

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE – SECTION 8.900

10 CCR 2505-10 8.900

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

8.900 COLORADO INDIGENT CARE PROGRAM (CICP)

PROGRAM OVERVIEW

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado residents, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to qualified health care providers who serve eligible persons who are indigent. The CICP issues procedures to ensure the funding is used to serve the indigent population in a uniform method. Any significant departure from these procedures will result in termination of the contract with, and the funding to, a health care provider. The legislative authority for this program was enacted in 1983 and is at 26-15-101, et seq., C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent."

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in Section 10-16-102 (22.5), C.R.S. Medically indigent persons receiving discounted health care services from qualified health care providers are subject to the limitations and requirements imposed by article 15, title 26, C.R.S.

8.901 DEFINITIONS

- A. "Applicant" means an individual who has applied at a qualified health care provider to receive discounted health care services.
- B. "Client" means an individual whose application to receive discounted health care services has been approved by a qualified health care provider.
- C. "Emergency care" is treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 25.5-3-103, C.R.S.
- D. "Urgent care" is treatment needed because of an injury or serious illness that requires immediate treatment because the client's life or health may be in danger.

- E. "General provider" means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. 1395x (aa)(4), a rural health clinic, as defined in 42 U.S.C. 1395x (aa)(2), a health maintenance organization issued a certificate authority pursuant to section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to section 25.5-3-108 (5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the program, "general provider" includes associated physicians.

42 U.S.C. 1395x is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203. Additionally, any incorporated material in these rules may be examined at any State publications depository library.

- F. "Qualified health care provider" means any general provider who is contracted with the Department to provide, and receive funding for, discounted health care services under the Colorado Indigent Care Program.
- G. "Hospital provider" means any "qualified health care provider" that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to C.R.S. §25-1.5-103 and which operates inpatient facilities.
- H. "State-owned hospital provider" is any "hospital provider" that is either owned or operated by the State.
- I. "Local-owned hospital provider" is any "hospital provider" that is either owned or operated by a government entity other than the State.
- J. "Private-owned hospital provider" is any "hospital provider" that is privately owned and operated.

8.902 DISCOUNTED HEALTH CARE SERVICES

- A. Funding provided under the CICIP shall be used to provide clients with discounted health care services determined to be medically necessary by the qualified health care provider.
- B. All health care services normally provided at the qualified health care provider should be available at a discount to clients. If health care services normally provided at the qualified health care provider are not available to clients at a discount, clients must be informed that the services can be offered without a discount prior to the rendering of such services.
- C. Qualified health care providers receiving funding under the CICIP shall prioritize the use of funding such that discounted health care services are available in the following order:
1. Emergency care;
 2. Urgent care; and
 3. Any other medical care.
- D. Additional discounted health care services may include:

1. Emergency mental health services if the qualified health care provider renders these services to a client at the same time that the client receives other medically necessary services.
2. Qualified health care providers may provide discounted pharmaceutical services. The qualified health care provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the qualified health care provider. Qualified health care providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible clients who are also eligible for Medicare.
3. Qualified health care providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for indigent women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The qualified health care provider is responsible for providing a description of the services included in the prenatal benefit to the client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.
2. Nursing home care.
3. Chiropractic services.
4. Sex change surgical procedures.
5. Cosmetic surgery.
6. Experimental and non-FDA approved treatments.
7. Elective surgeries that are not medically necessary.
8. Court ordered procedures, such as drug testing.
9. Abortions - Except as specified in Section 26-15-104.5, C.R.S.
10. Mental health services in clinic settings pursuant to 26-15-111, C.R.S., part 2 of article 1 of title 27, C.R.S., any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Contract Requirements for Qualified Health Care Providers

