – 1 (QI-1s).

Nursing Facility is a facility or distinct part of a facility which is maintained primarily for the care and treatment of inpatients under the direction of a physician. The patients in such a facility require supportive, therapeutic, or compensating services and the availability of a licensed nurse for observation or treatment on a twenty-four-hour basis.

OAP - Old Age Pension is a financial assistance program for low income adults age 60 or older.

OASDI - Old Age, Survivors and Disability insurance is the official term Social Security uses for Social Security Act Title II benefits including retirement, survivors, and disability. This does not include SSI payments.

Outpatient is a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment. Is a patient who does not require admittance to a facility to receive medical services.

PACE - Program of All-inclusive Care for the Elderly is a unique, capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Patient is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

PNA - Personal Needs Allowance means moneys received by any person admitted to a nursing care facility or Long Term Care Institution which are received by said person to purchase necessary clothing, incidentals, or other personal needs items which are not reimbursed by a Federal or state program.

Premium means the monthly amount an individual pays to participate in a Medicaid Buy-In Program.

Proportionate Share is the income attributed to or counted for each individual member of a household based on the individual's own income plus the equal share of income from the biological or adoptive parent or spouse as defined by the legal or biological relationship between members of a Family Medical Assistance household.

Provider is any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding a current valid license or certificate to provide such services or to dispense such goods.

Psychiatric facility is a facility that is licensed as a residential care facility or hospital and that provides inpatient psychiatric services for individuals under the direction of a licensed physician.

Public Institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

Questionable is defined as inconsistent or contradictory tangible information, statements, documents, or file records.

Recipient is any person who has been determined eligible to receive benefits.

Resident is any individual who is living within the state and considers the state as their place of residence. Residents include any unempancipated child whose parent or other person exercising custody lives within the state.

RRB - Railroad Retirement Benefits is a benefit program under Federal law 45 U.S.C.A. § 231 et seq that became effective in 1935. It provides retirement benefits to retired railroad workers and families from a special fund, which is separate from the social security fund.

Secondary School is a school or educational program that provides instruction or training towards a high school diploma or an equivalent degree such as a GED.

SGA – Substantial Gainful Activity is defined by the Social Security Administration. SGA is the term used to describe a level of work activity and earnings. Work is "substantial" if it involves performance of significant physical or mental activities or a combination of both, which are productive in nature. For work activity to be substantial, it does not need to be performed on a full-time basis. Work activity performed on a part-time basis may also be substantial gainful activity. "Gainful" work activity is work performed for

pay or profit; or work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

Single Entry Point Agency means the organization selected to provide case management functions for persons in need of Long Term Care services within a Single Entry Point District.

SISC- Supplemental Income Status Codes are system codes used to distinguish the different types of state supplementary benefits (such as OAP) a recipient may receive. Supplemental Income Status Codes determine the FFP for benefits paid on behalf of groups covered under the Medical Assistance program.

SSA - Social Security Administration is an agency of the United States federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' benefits.

SSI - Supplemental Security Income is a Federal income supplement program funded by general tax revenues (not Social Security taxes) that provides income to aged, blind or disabled individuals with little or no income and resources.

SSI eligible means eligible to receive Supplemental Security Income under Title XVI of the Social Security Act, and may or may not be receiving the monetary payment.

TANF - Temporary assistance to needy families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. The program began on July 1, 1997, and succeeded the Aid to Families with Dependent Children program. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

Third Party is an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of medical assistance.

Title XIX is the portion of the federal Social Security Act which authorizes a joint federal/state Medicaid program. Title XIX contains federal regulations governing the Medicaid program.

TMA - Transitional Medical Assistance is a Medical Assistance category for families that lost 1931 Medical Assistance coverage due to increased earned income or loss of earned income disregards.

ULTC 100.2 is an assessment tool used to determine level of functional limitation and eligibility for Long Term Care services in Colorado.

Unearned Income is defined for purposes of this volume as any income received from sources other than employment.

VA - Veterans Affairs is The Department of Veterans Affairs which provides patient care and Federal benefits to veterans and their dependents.

