THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Colorado Indigent Care Program (CICP), Sections 8.904.F and 8.907.B
Rule Number:	MSB 13-10-08-A
Division / Contact / Phone:	Financial & Administrative Services Office /Karen Talley/3170

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 13-10-08-A, Revison to the Medical Assistance Rule Concerning the Colorado Indigent Care Program (CICP), Sections 8.904.f.2d., and 8.907.B. a-d
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.f.2d., and 8.907.B. a-d, 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*

Delete current text at §8.904.F.2.d. Replace current text at the unnumbered paragraph immediately following §8.907.B.a; replace current text at the unnumbered paragraph immediately following §8.907.B.b.; remove current text at the unnumbered paragraph immediately following §8.907.B.c and replace current text at the unnumbered paragraph immediately following §8.907.B.d. with the new text provided. All text indicated in blue is for clarification only and should not be changed. This change is effective 03/02/2014.

*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THIS PAGE NOT FOR PUBLICATION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 (CICP), Sections 8.904.F and 8.907.B
Rule Number:	MSB 13-10-08-A
Division / Contact / Phone:	Financial & Administrative Services Office /Karen Talley/3170

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).

Language will be deleted in Section 8.904.F.2.d. of the CICP regulation that allows Adults without Dependent Children who have incomes below 10% of the Federal Poverty Level and are on a waitlist for Medicaid to receive discounted services under CICP. This policy existed because the number of Adults without Dependent Children Medicaid enrollees was limited and there was a waitlist. The waitlist will be eliminated with the expansion of Medicaid for eligible clients with incomes up to 133% of the Federal Poverty Level. Therefore, there is no longer a need to reference it in the CICP rules.

Language will be deleted from Section 8.907.B.a-d. of the CICP regulation which exempts homeless persons from applying for and being denied Medicaid benefits before being eligible for CICP. This policy existed because previously Medicaid did not cover low-income Adults without Dependent Children.

Effective January 2014, under the Affordable Care Act (ACA), Medicaid will be expanded to cover all adults age 19-64 with incomes at or below 133% of the Federal Poverty Level. This rule change will align CICP with changes to Medicaid. This rule change clarifies that low-income adults, including homeless persons, must be denied Medicaid before being eligible for CICP. Changes to sections 8.904F.2d and 8.907.B. a-d are needed to comply with program regulations, which require categorically applicants to apply for Medicaid prior to approval for 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. (2012);
   25.5-3-101, et seq.

Initial Review	**12/13/2013**	Final Adoption	**01/10/2014**
Proposed Effective Date	**03/02/2014**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Colorado Indigent Care Program (CICP), Sections 8.904.F and 8.907.B
Rule Number:	MSB 13-10-08-A
Division / Contact / Phone:	Financial & Administrative Services Office /Karen Talley/3170

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 that will be affected by and benefit from the proposed rule change would include clients that are at or below 133% of the Federal Poverty Level (FPL), because of the additional services covered under Medicaid. CICP providers (hospitals and clinics) will benefit from increased reimbursement through Medicaid.

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 the proposed rule will facilitate greater access to needed medical services for the low income, uninsured or underinsured residents of Colorado. CICP providers will benefit economically from the additional revenue from providing Medicaid services to the Colorado indigent population.

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.

   Available funding to all CICP providers is limited by the available appropriation. There will not be any additional costs to the Department or to any other agency as a result of the implementation and enforcement of the proposed rule change.

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

   The proposed rule will facilitate greater access to needed medical services for the low income, uninsured or underinsured residents of Colorado. CICP providers will benefit economically from the additional revenue from providing Medicaid services to the Colorado indigent population.

   CICP homeless clients with incomes up to 40% of the FPL are not charged copayments for medical services received. However, once enrolled in Medicaid under the Medicaid expansion, these individuals will be responsible for modest copayments under the Medicaid program.

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

   There is not a less intrusive method 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.

   No alternatives were considered. Processes of the Colorado Indigent Care Program must comply with program regulations.

8.904 PROVISIONS APPLICABLE TO CLIENTS

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.

8.907 CLIENT COPAYMENT

B. Z-Rating. These are homeless clients, clients living in transitional housing, clients residing with others, or recipients of Colorado's Aid to the Needy Disabled financial assistance program, who are at or below 40% of the Federal Poverty Level (qualify for an N-Rating). These clients are exempt from client copayments and are rated with the Z-rating. [Eff. 6/30/2008]

a. Homeless. A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law. [Eff. 6/30/2008]

In addition, homeless clients are exempt from client copayments, the income verification requirement, ~~and the verification of denied Medicaid benefits requirement~~ and providing proof of residency when completing the CICP application. [Eff. 6/30/2008]

b. Transitional Housing. Transitional housing is designed to assist individuals in becoming self-supporting, but not referenced in 8.904.E.2. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program. [Eff. 6/30/2008]

In addition, transitional housing clients are exempt from the income verification ~~and verification of denied Medicaid benefits~~ requirement~~s~~ when completing the CICP application. [Eff. 6/30/2008]

c. Residing with Others. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the client are considered residing with others. The individual allowing the client to reside with him or her may be asked to provide a written statement confirming that the client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent. [Eff. 6/30/2008]

~~In addition, clients residing with others are exempt from the verification of denied Medicaid benefits requirement when completing the CICP application. [Eff. 6/30/2008]~~

d. Recipient of Colorado's Aid to the Needy Disabled financial assistance program. A client who is eligible and enrolled to receive the monthly grant award from Colorado's Aid to the Needy Disabled financial assistance program. [Eff. 6/30/2008]

In addition, recipients of Colorado's Aid to the Needy Disabled financial assistance program are exempt from client copayments, and the income verification requirement ~~and the verification of denied Medicaid benefits requirement~~ when completing the CICP application. [Eff. 6/30/2008]

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.2000
Rule Number:	MSB 13-10-18-A
Division / Contact / Phone:	Special Financing / 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 13-10-18-A, Revision to the Medical Assistance Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.2000
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) 8.2000, 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*

At §8.2001 DEFINITIONS:

Add new text beginning “APR-DRG” means all patient . . . immediately following the definition for “Act” and before the definition for “Bad Debt”

Replace definition paragraph beginning “DRG” means diagnosis related group . . . with new text provided

Delete current text at definition paragraph beginning “DRG 801” means the DRG . .

Replace current definition paragraph beginning “Mediciad NICU Day” means a Medicaid Fee-for –Service . . . with new text provided

Add three new definition paragraphs provided immediately following “Medicaore-Medicaid Dual Eligible Day” . . . and immediately before “Non-Managed Care Day” means . . . the three paragraphs begin “Medicare Cost Report” . . .; “MMIS” means . ., and “MIUR” means . . .