1. A contract will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by 25.5-3-108 (5)(a)(I), C.R.S.

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2. A contract will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver metropolitan area and complex care that is not contracted for in the remaining areas of the state, as required by 25.5-3-108 (5)(a)(II), C.R.S.
 3. Contracts may be executed with general providers throughout Colorado that can meet the following minimum criteria:
 - a. Licensed or certified as a general hospital, community health clinic, or maternity hospital (birth center) by the Department of Public Health and Environment, or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.
 - b. Hospital providers shall assure that emergency care is available to all clients throughout the contract year.
 - c. Hospital providers shall have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.
 - d. If the general provider is located within the City and County of Denver, the general provider must offer discounted specialty health care services to a specific population, of which more than 50% must reside outside the City and County of Denver (does not apply to University Hospital or Denver Health).
- B. Determination of Client Eligibility to Receive Discounted Health Care Services Under Available CICIP Funds
1. Using the information submitted in connection with an application to receive discounted health care services under available CICIP funds, the provider shall determine whether the applicant meets all requirements to receive discounted health care services under available CICIP funds. If the applicant is eligible to receive discounted health care services under available CICIP funds, the qualified health care provider shall determine an appropriate rating and copayment for the client, using the current federal poverty levels published in The Federal Register (referred to as the ability-to-pay scale) and copayment table, under section 8.907 in these regulations.
 2. The qualified health care provider should determine if the applicant is eligible to receive discounted services under available CICIP funds at the time of application, unless required documentation is not available. The qualified health care provider shall determine whether the applicant is eligible to receive discounted health care services within 15 days from the date that the applicant submits a signed application and such other information, written or otherwise, as is necessary to process the application.

3. The qualified health care provider shall provide the applicant and/or representative a written notice of the provider's determination as to the applicant's eligibility to receive discounted services under available CICIP funds. If eligibility to receive discounted health care services is granted by the qualified health care provider, the notice shall include the date when eligibility began. If eligibility to receive discounted health care services is denied, the notice shall include a brief, understandable explanation of the reason(s) for the denial. Every notice of the qualified health care provider's decision, whether an approval or a denial, shall include an explanation of the applicant's appeal rights found at Section 8.908 in these regulations.

C. Distribution of Available Funds to Providers

1. Distribution of available funds to qualified hospitals is found in 10 CCR 2505-10 section 8.2000.
2. Distribution of available funds for indigent care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate medically indigent charges. Available medically indigent charges are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 of each fiscal year. Medically indigent costs are inflated forward to the budget year using the United States Department of Labor Bureau of Labor Statistics Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year. Providers will be notified of the distribution amounts for each State fiscal year no later than thirty (30) days prior to July 1 of each State fiscal year. The Department will notify the provider, without prior notice, of any changes in the distribution amounts applicable to the provider for a current State fiscal year that occur after July 1 of that State fiscal year.
3. Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department concerning the use of CICIP funding.
4. Providers shall deduct the full patient liability amount from total charges, which is the amount due from the client as identified in the CICIP Copayment Table, as defined under Section 8.907 in these regulations. The summary information submitted to the Department concerning the use of CICIP funding by the provider shall include the full patient liability amount even if the provider receives the full payment at a later date or through several smaller installments or no payment from the client.
5. Beyond the distribution of available funds made by the CICIP, allowable client copayments, and other third-party sources, a provider shall not seek payment from a client for the provider's CICIP discounted health care services to the client.
6. Pediatric Major Teaching Hospital Payment. Hospital providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:
 - a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s;
 - b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed;

- c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.
- d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and
- e. Participates in the Colorado Indigent Care Program

The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

- 7. Colorado Health Care Services Payment. This payment is repealed effective September 1, 2009.
- 8. Rural Hospital Payment. This payment is repealed effective September 1, 2009.
- 9. Public Hospital Payment. This payment is repealed effective September 1, 2009.

D. Audit Requirements

The qualified health care provider shall provide the Department with an annual audit compliance statement as specified in the CICP Manual. The purpose of the audit requirement is to furnish the Department with a separate audit report, which attests to the qualified health care provider's compliance with the use of CICP funding and other requirements for participation. In addition, the audit report will furnish verification that the qualified health care provider accurately reported to the Department Medicaid-eligible inpatient days and total inpatient days used to calculate the distribution of available funds to providers defined under 8.903(C).