8.100.3.F. Groups Assisted Under the Program

1. The Medical Assistance Program provides benefits to the following persons who meet the federal definition of categorically needy at the time they apply for benefits:

   a. Families and children as defined under the Family and Children's Medical Assistance section 8.100.4.

   b. Persons who meet legal immigrant requirements as outlined in this volume, who were or would have been eligible for SSI but for their alien status, if such persons meet the resource, income and disability requirements for SSI eligibility.

   c. Persons who are receiving financial assistance; and who are eligible for a SISC Code of A or B. See section 8.100.3.N for more information on SISC Codes.

   d. Persons who are eligible for financial assistance under Old Age Pension (OAP) and SSI, but are not receiving the money payment.

   e. Persons who would be eligible for financial assistance from OAP or SSI, except for the receipt of Social Security Cost of Living Adjustment (COLA) increases, or other retirement, survivors, or disability benefit increases to their own or a spouse's income. This group also includes persons who lost OAP or SSI due to the receipt of Social Security Benefits and who would still be eligible for the Medical Assistance Program except for the cost of living adjustments (COLA's) received. These populations are referenced as Pickle and Disabled Widow(er)s.

   f. Persons who are blind, disabled, or aged individuals residing in the medical institution or Long Term Care Institution whose income does not exceed 300% of SSI.

   g. Persons who are blind, disabled or aged receiving HCBS whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment.

   h. A disabled adult child who is at least 18 years of age and who was receiving SSI as a disabled child prior to the age of 22, and for whom SSI was discontinued on or after May 1, 1987, due to having received of OASDI drawn from a parent(s) Social Security Number, and who would continue to be eligible for SSI if the above OASDI and all subsequent cost of living adjustments were disregarded. This population is referenced as Disabled Adult Child (DAC).

   i. Children age 18 and under who would otherwise require institutionalization in an Long Term Care Institution, Nursing Facility (NF), or a hospital but for which it is appropriate to provide care outside of an institution as described in 1902(e)(3) of the Act Public Law No. 97-248 (Section 134).

   j. Persons receiving OAP-A, OAP-B, and OAP Refugees who do not meet SSI eligibility criteria but do meet the state eligibility criteria for the OAP State Only Medical Assistance Program. These persons qualify for a SISC Code C.

   k. Persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergencies only.

   l. Persons with a disability or limited disability who are at least 16 but less than 65 years of age, with income less than or equal to 450% of FPL after income disregards, regardless of resources, and who are employed.

8.100.3.H. Citizenship and Identity Documentation Requirements

9. Reasonable Opportunity Period

a. If a Medical Assistance applicant or recipient does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required documentation. If the applicant or recipient does not provide the required documentation within the reasonable opportunity period, then:

i) the applicant's Medical Assistance application shall be denied, or

ii) the recipient's Medical Assistance benefits shall be terminated.

b. The reasonable opportunity period for Family Programs covered under 8.100.3.H is 14 calendar days. For the purpose of this section, Family Programs are defined as the following:

Commonly Used Program Name	Rule Citation
1931 Medical Assistance	8.100.4.G.2
Transitional Medical Assistance	8.100.4.I.1-7
Four Month Extended Medical Assistance	8.100.4.I.8
Institutionalized under age 21	8.100.4.H.1.a
Parents Plus Program	8.100.4.G.8
Qualified Child	8.100.4.G.6
Expanded Child	8.100.4.G.6
Ribicoff Child	8.100.4.G.7
Qualified Pregnant	8.100.4.G.9
Expanded Pregnant	8.100.4.G.9

c. The reasonable opportunity period for Adult Programs covered under 8.100.3.F. is 70 calendar days. For the purpose of this rule, Adult Programs are defined as the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled	8.100.3.F.1.e

Widow/Widower Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Breast and Cervical Cancer Program (BCCP)	8.715
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.O

8.100.3.M. Consideration of Resources

1. Resources are counted in determining eligibility for the Aged, Blind and Disabled, and Long Term Care institutionalized and Home and Community Based Services categories of Medical Assistance. Resources are not counted in determining eligibility for the Family and Children's Medical Assistance programs, the Medicaid Buy-In Program for Working Adults with Disabilities, or AwDC. See section 8.100.5 for rules regarding consideration of resources.

8.100.3.N. Federal Financial Participation (FFP)

1. The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of groups covered under the Colorado Medical Assistance Program and also for the Medicare supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain groups of categorically needy persons.

