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Title of Rule: Revision to the Medical Assistance Rule Concerning Hospital Provider Fee Collection and Disbursement, Section 8.2000, et seq
Rule Number: MSB 16-02-22-D
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 16-02-22-D, Revision to the Medical Assistance Rule Concerning Hospital Provider Fee Collection and Disbursement, Section 8.2000, et seq

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*

Replace all current text beginning at section 8.2000 through the end of 8.200.4.F.5 with the new text provided. This revision is effective 06/30/2016.

*to be completed by MSB Board Coordinator

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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 (OAB), the proposed rule revisions include changes to fees assessed upon hospital providers and payments to hospital providers.

   The Colorado Health Care Affordability Act [section 25.5-4-402.3, C.R.S. (2015)] 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 with disabilities up to 450% of FPL and children with disabilities up to 300% of the FPL, and to fund 12 months of continuous eligibility for Medicaid children.

   The proposed rule updates the hospital provider fee and payment calculations in accordance with the recommendation of the OAB. The proposed rule revisions make changes to the fee and payment calculations that 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, and to cover the Department's administrative costs.

   The proposed rule also clarifies definitions and removes obsolete language identified through the Department's regulatory review process. These definitions and obsolete language concern information the Department is no longer gathering and terminology that was vendor-specific that has been revised to be applicable no matter the Department's vendor.

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:

Initial Review	**04/08/2016**	Final Adoption	**05/13/2016**
Proposed Effective Date	**06/30/2015**	Emergency Adoption	

DOCUMENT # 02

3. Federal authority for the Rule, if any:

   42 CFR Section 433.68

   42 U.S.C. Section 1396b(w).

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-4-402.3, C.R.S. (2015)

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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 bear the cost of the provider fee, but also benefit from increased reimbursements made possible through provider fee funding. Low-income persons benefit from the expanded Medicaid and CHP+ eligibility.

   In regard to the quality incentive payment, Colorado hospitals benefit from the receipt of supplemental provider fee payments based on performance on measures related to the quality of care provided. Medicaid clients benefit to the extent that the supplemental payments, as well as quality measurement and reporting activities, lead to improved quality of care and 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.

   For the year ending September 30, 2016, hospitals will pay approximately $668 million in fees, which will generate nearly $2.4 billion in federal funds to Colorado. Hospitals will receive $1.12 billion in supplemental and quality incentive payments resulting in increased reimbursement for care provided to Medicaid and CICP patients of $290 million. Currently more than 400,000 Coloradans are enrolled in expanded Medicaid and CHP+ coverage financed with hospital provider fees.

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 be able 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 state does not currently have the resources to fund the hospital payments and coverage expansions under the Colorado Health Care Affordability Act in absence of the provider fees.

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 section 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 an inpatient hospital 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.5.~~

"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. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

~~"Diagnosis Related Group" or "DRG" means 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.~~

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

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

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

"Fund" means the hospital provider fee 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 30,000 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.

"Health Maintenance Organization" or "HMO" ~~means a health maintenance organization~~ means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency. ~~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. § 1396r-4.

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

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

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

"Managed Care Day" means an inpatient hospital day for which the primary payer is a managed care health plan, including a ~~listed as~~ HMO, ~~or~~ PPO, POS, and EPO ~~D~~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 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 an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, ~~or~~ PPO, POS, or EPO.

"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.

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

"PPO" or ~~means a p~~"Preferred Pprovider Oorganization" means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost ~~that is a type of managed care health plan~~.

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

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

"Rehabilitation Hospital" means an inpatient rehabilitation facility.

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

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

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

~~"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 Cost" means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and ~~audited C~~cost-to-c~~C~~harge ratio from the Medicare ~~c~~Cost ~~r~~Report. ~~s applicable to the Uniform Cost Report.~~

~~"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 inpatient hospital 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 ~~Uniform Cost Report~~data reporting template to all hospitals no later than April 30 of each year. The Department shall include instructions for completing the ~~Uniform Cost Report~~data reporting template, including definitions and descriptions of each data element to be reported ~~in the Uniform Cost Report~~. Hospitals shall submit ~~the Uniform Cost Report, as~~the requested data ~~requested,~~ to the Department within ~~by May 31 of each year~~thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Department may estimate any data element not provided directly by the hospital.

2. Hospitals shall submit ~~the following data elements~~days and charges for Medicaid Managed Care, out-of-state Medicaid, and uninsured patients, Managed Care Days, ~~-~~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.

4. An authorized hospital signatory shall certify that the data included in the ~~Uniform Cost Report~~data reporting template are correct, are based on actual hospital records, and that all supporting documentation will be maintained for a minimum of ~~seven~~ six 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~~2. ~~Beginning in SFY 2010-11 t~~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.

43. 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.

a. For hospitals that do not participate in the electronic funds process utilized by the Department for the collection of fees, pPayments 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.

b. For hospitals that do not participate in the electronic funds process utilized by the Department for the disbursement of Ppayments, payments to hospitals shall be processed through a warrant (paper check) will be processed by the Department within two business days of receipt of the Outpatient Services Fee or and 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. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

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

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.94471.534% 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 $~~76.16~~79.54 per day for Managed Care Days and $~~340.39~~355.49 per day for all ~~other Days~~Non-Managed Care 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 $~~39.76~~41.53 per day for Managed Care Days and $~~177.72~~185.60 per day for all ~~other Days~~Non-Managed Care Days, and.

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~30.46~~31.82 per day for Managed Care Days and $~~136.16~~142.20 per day for Non-Managed Care Days~~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.

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 DSH payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.2004.D**,** exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding 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. Hospitals providing outpatient hospital services to Medicaid clients shall receive this payment.

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

3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado 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 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 Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned 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. Total payments to hospitals shall not

exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

8.2004.C. INPATIENT HOSPITAL BASE RATE SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients shall receive this payment.

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

3. Calculation methodology for payment. For each qualified hospital, the annual payment equals the ~~difference between the~~ hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate before add-ons, ~~and the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix,~~ multiplied by ~~the hospital's Medicaid base rate increased by~~ a percentage adjustment factor. The percentage adjustment factor may vary by hospital such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for ~~Major~~ Pediatric ~~Teaching~~ Specialty 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.

8.2004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

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

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

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

3. Calculation methodology for payment. ~~For each qualified hospital, the annual payment equals the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals multiplied by the State's total annual Disproportionate Share Hospital allotment in total computable published by the Center for Medicare and Medicaid Services in the Federal Register. No hospital shall receive a payment exceeding its Estimated Hospital-Specific Disproportionate Share Hospital Limit.~~

   a. Qualified hospitals whose CICP write-off costs are greater than or equal to 750% of all CICP hospitals write-off costs as published in the most recent CICP annual report will receive a DSH payment equal to 100% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.

   b. Qualified hospitals whose CICP write-off costs are less than 750% and more than 200% of all CICP hospitals write-off costs as published in the most recent CICP annual report

will receive a DSH payment equal to 96% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.

c. All other qualified hospitals will receive a DSH payment calculated as the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all remaining qualified hospitals multiplied by the remainder of the state's total annual Disproportionate Share Hospital allotment to not exceed 96% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.

8.2004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

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

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

3. Calculation methodology for payment. For each qualified hospital with twenty-five or fewer beds, the annual payment equals the hospital's percentage of beds compared to total beds for all qualified hospitals with twenty-five beds or fewer multiplied by ~~thirty~~ twenty three million five hundred thousand dollars ($~~32~~3,500,000). For each qualified hospital with greater than twenty-five beds, the annual payment equals the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals with greater than twenty-five beds multiplied by ~~eighty~~ ninety one million nine hundred eighty thousand one hundred seventy six dollars ($~~89~~1,980,176).

8.2004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals with an established Medicaid inpatient base rate~~,~~ and that meet the minimum criteria for 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. Quality incentive payment measures include five base measures and four optional measures. Hospitals can report data on up to five measures annually. Qualified hospitals must report all of the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed. ~~The measures for the Hospital Quality Incentive Payment are:~~

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

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

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

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

~~c. Rate of Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PPE/DVT),~~

~~d~~iv. Rate of thirty (30) day all-cause hospital readmissions, and

~~e~~v. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. ~~Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position.~~

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

i. Culture of safety,

ii. Active participation in the RCCO,

iii. Advance care planning, and

iv. Screening for tobacco use.

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 a~~A~~vailable ~~P~~points by hospital~~, subject~~ to a maximum of 10 points per measure.

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

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

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

d. Calculate a~~A~~djusted Medicaid ~~D~~discharges by hospital.

i. Adjusted Medicaid ~~D~~discharges are calculated by multiplying the number of Medicaid inpatient discharges by the ~~A~~adjusted ~~D~~discharge f~~F~~actor.

For hospitals with less than 200 annual Medicaid discharges, the total number of discharges is multiplied by ~~.~~125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare Prospective Payment System calculation.

ii. The a~~A~~djusted ~~D~~discharge f~~F~~actor is defined as the most recently available annual total gross Medicaid billed charges divided by the inpatient gross Medicaid billed charges.

e. Calculate ~~T~~total adjusted ~~D~~discharge p~~P~~oints

i. Adjusted d~~D~~ischarge p~~P~~oints are defined as the total number of points earned for all measures multiplied by the number of ~~A~~adjusted Medicaid ~~D~~ischarges.

f. ~~Calculate~~ Determine the d~~D~~ollars per d~~D~~ischarge p~~P~~oint.

i. Dollars per discharge point are tiered such that hospitals with higher quality point scores receive higher points per discharge. The dollar amount per discharge point for five tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	$13.18
2	11-20	$14.50
3	21-30	$15.82
4	31-40	$17.13
5	41-50	$18.45

~~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~~ Calculate ~~HQIP payout~~payment by hospital by multiplying the adjusted ~~total D~~ discharge p~~P~~oints for that hospital by the ~~D~~dollars per ~~D~~discharge ~~P~~point.

