

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Health Programs Office Benefits and Operations
Division Ambulatory Surgery Center (ASC) Rule Concerning
Amount, Scope and Duration of Services, Section 8.570.5

Rule Number: MSB 15-02-11-A

Division / Contact / Phone: HPO B&O / Ana Lucaci / x6163

**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 15-02-11-A, Revision to the Health Programs Office
Benefits and Operations Division Ambulatory Surgery
Center (ASC) Rule Concerning Amount, Scope and
Duration of Services, Section 8.570.5
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) 8.570.5, 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*

Replace current text beginning at §8.570.5.A through §8.570.5.A.7 with the new
text provided beginning at §8.570.5.A through the end of §8.570.5.A.8. This
change is effective 05/30/2015.

Title of Rule: Revision to the Health Programs Office Benefits and Operations
Division Ambulatory Surgery Center (ASC) Rule Concerning
Amount, Scope and Duration of Services, Section 8.570.5

Rule Number: MSB 15-02-11-A

Division / Contact / Phone: HPO B&O / Ana Lucaci / x6163

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The purpose of this update is to clarify language in the Non-Covered Services section to comply with the Department's Benefit Coverage Standard (BCS).

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:

§1905(a) of the Social Security Act, codified at 42 U.S.C. 1396d(a)(2); 42 CFR Section 440.230.

4. State Authority for the Rule:

§§25.5-1-301 through 25.5-1-303, C.R.S. (2014);

Initial Review **03/13/2015**

Final Adoption **04/10/2015**

Proposed Effective Date **05/30/2015**

Emergency Adoption

DOCUMENT #01

Title of Rule: Revision to the Health Programs Office Benefits and Operations
Division Ambulatory Surgery Center (ASC) Rule Concerning
Amount, Scope and Duration of Services, Section 8.570.5

Rule Number: MSB 15-02-11-A

Division / Contact / Phone: HPO B&O / Ana Lucaci / x6163

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.

This rule will impact the Providers of ASC services and Medicaid Clients.

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

Clearly defined and updated rules will improve client access to appropriate, high quality, cost-effective and evidence-based services while improving the health outcomes of Medicaid clients. Established criteria within the rule will provide guidance to clients and providers regarding benefit coverage. Medicaid covered residents will also be better served with clear transparent description of the ASC benefit.

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 does not have any costs to the Department or any other agency as a result of its implementation and enforcement.

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

Clearly defined and updated rules increase client access to appropriate services and allow the Department to administer benefits in compliance with federal and state regulations, as well as clinical best practices and quality standards. Defining this benefit in rule will educate clients about their benefits and provide better guidance to service providers. The cost of inaction could result in decreased access to services, poor quality of care, and/or lack of compliance with state and federal guidance.

All of the above translates into appropriate cost-effective care administered by the state.

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

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There are no less costly methods or less intrusive methods for achieving the purpose of this rule. The department must appropriately define amount, scope and duration of this benefit in order to responsibly manage it.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There are no alternative methods for achieving the purpose of the proposed rule. The Department also documents its benefit coverage policies in written coverage standards. The benefit coverage policies must be written into rule to have the force of law.

8.570.5 NON-COVERED SERVICES

8.570.5.A Non-covered services are those services that:

1. Are not commonly performed in an ASC;
- ~~2.~~ 2. ~~or M~~ay safely be performed in a physician's office;
- ~~3.~~ 3. Generally result in extensive blood loss;
- ~~43.~~ 43. Require major or prolonged invasion of body cavities;
- ~~54.~~ 54. Directly involve major blood vessels; ~~or~~
- ~~65.~~ 65. Are generally emergency or life-threatening in nature; ~~or~~
- ~~76.~~ 76. Pose a significant safety risk to clients or are expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay) when furnished in an ASC; ~~or~~;
- ~~87.~~ 87. Are not listed in the annual ASC billing manual.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1

Rule Number: MSB 14-02-12-A

Division / Contact / Phone: Office of Community Living / Nora Brahe / 303-866-3566

**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 14-02-12-A, Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1
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) Insert Section(s) 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*

Replace current text beginning at §8.553 (COMMUNITY TRANSITION SERVICES) through the end of paragraph 8.553.5.D with the new text provided. All text indicated in blue is for clarity only and should not be changed. This change is effective 05/30/2015.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1

Rule Number: MSB 14-02-12-A

Division / Contact / Phone: Office of Community Living / Nora Brahe / 303-866-3566

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

This rule will revise Community Transition Services (CTS), a benefit of the Home and Community Based Services - Elderly, Blind and Disabled (HCBS-EBD) waiver since 2006. The revision will implement CTS as a demonstration service of the Colorado Choice Transitions (CCT) program. CTS will continue to be a benefit of the HCBS-EBD waiver. The revision will expand eligibility of CTS to individuals with intellectual disabilities, brain injuries and mental illness.