2. The SISC codes are as follows:

   a. Code A - for institutionalized persons whose income is under 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; and non-institutionalized persons receiving Home and Community Based Services, whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; code A signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments;

   b. Code B - for persons eligible to receive financial assistance under SSI; persons eligible to receive financial assistance under OAP "A" who, except for the level of their income, would be eligible for an SSI payment; persons who are receiving mandatory State supplementary payments; and persons who continue to be eligible for Medical Assistance after disregarding certain Social Security increases; code B signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program and also for SMIB premium payments;

   c. Code C - for persons eligible to receive assistance under OAP "A", OAP "B", or OAP Refugee Assistance for financial assistance only; who do not receive SSI payment and do not otherwise qualify under SISC code B as described in item B. above; code C signifies that no FFP is available in Medical Assistance program expenditures.

   e. Code E1 - for persons eligible to receive assistance under the Medicaid Buy-In Program for Working Adults with Disabilities and whose annual adjusted gross income, as defined under IRS statute, is less than or equal to 450% of FPL – after SSI earned income deductions; code E1 signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program.

3. Recipients of financial assistance under State AND, State AB, or OAP "C" are not eligible for Medical Assistance and the SISC code which shall be entered on the eligibility reporting form is C.

8.100.5.A. Application Requirements

1. When an individual applies for Medical Assistance on the basis of disability or blindness, the eligibility sites shall take the application and determine whether the individual is eligible for Long Term Care or any of the categories of assistance described in section 8.100.6 under Qualified Disabled and Working Individuals. If the applicant does not qualify for Medical Assistance on one of those bases, he/she shall be referred to the local Social Security office to apply for SSI.

   a. Applicants who apply for Long-Term Care Medical Assistance on the basis of disability or blindness, or who apply for the Medicaid Buy-In Program for Working Adults with Disabilities without a current disability determination, shall complete a Medical Assistance disability determination application in addition to the required Medical Assistance application. The disability determination application is not required for individuals that have already been determined disabled by the Social Security Administration.

   b. The Medical Assistance disability determination application shall be collected by a designated eligibility site representative and shall be forwarded to the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated eligibility site representative.

   c. For the Medicaid Buy-In Program for Working Adults with Disabilities, if an individual does not meet the Social Security Administration definition of disability, the state disability determination contractor can review the individual's circumstances to determine if the individual meets limited disability.~~2. Applicants who apply for Long Term Care Medical Assistance on the basis of disability or blindness shall complete a Medical Assistance disability determination application in addition to the required Medical Assistance application. The Medical Assistance disability determination application shall be collected by a designated eligibility site representative and shall be forwarded the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated eligibility site representative.~~

   ~~The disability determination application is not required for individuals that have already been determined disabled by the Social Security Administration.~~

~~3~~2. Persons requesting Aged, Blind, and Disabled Medical Assistance need only to complete the Colorado Medical Assistance application.

8.100.5.F. Income Requirements

1. This section reviews how income is looked at for the ABD Medical Programs and determining premiums for the Medicaid Buy-In Program for Working Adults with Disabilities. For more general income information and income types refer to the General Medical Assistance General Eligibility Requirements section 8.100.3.

2. Earned income is countable as income in the month received and a countable resource the following month. Earned Income includes the following:

    a. Wages, which include salaries, commissions, bonuses, severance pay, and any other special payments received because of employment.

    b. Net earnings from self-employment

    c. Payments for services performed in a sheltered workshop

    d. Royalties and honoraria

3. Unearned income is countable as income in the month received and a countable resource the following month. Unearned income includes, but is not limited to, the following:

    a. Death benefits, reduced by the cost of last illness and burial

    b. Prizes and rewards

    c. Gifts and inheritances

    d. Interest payments on promissory notes established on or after March 1, 2007.

    e. Interest or dividend payments received from any resources

    f. lump sum payments from SSA/SSI, workman's compensation, insurance settlements

    g. Dividends, royalties or other payments from mineral rights or other resources listed for sale within the resource limits

    h. Income from annuities that meet requirements for exclusion as a resource

8.100.5.H. Income Disregards

1. The following income disregards are only applicable to SSI related, OAP, and Medicare Savings Programs (MSP), and the Medicaid Buy-In Program for Working Adults with Disabilities. Only the unearned income disregard is applicable to AwDC. These disregards are not applicable to the HCBS waivers or the LTC programs.