5. The total funds for the ~~Hospital Q~~quality ~~i~~Incentive p~~P~~ayment for the ~~Federal Fiscal Year~~year ~~beginning~~ ending September 30, 2016 ~~October 1, 2014 will be~~is $~~61,448,873~~84,810,386.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Provider Fee Financing Nursing Facility Rule Concerning Rate Effective Date, Section 8.443.13
Rule Number: MSB 16-03-08-A
Division / Contact / Phone: Special Finance / Matt Haynes / 6305

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 16-03-08-A, Revision to the Medical Assistance Provider Fee Financing Nursing Facility Rule Concerning Rate Effective Date, Section 8.443.13

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) 8.443.13, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace all current text beginning at section 8.443.13.A through the end of 8.443.13.E with the new text provided. This revision is effective 06/30/2016.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Provider Fee Financing Nursing Facility Rule Concerning Rate Effective Date, Section 8.443.13
Rule Number: MSB 16-03-08-A
Division / Contact / Phone: Special Finance / Matt Haynes / 6305

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).

   8.443.13 Addresses Rate Effective Dates for Class I skilled nursing facilities. The rules were incomplete in regard to the Schedule of Core Components Reimbursement Rates, and these revisions provide the detail needed concerning those rates.

   8.443.13 also prescribes the establishment of the July 1 Medicaid Management Information system (MMIS) rate based on an as-filed cost report without adjustments. MMIS rates are currently set by comparing the allowable growth to an interim rate calculated from the as-filed cost report, and setting the rate to the lower of the two. The rate is then reconciled to the rate calculated from the final audited cost report in the subsequent year in the form of a supplemental payment. The as-filed cost report often has errors, and adjustments must be made during the audit process. These errors and adjustments can result in an interim rate that is below the allowable growth for a provider and a final audited rate that is greater. This results in the provider's MMIS rate being set at the interim level below their allowable growth. The allowable growth for the provider for the next year is from the MMIS rate set by the as-filed cost report although the final audited rate was higher. The provider never catches up in terms of their MMIS rate.

   Additionally, utilizing as-filed cost reports to set reimbursement rates has led to significant delays in finalizing and implementing the provider fee model.

   The Department is recommending a change to this process so that MMIS rates are set by the allowable growth only. The change implements a standard increase to the MMIS rates for all providers with a reconciliation to the audited rate in the subsequent year. These changes obviate the risks to provider reimbursement rates and eliminate a source of delay, while also making the rate setting and true-up processes simpler and easier to understand. Providers will be able to anticipate their year over year change in MMIS rates when budgeting for their homes. There is no General Fund impact as a result of this change as the statewide growth remains the same.

2. An emergency rule-making is imperatively necessary

Initial Review	**04/08/2016**	Final Adoption	**05/13/2016**
Proposed Effective Date	**06/30/2016**	Emergency Adoption	

DOCUMENT #03

☐ to comply with state or federal law or federal regulation and/or
☐ for the preservation of public health, safety and welfare.

Explain:

3. Federal authority for the Rule, if any:

   42 CFR Section 433.68

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-6-202
   25.5-6-203

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Provider Fee Financing Nursing Facility Rule Concerning Rate Effective Date, Section 8.443.13
Rule Number: MSB 16-03-08-A
Division / Contact / Phone: Special Finance / Matt Haynes / 6305

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.

   Class I Nursing Facilities

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

   There is no change to the statutory limitations on general fund growth or any changes to the provider fees, so there is no anticipated significant impact on overall reimbursement to the class of providers. The rule will simplify the MMIS rate setting; making it easier for the providers to understand what change in MMIS rates to expect year over year. This change also simplifies the rate reconciliation process. The calculation of interim rates is often a cause of delay in completing the calculations of the provider fees and supplemental payments, and these changes will eliminate those delays.

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

   There are no additional costs to the Department or any anticipated significant effect on state revenues.

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

   Inaction will result in the continued use of an as-filed unaudited cost report to set MMIS reimbursement that can have negative impacts to providers who have errors in their as-filed cost reports. Inaction will also result in the continued complexity in the rate setting and rate reconciliation process, and will cause there to still be risk for significant delay in finalization and implementation of the provider fees and supplemental payments.

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

DO NOT PUBLISH THIS PAGE

There are no other 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.

   The only method for achieving the purpose of the proposed rule is to make a change to the rule.

8.443.13 RATE EFFECTIVE DATE

8.443.13.A. ~~For cost reports filed by all facilities except the State-administered Class IV facilities, the rate shall be effective on the first day of the eleventh (11th) month following the end of the nursing facility's cost reporting period.~~

For cost reports filed by all facilities except the State administered Class II and IV facilities, a July 1st and subsequent Schedule of Core Components Reimbursement Rates shall be established by the Department based on the last day of the cost reporting fiscal year end. The July 1st Schedule of Core Components Reimbursement Rate shall be based on the cost reporting period ending no later than the previous April 30th.

Additional Schedule of Core Components Reimbursement Rates shall be established as follows:

1. Rate effective on the first day of the 11th month following the end of the facility's cost reporting period.

2. Rate effective on the first day of the 6th month following the rate effective date stated in 8.443.13.A.1.

3. If the 11 month or 6 month rate stated in 8.443.13.A.1 and 8.443.13.A.2 coincide with July 1st, only two rates will be established.

4. If the 6 month rate stated in 8.443.13.A.2 is after the July 1st rate set by the subsequent cost report, only two rates will be established.

Provider Cost Report Fiscal Year End	Effective Date of Rate	Acuity Adjusted 11 Month Rate Effective Date	Acuity Adjusted 6 Month Rate Effective Date
01/31/Year 1	07/01/Year 1	12/01/Year 1	06/01/Year 2
02/28/Year 1	07/01/Year 1	01/01/Year 2	07/01/Year 2 (N/A)
03/31/Year 1	07/01/Year 1	02/01/Year 2	08/01/Year 2 (N/A)
04/30/Year 1	07/01/Year 1	03/01/Year 2	09/01/Year 2 (N/A)
05/31/Year 1	07/01/Year 2	04/01/Year 2	10/01/Year 2
06/30/Year 1	07/01/Year 2	05/01/Year 2	11/01/Year 2
07/31/Year 1	07/01/Year 2	06/01/Year 2	12/01/Year 2
08/31/Year 1	07/01/Year 2	07/01/Year 2 (N/A)	01/01/Year 3
09/30/Year 1	07/01/Year 2	08/01/Year 2	02/01/Year 3
10/31/Year 1	07/01/Year 2	09/01/Year 2	03/01/Year 3
11/30/Year 1	07/01/Year 2	10/01/Year 2	04/01/Year 3
12/31/Year 1	07/01/Year 2	11/01/Year 2	05/01/Year 3

8.443.13.B. For 12-month cost reports filed by the State-administered Class IV facilities, the rate shall be effective on the first day covered by the cost report.

8.443.13.C. ~~The permanent rate shall be established, issued and shall pay Medicaid claims billed on and after the later of the following dates:~~

~~1. The beginning of the provider's new rate period, as set forth in 10 CCR 2505-10 section 8.443.13.A, or~~

~~2. One hundred (100) days after the date the MED-13 is filed by the provider.~~

A July 1 Medicaid Management Information System (MMIS) rate shall be established and ~~,~~ issued. The July 1 MMIS rate shall ~~and~~ pay Medicaid claims with dates of services on and after, July 1 of each year. The rate shall be equal to the July 1 MMIS rate established in the previous year, prior to statutory adjustments, plus the applicable allowable growth. The July 1 MMIS rate shall not exceed limitations defined in C.R.S. 25.5-6-202(9)(b)(I) and may be subject to statutory adjustments.

8.443.13.D. ~~In the event a permanent rate cannot be established, issued and paid as set forth at 10 CCR 2505-10 section 8.443.13.A:~~

~~1. The Department shall establish and issue a temporary rate calculated on the provider's filed cost report without adjustments.~~

~~2. All temporary rates shall, at the time the permanent rate is established, issued and paid, be subject to adjustment and recovery of any over or under payments.~~

The July 1st MMIS rate established at 8.443.13.C will be reconciled to the Schedule of Core Components Reimbursement Rate(s) established in 8.443.13.A based on the adjusted MED-13. The reconciled amount will be included in the supplemental payment calculation for the state fiscal year following the calculation of the final Schedule of Core Components Reimbursement Rate and will be subject to available funding.

8.443.13.E. Any delay in completion of the audit of the MED-13 ~~that occurs within 90 days from the filing of the MED-13, and~~ that is attributable to the provider, shall operate, on a time equivalent basis, to extend the time in which the Department shall establish the Schedule of Core Components Reimbursement Rates, ~~issue and pay a temporary rate~~ under the provisions set forth in 8.443.13.A above.

8.443.13.F Delay in completion of the audit that is attributable to the provider shall include, but not be limited to, the following:

1. Failure of the provider to meet with the contract auditor at reasonable times requested by the auditor;

2. Failure of the provider to supply the contract auditor with information reasonably needed to complete the audit, including the Medicare cost report that the provider most recently filed with the Medicare fiscal intermediary or other Medicare information approved by the Department.

3. The time period that elapses during completion of the procedures described in 10 CCR 2505-10 section 8.442.1, whichever is relevant and later in a particular case.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Section 214 of the Children's Health Insurance Program Reauthorization act of 2009(CHIPRA) at section § 8.100.3.G, § 8.100.3.K and § 8.100.4.G
Rule Number: MSB 16-02-22-C
Division / Contact / Phone: Eligibility Division / Ana Bordallo / 303-866-3558

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 16-02-22-C, Revision to the Medical Assistance Eligibility Rules Concerning Section 214 of the Children's Health Insurance Program Reauthorization act of 2009(CHIPRA) at section § 8.100.3.G, § 8.100.3.K and § 8.100.4.G

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) § 8.100.3.G, § 8.100.3.K and § 8.100.4.G , 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 8.100.3.G.1.g through the end of 8.100.3.G.2. Insert new text at 8.100.3.K.1.a. Replace current text at 8.100.4.G.6. All text indicated in blue is for clarification only and should not be changed. This is effective 06/30/2016.