Replace definition paragraph beginning “State Teaching Hospital” means . . . with new text provided

Add new definition paragraph provided that begins “Uniform Inpatient and Outpatient Medicaid . . .” immediately following definition paragraph that begins “Uncompensated Charity Care Costs” . . . and immediately before definition paragraph that begins “Uninsured/Self Pay Day” means . . .

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Replace current text at §8.2002.A.1 with new text provided
Add new text provided at §8.2002.A.3
Replace current text at §8.2003.A.3 with new text provided
Replace current text from §8.2003.B.3 through §8.2003.B.3.b with new text provided
Add new text provided at §8.2003.D.2.vi
Delete current text at the unnumbered paragraph immediately following §8.2004.B.2 that begins "The percentage adjustment . . ." and delete the table that follows it
Replace current text at §8.2004.C.3 and the unnumbered paragraph that follows this cite with the new text provided
Replace current text at §8.2004.D.1 with new text provided
Replace current text at §8.2004.D.3 with new text provided
Replace current text from §8.200.4.E.3.i through §8.200.4.E.3.iii with new text provided
Replace current text from §8.2004.F.3.a through §8.2004.F.3.f with new text provided
Replace current text at §8.2004.G.3 with new text provided
Replace current text at §8.2004.I.3 with new text provided
Replace current text at §8.2004.J.2 with new text provided
Replace current text from §8.2004.K.3.a through §8.2004.K.3.c with new text provided
Replace current text at §8.2004.L.3 with new text provided
Replace current text at §8.2004.N.1 with new text provided
Delete current text at §8.2004.N.3.d and replace with new text provided
Add new text provided at §8.2004.N.3.e
Add new text provided at §8.2004.N.6

All text indicated in blue is for clarification purposes only and should not be changed. This rule change is effective 03/02/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.2000
Rule Number:	MSB 13-10-18-A
Division / Contact / Phone:	Special Financing / 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).

   Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers.

   The Colorado Health Care Affordability Act [25.5-4-402.3, C.R.S. (2013)] instructs the Department to charge hospital provider fees and obtain federal Medicaid matching funds. The hospital provider fee is the source of funding for supplemental Medicaid payments to hospitals and payments associated with the Colorado Indigent Care Program (CICP). It is also the source of funding for the expansion of eligibility for Medicaid adults to 133% of the federal poverty level (FPL), the expansion of the Child Health Plan Plus (CHP+) to 250% FPL implemented, the implementation of a Medicaid Buy-In Program for working adults and children with disabilities up to 450% of the FPL, and to fund 12-months continuous eligibility for Medicaid children.

   The proposed rule revisions will allow the Department to collect sufficient fees from hospitals to fund the health coverage expansions and hospital payments to comply with state statute and the Medicaid State Plan agreement with the Centers for Medicare and Medicaid Services. The proposed rule revisions ensure continuing health care coverage for the Medicaid and CHP+ expansions funded by hospital provider fees and access to discounted health care services for CICP clients.

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:

Initial Review	**10/13/2013**	Final Adoption	**01/10/2014**
Proposed Effective Date	**03/02/2014**	Emergency Adoption	

DOCUMENT #10

42 CFR Section 433.68

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2013);
25.5-4-402.3, C.R.S. (2013)

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Hospital Provider Fees Collection and Disbursement, Section 8.2000
Rule Number:	MSB 13-10-18-A
Division / Contact / Phone:	Special Financing / 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.

   Colorado hospitals benefit from increased Medicaid and Colorado Indigent Care Program (CICP) reimbursements made possible through provider fee funding. Low-income persons benefit from the expanded Medicaid and Child Health Plan Plus (CHP+) eligibility.

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

   For FFY 2013-14, hospitals will pay approximately $526.9 million in fees, which will generate nearly $1.4 billion in federal funds to Colorado. Hospitals will receive $899 million in payments and have an estimated net benefit of $209 million. In addition, by September 2014, an estimated 225,000 Coloradans will have health coverage due to expansions of the Medicaid and CHP+ programs.

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

   While there are administrative costs associated with implementation of the Colorado Health Care Affordability Act, all such costs are covered by provider fees collected; no state General Fund is used.

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

   If no action is taken, the Department will not have the ability to fully fund Medicaid and CHP+ expansions, affected over 84,000 currently enrolled persons and up to 250,000 persons by September 2014. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+ and reduce the federal revenue to the state.

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

   The state does not currently have the resources to fund the hospital payments and coverage expansions under the Colorado Health Care Affordability Act. The Department began

collecting fees from hospitals in April 2010, after the rules were established and federal approval was obtained.

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.

   No alternatives were considered. These rules are necessary for the Department to comply with the Colorado Health Care Affordability Act under 25.5-4-402.3, C.R.S.

8.2000: HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3, authorizes the Department of Health Care Policy and Financing (Department) to assess a hospital provider fee, pursuant to rules adopted by the State Medical Services Board, to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program (CICP). In addition, the Act requires the Department to use the hospital provider fee to expand health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without dependent children; to provide a Medicaid buy-in program for people with disabilities; to implement twelve month continuous eligibility for Medicaid eligible children; and to pay the Department's administrative costs of implementing and administering the Act.

8.2001: DEFINITIONS

"Act" means the Colorado Health Care Affordability Act, C.R.S. 25.5-4-402.3.

"APR-DRG" means all patient refined-diagnosis related group.

"Bad Debt" means the unpaid dollar amount for services rendered from a patient or third party payer, for which the hospital expected payment, excluding Medicare bad debt.

"Charity Care" means health care services resulting from a hospital's policy to provide health care services free of charge, or where only partial payments are expected, (not to include contractual allowances for otherwise insured patients) to individuals who meet certain financial criteria. Charity Care does not include any health care services rendered under the CICP or those classified as Bad Debt.

"Charity Care Day" means a day for a recipient of the hospital's Charity Care.

"Charity Care Write-Off Charges" means the hospital's charges for Charity Care less payments from a primary payer, less any copayment due from the client, less any other third party payments

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

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

"CICP Write-Off Charges" means those charges reported to the Department by the hospital in accordance with 10 CCR 2505-10, Section 8.903.C.6.

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

"Cost-to-Charge Ratio" means the sum of the hospital's total ancillary costs and physician costs divided by the sum of the hospital's total ancillary charges and physician charges.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. 1302 Section 1820(c) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"Diagnosis Related Group" or "DRG" means ~~diagnosis-related group,~~ a cluster of similar conditions within a classification system used for hospital reimbursement. It reflects clinically cohesive groupings of inpatient hospitalizations that utilize similar amounts of hospital resources.

~~"DRG 801" means the DRG for neonates weighing less than 1,000 grams.~~

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

"Fund" means the hospital provider cash fund described in C.R.S. 25.5-4-402.3(4).

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

"High Volume Medicaid and CICP Hospital" means a hospital with at least 35,000 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.