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. (2014);

Initial Review

03/13/2015

Final Adoption

04/10/2015

Proposed Effective Date

05/30/2015

Emergency Adoption

DOCUMENT #02

Title of Rule: Revision to Medical Assistance Long Term Services and Supports Rule Concerning Community Transition Services (CTS), Section 8.553.1

Rule Number: MSB 14-02-12-A

Division / Contact / Phone: Office of Community Living / Nora Brahe / 303-866-3566

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 CTS rule provides guidelines for services to elderly and disabled individuals 18 years and older residing in Medicaid skilled nursing facilities (SNFs) and adults aged 18 and older with intellectual or developmental disabilities residing in intermediate care facilities and SNFs.

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 primary intent of CTS is to assist people residing in nursing homes and other long-term care facilities in Colorado who may have the desire to return to a community based living arrangement. CTS will provide supports and services to facilitate their transition to the community.

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

None.

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

Provision of CTS services supports the successful transition of individuals from costly institutional care to less restrictive and expensive settings where they can receive home and community-based services. This impacts state Olmstead compliance, promotes the Department's strategic goal to transition institutionalized individuals and Colorado Choice Transition (CCT) ability to meet Money Follows the Person (MFP) transition goals.

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 or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

Revisions to the rule are based on input solicited from stakeholders. There were no other alternative methods identified.

8.553 COMMUNITY TRANSITION SERVICES

8.553.1 DEFINITIONS

Authorization Request (AR) -means a request submitted by the Transition Coordination Agency to the Single Entry Point agency to authorize payment for delivery of Community Transition Services.

Case Management means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic assessment of such client's needs.

Case Management Agency means the organization selected to provide case management functions for person in need of long term care services.

Community Transition Services (CTS) means activities essential to move a client from a skilled nursing facility and establish a community-based residence.

Independent Living Core Services means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; and individual and systems advocacy.

Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Case Management.

Transition Coordination Agency (TCA) means an agency that is certified by the Department to provide CTS and provides at least two Independent Living Core Services.

~~Transitional Case Management means case management exclusively supporting a client's transition from a skilled nursing facility to a community-based residence.~~

~~Transition Options Team means a group of individuals, chosen by the client and/or providing services to the client, who participate in the transition assessment and planning process.~~

8.553.2 BENEFITS

8.553.2.A. CTS shall only be available to clients currently residing in a skilled nursing facility or an Intermediate Care Facility-Individuals with Intellectual Disabilities (ICF-IID) who are eligible for adult Home and Community-Based Services ~~for the Elderly, Blind and Disabled (HCBS-EBD)~~ waivers except the Spinal Cord Injury Waiver.

8.553.2.B. CTS includes transition coordination services and funds to assist the client to set-up a household.~~shall only be for the benefit of the client and may include the following:~~

~~1. Transitional Case Management.~~

~~2. Payment made for the following:~~

~~a. Security deposits that are required to obtain a lease on a residence.~~

~~b. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.~~

~~c. Essential household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items.~~

~~d. Moving expenses required to occupy a community-based residence.~~

~~e. Health and safety assurances including a one-time pest eradication and a one-time cleaning prior to occupancy.~~

~~f. A one-time purchase of food not to exceed \$100.~~

8.553.2. C. ~~CTS shall be provided by Transition Coordinators who are employed by Transition Coordination Agencies certified by the Department. The cost of CTS shall not exceed \$2,000 per client unless otherwise authorized by the Department.~~

8.553.2. D. ~~CTS shall be provided using procedures and guidelines provided in the Department transition coordination and intensive case management training. Items purchased through CTS shall be the property of the client. The client may take the property with him or her in the event of a move to another residence.~~

8.553.2. E. The CTS household set-up assistance shall only be for the benefit of the client to set up a less restrictive living arrangement and may include the following:

a1. Security deposits that are required to obtain a lease on a residence.

b2. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.

c3. Essential household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items.

d4. Moving expenses required to occupy a community-based residence.

e5. Health and safety assurances including a one-time pest eradication and one-time cleaning prior to occupancy.

f6. A one-time purchase of food not to exceed \$100.

g7. Purchase of a cell phone to be used for safety monitoring.

h8. First month rent.

i9. Bus pass for period that covers the time period from referral to CTS to 30 days past the date of discharge from a facility described at 10 C.C.R. 2505-10, Section 8.553.2.Aa.

j10. Computer that is determined to be medically necessary to sustain a less restrictive living arrangement. (Client is required to complete computer training prior to receiving computer).

k11. Clothing that is appropriate for the community.