2. The gross amount of earned and unearned income is countable toward eligibility with the following exclusions:

   a. the first $20 of total available unearned income (except for SSI income) must be disregarded;

   b. an additional $65 plus 1/2 of the remainder of earned income must be disregarded;

   c. income of spouses living together is considered mutually available and must be compared to the current SSI benefit level for a couple; net income of a non recipient spouse must be reduced by an amount up to one half the individual SSI benefit level for unmet needs of each non recipient child in the family. This does not apply to the Medicaid Buy-In Program for Working Adults with Disabilities.

   d. income of single persons must be compared to the current SSI benefit level for an individual (a one third reduction applies to a person living in the household of another);

   e. unemancipated children are not subject to a one-third reduction, an amount of parental income equal to the individual or couple SSI benefit level must be allowed for the needs of the parent or parents, up to one half the individual SSI benefit level must be allowed for the unmet needs of each non recipient child in the family, and the remainder must be considered as income available to the applicant or recipient child. For the purposes of this rule, "unemancipated child" means (1) a child under age 18 who is living in the same household with a parent or spouse of a parent, or (2) a child under age 21 who is living in the same household with a parent or spouse of a parent, if the child is regularly attending a school, college, or university, or is receiving technical training designed to prepare the child for gainful employment;

   f. one third of child support for the applicant/recipient child from an absent parent must be disregarded;

   g. the first $400 of gross monthly earnings, not to exceed $1620 in a calendar year, shall be exempt from consideration as earned income of a disabled or blind child who is a student regularly attending school.

   h. any other applicable exemptions in 20 CFR 416.1112. 20 CFR 416.1112 is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

8.100.5.M. Resource Requirements

1. Consideration of resources: Resources are defined as cash or other assets or any real or personal property that an individual or spouse owns. The resource limit for an individual is $2,000. The resource limits for the QMB, SLMB, and QI programs are $8,180 for a single individual and $13,020 for a married individual living with a spouse and no other dependents. For a married couple, the resource limit is $3,000. If one spouse is institutionalized, refer to Spousal Protection-Treatment of Income and Resources for Institutionalized Spouses. Resources are not counted for the Medicaid Buy-In Program for Working Adults with Disabilities or AwDC.

2. The following resources are exempt in determining eligibility:

8.100.6.O. Medicaid Buy-In Program for Working Adults with Disabilities

1. To be eligible for the Medicaid Buy-In Program for Working Adults with Disabilities:

    a. Applicants must be at least age 16 but less than 65 years of age.

    b. Income must be less than or equal to 450% of FPL after income disregards. See 8.100.5.F for Income Requirements and 8.100.5.H for Income disregards. Only the applicant's income will be considered.

    c. Resources are not counted in determining eligibility.

    d. Individuals must have a disability as defined by Social Security Administration medical listing or a limited disability as determined by a state contractor.

    e. Individuals must be employed. Please see Verification Requirements at 8.100.5.B.1.c.

    f. Individuals will be required to pay monthly premiums on a sliding scale based on income.

        1. The amount of premiums cannot exceed 7.5% of the individual's income.

        2. Premiums are waived for the first month of eligibility and any retroactive period.

        3. Premium amounts are as follows:

            a. There is no monthly premium for individuals with income at or below 40% FPL.

            b. A monthly premium of $25 is applied to individuals with income above 40% of FPL but at or below 133% of FPL.

            c. A monthly premium of $100 is applied to individuals with income above 133% of FPL but at or below 200% of FPL.

            d. A monthly premium of $225 is applied to individuals with income above 200% of FPL but at or below 300% of FPL.

            e. A monthly premium of $400 is applied to individuals with income above 300% of FPL but at or below 450% of FPL.

        4. The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by $10 or more.

        5. A change in client net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Medicaid Managed Care Program, Section 8.205
Rule Number:	MSB 11-09-27-A
Division / Contact / Phone:	Medicaid & CHP+ Managed Care and Contracts Division / Jerry Smallwood / 5947

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 11-09-27-A, Medicaid Managed Care Program, Section 8.205
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) 8.205, 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). <Select One>

PUBLICATION INSTRUCTIONS*

Please delete all text indicated and insert all new text provided from §8.205.1.A through §8.205.4.J. All other text if for clarification purposes only. This change is effective 03/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Medicaid Managed Care Program, Section 8.205
Rule Number:	MSB 11-09-27-A
Division / Contact / Phone:	Medicaid & CHP+ Managed Care and Contracts Division / Jerry Smallwood / 5947

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 changes to the Medicaid Managed Care Program rule (1) modify the language so it covers Primary Care Case Management programs, including the Accountable Care Collaborative program; (2) gives the Department authority to mandatorily enroll clients in the Adults without Dependent Children eligibility category into the Accountable Care Collaborative program; and (3) removes the provision that clients may be charged for services if they do not get a required referral.