*to be completed by MSB Board Coordinator

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Section 214 of the Children's Health Insurance Program Reauthorization act of 2009(CHIPRA) at section § 8.100.3.G, § 8.100.3.K and § 8.100.4.G
Rule Number: MSB 16-02-22-C
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 § 8.100.3.G, § 8.100.3.K and § 8.100.4.G to incorporate changes to the rule authorized by Section 214 of the Children's Health Insurance Program Reauthorization act of 2009 (CHIPRA) which amends section 2107 of the Act granting states the option to provide benefits to children and pregnant women in Medicaid, who are lawfully residing in the United States and who have not met the 5-year waiting period. Revisions are needed to the current rule. This rule will incorporate changes elected by the state under the 2009 Colorado House Bill 09-1353 that authorized the Department to remove the 5-year waiting period for all lawfully residing children and pregnant women.

   Effective July 2015, the 5-year waiting period was removed for the MAGI- Medicaid and CHP+ categories for lawfully residing children. The proposed rule will lift the 5-year waiting period for children and pregnant women eligible in a Non-MAGI Medicaid category. By July 2016, the Department will have the Colorado Benefits Management System (CBMS) updated to align with our conditionally approved State Plan Amendment by removing the 5-year waiting period for all Medicaid categories.

   In addition to the proposed rule lifting of the 5-year waiting period for non-citizen, non-MAGI children and pregnant women, the proposed revisions to section 8.100.4.G.6 will further define the immigration categories of non-citizen MAGI pregnant women for whom the 5-year waiting period have been lifted.

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 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) which amends section 2107 of the Act, codified at 42 U.S.C 1396b(v)(4)(A)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   Colorado House Bill 09-1353,codified as sections 25.5-5-101(2)(b)(II);25.5-5-201(2)(b);25.5-8-109(6)

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Section 214 of the Children's Health Insurance Program Reauthorization act of 2009(CHIPRA) at section § 8.100.3.G, § 8.100.3.K and § 8.100.4.G
Rule Number: MSB 16-02-22-C
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 children and pregnant women who are lawfully residing and who have not met 5- year waiting period who are eligible for Medicaid in a Non-MAGI category. The proposed rule will benefit these children and pregnant women by eliminating the 5-year waiting period and making them eligible for Medicaid, as long as all other eligibility criteria are met.

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 allow lawfully residing children and pregnant women who have not met the 5-year waiting period and are eligible for Medicaid in a Non-MAGI category.

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.

   Eliminating the 5-year waiting period for children and pregnant women that are lawfully residing in the United States for less than 5 years and who are not eligible for a MAGI eligibility category will increase the State's expenditure as this change will expand eligibility for Medicaid. The 5-year waiting period has already been removed for Medicaid eligible pregnant women and Medicaid eligible children for individuals who qualify for MAGI populations; this rule needs to be implemented for individuals who qualify for non-MAGI populations as well.

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

   The Department expects a July 1, 2016 effect date of this policy, and an increase in expenditure of $302,981 total funds in FFY 2015-16 and $1,232,767 total funds in FFY 2016-17, with federal shares of $153,672 and $616,615 respectively. Currently Colorado provides Medicaid coverage to legally residing pregnant women and children who qualify for

MAGI populations and who have not met the 5-year waiting period. This proposed rule change would complete the implementation of HB 09-1353, expanding Medicaid coverage to legally residing pregnant women and children who would qualify for non-MAGI populations if not for the 5-year waiting period. Inaction would leave vulnerable Medicaid eligible children and pregnant women who have been lawfully residing in the United States for less than 5 years without medical assistance.

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 costly method to achieve the purpose of this proposed rule.

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

   There are no alternative methods for the proposed rule the Department considered.

8.100.3.G. General and Citizenship Eligibility Requirements

1. To be eligible to receive Medical Assistance, an eligible person shall:

   a. Be a resident of Colorado;

   b. Not be an inmate of a public institution, except as a patient in a public medical institution or as a resident of an Long Term Care Institution or as a resident of a publicly operated community residence which serves no more than 16 residents;

   c. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. See section 8.100.4.H for special provisions extending Medical Assistance coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

   d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;

   e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;

   f. Meet all other requirements of the Medical Assistance Program for which application is being made; and

   g. Fall into one of the following categories:

      i) Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or

      ii) Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

      iii) Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance benefits to begin no earlier than five years after the non-citizen's date of entry into the United States who falls into one of the following categories:

         1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");

         2) paroled into the United States for at least one year under ~~section~~ 8 U.S.C. § 1182(d)(5)~~212(d)(5) of the INA~~; or

         3) granted conditional entry under section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

         4) determined by the eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. §~~sec.~~ 1641(c), has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Medicaid); or

5) lawfully admitted for permanent residence under the INA with 40 qualifying quarters as defined under Title II of the Social Security Act. The 40 quarters is counted based on a combination of the quarters worked by the individual, the individual's spouse as long as they remain married or spouse is deceased, and/or the individual's parent while the individual is under age 18; or

~~6) The statutes and acts listed at 8.100.3.G.1.g.iii.1 through 8.100.3.G.1.g.iii.5 are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for public inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporatedreference by reference in this rule may be examined at any state publications depository library.~~

6~~7~~) Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

a) lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children),~~;~~ or

b) lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried, dependent children),~~;~~ or

c) granted asylum under section 208 of the INA for seven years after the date of entry into the United States,~~;~~ or

d) refugee under section 207 of the INA for seven years after the date of entry into the United States,~~;~~ or

e) deportation withheld under section 243(h) (as in effect prior to September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208) of the INA for seven years after the date of entry into the United States,~~;~~ or

f) Cuban or Haitian entrant, as defined in section 501(e)~~(2)~~ of the Refugee Education Assistance Act of 1980 for seven years after the date of entry into the United States,~~;~~ or

g) an individual who (1) was born in Canada and possesses at least 50 percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 450b(e),~~;~~ or

h) admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461) for seven years after the date of entry into the United States,~~;~~ or

i) lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict,~~;~~ or

j) a victim of a severe form of trafficking in persons, as defined in section 103 of the Victims of Trafficking and Violence Protection~~Victims~~ Act of 2000, Pub. L.106-386, as amended (~~-~~22 U.S.C. § 7105(b))~~2,~~ or

k) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA for seven years after the date of entry into the United States~~,~~ or

l) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA for seven years after the date of entry into the United States.

~~m) The statutes and acts listed at 8.100.3.G.1.g.iii.7.c through 8.100.3.G.1.g.iii.7.l are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.~~

7) The statutes listed at sections 8.100.3.G.1.g.iii.1-5 and at 8.100.3.G.1.g.iii.6.c-l are incorporated herein by reference. No amendments or later editions are incorporated. These regulations are available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

iv) Be a lawfully admitted non-citizen who is a pregnant women or a child under the age of 19 years in the United States who falls into one of the categories listed in 8.100.3.G.1.g.iii.1-6 or into one of the following categories listed below. These individuals are exempt from the 5-year waiting period:

1) granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a,or

2) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C 1254a and pending applicants for TPS granted employment authorization,

3) granted employment authorization under 8 CFR 274a.12(c),or

4) Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.

5) Deferred Enforced Departure (DED), pursuant to a decision made by the President,

6) granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum,

7) granted an administrative stay of removal under 8 CFR 241, or

8) Beneficiary of approved visa petition who has a pending application for adjustment of status.

9) Pending an application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who-

a) as been granted employment authorization; or

b) -Is under the age of 14 and has had an application pending for at least 180 days.

10) granted withholding of removal under the Convention Against Torture,

11) A child who has a pending an application or is a recipient of Special Immigrant Juvenile status under 8 U.S.C. 1101(a)(27)(J), or

12) Citizens of Micronesia, the Marshall Islands, and Palau, or

13) is lawfully present American Samoa under the immigration of laws of American Samoa.

14) A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or under 8 U.S.C. 1101(a)(17), or

15) A non-citizen who has been paroled into the United States for less than one year under 8 U.S.C. § 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings.

~~i~~v) Exception: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergency medical care only. The rules on confidentiality prevent the Department or eligibility site from reporting to the United States Citizenship and Immigration Services persons who have applied for or are receiving assistance. These persons need not select a primary care physician as they are eligible only for emergency medical services.

For non-qualified aliens receiving Medical Assistance emergency only benefits, the following medical conditions will be covered:

An emergency medical condition (including labor and delivery) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1) placing the patient's health in serious jeopardy;

2) serious impairment of bodily function; or

3) serious dysfunction of any bodily organ or part.

A physician shall make a written statement certifying the presence of an emergency medical condition when services are provided and shall indicate that services were for a medical emergency on the claim form. Coverage is limited to care and services that are necessary to treat immediate emergency medical conditions. Coverage does not include prenatal care or follow-up care.

2. For determinations of eligibility for Medical Assistance, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 8.100.3.G(1)(g)(ii) ~~or~~ (iii) or (iv) and has declared that he or she has a legal immigration status.

a. The Verify Lawful Presence (VLP) interface will be used to verify immigration status. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) Program. The VLP interface has three steps to verify legal immigration status.

i) An automated response from VLP confirms that the information submitted is consistent with VLP data for immigration status verification requirements. No further action is required for the individual and no additional documentation of immigration status is required. If Step 1 does not verify the legal immigration status of the individual and the VLP interface indicates additional information is required, Step 2 will automatically be initiated.

ii) Step 2: A response from the VLP interface confirms that the information submitted verifies the legal immigration status of the individual. No further action is required for the individual and no additional documentation of immigration status is required. If Step 2 does not verify the legal immigration status of the individual and the VLP interface indicates additional information is required Step 3 will be initiated.

iii) Step 3: The individual will be contacted by a state appointed designee with a request for additional documents and/or information needed to verify their legal immigration status through the VLP interface. A response from the VLP interface confirms that the documents and/or information received from the individual verifies their legal immigration status. No further action is required for the individual and no additional documentation of immigration status is required.