E. HIPAA

The Department has determined that the Colorado Indigent Care Program (CICP) is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the Colorado Indigent Care Program (CICP) is not a part of Medicaid, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a qualified health care provider or client.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an applicant shall satisfy the following requirements:

- 1. Execute an affidavit regarding citizenship status;
- 2. Be lawfully present in the United States;
- 3. Be a resident of Colorado;
- 4. Meet all CICP eligibility requirements as defined by state law and procedures; and

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5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, where required by 10 C.C.R. 2505-10, Section 8.904.E (2007.)
- B. Affidavit
1. Each first-time applicant, or applicant seeking to reapply, eighteen (18) years of age or older shall execute an affidavit stating:
 - a. That he or she is a United States citizen, or
 - b. That he or she is a legal permanent resident, or is otherwise lawfully present in the United States pursuant to federal law.
 2. For an applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall, within 30 days of the application date, verify lawful presence through the Federal Systematic Alien Verification of Entitlement Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security. Until verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.
- C. Establishing Lawful Presence
1. Each first-time applicant, or applicant seeking to reapply, eighteen (18) years of age or older shall produce one of the following. Any document submitted pursuant to 8.904.C.1 shall be presumed to be genuine unless there is a reasonable basis for questioning the authenticity of the document.
 - a. A valid Colorado Driver's License or a Colorado Identification Card, issued pursuant to Article 2 of Title 42, C.R.S. A valid Colorado Driver's License or Identification Card includes only a current Driver's License, Minor Driver's License, Probationary Driver's License, Commercial Driver's License, Restricted Driver's License, Instruction Permit or Identification Card.
 - b. A United States Military Identification Card or a Military Dependents' Identification Card;
 - c. A United States Coast Guard Merchant Mariner Card;
 - d. A Native American Tribal Document; OR
 - e. A driver's license or state-issued identification card issued in a state approved by the Director, Motor Vehicle Division, Department of Revenue.
 2. If an applicant is unable to provide a document listed in 8.904.C.1, then he/she must provide a document listed in 8.904.C.2. Any document submitted pursuant to 8.904.C.2 shall be presumed to be genuine unless there is a reasonable basis for questioning the authenticity of the document.
 - a. Documents applicable to U.S. citizens and non-citizen nationals
 - I. Copy of applicant's birth certificate from any state, the District of Columbia and all United States territories.
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- II. United States Passports, except for “limited” passports issued for less than five years.
 - III. Report of Birth Abroad of a United States Citizen, form FS-20.
 - IV. Certificate of Birth issued by a foreign service post (FS-545) or Certification of Report of Birth (DS-1350).
 - V. Certification of Naturalization (N-550 or N-570).
 - VI. Certificate of Citizenship (N-560 or N-561).
 - VII. U. S. Citizen Identification Card (I-97).
 - VIII. Northern Mariana Identification Card for an applicant born prior to November 3, 1986.
 - IX. Statement provided by a U.S. consular officer certifying that the individual is a U.S. citizen.
 - X. American Indian Card with classification code “KIC” and a statement on the back identifying U.S. Citizen members of the Texas Band of Kickapoos.
 - XI. Religious records recorded in one of the fifty states, the District of Columbia or U.S. territories issued within three months after birth showing that the birth occurred in such jurisdiction and the date of the birth or the individual’s age at the time the record was made.
 - XII. Evidence of civil service employment by the U.S. government before June 1, 1976.
 - XIII. Early school records showing the date of admission to the school, the child’s date and place of birth and the names’ and places of birth of the parents;
 - XIV. Census record showing name, U.S. citizenship or a U.S. place of birth or age of applicant;
 - XV. Adoption Finalization Papers showing the child’s name and place of birth in one of the 50 states, D.C., or U.S. territories or where the adoption is not finalized and the State or other jurisdiction listed above in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency showing the child’s name and place of birth in one of such jurisdictions. The source of the information must be an original birth certificate and must be indicated in the statement; or
 - XVI. Any other document that establishes a U.S. place of birth or in some way indicates U.S. citizenship.