8.553.2. F. The cost of CTS shall not exceed the established amount per client unless otherwise authorized by the Department.

8.55.3.2. G. Items purchased through CTS, returned security deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.a. and returned deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.b. shall be the property of the client. The client may take the property with him or her in the event of a move to another residence.

8.553.3 NON-BENEFITS

8.553.3. A. CTS shall not include the following:

1. Monthly rental expenses or other ongoing periodic residential expenses.
2. Recreation, entertainment or convenience items.

3. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.~~EB-2~~ when already provided through other means.
4. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.~~EB-2~~ when provided for the benefit of persons other than the client.
5. Monthly cell phone expenses.
6. Monthly bus pass expenses not described in 10 C.C.R. 2505-10, Section 8.553.2.E.i.

8.553.4 TCA QUALIFICATIONS

- 8.553.4.A. A TCA shall conform to all certification standards and procedures described in 10 C.C.R. 2505-10, Section 8.487 for HCBS-EBD Provider Agencies.
- 8.553.4.B. A TCA shall meet all requirements as set forth in 10 C.C.R. 2505-10, Section 8.553.5.

8.553.5 TCA RESPONSIBILITIES

- 8.553.5.A. TCAs shall administer the CTS benefit.
- 8.553.5.B. The TCA shall perform administrative functions, including supervision of Transition Coordinators, attendance at required meetings, ensuring timely reporting, compliance with transition procedures defined by the Department with input from stakeholders, on-site visits to clients, community coordination and outreach, client monitoring and on-site visits.
- 8.553.5.C. Staffing Requirements
 1. The TCA shall ensure and document that each Transition Coordinator has completed the required Department Transition Coordinator training and has received a satisfactory proficiency rating, received 20 hours of training or passed a Department-approved skills validation test in transition coordination knowledge and skills. The Transition Coordinator training or skills validation test shall include, but not be limited to:
 2. The TCA shall ensure that each Transition Coordinator has received training in the following:
 - a. Knowledge of populations served by the TCA and the target population served by ~~the HCBS-EBD waiver~~s.
 - b. Client interviewing and assessment skills.
 - c. Intervention and interpersonal communication skills.
 - d. Knowledge of available community resources and public assistance programs.
 - e. Team coordination skills.
 - fe. Meeting facilitation skills, Transition plan development.
 32. The TCA supervisor(s), at a minimum, shall have two years supervisory experience and meet all qualifications for a Transition Coordinator.
 4. The TCA supervisor shall complete the Department transition coordination supervision training.
 5. Supervision of Transition Coordinators shall include, but not be limited to, the following activities: Supervision shall include, but not be limited to, the following activities:

a

- a.- Arrangement and documentation of training or skills validation testing.
 - b. ~~Review of transition aAssessments and plans and risk mitigation plans, of client's satisfaction with services.~~
 - c. ~~Oversight of transition coordination activities. Investigation of complaints.~~
 - d. ~~Assessment of client's satisfaction with services.~~
~~Counseling with staff on difficult cases.~~
 - e. ~~Investigation of complaints~~ regarding provision of CTS.
 - f. ~~Counseling with staff on difficult cases.~~
 - g. ~~Oversight of recordkeeping by staff. Oversight of record keeping by staff.~~
63. Training ~~and skills validation~~ shall be completed prior to the delivery of CTS.

8.553.5. D. The Transition Coordinator shall conduct transition activities in accordance with training, policies and procedures defined by the Department.

8.553.5. E. The Transition Coordinator shall, in collaboration with the client's Transition Options Team, complete a Department-approved assessment to determine the client's preferences, desires, and needs for housing, services and items necessary to establish a community-based residence.

8.553.5. F The Transition Coordinator shall work with the client and the Transition Options Team to create and implement a transition plan that meets the client's preferences, desires and needs identified on the transition assessment. The Transition Coordinator and the client shall sign the transition plan to signify agreement.