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:

   42 CFR 438 (2010)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-5-401 through 25.5-5-414, C.R.S. (2010)

Initial Review	**12/09/2011**	Final Adoption	**01/13/2012**
Proposed Effective Date	**03/01/2012**	Emergency Adoption	

DOCUMENT # 09

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Medicaid Managed Care Program, Section 8.205
Rule Number:	MSB 11-09-27-A
Division / Contact / Phone:	Medicaid & CHP+ Managed Care and Contracts Division / Jerry Smallwood / 5947

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 rule affects any client in the Accountable Care Collaborative (ACC) program, especially the Adults without Dependent Children eligibility group. It also affects the primary care case managers for the ACC program: the Regional Care Collaborative Organizations and the Primary Care Medical Providers.

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 require clients in the Adult without Dependent Children eligibility category to enroll in the ACC program to receive their Medicaid benefits.

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 costs for the ACC program (the Department's newest PCCM program) in the short-term, but the program is anticipated to generate budget savings in the long term. These costs and savings were presented to the Joint Budget Committee in the FY2009-10 and FY2010-11 budget change requests. There is a cost of approximately $20 per-member-per-month for clients in the ACC program, including those in the Adults without Dependent Children eligibility category. For these Adults without Dependent Children clients, the savings associated with managing their care is approximately $34 per member per month.

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

   The benefits of rule implementation outweigh the costs. In addition, clients will likely have better health outcomes if there is care coordination and management through the ACC program.

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

   Because these programs build on existing infrastructure, such as fee-for-service regular Medicaid, there is no less intrusive or costly method for achieving the purpose 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.

   The Department considered having a leaner benefit package for Adults without Dependent Children in order to save costs. However, stakeholders were concerned about access to needed services, and the costs and logistics of implementing a new benefit package were prohibitive. The proposed method uses existing infrastructure to provide care to this newly eligible population.

8.205 MEDICAID MANAGED CARE PROGRAM

8.205.1 CLIENT ELIGIBILITY

8.205.1.A. A Medicaid client may choose to enroll in ~~the~~ any Medicaid Managed Care Program ~~in the Primary Care Physician Program or with a Managed Care Organization~~for which the client meets the eligibility criteria.

1. For the purposes of this rule, Medicaid Managed Care Programs include any Managed Care Organization (MCO), Primary Care Case Management program (PCCM), or any Prepaid Inpatient Health Plan (PIHP) that is not a part of the Community Mental Health Services Program.

2. Rules for the Community Mental Health Services program PIHPs are located in Section 8.212 of these rules, "Community Mental Health Services."

8.205.1.B. A Medicaid client who receives limited benefits and is not otherwise eligible for Medicaid, ~~shall~~ is not ~~be~~ eligible to receive services through a Medicaid Managed Care ~~Organization~~Program.

~~8.205.1.C. In order to be eligible to be enrolled with a Managed Care Organization, a Medicaid client must live within the service area covered by the Managed Care Organization.~~

8.205.2 CLIENT RESPONSIBILITIES

8.205.2.A. ~~By choosing to enroll in the Primary Care Physician Program, a~~A client in a PCCM program agrees to comply with the following responsibilities:

1. Select a primary care ~~physician~~ provider from those ~~physicians~~ participating in the ~~Primary Care Physician~~PCCM ~~P~~program.

2. Obtain a referral from his/her primary care ~~physician~~ provider for care that requires a referral according to the program guidance, when the care is provided by anyone other than his/her primary care ~~physician~~provider. ~~Referrals are not necessary for family planning services and emergency services as defined at 42 CFR 438.114.~~

3. Request any change of primary care ~~physician~~ provider from the Department or its designee.

~~4. Pay for any health care provided, except for family planning services and emergency services as defined at 42 CFR 438.114, when health care services are sought and received without a referral from his/her primary care physician.~~

~~5~~4. Pay for any services received which are not Medicaid covered services.

~~6~~5. Notify the primary care ~~physician~~ provider of any third party insurance, including Medicare.

8.205.2.B. A client in an ~~By choosing to enroll with a Managed Care Organization~~MCO or PIHP~~, a client~~ agrees to comply with the following responsibilities:

1. Select a primary care ~~physician~~provider from those ~~physician~~providers available in the ~~Managed Care. Organization~~MCO or PIHP.

2. Follow all requirements of the Medicaid managed care program as described in the Member Handbook ~~of the Managed Care Organization~~for the MCO or PIHP.