- XVII. A written declaration, which shall be either:
- a) A written declaration from one or more third parties made under penalty of perjury and possibly subject to later verification of status, indicating a reasonable basis for personal knowledge that the applicant is a U.S. citizen or non-citizen national, or
 - b) The applicant's written declaration, made under penalty of perjury and possibly subject to later verification of status that he or she is a U.S. citizen or non-citizen national.
- XVIII. The following documents may be accepted as evidence of U.S. citizenship for collectively naturalized individuals:
- a) Puerto Rico
 - 1) Evidence of birth in PR on or after April 11, 1899 and the applicants' statement that he or she was residing in the U.S., a U.S. possession, or PR on January 13, 1941; or
 - 2) Evidence that the applicant was a PR citizen and the applicant's statement that he or she was residing in PR on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.
 - b) U.S. Virgin Islands
 - 1) Evidence of birth in the U.S. Virgin Islands (VI) and the applicant's statement of residence in the U.S., a U.S. possession, or the U.S. VI on February 25, 1927; or
 - 2) The applicant's statement indicating residence in the U.S. VI as a Danish citizen on January 17, 1917 and that he or she did not make a declaration to maintain Danish citizenship; or
 - 3) Evidence of birth in the U.S. VI and the applicant's statement indicating residence in the U.S., U.S. Possession or Territory or the Canal Zone on June 28, 1932.
 - c) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI))
 - 1) Evidence of birth in NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or
 - 2) Evidence of TTPI citizenship in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

- 3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

XIX. Derivative U.S. Citizenship may be determined as follows:

- a) Applicant born abroad to two U.S. citizens:
 - 1) The applicant shall present evidence of U.S. citizenship of the parents and the relationship of the applicant to the parents, and the evidence that at least one parent resided in the U.S. or an outlying possession prior to the applicant's birth.
- b) Applicant born abroad to a U.S. citizen parent and a U.S. non-citizen national parent:
 - 1) The applicant shall present evidence that one parent is a U.S. citizen and the other is a U.S. non-citizen national, evidence of the relationship of the applicant to the U.S. citizen parent and the evidence the U.S. citizen parent resided in the U.S., a U.S. possession, American Samoa or Swain's Island for a period of at least one year prior to the applicant's birth.
- c) Applicant born out of wedlock abroad to a U.S. citizen mother:
 - 1) The applicant shall present evidence of U.S. citizenship of the mother, evidence of the relationship to the applicant and, for births on or before December 24, 1952, evidence that the mother resided in the U.S. prior to the applicant's birth or, for births after December 24, 1952, evidence that the mother had resided, prior to the child's birth, in the U.S. or a U.S. possession for a period of one year.
- d) Applicant born in the Canal Zone or the Republic of Panama:
 - 1) The applicant shall present a birth certificate showing birth in the Canal Zone on or after February 26, 1904 and before October 1, 1979 and evidence that one parent was a U.S. citizen at the time of the applicant's birth; or
 - 2) A birth certificate showing birth in the Republic of Panama on or after February 26, 1904 and before October 1, 1979 and evidence that at least one parent was a U.S. citizen and employed by the U.S. government or the Panama Railroad Company or its successor in title.

- e) All other situations where an applicant claims to have a U.S. citizen parent and an alien parent, or claims to fall within one of the above categories but is unable to present the listed documentation:
 - 1) If the applicant is in the U.S., refer him or her to the local Department of Homeland Security (formerly known as the Immigration and Naturalization Service, or INS) office for determination of U.S. citizenship; or
 - 2) If the applicant is outside the U.S., refer him or her to the State Department consular office for a U.S. citizenship determination.

- XX. Adoption of foreign-born child by U.S. citizen:
 - a) If the birth certificate shows a foreign place of birth and the applicant cannot be determined to be a naturalized citizen under any of the above criteria, refer the applicant to the local Department of Homeland Security office for a determination of U.S. citizenship.