1. The Transition Coordinator shall submit the completed transition assessment, transition plan and risk mitigation plan to the Department Transitions Administrator (TA) for review prior to implementation of both plans.
 - a. The transition plan shall include the items needed for the client to transition to a community-based residence.

8.553.5. G. The Transition Coordinator shall work with the client and Transition Options Team to create and implement a risk mitigation plan that identifies known risk factors and a strategy to mitigate each factor.

8.553.5. H. The Transition Coordinator shall work with the client to obtain a residence and any items necessary to establish a community-based residence.

8.553.5. I. The Transition Coordinator shall conduct a minimum of four visits of the residence to ensure all essential furnishings, utilities, community resources and services are in place.

8.553.5. J. If the Transition Coordinator finds any of the supports to be insufficient for the client to live successfully in the community, the Transition Coordinator shall work with the case manager to correct the deficiencies.

8.553.5. K. The Transition Coordinator shall perform on-site visits to the client's community-based residence at the following intervals:

1. Prior to the client's discharge from the skilled nursing facility.

- a. If possible, the client shall accompany the Transition Coordinator during the on-site visit prior to discharge.
 - b. If the client is unable to participate in the on-site visit, the Transition Coordinator shall document the reason in the client's file.
2. The day of the move to ensure that the client's belongings and medications are moved from the facility; that all required services are in place; and that the necessary household set-up is complete.
 3. One week after the transition to ensure that the supports and services identified on the transition assessment and plan are being provided and received.
 4. One month after the transition to ensure the client has the proper supports to continue successfully living in the community.
 5. The Transition Coordinator shall complete a transition report after the last on-site visit.

8.553.6 CASE MANAGEMENT AGENCY RESPONSIBILITIES

- 8.553.6. A. The case manager shall participate in the Transition Options Team meetings.
- 8.553.6. B. The case manager shall conduct service brokering for Medicaid services, including HCBS and state plan benefits, such as behavioral health services and home health. Service brokering includes determining whether services that meet the client's needs are available in the community where the client wants to live.
- 8.553.6. C. The case manager shall authorize CTS services.
- 8.553.6. D. The case manager shall provide joint monitoring with the transition coordinator of the client during the 30 day post-discharge period.

8.553.7 AUTHORIZATION REQUESTS

- 8.553.7. A. The TCA shall submit the CTS AR form to the case management agency to authorize payment for CTS and for any purchases or deposits after client discharges from the facility.
1. The AR shall include copies of cancelled checks and copies of receipts detailing the items purchased and the cost.
 2. Any expenses submitted on the CTS AR for items that are not included in the approved transition plan shall be considered non-allowable expenses and shall not be reimbursed.
 3. The case manager shall complete a review of the AR and shall notify the TCA of approval or denial of the AR and, if applicable, any non-allowable expenses on the cost report within ten business days of receipt.
 4. The TCA shall submit the AR for Transitional Case Management once the client has discharged from the facility.
 - a. The case manager shall verify that the client is established in a community-based residence.
 - b. The case manager shall complete a review of the AR and shall notify the TCA of approval or denial within ten business days of receipt.
 - c. The case manager shall notify the TCA of approval of any non-allowable expenses on the cost report, if applicable.

d. Incomplete ARs shall be returned to the TCA for correction within 10 business days of receipt by the case management agency.

8.553.7. B. If after the transition plan has been reviewed the Transition Coordinator determines additional purchases are required, the Transition Coordinator shall submit a revised AR to the case management agency.

8.553.7. C. Approval of the AR by the case manager shall authorize the TCA to submit claims to the Department's fiscal agent. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the TCA's use of correct billing procedures.

8.553.8 REIMBURSEMENT

8.553.8. A. The TCA shall conform to all reimbursement procedures described in 10 C.C.R. 2505-10, Section 8.487.200 Provider Reimbursement.

8.553.8. B. Payment for CTS shall be the lower of the billed charges or the maximum rate of reimbursement.

8.553.8. C. The cost of transitional coordination services shall be reimbursed by one unit of service completed when the client is established in a community-based residence as verified by the case manager.

8.553.8. D. Reimbursement for household set-up shall be made only for items listed on the transition plan with an accompanying receipt. The cost of household set-up shall be reimbursed at one unit of service completed when the client is established in a community-based residence as verified by the case manager.

8.553.9 CONFLICT- FREE TRANSITION COORDINATION

8.553.9. A. TCAs shall separate transition coordination from direct service provision. Examples of this separation are separate staff, intake lines, office space and client files.