3. Reasonable Opportunity Period

a. If the verification through Step 1 of the electronic interface is unsuccessful then the applicant will be provided a reasonable opportunity period, of 90 days, to submit documents indicating a legal immigration status. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period.

b. If the verification through Step 2 of the electronic interface is unsuccessful and Step 3 is initiated, the reasonable opportunity period will be reset to 90 calendar days which will commence on the date of the failure of Step 2.

c. If the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

d. The reasonable opportunity period applies to MAGI, Adult and Buy-In Programs.

i) For the purpose of this section only, MAGI Programs for persons covered pursuant to 8.100.4.G or 8.100.4.I. include the following:

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical Assistance	8.100.4.G.3
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Legal Immigrant Prenatal Medical Assistance	8.100.4.G.6
Transitional Medical Assistance	8.100.4.I.1-5

ii) For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715. include the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.P
Medicaid Buy-In Program for Children with Disabilities	8.100.6.Q
Breast and Cervical Cancer Program (BCCP)	8.715

8.100.3.K. Consideration of Income

1. Income or resources of an alien sponsor or an alien sponsor's spouse shall be countable to the sponsored alien effective December 19, 1997. Forms used prior to December 19, 1997, including but not limited to forms I-134 or I-136 are legally unenforceable affidavits of support. The attribution of the income and resources of the sponsor and the sponsor's spouse to the alien will continue until the alien becomes a U.S. citizen or has worked or can be credited with 40 qualifying quarters of work, provided that an alien crediting the quarters to the applicant/client has not received any public benefit during any creditable quarter for any period after December 31, 1996.

    a. Exception: When the sponsored alien is a pregnant woman or a child the income or resources of an alien sponsor or an alien sponsor's spouse will not be countable to the sponsored alien.

2. Income, in general, is the receipt by an individual of a gain or benefit in cash or in kind during a calendar month. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, interest, etc., that are received by an individual or family.

8.100.4.G. MAGI Covered Groups

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level (MAGI-equivalent) 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 will be provided regardless of changes in the woman's financial circumstances.

6. A lawfully admitted non-citizen who is pregnant ~~legal immigrant~~ and who has been in the United States ~~a legal immigrant~~ for less than five years is eligible for Medical Assistance if she meets all of the other~~the~~ eligibility requirements specified at 8.100.4.G.5 and fits into one of the immigration categories listed in 8.100.3.G.1.g.iii.1-6 and 8.100.3.G.1.g.iv.1-15. ~~for expectant mothers listed in 8.100.4.G.5.~~ This population is referenced as Legal Immigrant Prenatal.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Home and Community Based Services Rule Concerning Supported Living Program, Section 8.515.85
Rule Number: MSB 16-02-25-A
Division / Contact / Phone: LTSS / Diane Byrne / 303-866-4030

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 16-02-25-A, Revision to the Medical Assistance Home and Community Based Services Rule Concerning Supported Living Program, Section 8.515.85

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) 10 C.C.R. 2505-10 8.515.85, 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 in 8.515.85.A unnumbered paragraph 8 and insert text in unnumbered paragraph 19. Replace the current text beginning at 8.515.85.D through the end of 8.515.85.D.5. Replace current text at 8.515.85.G.2 and current text at 8.515.85.G.6. Replace current text beginning at 8.515.85.I through the end of 8.515.85.I.3. All blue text is for clarification only. This revision will be effective 06/30/2016.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Home and Community Based Services Rule Concerning Supported Living Program, Section 8.515.85
Rule Number: MSB 16-02-25-A
Division / Contact / Phone: LTSS / Diane Byrne / 303-866-4030

STATEMENT OF BASIS AND PURPOSE

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

   The rules set forth at 10 CCR 2505-10 8.515.85 are being revised to make minor changes to clarify the compliance requirements for Supportive Living Program (SLP) providers that provided SLP services before December 31, 2014.

   There has been confusion on the part our sister agencies, the Department of Public Health and Environment (CDPHE) and the Department of Fire Prevention and Control (DFPC), about the compliance requirements for existing SLP providers. After meeting with SLP providers, CDPHE officials, and DFPC officials, it was requested that the Department clarify how existing providers show compliance with licensure and certification requirements.

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. §1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   C.R.S. 25.5-6-704

Initial Review	**04/08/2016**	Final Adoption	**05/13/2016**
Proposed Effective Date	**06/30/2016**	Emergency Adoption	

DOCUMENT #04

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Home and Community Based Services Rule Concerning Supported Living Program, Section 8.515.85
Rule Number: MSB 16-02-25-A
Division / Contact / Phone: LTSS / Diane Byrne / 303-866-4030

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.

   Persons who utilize SLP services through the BI waiver will benefit from increased communication and clarity on how existing SLP providers show compliance with licensure and certification requirements. Without this change, existing SLP providers are in danger of being unable to continue providing services due to confusion about compliance requirements. This would endanger the services and residences of many clients on the BI waiver and put them at risk of institutionalization.

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

   Without this rule change, clients currently receiving SLP services would be at risk of losing residential placement and services because some SLP providers with older physical facilities would be unable to comply with Department rules, CDPHE rules, and DFPC rules. Those SLP providers serve approximately ninety clients that would be at risk of institutionalization.

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 should have no cost to the Department, CDPHE, or DFPC. There is no anticipated effect on state revenues.

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

   The probable costs of inaction would be the loss of at least two out of five current SLP providers. The clients served by these providers would be at high risk of institutionalization, which would result in increased costs to the Department.

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

As there is no cost to the Department, there are no less costly methods of achieving this rule's purpose. This rule change is the least intrusive method of achieving this purpose as it comes at the request of two sister agencies responsible for enforcing the rule.

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

   All alternative methods of achieving this rule's purpose would involve much more complicated rule changes on the part of CDPHE and DFPC. These were rejected as impractical and more time-consuming.

8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.A DEFINITIONS

Activities of Daily Living (ADLs) mean basic self-care activities, including mobility, bathing, toileting, dressing, eating, transferring, support for memory and cognition, and behavioral supervision.

Assistance means the use of manual methods to guide, assist, with the initiation or completion of voluntary movement or functioning of an individual's body through the use of physical contact by others, except for the purpose of providing physical restraint.

Assistive Technology Devices means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

Authorized Representative means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to assist the client in acquiring and utilizing supports and services.

Behavioral Management and Education means services as defined in 10 CCR 2505-10 § 8.516.40.A and inclusions as defined at § 8.516.40.B, as an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the client's ability to remain integrated in the community.

Case Management Agency (CMA) means an agency within a designated service area where an applicant or client can obtain Case Management services. CMAs include Single Entry Points (SEP), Community Centered Boards (CCB), and private case management agencies.

Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and person-centered Service Plan for the client, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.

~~Certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) certifying that the Supportive Living Program (SLP) provider has met all licensing requirements as a Home Care Agency Class A (HCA) or Assisted Living Residence (ALR), in addition to all requirements in these regulations at 10 CCR 2505-10, § 8.515.85.~~

Critical Incident means an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a client that could have, or has had, a negative impact on the mental and/or physical well-being of a client in the short or long term. A critical incident includes accidents, suspicion of abuse, neglect, or exploitation, and criminal activity.

Department means the Department of Health Care Policy and Financing.

Health Maintenance Activities means those routine and repetitive health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These activities include, but are not limited to, catheter irrigation, administration of medication, enemas, suppositories, and wound care.

Independent Living Skills Training means services designed and directed at the development and maintenance of the client's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

Instrumental Activities of Daily Living (IADLs) means activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework and communication.

Interdisciplinary Team means a group of people responsible for the implementation of a client's individualized care plan, including the client receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by the client's needs and preferences, who are assembled in a cooperative manner to develop or review the person-centered care plan.

Personal Care Services includes providing assistance with eating, bathing, dressing, personal hygiene or other activities of daily living. When specified in the service plan, Personal Care Services may also include housekeeping chores such as bed making, dusting, and vacuuming. Housekeeping assistance must be incidental to the care furnished or essential to the health and welfare of the individual rather than for the benefit of the individual's family.

Person-Centered Care Plan is a service plan created by a process that is driven by the individual and can also include people chosen by the individual. It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the client needs to function safely in the community.

Protective Oversight is defined as monitoring and guidance of a client to assure his/her health, safety, and well-being. Protective oversight includes, but is not limited to: monitoring the client while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the client to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the client's choice and ability to travel and engage independently in the wider community, and providing guidance on safe behavior while outside the Supportive Living Program.

Room and Board is defined as a comprehensive set of services that include lodging, routine or basic supplies for comfortable living, and nutritional and healthy meals and food for the client, all of which are provided by the Supportive Living Program provider, and are not included in the per diem.

SLP certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to HCPF ~~that~~ after the Supportive Living Program (SLP) provider has met all licensing requirements as an Assisted Living Residence (ALR), in addition to all requirements in these regulations at 10 CCR 2505-10, § 8.515.85.

8.515.85.B CLIENT ELIGIBILITY

1. Supportive Living Program services are available to individuals who meet all of the following requirements:

    a. Clients are determined functionally eligible for Home and Community Based Services Brain Injury waiver by a certified case management agency;

    b. Clients are enrolled in the Home and Community Based Services Brain Injury waiver; and

    c. Clients require the specialized services provided under the Supportive Living Program as determined by assessed need.

8.515.85.C SUPPORTIVE LIVING PROGRAM INCLUSIONS

1. Supportive Living Program services consist of structured services designed to provide:

    a. Assessment;

    b. Protective Oversight and supervision;

    c. Behavioral Management and Education;

    d. Independent Living Skills Training in a group or individualized setting to support:

        i. Interpersonal and social skill development;

        ii. Improved household management skills; and

        iii. Other skills necessary to support maximum independence, such as financial management, household maintenance, recreational activities and outings, and other skills related to fostering independence;

    e. Community Participation;

    f. Transportation between therapeutic activities in the community;

    g. Activities of Daily Living (ADLs);

    h. Personal Care and Homemaker services; and

    i. Health Maintenance Activities.