- XXI. U.S. citizenship by marriage:
 - a) The applicant shall present evidence that she was married to a U.S. citizen before September 22, 1922, or
 - b) If the husband was an alien at the time of their marriage, that the husband became a U.S. citizen before September 22, 1922.
 - c) If the marriage was later terminated, the woman shall demonstrate that she resided in the U.S. at the time it was terminated and that she has continued to reside in the U.S.

- b. Documents applicable to non-U.S. citizens
 - I. Alien lawfully admitted for permanent residence
 - a) Department of Homeland Security Form I-551, Alien Registration Receipt Card, commonly called or known as a "green card"; or
 - b) Unexpired Temporary I-551 Stamp in foreign passport or on Department of Homeland Security Form I-94.

 - II. Asylee
 - a) Department of Homeland Security Form I-94 annotated with stamp showing grant of asylum under section 208 of the Immigration and Nationality Act (INA); or
 - b) Department of Homeland Security Form I-688B (Employment Authorization Card) annotated "274a.12(a)(5)"; or
 - c) Department of Homeland Security Form I-776 (Employment Authorization Document) annotated "A5"; or

- d) Grant Letter from the Asylum Office or U.S.C.I.S..
- III. Refugee
- a) Department of Homeland Security Form I-94 annotated with stamp showing admission under Section 207 of the INA; or
 - b) Department of Homeland Security Form I-688B (Employment Authorization Card) annotated "274a.12(a)(3)"; or
 - c) Department of Homeland Security Form I-766 (Employment Authorization Document) annotated "A3"; or
 - d) Department of Homeland Security Form I-571(Refugee Travel Document); or
 - e) I-765 Employment Authorization Document; or
 - f) Grant letter from the U.S. Department of Health and Human Services granting refugee status to human trafficking victims.
- IV. Alien paroled into the U.S. for a least one year
- a) Department of Homeland Security Form I-94 with stamp showing admission for at least one year under Section 212(d)(5) of the INA. (Applicant cannot aggregate periods of admission for less than one year to meet the one-year requirement).
- V. Alien whose deportation or removal was withheld
- a) Department of Homeland Security Form I-688B (Employment Authorization Card) annotated "274a.12(a)(10)"; or
 - b) Department of Homeland Security Form I-766 Employment Authorization Document annotated "A10"; or
 - c) Order from an immigration Judge showing deportation withheld under Section 243(h) of the INA as in effect prior to April 1, 1997, or removal withheld under Section 241(b)(3) of the INA.
- VI. Alien granted conditional entry
- a) Department of Homeland Security Form I-94 with stamp showing admission under Section 203(a)(7)of the INA; or
 - b) Department of Homeland Security Form I-688B (Employment Authorization Card) annotated "A3"; or
 - c) Department of Homeland Security Form I-766 (Employment Authorization Document) annotated "A3".
- VII. Cuban / Haitian entrant

- a) Department of Homeland Security Form I-551, Alien Registration Receipt Card, commonly known as the "Green Card" with the code CU6, CU7, or CH6; or
 - b) Unexpired temporary I-551 stamp in foreign passport or on Department of Homeland Security Form I-94 with the code CU6, CU7, or CH6; or
 - c) Department of Homeland Security Form I-94 with stamp showing parole as "Cuba/Haitian Entrant" under Section 212(d) (5) of the INA.
- VIII. Alien who has been battered or subjected to extreme cruelty
- a) See Attachment 5, Exhibit B, at U.S. Attorney General Order No. 2129-97. The documentation for Violence Against Women Act self- petitioners is the Department of Homeland Security issued "Notice of Prima Facie Determination" or "Notice of Approval".
3. If an individual is unable to present any of the documents listed in 8.904.C.1 and 8.904.C.2 the provider may accept a waiver. A first-time applicant or applicant seeking to reapply may demonstrate lawful presence by executing both the affidavit required in 8.904.B. and by executing a Request for Waiver. The Request for Waiver form, seeking a determination of lawful presence by the Department of Revenue, may be completed by the applicant or the applicant's representative. The Request for Waiver must be accompanied by all documents that the applicant is able to produce to assist in verification of lawful presence.
4. Submission, Receipt and Retention of Documentation
- a. Lawful presence documentation may be accepted from the applicant, the applicant's spouse, parent, guardian, or authorized representative in person, by mail, or facsimile.
 - b. Providers shall develop procedures for handling original documents to ensure that the documents are not lost, damaged or destroyed. Providers shall develop and follow procedures for returning or mailing original documents to applicants within five business days of receipt.
 - c. Providers shall accept copies of an applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter, provided that the verification identifies that the copy is from an original and that the individual who reviewed the document(s) signifies such by including their name, organization, address, telephone number and signature on the copy.
 - d. The qualified health care provider shall retain photocopies of the affidavit and lawful presence documentation listed in 8.904.C with the application.
5. Expired or absent documentation for non-U.S. citizens
- a. If an applicant presents expired documents or is unable to present any documentation evidencing his or her immigration status, refer the applicant to the local Department of Homeland Security office to obtain documentation of status.