3. Obtain a referral from his/her primary care ~~physician~~provider for specialty care as required by the MCO or PIHP.

4. Follow ~~the Managed Care Organization's~~MCO's or PIHP's procedures for complaints and grievances.

5. Request any change of primary care ~~physician~~ provider from the ~~Managed Care Organization~~MCO or PIHP.

~~6. Pay for any health care provided, except for emergency services as defined at 42 CFR 438.114, when health care services are sought and received without a referral from his/her primary care physician in the Managed Care Organization. This shall not apply where the health care services is a Medicaid covered service that is not covered by the Managed Care Organization.~~

~~7~~6. Pay for any services received which are not Medicaid covered services.

~~8~~7. Notify the Managed Care Organization of any third party insurance, including Medicare.

8.205.3 CLIENT RIGHTS AND PROTECTIONS

8.205.3.A. A client ~~who chooses to~~ enrolled in ~~the~~ a ~~Primary Care Physician Program or with a Managed Care Organization shall~~PCCM, MCO, or PIHP ha~~s~~ve the following rights and protections:

1. To be treated with respect and with due consideration for his/her dignity and privacy.

2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

3. To participate in decisions regarding his/her health care, including the right to refuse treatment and the right to a second opinion.

4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

5. To obtain family planning services directly from any provider duly licensed or certified to provide such services without regard to enrollment in ~~the Primary Care Physician Program or in a Managed Care Organization~~a PCCM, MCO, or PIHP, without referral.

6. To request and receive a copy of his/her medical records and to request that they be amended or corrected, as specified in 45. CFR Part 164.

7. To exercise his/her rights without any adverse effect on the way he/she is treated.

8.205.4 CLIENT ENROLLMENT AND DISENROLLMENT

8.205.4.A. Enrollment in ~~the managed care program~~a PCCM, MCO, or PIHP is ~~shall be~~ voluntary, except for the following:~~.~~

1. Clients in the Adults without Dependent Children eligibility category are mandatorily enrolled into the Accountable Care Collaborative program.

8.205.4.B. Members who are disenrolled from a ~~managed care provider~~PCCM, MCO, or PIHP for a period of two (2) months or less due to loss of eligibility shall be reenrolled ~~with the same~~

~~managed care provider~~into the same program upon regaining eligibility within the two (2) month period.

8.205.4.C. A client who is enrolled~~s~~ with a ~~managed care provider~~PCCM, MCO, or PIHP ~~shall~~ remains assigned to ~~the managed care provider~~ that PCCM, MCO, or PIHP for a period of twelve (12) months except as otherwise provided in these rules.

8.205.4.D. A client who is not subject to mandatory enrollment may request disenrollment from their ~~managed care provider~~PCCM, MCO, or PIHP without cause during the ninety (90) days following the date of their initial enrollment or the date the Department or its designee sends the notice of enrollment, whichever is later.

8.205.4.E. A client who is not subject to mandatory enrollment may request disenrollment without cause at least every twelve (12) months after the date of initial enrollment with a ~~managed care provider~~PCCM, MCO, or PIHP.

1. A client who is not subject to mandatory enrollment may request disenrollment within 30 days of ~~upon~~ automatic enrollment into a PCC, MCO, or PIHP if the ~~temporary loss of eligibility~~client was ineligible ~~has caused the client to miss~~during the annual disenrollment opportunity and was automatically enrolled after becoming eligible for Medicaid again.

8.205.4.F. A client may request disenrollment when the Department imposes intermediate sanctions as set forth in the Department's contract with the ~~managed care provider~~PCCM, MCO, or PIHP.

8.205.4.G. A client who is not subject to mandatory enrollment may request disenrollment for cause at any time. Cause shall be defined as any of the following:

1. The client moves out of the ~~managed care provider's~~PCCM, MCO, or PIHP service area.

2. The ~~managed care provider~~plan or program does not, because of moral or religious objections, cover the service the client needs.

3. The client needs related services ~~(for example, a caesarian section and a tubal ligation)~~ to be performed at the same time and~~;~~ not all related services are available within the plan or program network~~,~~; and the client's ~~primary care provider or another~~ provider determines that receiving the services separately would subject the client to unnecessary risk.

4. ~~Administrative error on the part of t~~The Department or its designee~~, the Managed Care Organization or the Primary Care Physician including, but not limited to, system error~~ unintentionally enrolls a client into the wrong plan.