2. Person-Centered Care Planning

    Supportive Living Program providers must abide by the Person-Centered Care Planning process. Providers will work with Case Management Agencies to ensure coordination of a client's Person-Centered Care Plan. Additionally, Supportive Living Program providers must provide the following actionable plans for all HCBS-BI waiver clients updated every six (6) months:

    a. Transition Planning; and

    b. Goal Planning.

    These elements of a Person-Centered Care Plan are intended to ensure the client actively engages in his or her care and activities as well as ensure he or she is able to transition to any other type of setting or service at any given time.

3. Exclusions

    The following are not included as components of the Supportive Living Program:

    a. Room and board; and

    b. Additional services which are available as a State Plan benefit or other HCBS-BI waiver service. Examples include, but are not limited to: physician visits, mental health counseling, substance abuse counseling, specialized medical equipment

and supplies, physical therapy, occupational therapy, long term home health, and private duty nursing.

8.515.85.D PROVIDER LICENSING AND CERTIFICATION REQUIREMENTS

1. Supportive Living Program providers shall be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. 7~~, or as a Home Care Agency Class A (HCA) pursuant to 6 CCR 1011-1, Ch. 26~~. ~~Providers participating in the Supportive Living Program as of December 1, 2014, must fully comply with these regulations at 10 CCR 2505-10, § 8.515.85, no later than January 1, 2016.~~

   a. Providers that provided and billed SLP services prior to December 31, 2014, either licensed by CDPHE as an ~~Assisted Living Residence (~~ALR ~~)~~ pursuant to 6 CCR 1011-1, Ch. 7,~~-~~ as a Home Care Agency Class A (HCA) pursuant to 6 CCR 1011-1, Ch. 26**,** or under another certification approved by the Department shall be considered existing providers.

   b. Existing providers not fully in compliance with the requirements of § 8.515.85.D or § 8.515.85.I may continue to provide services under a request for exception and plan for compliance approved by the Department until they become fully compliant. Existing providers shall submit a renewal request for exception and plan of compliance to the Department each year for review and approval.

      i. Existing providers must show coordination with CDPHE and the Colorado Division of Fire Prevention & Control (DFPC) and their approval of progress with a plan of compliance with this request. The Department shall coordinate with CDPHE and DFPC in the application of regulatory requirements of both license and certification requirements.

2. In addition to the requirements of § 8.515.85.D.1, Supportive Living Program providers must also receive ~~annual~~ SLP Certification by CDPHE. CDPHE issues or renews a Certification when the provider is in full compliance with the requirements set out in these regulations. Certification is valid for ~~one~~ three years from the date of issuance unless voluntarily relinquished by the provider, revoked, suspended, or otherwise sanctioned pursuant to these regulations.

3. No Certification shall be issued or renewed by CDPHE if the owner, applicant, or administrator of the Supportive Living Program has been convicted of a felony or of a misdemeanor involving moral turpitude as defined by law or involving conduct that CDPHE determines could pose a risk to the health, safety, and welfare of clients.

4. In addition to meeting the requirements of this section, Supportive Living Program providers shall be licensed in accordance with C.R.S. §§ 25-1.5-103 (2013) and 25-3-101, et seq. (2013). ~~Supportive Living Program providers who are Home Care Agencies shall be licensed in accordance with C.R.S. § 25-27.5-101, et seq. (Aug. 5, 2013)~~ Supportive Living Program providers who are Assisted Living Residences shall be licensed in accordance with C.R.S. § 25-27-101, et seq. (Jul. 1, 2013).These statutes are hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

5. CDPHE may deny, suspend, revoke, or not renew the Certification of any Supportive Living Program provider who is out of compliance with the requirements of these regulations. Providers may appeal this process pursuant to the State Administrative Procedure Act, C.R.S. § 24-4-101, et seq. (2013).

8.515.85.E PROVIDER RESPONSIBILITIES

Supportive Living Program providers must follow all person-centered planning initiatives undertaken by the State to ensure client choice.

8.515.85.F HCBS PROGRAM CRITERIA

1. All HCBS Program Criteria must be fully implemented in accordance with the final Department transition plan for compliance with federal Home and Community-Based Settings requirements. The federal regulations can be found at 42 C.F.R., Chapter IV, Parts 430, 431, 435, 436, 440, 441, and 447 (Mar. 17, 2014), which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

   The following will be used to establish program criteria for Supportive Living Program providers in establishing a home-like environment pursuant to 42 C.F.R. § 440.180. In accordance with 42 C.F.R. § 441.301, the setting must:

   a. Be integrated in and support full access to the greater community;

   b. Be selected by the client from among setting options;

   c. Ensure client rights of privacy, dignity, and respect, and freedom from coercion and restraint;

   d. Optimize individual initiative, autonomy, and independence in making life choices;

   e. Facilitate client choice regarding services and supports, and who provides them;

   f. Put in place a lease or other written agreement providing similar protections for the client that addresses eviction processes and appeals;

   g. Ensure privacy in the client's unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;

   h. Ensure that clients have the freedom and support to control their own schedules and activities, and have access to food at any time;

   i. Each client shall have the right to receive and send packages. No client's outgoing packages shall be opened, delayed, held, or censored by any person;

   j. Each client has the right to receive and send sealed, unopened correspondence. No client's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person;

k. Enable clients to have visitors of their choosing at any time; and

l. Be physically accessible.

2. The provider must ensure adherence to all state assurances set forth at 42 C.F.R. § 441.302 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

3. Exceptions

Exceptions exist to the aforementioned HCBS Program Criteria listed in Section 8.515.85.F.1 of this rule when clear rationale and reasoning exist and is supported by appropriate documentation. These exceptions are for the corresponding sections in Section 8.515.85.F.1 of this rule, and are as follows:

a. HCBS Program Criteria under 8.515.85.F.1, a through k:

Requirements of program criteria may be modified if supported by a specific assessed need and justified and agreed to in the person-centered care plan pursuant to 42 C.F.R. § 441.302 (Jan. 16, 2014). The following requirements must be documented in the person-centered care plan:

i. Identify a specific and individualized assessed need.

ii. Document the positive interventions and supports used prior to any modifications to the person-centered care plan.

iii. Document less intrusive methods of meeting the need that have been tried but did not work.

iv. Include a clear description of the modification that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

viii. Include an assurance that interventions and supports will cause no harm to the individual.

b. HCBS Program Criteria under 8.515.85.F.1.b and e:

i. When a client chooses to receive Home and Community-Based Services in a provider-owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the client cannot choose an alternative provider to deliver services that are included in the bundled rate.

ii. For any services that are not included in the bundled rate, the client may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle.

iii. To illustrate these HCBS Program Criteria b and e requirements by way of example, if a program provides habilitation connected with daily living and on-site supervision under a bundled rate, an individual is choosing the residential provider for those two services when he or she chooses the residence. The individual has free choice of providers for any other services in his or her service plan, such as therapies, home health or counseling.

c. HCBS Program Criteria under 8.515.85.F.1.c:

When a client needs assistance with challenging behavior, including a client whose behavior is dangerous to himself, herself, or others, or when the client engages in behavior that results in significant property destruction, the Supportive Living Program must properly create service and support plans detailing plans to appropriately address these behaviors.

d. HCBS Program Criteria under 8.515.85.F.1.g:

Requirements for a lockable entrance door may be modified if supported by a specific assessed need and justified and agreed to in the person-centered service plan pursuant to 42 C.F.R. § 441.302 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.515.85.G STAFFING

1. The Supportive Living Program provider shall ensure sufficient staffing levels to meet the needs of clients, and shall meet all other staffing requirements pursuant to 6 CCR 1011-1, Ch. 7, § 1.104(4)(a) , which states the following:

a. The owner shall employ sufficient staff to ensure the provision of services necessary to meet the needs of the residents; and

b. In determining staffing, the facility shall give consideration to factors including but not limited to:

i. Services to meet the residents' needs,

ii. Services to be provided under the care plan, and

iii. Services to be provided under the resident agreement.

c. Each facility shall ensure that at least one staff member who has the qualifications and training listed under Sections 1.104(3)(e) and (f), and who shall be at least 18 years of age, is present in the facility when one or more residents is present. These regulations are hereby incorporated by reference. The incorporation of these regulations exclude later amendments to, or editions of the

referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

In addition to these regulations, staff should be trained in how to work with an individual or individuals in difficult situations that may arise in the course of their work.

2. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in relevant precautions and emergency procedures, including first aid, to ensure the safety of the clientele. The SLP provider shall adhere to all other regulations pursuant to 6 CCR 1011-1, Ch. 7, §§ 1.103(8) and § 1.104(1)-(2) (Aug. 14, 2013), which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

3. Within one month of the date of hire, the Supportive Living Program provider shall provide adequate training for staff on each of the following topics:

   a. Crisis prevention;

   b. Identifying and dealing with difficult situations;

   c. Cultural competency;

   d. Infection control; and

   e. Grievance and complaint procedures.

4. Prior to providing direct care, the Supportive Living Program provider shall provide to the operator, staff, and volunteers an orientation of the location in which the program operates and adequate training on person-centered care planning.

5. All staff training shall be documented. Copies of person-centered care plan training and related documentation must be submitted to the Department. Copies must also be submitted for inspection and approval upon changing the training curriculum.

6. In addition to the relevant requirements imposed by CDPHE in 6 CCR 1011-1 Ch. 7 on Assisted Living Residence ~~and 6 CCR 1011-1 Ch. 26 on Home Care Agencies~~, the Department requires that the program director shall have an advanced degree in a health or human service related profession plus two years of experience providing direct services to persons with a brain injury. A bachelor's or nursing degree with three years of similar experience or a combination of education and experience shall be an acceptable substitute.