- b. In unusual circumstances involving applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the applicant can provide an alien registration number, the provider may file U.S.C.I.S. Form G-845 and Supplement, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status.
 - c. If an applicant presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document for one of the documents listed in 8.904.2.b, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.
6. The provider shall not discriminate against applicants on the basis of race, national origin, gender, religion, age or disability. If an applicant has a disability that limits the applicant's ability to provide the required evidence of citizenship or lawful presence, the provider shall assist the individual to obtain the required evidence.
- a. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the applicant may provide the required documentation; or referring the client to other agencies or organizations which may be able to provide assistance.
 - b. Examples of additional assistance that shall be provided to applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the applicant.
 - c. The provider shall not be required to pay for the cost of obtaining required documentation.
 - d. The provider shall document its efforts of providing additional assistance to the client. Documentation of such shall be retained in the applicant's application file.
- D. Residence in Colorado

An applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons;
2. Meet the lawful presence criteria, as defined in paragraph B of this section; and
3. Employed in Colorado.

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- E. Social security number(s) shall be required for all clients receiving discounted health care services under available CICP funding. If an applicant does not have a social security number, documentation that the applicant has applied for a social security number must be provided to complete the application to receive discounted health care services under available CICP funding. This section shall not apply to unborn children or homeless individuals who are unable to provide a social security number.
- F. Applicants Not Eligible
1. The following individuals are not eligible to receive discounted services under available CICP funds:
 - a. Individuals for whom lawful presence cannot be verified.
 - b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who have not been released on parole, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.
 - c. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.
 - d. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.
 2. Persons who qualify for Medicaid. However, applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:
 - a. QMB benefits described at section 10 C.C.R. 2505-10, Section 8.111.1 (2007) of these regulations;
 - b. SLMB benefits described at section 10 C.C.R. 2505-10, Section 8.122 (2007), or
 - c. The QI1 benefits described at section 10 C.C.R. 2505-10, Section 8.123 (2007).
 3. Individuals who are eligible for the Children's Basic Health Plan. However, individuals who are waiting to become an enrollee in the Children's Basic Health Plan and/or have incurred charges at a participating qualified health care provider in the 90 days prior to the application date shall not be excluded from consideration for eligibility on a temporary basis. Once the applicant becomes enrolled in the Children's Basic Health Plan, the applicant is no longer eligible to receive discounted health care services under available CICP funding.
- G. Application
1. Regular Application Process

The applicant or an authorized representative of that applicant must sign the application to receive discounted health care services submitted to the qualified health care provider within 90 calendar days of the date of health care services. If an applicant is unable to sign the application or has died, a spouse, relative, or guardian may sign the application. Until it is signed, the application is not complete, the applicant cannot receive discounted health care services under available CICP funding and the applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

2. Emergency Application

- a. In emergency circumstances, an applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the qualified health care provider shall follow these steps in processing the application:
 - I. Use the regular application to receive discounted health care services under available CICP funding, but check emergency application on the application.
 - II. Ask the applicant to give spoken answers to all questions and to sign the application to receive discounted health care services under available CICP funding.
 - III. Assign a discount rating based on the spoken information provided.
- b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the client receives any care other than the emergency room visit, the qualified health care provider must request the client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the client does not support the earlier, spoken information, the qualified health care provider must obtain a new application from the client. If the client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.
- c. In emergency circumstances, an applicant is not required to provide identification or execute an affidavit as specified at 10 C.C.R. 2505-10, Section 8.904.B.