5. Poor quality of care, as documented by the Department.

6. Lack of access to covered services, as documented by the Department.

7. Lack of access to providers experienced in dealing with the client's health care needs, as documented by the Department.

8. The client ‘s primary care provider leaves the PCCM, MCO, or PIHP~~enrolled in a Managed Care Organization with his/her physician and the physician leaves the Managed Care Organization~~.

9. Other reasons satisfactory to the Department.

8.205.4.H A client who is subject to mandatory enrollment may request to be exempt from enrollment, or request to be disenrolled ~~in~~from the program if:

1. The client does not have access to a primary care ~~physician~~provider contracted with the program.

2. There is poor quality of care, as documented by the Department, and there is no access to another primary care ~~physician~~provider contracted with the program.

3. The client and the program have been unable to develop a healthy working relationship and continued best clinical interest of the client.

4. The Department, at its discretion, decides that ~~I~~it would meet the considerations of equity to do so~~, the Department may in its discretion allow disenrollment from the ACC~~.

8.205.4.~~H~~I. For clients who are unable to make decisions for themselves, a family member, legal guardian or designated advocate shall be included in all decision-making concerning enrollment and disenrollment of the client.

8.205.4.~~I~~J. Primary care ~~physicians~~ providers participating in ~~the programa~~ PCCM, MCO, or PIHP may dismiss an enrolled client from their practice for cause at any time. The primary care ~~physician~~ provider shall give no less than 45 days notice to both the Department and the client Cause shall be defined as any of the following:

1. The client misses multiple scheduled appointments.

2. The client fails to follow the recommended treatment plan or medical instructions.

3. The primary care ~~physician~~ provider cannot provide the level of care necessary to meet the client's needs.

4. The client and /or client's family is abusive to provider and/or staff in compliance with 42 CFR 438.56(a)(2).

5. The ~~physician~~ provider moves out of the service area.

6. Other reasons satisfactory to the Department.

8.205.5 ESSENTIAL COMMUNITY PROVIDERS

8.205.5.A In order to be eligible for designation as an Essential Community Provider, the following health care providers shall be determined to have historically served medically needy or medically indigent patients and demonstrated a commitment to serve low-income and medically indigent populations who make up a significant portion of their patient population or, in the case of a sole community provider, serve the medically indigent patients within their medical capability:

1. Disproportionate share hospitals.

2. Local county and district health departments, county nursing services and regional health department operating pursuant to Title 25, C.R.S., as amended.

3. Federally Qualified Health Centers (FQHCs).

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities
Rule Number:	MSB 11-11-21-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles / 303-866-2830

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: Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, 8.765.4.A.5,
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) 8.765.4.A.5, 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). <Select One>

PUBLICATION INSTRUCTIONS*

Please remove text indicated at

Please delete text at the very end of the sentence in §8.765.4.A.5. All other text is for clarification purposes only. This change is effective 03/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities
Rule Number:	MSB 11-11-21-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles / 303-866-2830

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 change eliminates the requirement for a Department of Human Services Trails system level C determination to be eligible for placement into a Psychiatric Residential Treatment Facility (PRTF).

As of January 1, 2012, a thorough medical necessity evaluation known as a Colorado Client Assessment Record (CCAR) will be done once a client has been enrolled into a PRTF. This information will be housed in a Division of Behavioral Health (DBH) system instead of the Trails system, and does not use a "levels" system. Therefore, this requirement is no longer relevant.

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:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);

Initial Review — Final Adoption **01/13/2012**

Proposed Effective Date **03/01/2012** — Emergency Adoption

DOCUMENT # 10

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities
Rule Number:	MSB 11-11-21-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles / 303-866-2830

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 classes of persons who will be affected by this proposed revision of section 8.765.4.A.5, include the Department of Health Care Policy and Financing, the Department of Human Services, the Division of Behavioral Health, PRTFs, and clients who require PRTF services but are not able to be placed into a PRFT because of the unnecessary level C requirement.

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 probable quantitative and qualitative impact of not revising this section, as previously stated would be that it would make it impossible for any placements into PRTFs. For the preservation of public health, safety, and welfare of both the children that require the level of services attained at a PRTF and for the safety and interest of the general public, this section needs to be revised to remove the level C requirement for placement.

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.

   We do not anticipate that this proposed rule change will increase the utilization or costs to the Department or to any agency associated with this rule change. Nor do we anticipate that this rule change will affect state revenues.