7. The provider shall employ or contract for behavioral services and skill training services according to client needs.

8. The Supportive Living Program provider shall employ staff qualified by education, training, and experience according to orientation and training requirements indicated within 10 CCR 2505-10, § 8.525.85.G. The Supportive Living Program shall have staff on

duty as necessary to meet the needs of clients at all times, so that provision of services is not dependent upon the use of clients to perform staff functions. Volunteers may be utilized in the home but shall not be included in the provider's staffing plan in lieu of employees.

9. The Supportive Living Program provider shall have written personnel policies. Each staff member shall be provided a copy upon employment and the administrator or designee shall explain such policies during the initial staff orientation period.

10. All Supportive Living Program provider staff, prospective staff, and volunteers shall undergo a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider.

8.515.85.H CLIENT RIGHTS AND PROPERTY

1. Clients shall have all rights stated in 10 CCR 2505-10 § 8.515.85.F.1, (HCBS Program Criteria) and in accordance with 42 C.F.R. § 441.301 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

2. The provider shall have policies on management of client funds and property consistent with those at 6 CCR 1011-1 Ch. 7, §1.105(3), which states the following:

    a. A facility may enter into a written agreement with the resident or resident's legal representative for the management of a resident's funds or property. However, there shall be no requirement for the facility to handle resident funds or property.

        i. Written Agreement. A resident or the resident's legal representative may authorize the owner to handle the resident's personal funds or property. Such authorization shall be in writing and witnessed and shall specify the financial management services to be performed.

        ii. Fiduciary Responsibility. In the event that a written agreement for financial management services is entered into, the facility shall exercise fiduciary responsibility for these funds and property, including, but not limited to, maintaining any funds over the amount of five hundred dollars ($500) in an interest bearing account, separate from the general operating fund of the facility, which interest shall accrue to the resident.

        iii. Surety Bond. Facilities which accept responsibility for residents' personal funds shall post a surety bond in an amount sufficient to protect the residents' personal funds.

        iv. Accounting.

            1) A running account, dated and in ink, shall be maintained of all financial transactions. There shall be at least a quarterly accounting provided to the resident or legal representative

itemizing in writing all transactions including at least the following: the date on which any money was received from or disbursed to the resident; any and all deductions for room and board and other expenses; any advancements to the resident; and the balance.

2) An account shall begin with the date of the first handling of the personal funds of the resident and shall be kept on file for at least three years following termination of the resident's stay in the facility. Such record shall be available for inspection by the Department.

v. Receipts. Residents shall receive a receipt for and sign to acknowledge disbursed funds.

3. Upon client request, a client shall be entitled to receive available money or funds held in trust.

8.515.85.I FIRE SAFETY AND EMERGENCY PROCEDURES

1. Applicants for initial provider Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by ~~the Colorado Division Of Fire Prevention &~~DFPC ~~Control~~, in accordance with 8 CCR 1507-31 (Aug. 26, 2013), which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

2. Existing ~~Supportive Living Program~~SLP providers ~~with a Certification in effect~~as defined at 10 CCR 2505-10, § 8.515.85.D.1 ~~prior to December 31st, 2014,~~ may continue, through the use of a Department-approved exception as defined in 10 CCR 2505-10, § 8.515.85.D.1.b, ~~to utilize existing approved~~ fire safety systems approved by the local fire authority having jurisdiction ~~provided they remain~~until ~~??/??/??? or~~ they demonstrate ~~in~~ compliance with 8 CCR 1507-31 provided they remain in compliance with the following:

a. There is ~~those fire safety systems as verified by the Department of Fire Control and Prevention (DFCP), and provided there is~~ no change in evacuation status of a client,

b. nor a client admission or discharge that alters the residence overall fire safety rating, and~~and provided~~

c. no renovation of 25 percent or greater to the total interior of the physical plant is performed.

d. If such a change, admission, discharge or renovation occurs, the home shall be required to meet the applicable standards referenced in 10 CCR 2505-10 § 8.515.85.I.1.

3. Providers shall develop written emergency plans and procedures for fire, serious illness, severe weather, disruption of essential utility services, and missing persons for each client. Emergency and evacuation procedures shall be consistent with any relevant local

and state fire and life safety codes and the provisions set forth in 6 CCR 1011-1 Ch. 7, §1.104(5)(b) and (c),which state the following:

a. Emergency plan. The emergency plan shall include planned responses to fire, gas explosion, bomb threat, power outages, and tornadoes. Such plan shall include provisions for alternate housing in the event evacuation is necessary.

b. Disclosure to residents. Within three (3) days of admission, the plan shall be explained to each resident or legal representative, as appropriate.

c. The policy shall describe the procedures to be followed by the facility in the event of serious illness, serious injury, or death of a resident.

d. The policy shall include a requirement that the facility notify an emergency contact when the resident's injury or illness warrants medical treatment or face-to-face medical evaluation. In the case of an emergency room visit or unscheduled hospitalization, a facility must notify an emergency contact immediately, or as soon as practicable.

4. Within three (3) days of scheduled work or commencement of volunteer service, the program shall provide adequate training for staff in emergency and fire escape plan procedures.

5. Staff and clients shall have training on, and practices of, emergency plans and procedures, in addition to fire drills, at intervals throughout the year. There shall be at least two fire drills conducted annually during the evening and overnight hours while clients are sleeping. All such practices and training shall be documented and reviewed every six (6) months. Such documentation shall include any difficulties encountered and any needed adaptations to the plan. Such adaptations shall be implemented immediately upon identification.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Eligibility Rule Concerning the Use of Annualized Income at Sections 8.100.1 and 8.100.4
Rule Number: MSB 16-02-22-B
Division / Contact / Phone: Eligibility Division / Geoffrey Oliver / 303-866-2686

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 16-02-22-B, Revision to the Medical Assistance Eligibility Rule Concerning the Use of Annualized Income at Sections 8.100.1 and 8.100.4

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) 8.100.1 and 8.100.4, 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*

Insert current text at 8.100.1 at unnumbered paragraph 32 and unnumbered paragraph 102. Replace current text at 8.100.4.C.1.e.xi. Insert current text at 8.100.4.C.1.f. Insert current text at 8.100.4.C.4.a. All text in blue is for clarification only and should not be changed. This revision will take effect 06/30/2016.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Eligibility Rule Concerning the Use of Annualized Income at Sections 8.100.1 and 8.100.4
Rule Number: MSB 16-02-22-B
Division / Contact / Phone: Eligibility Division / Geoffrey Oliver / 303-866-2686

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 change amends 10 CCR 2505-10, Sections 8.100.1 and 8.100.4 to allow the use of annualized income for MAGI-based Medicaid and CHP+ eligibility determinations for those individuals who have income that the Department has identified as causing individuals' income to fluctuate from month to month. The Department has identified earned income from self-employment, commission-based, and seasonal employment as such income. By implementing this rule the Department expects to reduce churn for these individuals and promote a continuity of care. The Colorado Benefits Management System (CBMS) is being updated to reflect these changes to sections 8.100.1 and 8.100.4 and this new functionality is currently on track to go live simultaneously with the requested effective date of this rule.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR §435.603, Section 1902(e)(14) of the Social Security Act

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-4-104 C.R.S. (2014).

Initial Review	**04/08/2016**	Final Adoption	**05/13/2016**
Proposed Effective Date	**06/30/2016**	Emergency Adoption	

DOCUMENT #04

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Eligibility Rule Concerning the Use of Annualized Income at Sections 8.100.1 and 8.100.4
Rule Number: MSB 16-02-22-B
Division / Contact / Phone: Eligibility Division / Geoffrey Oliver / 303-866-2686

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 individuals who are applicants/beneficiaries who meet all eligibility criteria except have been found financially ineligible for Medical Assistance based upon their monthly income when using Modified Adjusted Gross Income (MAGI) methodology, and the individual has earned income from either self-employment, commission based employment, or seasonal employment that is counted in their eligibility determination. In this situation, because income from self-employment, commission based employment, and seasonal employment frequently causes individuals' income to change from month to month, self-employment, seasonal and commission based income will be annualized. The annualized amount will then be used to determine the financial eligibility of the individual. This proposed rule will not impact Medicaid programs that use Non-MAGI methodologies to determine eligibility.

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

   The impact of annualizing this income that is given to monthly fluctuations is to reduce individuals churning between insurance programs and maintaining a continuity of care.

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 anticipates total costs in FY 2016-17 of approximately $16,205,773; however, this is primarily expected to consist of federal funds and the impact to the state is expected to be approximately $1,765,169 General Fund and $279,471 cash funds. To arrive at these estimates, the Department analyzed client history for Medicaid for clients with gaps in coverage of 6 months or less, since gaps in coverage greater than 6 months are not assumed to be due to seasonal changes in client income (as seasonal income dos not typically last longer than 6 months). The Department assumed that MAGI Eligible Children would not be affected by this change, due to continuous eligibility, and that annualization of income would have no impact on prenatal clients. Per capita costs decline as clients are eligible for longer periods of time, so the Department multiplied current per capita estimates by 50%, based in the methodology used in the analysis for estimating the cost of implementing

continuous eligibility for children. Costs stem from Medicaid coverage during gaps when clients otherwise would have churned out of Medicaid, but are offset by savings through continuous access to preventive medical services reducing the occurrence of higher-cost services.

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

   The proposed rule would result in a cost to the Department for clients who churn on and off of Medicaid due to fluctuating income, by allowing these clients to remain on Medicaid based on their income annualized for the full year. Benefits of the proposed rule include lowering the burden to clients who must continuously apply and re-apply for Medicaid due to their fluctuating income. Because these clients' annual income would allow them to be eligible for Medicaid for the year if their income were annualized, churning to private insurance represents a financial burden for these clients and could result in coverage gaps. Lack of access to preventive care could result in higher costs for treating preventable, exacerbated conditions in the future. The proposed rule also more closely aligns income methodology between Medicaid and the Marketplace.

   Inaction would potentially result in higher per capita costs for clients with fluctuating income, as clients go without preventive medical care during coverage gaps and seek treatment for exacerbated, preventable conditions when they churn back onto Medicaid. Inconsistencies between eligibility policy and Insurance Affordability Programs through the Marketplace would remain unresolved. Clients would continue to be burdened by reapplying for Medicaid throughout the year as their monthly income causes them to churn off Medicaid and then become eligible again.