"HMO" means a health maintenance organization that provides health care insurance coverage to an individual.

"Hospital-Specific Disproportionate Share Hospital Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. 1302 Section 1102.

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

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

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

"Managed Care Day" means a day listed as HMO or PPO Days on the hospital's patient census.

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

"Medicaid Fee-for-Service Day" means a Non-Managed Care Day for which Medicaid is the primary payer. For these days the hospital is reimbursed directly through the Department's fiscal agent.

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

"Medicaid NICU Day" means a Medicaid Fee-for-Service Day in a hospital's neo-natal intensive care unit, reimbursed under APR-DRG ~~801~~588, 591, 593, 602, 609, 630, or 631~~,~~ up to the average length of stay.

"Medicaid Nursery Day" means a Managed Care Day or Non-Managed Care Day provided to Medicaid newborns while the mother is in the hospital.

"Medicaid Psychiatric Day" means a Managed Care Day or Non-Managed Care Day provided to a Medicaid recipient in the hospital's sub-acute psychiatric unit.

"Medicaid Rehabilitation Day" means a Managed Care Day or Non-Managed Care Day provided to a Medicaid recipient in the hospital's sub-acute rehabilitation unit.

"Medicare Fee-for-Service Day" means a Non-Managed Care Day for which Medicare is the primary payer and the hospital is reimbursed on the basis of a DRG.

"Medicare HMO Day" means a Managed Care Day for which the primary payer is Medicare.

"Medicare-Medicaid Dual Eligible Day" means a day for which the primary payer is Medicare and the secondary payer is Medicaid.

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

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

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

"Non-Managed Care Day" means a day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO or PPO.

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

"Other Payers Day" means a day where the primary payer is not Medicaid or Medicare, which is not a CICP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care Day.

"Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges

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

"Oversight and Advisory Board" means the hospital provider fee oversight and advisory board described in C.R.S. 25.5-4-402.3(6).

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

"PPO" means a preferred provider organization that is a type of managed care health plan.

"Privately-owned Hospital" means a hospital that is privately owned and operated.

"Psychiatric Hospitals" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

"Rehabilitation Hospital" means an inpatient rehabilitation facility.

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

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

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

"Third-Party Medicaid Day" means a day for which third party coverage, other than Medicare, is the primary payer and Medicaid is the secondary payer.

"Uncompensated CICP Costs" means CICP Write-Off Charges multiplied by the most recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment year.

"Uncompensated Charity Care Costs" means Charity Care Write-Off Charges multiplied by the most recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment year.

"Uniform Inpatient and Outpatient Medicaid and Uninsured Care Cost and Charge Report" or "Uniform Cost Report" means the online hospital data reporting system which combines information from hospitals' Medicare Cost Reports, the MMIS, hospital financial statements, and other hospital records.

"Uninsured/Self Pay Day" means a day for self-pay patients and patients without third party health insurance coverage. Uninsured/Self Pay Day does not include Charity Care Days or CICP Days.

"Uninsured/Self Pay Write Off Charges" means charges for self-pay patients and those with no third party coverage less adjustments for a hospital's courtesy or uninsured or self-pay policy discounts.

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

8.2002: Responsibilities of the Department and Hospitals

8.2002.A. Data Reporting

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Department shall distribute a ~~data survey~~Uniform Cost Report to all hospitals ~~by~~ no later than April 30~~March 30~~ of each year. The Department shall include instructions for completing the Uniform Cost Report, including definitions and descriptions of each data element ~~requested in the survey~~to be reported in the Uniform Cost Report. Hospitals shall submit the ~~data survey~~Uniform Cost Report, as requested, to the Department by ~~April~~ May 31~~0~~ of each year. The Department may estimate any ~~survey~~ data element not pro-vided directly by the hospital.

2. Hospitals shall submit the following data elements and any additional elements requested by the Department: (a) Managed Care Days, (b) Non-Managed Care Days, (c) Medicaid Fee-for-Service Days, (c) Medicaid Nursery Days, (e) Medicaid Managed Care Days, (f) Medicaid Psychiatric Days, (g) Medicaid Rehabilitation Days, (h) Medicare Non-Managed Care Days, (i) Medicare HMO Days, (j) CICP Days, (k) Charity Care Days, (l) Uninsured/Self-Pay Days, (m) Other Payers Days, (n) Total days reported on the patient census, (o) Charity Care Write-Off Charges, (p) Bad Debt, (q) Uninsured/Self Pay Write-Off Charges, (r) Medicare-Medicaid Dual Eligible Days, and (s) Third Party Medicaid Days.

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

3. An authorized hospital signatory shall certify that the data included in the Uniform Cost Report are correct, are based on actual hospital records, and that all supporting documentation will be maintained for a minimum of seven years.

8.2002.B. Fee Assessment and Collection

1. Establishment of Electronic Funds Process. The Department shall utilize an Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental payments in financial accounts authorized by hospitals. The Department shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

2. Fee Collection and Payment Disbursement. In state fiscal year (SFY) 2009-10 Outpatient Services Fee and Inpatient Services Fee (collectively referred to as “fee”) will be assessed on an annual basis and collected in four installments on or about, April 16, 2010; April 30, 2010; May 14, 2010 and June 11, 2010.

For those hospitals that participate in the electronic funds process utilized by the Department, payments will be calculated on an annual basis and disbursed in four installments on the same date the fee is assessed.

3. Beginning in SFY 2010-11 the Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve monthly installments. Payments to hospitals will be calculated on an annual basis and disbursed in twelve monthly installments.

    a. For those hospitals that participate in the electronic funds process utilized by the Department , fees will be assessed and payments will be disbursed on the second Friday of the month, except when State offices are closed during the week of the second Friday, then fees will be assessed and payment will be disbursed on the following Friday of the month If the Department must diverge from this schedule due to unforeseen circumstances, the Department shall notify hospitals in writing or by electronic notice as soon as possible.

        i. The Department may assess fees and disburse payments for Urban Center Safety Net Specialty Hospitals on an alternate schedule determined by the Department.

    b. At no time will the Department assess fees or disburse payments prior to the state fiscal year for which they apply.

4. Payments to hospitals shall be processed by the Department within two business days of receipt of a warrant (paper check) or wire transfer to pay the Outpatient Services Fee and Inpatient Services Fee from hospitals that do not participate in the ACH debit process utilized by the Department. Payments through a warrant (paper check) will be processed by the Department within two business days of receipt of the Outpatient Services Fee or Inpatient Services Fee for those hospitals that do not participate in the EFT payment process utilized by the Department to deposit supplemental payments in financial accounts authorized by hospitals.

5. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Department for the collection of fees and the disbursement of payments unless the Department has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Department describing an alternative fee collection process and/or payment process. The Department shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

8.2003: Hospital Provider Fee

8.2003.A. Outpatient Services Fee

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

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

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.~~983~~5473% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.2003.B. Inpatient Services Fee

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

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

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $~~82.44~~71.34 per day for Managed Care Days and $~~368.45~~318.83 per day for all other Days as reported to the Department by each hospital by April 30 with the following exceptions:

    a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $~~43.04~~37.24 per day for Managed Care Days and $~~192.37~~166.46 per day for all other Days.

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~32.98~~28.53 per day for Managed Care Days and $~~147.38~~127.53 per day for all other Days.

8.2003.C. Assessment of Fee

1. The Department shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Oversight and Advisory Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Department shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed.

2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Department will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2003.D. Refund of Excess Fees

1. If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Department shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Department shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.2002.B.

2. After the close of each State fiscal year and no later than the following August 31, the Department shall present a summary of fees collected, expenditures made or encumbered, and interest earned in the Fund during the State fiscal year to the Oversight and Advisory Board.

a. If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Department has not expended or encumbered those fees at the close of each State fiscal year:

i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less four percent of the estimated expenditures for health coverage expansions authorized by the Act for the subsequent State fiscal year as most recently published by the Department.

ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the State fiscal year.

iii. The Department shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.2002.B.

iv. For State fiscal year ending June 30, 2011 only, the Department shall not refund unencumbered and unexpended fees for which the intended expenditure had received approval for federal Medicaid matching funds by CMS. Unencumbered and unexpended fees in the Fund shall remain in the Fund to be used for allowable expenditures in State fiscal year 2011-12.

v. For State fiscal year ending June 30, 2012 only, the Department shall not refund unencumbered and unexpended fees for which the intended expenditure had received approval for federal Medicaid matching funds by CMS. Unencumbered and unexpended fees in the Fund shall remain in the Fund to be used for allowable expenditures in State fiscal year 2012-13.

vi. For State fiscal year ending June 30, 2013 only, the Department shall not refund unencumbered and unexpended fees for which the intended expenditure had received approval for federal Medicaid matching funds by CMS. Unencumbered and unexpended fees in the Fund shall remain in the Fund to be used for allowable expenditures in State fiscal year 2013-14.

8.2004: Supplemental Medicaid and Disproportionate Share Hospital Payments

8.2004.A. Conditions applicable to all supplemental payments

1. All supplemental payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Department.

2. No hospital shall receive a payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the CICP Disproportionate Share Hospital payment or the Uninsured Disproportionate Share Hospital payment exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, that hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction for the CICP Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated CICP Costs, relative to the aggregate of Uncompensated CICP Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate

Share Hospital Limit. The amount of the retroactive reduction for the Uninsured Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated Charity Care Costs relative to the aggregate of Uncompensated Charity Care Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit.

3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2004.B. Outpatient Hospital Supplemental Medicaid Payment

1. Qualified hospitals. Licensed or certified as a General Hospital by the Colorado Department of Public Health and Environment and provides outpatient hospital services to Medicaid clients.

2. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado Medicaid Management Information System (MMIS) are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient Hospital Payment Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. The percentage adjustment factor may vary for state-owned, non-state government owned, and private hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

~~The percentage adjustment factors for each qualified hospital are:~~

~~Provider Name~~	~~FFY 11-12 OP Percentage Adjustment Factor~~	~~FFY 12-13 OP Percentage Adjustment Factor~~
~~Animas Surgical Hospital~~	~~141.39%~~	~~155.18%~~
~~Arkansas Valley Regional Medical Center~~	~~31.55%~~	~~31.67%~~
~~Aspen Valley Hospital~~	~~57.45%~~	~~63.94%~~
~~Boulder Community Hospital~~	~~48.60%~~	~~63.92%~~
~~Centura Health - Avista Adventist Hospital~~	~~38.57%~~	~~44.33%~~
~~Centura Health - Littleton Adventist Hospital~~	~~25.76%~~	~~25.66%~~
~~Centura Health - Mercy Regional Medical Center~~	~~48.91%~~	~~50.85%~~
~~Centura Health - Parker Adventist Hospital~~	~~55.89%~~	~~46.20%~~
~~Centura Health - Penrose -St. Francis Health Services~~	~~27.22%~~	~~24.88%~~

~~Centura Health - Porter Adventist Hospital~~	~~44.95%~~	~~44.50%~~
~~Centura Health - Saint Anthony Central Hospital~~	~~5.65%~~	~~5.68%~~
~~Centura Health - Saint Anthony North Hospital~~	~~35.57%~~	~~44.22%~~
~~Centura Health - Saint Anthony Summit Hospital~~	~~57.59%~~	~~61.01%~~
~~Centura Health - St. Mary-Corwin Medical Center~~	~~52.83%~~	~~64.10%~~
~~Centura Health - St. Thomas More Hospital~~	~~96.34%~~	~~117.04%~~
~~Children's Hospital Colorado~~	~~25.61%~~	~~28.20%~~
~~Colorado Plains Medical Center~~	~~9.46%~~	~~8.96%~~
~~Community Hospital~~	~~33.81%~~	~~45.53%~~
~~Conejos County Hospital~~	~~216.33%~~	~~193.27%~~
~~Craig Hospital~~	~~196.20%~~	~~339.46%~~
~~Delta County Memorial Hospital~~	~~99.65%~~	~~147.11%~~
~~Denver Health Medical Center~~	~~18.32%~~	~~21.59%~~
~~East Morgan County Hospital~~	~~68.40%~~	~~65.95%~~
~~Estes Park Medical Center~~	~~12.28%~~	~~11.94%~~
~~Exempla Good Samaritan Medical Center~~	~~49.39%~~	~~54.62%~~
~~Exempla Lutheran Medical Center~~	~~17.55%~~	~~17.95%~~
~~Exempla Saint Joseph Hospital~~	~~39.43%~~	~~44.77%~~
~~Family Health West Hospital~~	~~139.02%~~	~~154.85%~~
~~Grand River Medical Center~~	~~41.05%~~	~~38.63%~~
~~Gunnison Valley Hospital~~	~~9.34%~~	~~9.63%~~
~~Haxtun Hospital~~	~~57.35%~~	~~74.61%~~
~~HealthOne Medical Center of Aurora~~	~~29.10%~~	~~39.96%~~
~~HealthOne North Suburban Medical Center~~	~~23.02%~~	~~32.52%~~