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

   The probable cost of not revising section 8.765.4.A.5 as previously stated would be that it would make it impossible for any placement into a PRTF, which would be a detriment to clients who require the level of services offered at a PRTF.

   Te probable benefit of revising this section, would be that clients who require the level of services offered at a PRTF would still be able to be placed into the PRTF facility to receive these services.

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

We see the process of revising this section as the least costly and least intrusive method for ensuring that clients who require the level of services offered at a PRTF may still be placed into a PRTF to receive these services.

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.

   We do not foresee any alternative methods for achieving the purpose.

8.765.4 PRTF CLIENT ELIGIBILITY [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.4.A. To receive benefits in a PRTF, the client shall:

1. Be between the ages of three and twenty-one.

2. Be certified to need PRTF level of care by an Independent Team. The Team shall certify that:

   a. Ambulatory care resources available in the community do not meet the treatment needs of the client.

   b. Proper treatment of the client's mental illness condition requires services on an inpatient basis under the direction of a physician.

   c. The services can reasonably be expected to improve the client's mental health or prevent further regression so that the services shall no longer be needed.

3. Be certified to have a diagnosis of a psychiatric disorder classified as a Diagnostic Statistical Manual (DSM) IV Text Revision, Fourth Edition, diagnosis that is the primary reason for placement from one of the following diagnostic categories:

   295 Schizophrenic disorders

   296 Affective psychoses

   297 Paranoid states

   298 Other nonorganic psychoses

   300 Neurotic disorders

   301 Personality disorders

   307 Eating Disorders, Tic Disorders and Sleep Disorders

   308 Acute reaction to stress

   309 Adjustment reaction

   311 Depressive disorder, not elsewhere classified

   312 Disturbance of conduct, not elsewhere classified

   313 Disturbance of emotions specific to childhood and adolescence

   314 Hyperkinetic syndrome of childhood

4. Be certified to have a DSM Axis 5 GAF score of 40 or less.

5. Be assessed using a current valid Colorado Client Assessment Record (CCAR) that supports medical necessity. ~~and scores at a level C.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Pharmacy Rule for Determining Reimbursement Rates of Pharmaceuticals, Section 8.800
Rule Number:	MSB 11-11-04-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 11-11-04-A, Revision to the Pharmacy Rule for Determining Reimbursement Rates of Pharmaceuticals, Section 8.800
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)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text from the first unnumbered paragraph after §8.800.13 through §8.800.13.P.6 and replace with the new text provided. This rule is effective 03/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Pharmacy Rule for Determining Reimbursement Rates of Pharmaceuticals, Section 8.800
Rule Number:	MSB 11-11-04-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).

   The proposal is to continue the rule that is currently in place for pharmaceutical reimbursement.

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:

4. State Authority for the Rule:

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

Initial Review — Final Adoption **01/13/2012**

Proposed Effective Date **03/01/2012** — Emergency Adoption

DOCUMENT # 11

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Pharmacy Rule for Determining Reimbursement Rates of Pharmaceuticals, Section 8.800
Rule Number:	MSB 11-11-04-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 for fee-for-service outpatient drugs 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.

   Passage of the proposed rule allows the state to continue to work toward a rule that meets CMS approval. The Department will continue to work with stakeholders through this process.

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.

   The benefit to the proposed rule is that there will be a rule regarding pharmaceutical reimbursement. The cost of inaction would be that with no rule in place, the Department is at risk for auditing, tracking and hearing issues.

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 loss of AWP information.

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.A~~I~~. 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.~~L~~D. 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.~~O~~G.

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.~~M~~E. The allowed ingredient cost is determined utilizing different methodologies as applicable.

~~1. Effective September 23, 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. L, 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, t~~The allowed ingredient cost will be the lesser of the MAC price as defined in10 C.C.R. 2505-10, Section 8.800.13. ~~L,~~D 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.~~N~~F. The MAC Price List is~~will be~~ posted on the Department's web site (~~-~~www.colorado.gov/hcpf) on a weekly basis. ~~beginning September 23, 2011.~~

8.800.13.~~O~~G. 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 23, 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. L. If no MAC price is available, the allowed ingredient cost will be AWP minus twelve percent (12.0%).~~

~~Effective October 1, 2011, a r~~Rural pharmacies~~y~~ will be reimbursed using the MAC price as defined in 10 C.C.R. 2505-10, Section 8.800.13. ~~L~~E. 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.~~P~~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.