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

   The Department is not aware of less costly methods for achieving the purpose of the proposed rule at this time. Another option for resolving this issue would be continuous eligibility for adults, but the Department does not have sufficient data to perform a cost-benefit analysis between that potential solution and this one. A study would be required to analyze the potential benefits of implementing continuous eligibility for Medicaid eligible adults as well as other options that could potentially reduce churn. Continuous eligibility for adults would likely cost more than annualized income, as it would affect all adults, and not just those who churn on and off of Medicaid due to monthly fluctuations in income, but who would be Medicaid eligible for the year if their eligibility was based on annualized income and not their income in particular month.

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.

   Alternative methods that have been reviewed to reduce churn include use of 1115 and 1332 waivers. While the employment of these waivers is an attractive method, it is not currently feasible as these 1332 waivers do not become effective until 2017.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

300% Institutionalized Special Income Group is a Medical Assistance category that provides Long-Term Care Services to aged or disabled individuals.

1619b is section 1619b of the Social Security Act which allows individuals who are eligible for Supplemental Security Income (SSI) to continue to be eligible for Medical Assistance coverage after they return to work.

AB - Aid to the Blind is a program which provides financial assistance to low-income blind persons.

ABD - Aged, Blind and Disabled Medical Assistance is a group of Medical Assistance categories for individuals that have been deemed to be aged, blind, or disabled by the Social Security Administration or the Department.

Adult MAGI Medical Assistance Group provides Medical Assistance to eligible adults from the age of 19 through the end of the month that the individual turns 65, who do not receive or who are ineligible for Medicare.

AND - Aid to Needy Disabled is a program which provides financial assistance to low-income persons over age 18 who have a total disability which is expected to last six months or longer and prevents them from working.

AFDC - Aid to Families with Dependent Children is the Title IV federal assistance program in effect from 1935 to 1997 which was administered by the United States Department of Health and Human Services. This program provided financial assistance to children whose families had low or no income.

AP-5615 is the form used to determine the patient payment for clients in nursing facilities receiving Long Term Care.

Alien is a person who was not born in the United States and who is not a naturalized citizen.

Ambulatory Services is any medical care delivered on an outpatient basis.

Annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years.

Applicant is an individual who is seeking an eligibility determination for Medical Assistance through the submission of an application.

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

Application for Public Assistance is the designated application used to determine eligibility for financial assistance. It can also be used to determine eligibility for Medical Assistance.

Blindness is defined in this volume as the total lack of vision or vision in the better eye of 20/200 or less with the use of a correcting lens and/or tunnel vision to the extent that the field of vision is no greater than 20 degrees.

Burial Spaces are burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use, including necessary and reasonable improvements or additions to or upon such burial spaces such as: vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

Burial Trusts are irrevocable pre-need funeral agreements with a funeral director or other entity to meet the expenses associated with burial for Medical Assistance applicants/recipients. The agreement can include burial spaces as well as the services of the funeral director.

Caretaker Relative is any relation by blood, marriage or adoption who is within the fifth degree of kinship to the dependent child, such as: a parent; a brother, sister, uncle, aunt, first cousin, first cousin once removed, nephew, niece, or persons of preceding generations denoted by prefixes of grand, great, great great, or great-great-great; a spouse of any person included in the above groups even after the marriage is terminated by death or divorce; or stepparent, stepbrother, stepsister, step-aunt, etc.

Case Management Services are services provided by community mental health centers, clinics, community centered boards, and EPSDT case managers to assist in providing services to Medical Assistance clients in gaining access to needed medical, social, educational and other services.

Cash Surrender Value is the amount the insurer will pay to the owner upon cancellation of the policy before the death of the insured or before maturity of the policy.

Categorically Eligible means persons who are eligible for Medical Assistance due to their eligibility for one or more Federal categories of public assistance.

CBMS - Colorado Benefits Management System is the computer system that determines an applicant’s eligibility for public assistance in the state of Colorado.

CDHS -Colorado Department of Human Services is the state department responsible for administering the social service and financial assistance programs for Colorado.

Children MAGI Medical Assistance group provides Medical Assistance coverage to tax dependents or otherwise eligible applicants through the end of the month that the individual turns 19 years old.

Child Support Services is a CDHS program that assures that all children receive financial and medical support from each parent. This is accomplished by locating each parent, establishing paternity and support obligations, and enforcing those obligations.

Citizen is a person who was born in the United States or who has been naturalized.

Client is a person who is eligible for the Medical Assistance Program. “Client” is used interchangeably with “recipient” when the person is eligible for the program.

CMS - Centers for Medicare and Medicaid Services is the Federal agency within the US Department of Health and Human Services that partners with the states to administer Medicaid and CHP+ via State Plans in effect for each State. Colorado is in Region VIII.

CHP+ - Child Health Plan Plus is low-cost health insurance for Colorado's uninsured children and pregnant women. CHP+ is public health insurance for children and pregnant women who earn too much to qualify for The Medical Assistance Program, but cannot afford private health insurance.

COLA - Cost of Living Adjustment is an annual increase in the dollar value of benefits made automatically by the United States Department of Health and Human Services or the state in OASDI, SSI and OAP cases to account for rises in the cost of living due to inflation.

Colorado State Plan is a written statement which describes the purpose, nature, and scope of the Colorado's Medical Assistance Program. The Plan is submitted to the CMS and assures that the program is administered consistently within specific requirements set forth in both the Social Security Act and the Code of Federal Regulations (CFR) in order for a state to be eligible for Federal Financial Participation (FFP).

Commission Based Employment ~~mean~~is employment where part or all of the earned income ~~earned~~ is based on a percentage of sales made or a fixed amount per sale.

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

Community Centered Boards are private non-profit organizations designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities.

Community Spouse is the spouse of an institutionalized spouse.

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

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

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

Dependent Child is a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 19, a full-time student, and expected to graduate by age 19.

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

Difficulty of Care Payments is a payment to an individual as compensation for providing additional care to an individual who qualifies for foster care and lives in the home of the care provider. This additional care must be required due to a physical, mental, or emotional handicap suffered by the foster care individual.

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

Dual Eligible clients are Medicare beneficiaries who are also eligible for Medical Assistance.

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

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

Electronic Data Source is an interface established with a federal or state agency, commercial entity, or other data sources obtained through data sharing agreements to verify data used in determining eligibility. The active interfaces are identified in the Department's verification plan submitted to CMS.

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

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

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

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

Ex Parte Review is an administrative review of eligibility during a redetermination period in lieu of performing a redetermination from the client. This administrative review is performed by verifying current information obtained from another current aid program.

Face Value of a Life Insurance Policy is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or other special provisions.

Fair Market Value is the average price a similar property will sell for on the open market to a private individual in the particular geographic area involved. Also, the price at which the property would change hands between a willing buyer and a willing seller, neither being under any pressure to buy or to sell and both having reasonable knowledge of relevant facts.

FBR - The Federal Benefit Rate is the monthly Supplemental Security Income payment amount for a single individual or a couple. The FBR is used by the Aged, Blind and Disabled Medical Assistance Programs as the eligibility income limits.

FFP - Federal Financial Participation as defined in this volume is the amount or percentage of funds provided by the Federal Government to administer the Colorado Medical Assistance Program.

FPL - Federal Poverty Level is a simplified version of the federal poverty thresholds used to determine financial eligibility for assistance programs. The thresholds are issued each year in the Federal Register by the Department of Health and Human Services (HHS).

Good Cause is the client’s justification for needing additional time due to extenuating circumstances, usually used when extending deadlines for submittal of required documentation.

Good Cause for Child Support is the specific process and criteria that can be applied when a client is refusing to cooperate in the establishment of paternity or establishment and enforcement of a child support order due to extenuating circumstances.

HCBS are Home and Community Based Services are also referred to as “waiver programs”. HCBS provides services beyond those covered by the Medical Assistance Program that enable individuals to remain in a community setting rather than being admitted to a Long-Term Care institution.

In-Kind Income is income a person receives in a form other than money. It may be received in exchange for work or service (earned income) or a non-cash gift or contribution (unearned income).

Inpatient is an individual who has been admitted to a medical institution on recommendation of a physician or dentist and who receives room, board and professional services for 24 hours or longer, or is expected to receive these services for 24 hours or longer.

Institution is an establishment that furnishes, in single or multiple facilities, food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

Institutionalization is the commitment of a patient to a health care facility for treatment.

Institutionalized Individual is a person who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

Institutionalized Spouse is a Medicaid eligible client who begins a stay in a medical institution or nursing facility on or after September 30, 1989, or is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or receives Home and Community Based Services (HCBS) on or after July 1, 1999; and is married to a spouse who is not in a medical institution or nursing facility. An institutionalized spouse does not include any such individual who is not likely to be in a medical institution or nursing facility or to receive HCBS or PACE for at least 30 consecutive days. Irrevocable means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than outlined in the document.

Insurance Affordability Program (IAP) refers to Medicaid, Child Health Plan *Plus* (CHP+), and premium and cost-sharing assistance for purchasing private health insurance through state insurance marketplace.

Legal Immigrant is an individual who is not a citizen or national and has been permitted to remain in the United States by the United States Citizenship and Immigration Services (USCIS) either temporarily or as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by USCIS.

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

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

Long-Term Care is Medical Assistance services that provides nursing-home care, home-health care, personal or adult day care for individuals aged at least 65 years or with a chronic or disabling condition.

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

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

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

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

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

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

MAGI - Modified Adjusted Gross Income 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 8.100.4.

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).

Non-Filer is an individual who neither files a tax return nor is claimed as a tax dependent. For a more complete description of how household composition is determined for the MAGI Medical Assistance groups, please refer to the MAGI household composition section at 8.100.4.E.