~~HealthOne Presbyterian/St. Luke's Medical Center~~	~~8.94%~~	~~7.61%~~
~~HealthOne Rose Medical Center~~	~~49.52%~~	~~60.85%~~
~~HealthOne Sky Ridge Medical Center~~	~~69.35%~~	~~74.97%~~
~~HealthOne Spalding Rehabilitation Hospital~~	~~5.91%~~	~~42.97%~~
~~HealthOne Swedish Medical Center~~	~~30.44%~~	~~35.94%~~
~~HealthSouth Rehabilitation Hospital~~	~~208.96%~~	~~298.04%~~
~~Heart of the Rockies Regional Medical Center~~	~~27.56%~~	~~22.85%~~
~~Keefe Memorial Hospital~~	~~102.55%~~	~~89.19%~~
~~Kit Carson County Memorial Hospital~~	~~51.56%~~	~~62.07%~~
~~Kremmling Memorial Hospital~~	~~36.14%~~	~~32.08%~~
~~Lincoln Community Hospital and Nursing Home~~	~~152.37%~~	~~165.25%~~
~~Longmont United Hospital~~	~~6.44%~~	~~7.44%~~
~~McKee Medical Center~~	~~46.96%~~	~~59.20%~~
~~Medical Center of the Rockies~~	~~19.82%~~	~~17.88%~~
~~Melissa Memorial Hospital~~	~~268.09%~~	~~384.80%~~
~~Memorial Hospital~~	~~33.00%~~	~~36.37%~~
~~Montrose Memorial Hospital~~	~~13.77%~~	~~16.03%~~
~~Mount San Rafael Hospital~~	~~50.09%~~	~~44.48%~~
~~National Jewish Health~~	~~75.49%~~	~~90.04%~~
~~North Colorado Medical Center~~	~~14.57%~~	~~17.23%~~
~~Northern Colorado Rehabilitation Hospital~~	~~143.06%~~	~~465.18%~~
~~Pagosa Mountain Hospital~~	~~140.61%~~	~~100.56%~~
~~Parkview Medical Center~~	~~24.75%~~	~~24.11%~~
~~Pikes Peak Regional Hospital~~	~~138.50%~~	~~124.31%~~

~~Pioneers Hospital~~	~~124.87%~~	~~144.40%~~
~~Platte Valley Medical Center~~	~~29.63%~~	~~34.86%~~
~~Poudre Valley Hospital~~	~~21.94%~~	~~23.03%~~
~~Prowers Medical Center~~	~~51.40%~~	~~61.56%~~
~~Rangely District Hospital~~	~~36.71%~~	~~55.81%~~
~~Rio Grande Hospital~~	~~206.37%~~	~~219.71%~~
~~San Luis Valley Regional Medical Center~~	~~15.13%~~	~~16.55%~~
~~Sedgwick County Memorial Hospital~~	~~111.09%~~	~~111.81%~~
~~Southeast Colorado Hospital~~	~~176.46%~~	~~198.63%~~
~~Southwest Memorial Hospital~~	~~31.94%~~	~~35.67%~~
~~Spanish Peaks Regional Health Center~~	~~66.00%~~	~~88.70%~~
~~St. Mary's Hospital and Medical Center~~	~~15.14%~~	~~25.33%~~
~~St. Vincent General Hospital District~~	~~41.86%~~	~~50.76%~~
~~Sterling Regional MedCenter~~	~~29.81%~~	~~35.22%~~
~~The Memorial Hosptial~~	~~31.28%~~	~~30.30%~~
~~University of Colorado Hospital~~	~~32.77%~~	~~36.66%~~
~~Vail Valley Medical Center~~	~~59.79%~~	~~50.58%~~
~~Valley View Hospital~~	~~9.46%~~	~~13.10%~~
~~Vibra Long Term Acute Care Hospital~~	~~2358.41%~~	~~0.00%~~
~~Weisbrod Memorial County Hospital~~	~~243.12%~~	~~234.54%~~
~~Wray Community District Hospital~~	~~76.53%~~	~~68.58%~~
~~Yampa Valley Medical Center~~	~~12.57%~~	~~13.49%~~
~~Yuma District Hospital~~	~~74.84%~~	~~71.76%~~

8.2004.C. CICP Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

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

3. Calculation methodology for payment. There will be three categories for qualified hospitals: State-Owned Government Hospitals, Non-State-Owned Government Hospitals, and Private-Owned Hospitals. State-Owned Government Hospitals shall receive ~~20.47~~19.67% of the State's annual Disproportionate Share Hospital Allotment, Non-State-Owned Government Hospitals shall receive ~~32.28~~49.18% and Private-Owned Hospitals shall receive 2~~5.98~~9.51%.

   A qualified hospital's annual payment shall equal its share of the percent of Uncompensated CICP Costs of all qualified hospitals in the category divided by the State's annual Disproportionate Share Hospital allotment allocated to the category, except that no hospital shall receive a payment which exceeds its estimated Hospital-Specific Disproportionate Share Hospital Limit.

8.2004.D. Uninsured Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and that report charges for services provided to low-income uninsured persons to the Department in a manner as prescribed by the Department shall receive this payment.

2. Excluded hospitals. Hospitals that participate in the CICP, Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. ~~Twenty-one and twenty eight hundredths percent (21.28%)~~Three million dollars ($3,000,000) of the State's annual Disproportionate Share Hospital allotment shall be allocated to the Uninsured Disproportionate Share Hospital Payment. A qualified hospital's annual payment shall equal its share of the percent of Uncompensated Charity Care Costs of all qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital Payment, except that no hospital shall receive a payment which exceeds its estimated Hospital-Specific Disproportionate Share Hospital Limit.

8.2004.E. CICP Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals and hospitals that do not participate in the CICP shall not receive this payment.

3. Calculation methodology for payment.

   a. Qualified hospitals shall receive an annual payment, such that, when combined with the CICP Disproportionate Share Hospital Payment, shall total to a percentage of Weighted Uncompensated CICP Costs. The percentage applied to Weighted Uncompensated CICP Costs shall be:

      i. Fifty~~-three~~ percent (5~~3~~0.0%) for High Volume Medicaid and CICP Hospitals,

      ii. Seventy-five percent (7~~0~~5%) for Rural and Critical Access Hospitals, or

      iii. Fifty~~-four~~ percent (50~~4~~%) for all other qualified hospitals.

4. Calculation methodology for weighting CICP uncompensated costs

a. Hospitals can qualify for up to two increases to weight their inflated CICP costs. Weighted CICP costs are calculated separately for hospitals within a Rural Area and hospitals not within a Rural Area. Qualifying for, and weighting inflated CICP costs are determined and calculated as follows:

i. CICP Cost as a percentage of total cost

a. Hospitals not within a Rural Area whose CICP costs as a percentage of total costs is greater than the mean plus one standard deviation percentage for all hospitals not within a Rural Area will have their inflated CICP costs increased by 2% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

b. Hospitals within a Rural Area whose CICP costs as a percentage of total costs is greater than the mean plus one standard deviation percentage for all hospitals within a Rural Area will have their inflated CICP costs increased by 2% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

ii. Medicaid and CICP Days as a percentage of total days

a. Hospitals not within a Rural Area whose combined Medicaid and CICP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all hospitals not within a Rural Area will have their inflated CICP costs increased by 5% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

b. Hospitals within a Rural Area whose combined Medicaid and CICP Days as a percentage of Total Days is greater than the mean plus one standard deviation percentage for all hospitals within a Rural Area will have their inflated CICP costs increased by 5% for the purposes of calculating the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital Payment.

c. For those facilities that qualify for both CICP Inflated Cost weightings, the inflated CICP cost will be increased by 2% first, and the resulting weighted CICP costs will then be increased by 5%.