1. Transition Coordinators who are involved in the determination that a transition is feasible are required to do so distinctly so that there is not an incentive to increase business for their organization.

2. In circumstances when one entity is responsible for providing transition coordination and service delivery, appropriate safeguards and firewalls shall exist to mitigate risk of potential conflicts of interest and to ensure that consumer choice and control are not compromised. The safeguards and firewalls shall be submitted to the Department for approval.

3. In circumstances where the TC is an employee of an agency providing other services, the TC shall comply with safeguards and firewalls established to mitigate conflict of interest and to ensure client choice and control.

8.553.9. B. Determination that a transition is feasible is made by the Transition Options Team.

8.553.9. C. Transition Coordinators shall not be related to the parent, child, spouse, sibling, grandparent, niece, nephew, uncle or aunt of any of the individual's caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Sections 8.100.1 and 8.100.4.G.3

Rule Number: MSB 15-02-06-A

Division / Contact / Phone: Eligibility Division / Ana Bordallo / 303-866-3239

**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 15-02-06-A, Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Sections 8.100.1 and 8.100.4.G.3
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.G.3, 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: April 2015
Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

At §8.100.1 insert a new unnumbered paragraph that begins with “MAGI equivalent is the resulting standard . . .”. This paragraph is inserted immediately following the unnumbered paragraph that reads “Modified Adjusted Gross Income (MAGI) refers to the methodology . . .” and immediately before the paragraph that reads “MIA - Monthly Income Allowance is the amount . . .”.

Replace current text at §8.100.4.G.3 and §8.100.4.G.4 with new text provided.
Remove current text at §8.100.4.G.3.a.

All text indicated in blue is for context only and should not be changed. This revision is effective 05/30/2015.

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Sections 8.100.1 and 8.100.4.G.3

Rule Number: MSB 15-02-06-A

Division / Contact / Phone: Eligibility Division / Ana Bordallo / 303-866-3239

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

The purpose of the rule change is to make a revision to the current policy regarding MAGI Parent/Caretaker Relatives Federal Poverty Level (FPL) changing from 100% FPL to 60% MAGI-converted. The state will be updating the Colorado Benefits Management System (CBMS) to be in alignment with our federal regulations effective April 1, 2015. This rule also needs to be updated to ensure the state is in compliance with federal regulations..

2. An emergency rule-making is imperatively necessary

to comply with state or federal law or federal regulation and/or

for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

Section 1902(e)(14)(E) of the Social Security Act

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2014);

Initial Review

Final Adoption

04/10/2015

Proposed Effective Date

07/01/2015

Emergency Adoption

DOCUMENT #03

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Parents and Caretaker Relatives, Sections 8.100.1 and 8.100.4.G.3

Rule Number: MSB 15-02-06-A

Division / Contact / Phone: Eligibility Division / Ana Bordallo / 303-866-3239

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 those currently enrolled on the Parent/Caretaker Relatives category. Changing the Federal Poverty Level (FPL) percent to 60 % MAGI-converted will transition a number of adults from MAGI Parents/Caretaker Relatives category to the MAGI Adult category. Also, individuals who do not meet the FPL percentage of 60 % MAGI-converted and who currently have Medicare will no longer be eligible for Medicaid. The benefit from the proposed rule is more adults will be eligible for MAGI Adult category.

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

The proposed rule will transition a number of adults from Parent/Caretaker Relatives to MAGI Adult category. Those affected are adults who do not meet the FPL percentage of 60 % MAGI-converted and who are on Medicare will no longer be eligible for Medicaid.

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.

A small number of clients could lose eligibility as a result to this change, but the Department assumes that the majority of the clients in this small population could be eligible in other aid categories. Consequently, the actual fiscal impact is anticipated to be nominal.

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

Action is needed for compliance with federal regulation; inaction is not an option.

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

There is no alternative action available to achieve federal compliance.

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.

8.100.1 Definitions

Modified Adjusted Gross Income (MAGI) refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act. These MAGI groups include Parents and Caretaker Relatives, Pregnant Women, Children, and Adults. For a more complete description of the MAGI categories and pursuant rules, please refer to section

MAGI-equivalent is the resulting standard identified through a process that converts a state's net-income standard to equivalent MAGI standards.

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

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

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 ~~60-100%~~ 100% of the federal poverty level ~~(MAGI-equivalent converted)~~ 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. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.
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.