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

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

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

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

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

Parent and Caretaker Relative is a MAGI Medical Assistance group that provides Medical Assistance to adults who are parents or Caretaker Relatives of dependent children.

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

PEAK – the Colorado Program Eligibility and Application Kit is a web-based portal used to apply for public assistance benefits in the State of Colorado, including Medical Assistance.

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

Pregnant Women is a MAGI Medical Assistance group that provides Medical Assistance coverage to pregnant women whose MAGI-based income calculation is less than 185% FPL, including women who are 60 days post-partum.

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

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

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

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

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

Reasonable Compatibility refers to an allowable difference or discrepancy between the income an applicant self attests and the amount of income reported by an electronic data source. For a more complete description of how reasonable compatibility is used to determine an applicant's financial eligibility for Medical Assistance, please refer to the MAGI Income section at 8.100.4.C

Reasonable Explanation refers to the opportunity afforded an applicant to explain a discrepancy between self-attested income and income as reported by an electronic data source, when the difference is above the threshold percentage for reasonable compatibility.

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

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

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

Seasonal Employment ~~meani~~s employment where the work is performed only for part of the year for a set period ~~of time, usually less than six months~~.

Secondary School is a school or educational program that provides instruction or training towards a high school diploma or an equivalent degree such as a High School Equivalency Diploma (HSED).

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

a part-time basis may also be substantial gainful activity. “Gainful” work activity is work performed for pay or profit; or work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

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

Single Streamlined Application or “SSAp” is the general application for health assistance benefits through which applicants will be screened for Medical Assistance programs including Medicaid, CHP+, or premium and cost-sharing assistance for purchasing private health insurance through a state insurance marketplace.

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

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

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

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

TANF - Temporary Assistance to Needy Families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

Tax Dependent is anyone expected to be claimed as a dependent by a Tax-Filer.

Tax-Filer is an individual, head of household or married couple who is required to and who files a personal income tax return.

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

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

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

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

Unearned Income is the gross amount received in cash or kind that is not earned from employment or self-employment.

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

8.100.4.C. MAGI Methodology for Income Calculation

1. For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated by reference. The incorporation of 26 U.S.C. § 61 (2014) 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. Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all income from all derived sources, The Modified Adjusted Gross Income calculation for the purposes of determining a household's financial eligibility for Medical Assistance shall consist of, but is not limited to, the following:

    a. Earned Income:

        i) Wages, salaries, tips;

        ii) Gross income derived from business;

        iii) Gains derived from dealings in property;

        iv) Distributive share of partnership gross income (not a limited partner);

        v) Compensation for services, including fees, commissions, fringe benefits and similar items;and

        vi) Taxable private disability income.

    b. Unearned Income:

        i) Interest (includes tax exempt interest);

        ii) Rents;

        iii) Royalties;

        iv) Dividends;

        v) Alimony payments made directly to the household from a non-household member and separate maintenance payments;

        vi) Pensions and annuities;

        vii) Income from life insurance and endowment contracts;

        viii) Income from discharge of indebtedness;

        ix) Income in respect of a decedent; and

        x) Income from an interest in an estate or trust.

        xi) Social Security (SSA) income

        xii) Distributive share of partnership gross income (limited partner)

c. Additional Income: In addition to the types of income identified in section 8.100.4.C.1.a-b., the following income is included in the MAGI calculation.

i) Any tax exempt interest income

ii) Untaxed foreign wages and salaries

iii) Social Security Title II Benefits (Old Age, Disability and Survivor's benefits)

d. The following are Income exclusions:

i) An amount received as a lump sum is counted as income only in the month received.

ii) Scholarships, awards, or fellowship grants used for educational purposes and not for living expenses.

iii) Child support received

iv) Worker's Compensation

v) Supplemental Security Income (SSI)

vi) Veteran's Benefits

vii) American Indian/Alaskan Native income exceptions listed at 42 C.F.R. § 435.603(e) (2012) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 435.603(e) (2012) 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.

e. Allowable Deductions: For an in depth treatment of allowable deductions from gross income, please refer to 26 U.S.C. 62, which is hereby incorporated by reference. The incorporation of 26 U.S.C. 62 (2014) 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. The following deductions are allowed to be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income including (but not limited to):

i) Student loan interest deductions

ii) Certain Self- employment expenses (SEP, SIMPLE and qualified plans, and health insurance deductions)

iii) Deductible part of self-employment tax

iv) Health savings account deduction

v) Certain Business expenses of reservists, performing artist, and fee-basis government officials

vi) Certain reimbursed expenses of employees

vii) Moving expenses

viii) IRA deduction

ix) Penalty on early withdrawal

x) Domestic production activities deduction

xi) Alimony paid outside the home~~f. Income of children and tax dependents:~~

f. Income of children and tax dependents:

i) The income of a child who is included in the household of their natural, adopted, or step parent will not be included in the household income unless that child has income sufficient to require that the child file a tax return.

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a child is required to file taxes.

ii) The income of a person, other than a child or spouse, who expects to be claimed as a tax dependent will not be included in the household income of the taxpayer unless that tax dependent has income sufficient to require that the tax dependent file a tax return.

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a tax dependent is required to file taxes.

2. Income verifications: When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see section 8.100.3.H.9.

a. Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 10%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall be determined ineligible due to income.

b. If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy shall be requested. If the applicant is unable to provide a reasonable explanation, paper documentation shall be requested.

i) The Department may request paper documentation only if the Department does not find income to be reasonably compatible and if the applicant does not provide a reasonable explanation or if electronic data are not available.

3. Self-Employment – If the applicant is self-employed the ledger included in the Single Streamlined Application shall be sufficient verification of earnings, unless questionable.

4. Budget Periods for MAGI-based Income Dd~~d~~etermination – The financial eligibility of applicants for Medical Assistance shall be determined based on current or previous monthly household income and family size.

a. Applicants who are found financially ineligible based on current or previous monthly household income and family size, and whose household has earned income from self-employment, seasonal employment, and/or commission-based employment, shall have their financial eligibility determined using ~~an~~ annualized ~~amount from the~~ self-employment, seasonal employment, and commission-based employment income.

5. If an applicant does not meet the financial eligibility requirements for Medical Assistance based on MAGI, but meets all other eligibility requirements, the applicant shall be found eligible for MAGI Medical Assistance if the applicant's income, as calculated using the methodology for determining eligibility for Advanced Premium Tax Credits or Cost Sharing Reductions through the marketplace, is below 100% of the federal poverty level.

b. If the countable income is below the income threshold for the applicable MAGI program, the individual is income eligible and the five percent (5%) disregard will not be applied to determine eligibility.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Provider Payment Division Rule Concerning the Provider Screening Deadline, Section 8.125.10
Rule Number: MSB 16-2-22-A
Division / Contact / Phone: Health Information Office Provider Operations Division / Micah Jones / 303-866-5185

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 16-2-22-A, Revision to the Medical Assistance Provider Payment Division Rule Concerning the Provider Screening Deadline, Section 8.125.10

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) 8.125, 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:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text beginning at 8.125.10 through the end of 8.125.10.D. Revision becomes effective 06/30/2016.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Provider Payment Division Rule Concerning the Provider Screening Deadline, Section 8.125.10
Rule Number: MSB 16-2-22-A
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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 Provider Screening Rule (the Rule) currently places a deadline on providers to revalidate with the Department on or before March 31, 2016. CMS previously required State Medicaid Agencies to revalidate all Medicaid providers by March 24, 2016. CMS has since released new guidance that pushed back the revalidation requirement to September 24, 2016. CMS' March 24 and September 24 deadlines only applied to the Department, not providers. Also, not all providers were revalidated by March 31, 2016. Since the Department has more time to revalidate providers and because the deadline does not apply to providers, the Department believes the best course is to remove the March 31, 2016 deadline from the rule.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR § 455 (b) and (e)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);

Initial Review — Final Adoption **05/13/2016**
Proposed Effective Date **06/30/2016** — Emergency Adoption

DOCUMENT #06

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Provider Payment Division Rule Concerning the Provider Screening Deadline, Section 8.125.10
Rule Number: MSB 16-2-22-A
Division / Contact / Phone: Health Information Office Provider Operations Division / Micah Jones / 303-866-5185

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 update affects providers that are enrolled in 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.

   No quantitative or qualitative impact on all other providers.

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 rule update will not impose any additional costs to the Department or any other agency.

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

   If the rule is left as is the Department and providers will be out of compliance with the March 31 revalidation deadline set forth in the rule.

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

   There are no less costly or less intrusive methods.

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.

8.125 PROVIDER SCREENING

8.125.10 RE-VALIDATION

8.125.10.A. Providers ~~were~~enrolled in Medicaid on or before September 15, 2015, must complete all requirements for revalidation on a schedule established by the Department~~. Providers who are enrolled in Medicaid as of July 1, 2015, must re-validate before March 31, 2016,~~ and at least every five years thereafter on a schedule as established by the Department. The revalidation schedule is available on the Department's provider webpage under "Revalidation Wave Schedule."

8.125.10.B. All Providers ~~who enroll in Medicaid after July 1, 2015~~, must complete the requirements for re-validation~~e at least~~ every five years ~~thereafter~~from the date of enrollment or last revalidation.

8.125.10.C. ~~A provider shall comply with all requirements for Re-validation by the dates in Sections 8.125.10.A or 8.125.10.B.~~ If a provider fails to comply with any requirement for re~~Re-~~validation ~~by the dates~~specified in ~~Sections~~ sections 8.125.10.A or 8.125.10.B, the provider agreement shall be suspended.

8.125.10.D. If a provider fails to comply with all requirements for re~~Re-~~validation within 30 days of the ~~dates in~~deadlines established by ~~Sections~~ sections 8.125.10.A or 8.125.10.B, the provider agreement may be terminated. In the event that the provider agreement is terminated pursuant to this section, any claims submitted after ~~the dates~~deadlines established in ~~Sections~~ sections 8.125.10.A or 8.125.10.B~~, above,~~ are not reimbursable beginning on the day after the date that the provider's revalidation application was due to the Department.