8.2004.F. Inpatient Hospital Base Rate Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Long Term Care Hospitals and Critical Access Hospitals with an established Medicaid inpatient base rate shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this annual payment equals the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate with increases as follows:

a. Pediatric Specialty Hospitals shall have a 9.5~~16.0~~% increase.

b. State University Teaching Hospitals shall have a 20~~3~~.0% increase.

c. Long Term Care Hospitals and Rehabilitation Hospitals shall have a 10.0% increase.

d. Hospitals located in Rural Areas ~~and Critical Access Hospitals~~ shall have a 7~~5~~.0% increase.

e. Urban Safety Net Hospitals shall have a ~~15~~36.00% increase.

f. Other General Hospitals and Critical Access Hospitals shall have an 38~~45~~.0% increase.

8.2004.G. High Level Neo-natal Intensive Care Unit (NICU) Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals certified level IIIb or IIIc neo-natal intensive care unit (NICU) shall receive this payment.

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

3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $2,~~54~~00 per Medicaid NICU Day.

8.2004.H. State Teaching Hospital Supplemental Medicaid Payment

1. Qualified hospitals. State Teaching Hospitals shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $100 per Medicaid Day.

3. Effective October 1, 2012 the State Teaching Hospital Supplemental Medicaid Payment is suspended.

8.2004.I. Acute Care Psychiatric Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals with distinct-part psychiatric units shall receive this payment.

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

3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $~~2~~100 per Medicaid Psychiatric Day.

8.2004.J. Large Rural Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in a Rural Area with 26 or more licensed beds shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $~~750~~525 per Medicaid Day, Qualified hospitals who participate in the CICP, and whose percentage of Medicaid Days plus CICP Days to total days is in the top 25% of all providers will receive an additional $~~100~~50 per Medicaid Day.

8.2004.K. Denver Metro Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County or Douglas County shall receive this payment.

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

3. Calculation methodology for payment.

a. For each qualified hospital located in Adams County or Arapahoe County, this payment is calculated on an annual basis at $~~800~~770 per Medicaid Day. Qualified hospitals who participate in the CICP, and whose percentage of Medicaid Days plus CICP Days to total days is in the top 25% of all providers will receive an additional $~~100~~50 per Medicaid Day.

b. For each qualified hospital located in Denver County, this payment is calculated as $~~865~~755 per Medicaid Day. Qualified hospitals who participate in the CICP, and whose percentage of Medicaid Days plus CICP Days to total days is in the top 25% of all providers will receive an additional $~~100~~50 per Medicaid Day.

c. For each qualified hospital located in Boulder County, Broomfield County, or Jefferson County, this payment is calculated as $~~1075~~ 770 per Medicaid Day. Qualified hospitals who participate in the CICP, and whose percentage of Medicaid Days plus CICP Days to Total Days is in the top 25% of all providers will receive an additional $~~100~~50 per Medicaid Day.

8.2004.L. Metropolitan Statistical Area Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in El Paso County, Larimer County, Mesa County, Pueblo County or Weld County shall receive this payment.

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

3. Calculation methodology for payment. For each qualified hospital this payment is calculated on an annual basis at $~~650~~550 per Medicaid Day.

8.2004.M. Pediatric Specialty Hospital Provider Fee Payment

1. Qualified hospitals. Hospitals qualified to receive the Pediatric Major Teaching Hospital Payment in 10 CCR 2505-10 Section 8.903.C.6 shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis and shall equal $1 million.

8.2004.N. Hospital Quality Incentive Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Pediatric Hospitals, Long Term Acute Care Hospitals and Critical Access Hospitals with an established Medicaid inpatient base rate, and that meet the minimum criteria for ~~no less than two~~one or more of the selected measures, may qualify to receive this payment.

2. Excluded hospitals. Psychiatric Hospitals and Out-of-State Hospitals in both bordering and non-bordering states.

3. Measures. The measures for the Hospital Quality Incentive Payment are:

a. Rate of Central Line-Associated Blood Stream Infections (CLABSI)

b. Rate of elective deliveries between 37 and 39 weeks gestation

c. Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT)

d. Rate of thirty (30) day all-cause readmissions

e. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position.

~~Structured efforts to reduce readmissions and improve care transitions~~

4. Calculation methodology for payment. Payments shall be calculated on an annual Federal Fiscal Year (October 1 through September 30) basis and dispensed in monthly installments. For each qualified hospital, this payment will be calculated as follows:

a. Determine Available Points by hospital, subject to a maximum of 10 points per measure

i. Available Points are defined as the number of measures for which a hospital qualifies multiplied by 10

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

c. Normalize the total points earned per measure to total possible points for all measures by hospital

d. Calculate Adjusted Medicaid Discharges by hospital

i. Adjusted Medicaid Discharges are calculated by multiplying the number of Medicaid inpatient discharges by the Adjusted Discharge Factor

ii. The Adjusted Discharge Factor is defined as the most recently available annual total gross Medicaid billed charges divided by the inpatient gross Medicaid billed charges

iii. The Adjusted Discharge Factor shall be no greater than 5

e. Calculate Total Discharge Points

i. Discharge Points are defined as the number of points earned per measure multiplied by the number of Adjusted Medicaid Discharges

f. Calculate the Dollars per Discharge Point

i. Dollars per Discharge Point will be calculated by dividing the total HQIP funds available under the inpatient UPL by the total number of Discharge Points across qualified hospitals

g. Determine HQIP payout by hospital by multiplying the total Discharge Points for that hospital by the Dollars per Discharge Point.

5. The total funds for the Hospital Quality Incentive Payment for the Federal Fiscal Year beginning October 1, 2012 will be $32,000,000.

6. The total funds for the Hospital Quality Incentive Payment for the Federal Fiscal Year beginning October 1, 2013 will be $34,388,388.

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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 13-10-31-B, Revision to the Medical Assistance Eligibility Rule Concerning Continuous Eligibility Section 8.100.4.G
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) 8.100.4.G affected, 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*

Add new text provided at §8.100.4.G.2.a immediately following §8.100.4.G.2 and immediately prior to §8.100.4.G.3. This is the only change to the rule. All text indicated in blue is for context only and should not be changed. This change is effective 03/02/2014.

*to be completed by MSB Board Coordinator

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Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Continuous Eligibility, Section 8.100.4.G
Rule Number:	MSB 13-10-31-B
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 303-866-3558

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 rule changes amend 10 CCR 2505-10, Section 8.100.4.G to grant continuous eligibility for children eligible for Medicaid. This rule will guarantee coverage without interruption for 12 months regardless of change in income or household size. Continuous coverage ensures that children are not suddenly dropped from coverage, therefore preventing harmful disruptions in their healthcare coverage.

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:

   Balanced Budget Act of 1997

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   C.R.S.§ 25.5-5-204.5.

Initial Review	**12/13/2013**	Final Adoption	**01/10/2014**
Proposed Effective Date	**03/02/2014**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Continuous Eligibility, Section 8.100.4.G
Rule Number:	MSB 13-10-31-B
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 303-866-3558

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 will impact new and current children enrolled in Medicaid. The rule will benefit children in Medicaid by providing continuity of care by granting 12 months of continuous eligibility regardless of changes in income and household size.

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

   Children that would have otherwise lost Medicaid eligibility will maintain coverage for a minimum of 12 months; this ensures continuity of care for children which have a positive impact on health outcomes.

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

   The department estimated costs of $3,495,406 total funds in fiscal year 2013-2014, $14,947,224 total funds in fiscal year 2014-2015, and $15,439,914 in fiscal year 2015-2016.

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

   Continuous eligibility is a provision of HB 09-1293 that has yet to be implemented. With additional federal revenue from the implementation of the Affordable Care Act, implementation of this provision of HB 09-1293 is now viable without utilization of state General Fund in fiscal year 2013-2014 and fiscal year 2014-2015. Continuous eligibility ensures continuity of care for children, which is a critical component for ensuring long-term positive health outcomes.

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

   There are no alternative methods for implementing the eligibility change included in HB 09-1293.

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 the proposed rule that were considered.

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance.

    a. Medical Assistance eligibility is guaranteed for 12 continuous months from the application month regardless of changes in income or household size.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 100% of the federal poverty level shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household receiving Medical Assistance.

    a. Effective January 1, 2014, Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance

4. Effective January 1, 2014, Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage must be provided regardless of changes in the woman's financial circumstances.

6. A pregnant legal immigrant who has been a legal immigrant for less than five years is eligible for Medical Assistance if she meets the eligibility requirements for expectant mothers listed in 8.100.4.G.3. This population is referenced as Legal Immigrant Prenatal.

7. A child born to a woman receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This provision also applies in instances when the woman received Medical Assistance to cover the child’s birth through retroactive Medical Assistance. To receive Medical Assistance under this category, the individual need not file an application nor provide a social security number or proof of application for a social security number for the newborn. Anyone can report the birth of the baby verbally or in writing. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time. Once reported, a newborn meeting the above criteria shall be added to the Medical Assistance case according to timelines defined by the Department. Please review the Department User Reference Guide for timeframes. This population is referenced as Eligible Needy Newborn.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Changes Set Forth in the Affordable Care Act to Provide Medical Assistance to Former Foster Care Youth, Section 8.100.4.H
Rule Number:	MSB 13-11-12-A
Division / Contact / Phone:	Eligibility Division / Beverly Hirsekorn / 303-866-6320

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 13-11-12-A, Revision to the Medical Assistance Eligibility Rule Concerning Changes Set Forth in the Affordable Care Act to Provide Medical Assistance to Former Foster Care Youth, Section 8.100.4.H
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) 8.100.4.H, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 1/1/14
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at §8.100.4.H. Needy Persons Under 21 with the new text provided.
Delete current text at §8.100.4.H.1.g.i)
Add new text provided from §8.100.4.H.2 through the end of §8.100.4.H.2.c)
All text indicated in blue is for clarification only and should not be changed.
This change is effective 03/02/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Changes Set Forth in the Affordable Care Act to Provide Medical Assistance to Former Foster Care Youth, Section 8.100.4.H
Rule Number:	MSB 13-11-12-A
Division / Contact / Phone:	Eligibility Division / Beverly Hirsekorn / 303-866-6320

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 rule addresses youth in foster care under the state's or tribes' responsibility and also enrolled in Medicaid under the state's Medicaid State Plan. The proposed rule change amends 10 CCR 2505-10, Section 8.100.4.H to comply with the Affordable Care Act, Public Law 111-148, extending medical assistance to age 26 for former foster care youth that were in Colorado foster care at ages 18,19, 20 or 21 and receiving Medicaid. It intends to continue their Medicaid beyond the age they would leave the foster care system and provide insurance consistent with peers that have families with insurance that typically can continue to provide health insurance until age 26.

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 Patient Protection and Affordable Care Act of 2010, Public Law 111-148, amended Section 1902(a)(10)(A)(i)(IX)(aa)-(dd) of the Social Security Act, 42 U.S.C. 1396a

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review	Final Adoption	**01/10/2014**
Proposed Effective Date	Emergency Adoption	**03/02/2014**

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Changes Set Forth in the Affordable Care Act to Provide Medical Assistance to Former Foster Care Youth, Section 8.100.4.H
Rule Number:	MSB 13-11-12-A
Division / Contact / Phone:	Eligibility Division / Beverly Hirsekorn / 303-866-6320

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 will impact former foster care youth under the age of 26 as of 1/1/2014 and going forward, who were in Colorado foster care at ages 18,19, 20 or 21, and were receiving Medicaid, to be able to receive Medicaid through ages 21 to the end of the month of their 26th birthday.

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 estimated number of clients in FY 2013-14 is 51 for a half year, FY 2014-15 is 554 and FY 2015-16 is 1,116. Former foster care youth are challenged with acute and chronic physical, mental and developmental health issues as a result of maltreatment or neglect. Additionally, they often do not have resources to pay for health insurance, jobs that include health benefits, or families to help support their health requirements once they have aged out of foster care or emancipated. Without this rule, former foster care youth would not have access to medical services.

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

   The Department estimates costs of $438,760 in FY 2013-14 and $3,359,458 in FY 2014-15. Of these amounts, $219,380 and $1,679,729 are General Fund respectively. These costs represent expenditure on physical and mental health services for the newly eligible clients.

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

   There is no alternative action. Extension of eligibility to these clients is required under the Affordable Care Act.

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

   There are no alternative methods for implementing the eligibility change required to be in place by 1/1/14 by the Patient and Affordable Care Act of 2010.

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 the proposed rule that were considered.

8.100.4.H. Needy Persons ~~Under 21~~

1. Medical Assistance shall be provided to certain needy persons under 21 years of age, including the following:

    a. Those receiving care in a Long Term Care Institution eligible for Medical Assistance reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement and whose household income is less than the MAGI needs standard for his/her family size when the client applies for assistance. Clients that are receiving benefits under this category and are still receiving active inpatient treatment in the facility at age 21 shall be eligible to age 22. This population is referenced as Psych < 21.

    b. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. A child shall be the responsibility of the county, even if the child may be in a medical institution at that time. See Colorado Department of Human Services "Social Services Staff Manual" section 7 for specific eligibility requirements (12 CCR § 2509-1). 12 CCR § 2509-1 (2013) is hereby incorporated by reference. The incorporation of 12 CCR § 2509-1 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

    c. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.

    d. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose household income is less than the MAGI needs standard for his/her family size.

    e. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.

    f. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption program, including a clause in the subsidized adoption agreement to provide Medical Assistance for the child.

    g. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments from the State of Colorado pursuant to article 7 of title 26, C.R.S. immediately prior to the date the individual attained 18 years of age or was emancipated. Eligibility shall be extended until the individual's 21st birthday for these individuals with the exception of those receiving subsidized adoption payments.

        ~~i) Eligibility shall be extended until the individual's 26th birthday for individuals receiving subsidized adoption payments.~~

2. Medical Assistance shall be extended to certain needy persons until the end of the month of the individual's 26th birthday, including the following:

~~h~~a. Those ~~I~~individuals that were formerly in foster care under the responsibility of the State or Tribe on their 18th, 19th, 20th or up to their 21st birthday and were receiving Medical Assistance~~, shall have eligibility extended until the end of the month of the individual's 26th birthday~~.

i) This extension does not apply to adopted youth that are receiving subsidized adoption payments or

ii) To youth that are enrolled in mandatory Medical Assistance.

~~i~~b) Former Foster Care youth are not subject to either an income or resource test.

~~ii~~c) ~~A~~ Former Foster Care youth's newborn shall be considered a needy newborn.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Rule Concerning the Removal of Co-Payments for Clients Receiving Preventive Services, Section 8.754.5
Rule Number:	MSB 13-11-29-A
Division / Contact / Phone:	Health Programs Office / Max Salazar / x3289

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 13-11-29-A, Revision to the Medical Assistance Health Programs Rule Concerning the Removal of Co-Payments for Clients Receiving Preventive Services, Section 8.754.5
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) 8.754.5, 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). Yes

PUBLICATION INSTRUCTIONS*

Add new paragraph and text provided at §8.754.5.G that immediately follows §8.754.5.F. All text indicated in blue is for context only and should not be changed. This change is effective 03/02/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Rule Concerning the Removal of Co-Payments for Clients Receiving Preventive Services, Section 8.754.5
Rule Number:	MSB 13-11-29-A
Division / Contact / Phone:	Health Programs Office / Max Salazar / x3289

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 Affordable Care Act (ACA) (42 USC § 1396d(a)(13) (2010)) requires that preventive services be included in the new benefit package made available to all Medicaid expansion clients. The law also requires that the services be provided without a co-pay.

In order to align the benefit packages for expansion and non-expansion Medicaid clients, the Department is adding preventive services to the benefit package for non-expansion Medicaid clients.

To comply with the ACA, the attached rule eliminates cost sharing for all preventive and wellness services for all Medicaid clients.

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 U.S.C. § 1396d(b)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review	**12/13/2013**	Final Adoption	**01/10/2014**
Proposed Effective Date	**03/02/2014**	Emergency Adoption	

DOCUMENT #07

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Programs Rule Concerning the Removal of Co-Payments for Clients Receiving Preventive Services, Section 8.754.5
Rule Number:	MSB 13-11-29-A
Division / Contact / Phone:	Health Programs Office / Max Salazar / x3289

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.

   All current Medicaid clients will be affected by this rule in addition to the providers who render these services. Each class will benefit from this rule change as access to the services will increase and in the long-term, better access to preventive services will increase positive health outcomes.

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 health outcomes of all Medicaid clients will be positively affected in the long-term as access to these services will increase.

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.

   This rule change will be cost neutral. Enhanced federal funding is available for providing these services and it will offset the cost of eliminating co-payments. Additionally, health care costs will likely decrease over time as clients have access to preventive care that helps to avoid acute care needs in the future.

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

   Compliance with this federal regulation is mandatory. Therefore, inaction is not a choice.

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 methods of achieving this goal as it is a federal requirement.

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 this goal as it is a federal requirement.

8.754.5 EXEMPTIONS

The following clients and services are exempt from co-payment requirements:

8.754.5.A. Children under the age of 19.

8.754.5.B. All services to women in the maternity cycle.

1. The maternity cycle means pregnancy, labor, birth and the immediate postpartum period not to exceed six weeks.

2. The client must inform the provider of her pregnancy or postpartum condition at the time of service, and all providers must indicate pregnancy on the claim form in order to claim this exemption.

3. In the case of prescription drugs, the prescribing physician should note pregnancy or postpartum on the prescription.

4. Providers may request oral or written verification of pregnancy or postpartum condition by contacting the physician.

5. If the provider questions the client's statement that she is pregnant or postpartum and the provider is unable to obtain verification of the pregnancy or postpartum condition, then the provider may collect the co-payment amount imposed by this regulation from the recipient.

6. If the recipient feels that she has been wrongly denied an exemption due to an unverified pregnancy or postpartum condition, she has the right of appeal through the recipient appeal process set forth at 10 C.C.R. 2505-10, Section 8.057.

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

8.754.5.D. Family planning services and supplies furnished to clients of child-bearing age. The fiscal agent shall identify the family planning services and supplies exempted on the Medicaid claim form.

8.754.5.E. All emergency services.

1. Emergency services means for all Medicaid clients care for any condition which is life threatening or requires immediate medical intervention.

2. Emergency treatment can be given in the emergency room, the outpatient department, or a physician's office.

3. The attending medical personnel shall define the emergent nature of the recipient's condition.

4. For cases where it is not clear if an emergency exists, a triage of the recipient may be conducted as set forth in 10 C.C.R. 2505-10, Section 8.253.6.

5. There shall be no co-payment charge for the triage.

8.754.5.F. All services provided under the Community Mental Health Services program and Managed Care programs.

8.754.5.G All preventive and ~~wellness~~ vaccine services as required by the Affordable Care Act (42 USC § 1396d(a)(13) (2010)). ~~A list of all preventive and wellness services is available from the Department (http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1197969485906).~~ and described in the United States Preventive Services Task Force (USPSTF) A and B recommendations and the Advisory Committee for Immunization Practices (ACIP) recommended vaccines and their administration which are hereby incorporated by reference. The incorporation of the USPSTF A and B recommendations and the ACIP recommended vaccines excludes later amendments to, or editions of, the referenced material.

The USPSTF A and B recommendations is available from the US Preventive Services Task Force web page at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. The ACIP recommended vaccines is available at the Centers for Disease Control and Prevention webpage at http://www.cdc.gov/vaccines/hcp/acip-recs/. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.