H. Applicants

1. Any adult, over the age of 18, may apply to receive discounted health care services under available CICP funding on behalf of themselves and members of the applicant's family household.
2. If an applicant is deceased, the executor of the estate or a family member may complete the application on behalf of the applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.
3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the applicant's family household. In determining household size, a family member of any age may be included as long as s/he receives at least 50% of his/her support from the household.

4. A minor shall not be rated separately from his/her parents or guardians unless s/he is emancipated or there exists a special circumstance as outlined in the CICIP Manual. A minor is an individual under the age of 18.

I. Health Insurance Information

The applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

J. Subsequent Insurance Payments

If a client receives discounted health care services under available CICIP funding, and their insurance subsequently pays for services, or if the patient is awarded a settlement, the insurance company or patient shall reimburse the qualified health care provider for discounted health care services rendered to the patient.

8.905 FINANCIAL ELIGIBILITY

General Rule: An applicant shall be financially eligible for discounted health care services under available CICIP funding if the client's household income and resources (minus allowable deductions and adjustments) are no more than 250% of the most recently published federal poverty level (FPL) for a household of that size.

1. The determination of financial eligibility for applicants, also known as "the rating process," is intended to be uniform throughout Colorado. The application must be completed with the eligibility technician at the qualified health care provider's site.
2. All qualified health care providers must accept each other's CICIP Ratings, unless the provider believes that the rating was determined incorrectly or that the rating was a result of a provider management exception.
3. The rating process looks at the financial circumstances of a household as of the date that a signed application is completed.
4. CICIP Ratings are retroactive for services received from a qualified health care provider up to 90 days prior to application.
5. Every effort must be made by the qualified health care provider to obtain the necessary documentation needed concerning the applicant's financial status.

8.906 CICIP RATING

The federal poverty levels or the ability-to-pay scale is divided into eleven ratings. The result of the calculated income and resources and the family household size are used to determine what percentage of the federal poverty level the family meets.

Ability-to-Pay Scale Percentage of Federal poverty levels

CICIP Rating	Percent of Federal Poverty Levels	Further Descriptions
N	40%	.
A	62%	.
B	81%	.
C	100%	.
D	117%	.

E	133%	.
F	159%	.
G	185%	.
H	200%	.
I	250%	.
.	.	.
Z	40%	Homeless Clients Only

A qualified health care provider shall assign a CICIP Rating or denial, and notify the applicant of his status within five working days of the applicant completing the application to receive discounted health care services. Members of applicant's family household receiving discounted health care services under the same application shall all have the same CICIP Rating.

The rating letter or letter denying the application to receive discounted health care services shall include a statement informing the applicant that s/he has 15 days to appeal the denial or CICIP Rating.

The CICIP Rating determines a family's copayment and client copayment annual cap. CICIP Ratings are effective for a maximum of one year from the date of the rating, unless the client's financial or family situation changes or the rating is a result of a qualified health care provider management exception, according to Section 8.908 (E) of these regulations.

Any family member eligible for the Children's Basic Health Plan may only receive a CICIP Rating on a temporary basis. The CICIP Rating is retroactive for services received 90 days prior to the application to receive discounted health care services and valid for a temporary basis from the application date.

A. Determining the CICIP Rating

The CICIP Rating of an eligible client shall be determined by matching the family's net CICIP income and resources to the appropriate bracket on the ability-to-pay scale, taking into account the current federal poverty level for a household of the same size.

B. CICIP Re-rating

A client is required to receive a re-rating because his/her financial or family situation has changed since the initial rating. To re-rate a client, the qualified health care provider must complete a new application. Client re-ratings affect only future charges. Therefore, bills incurred after the initial rating but prior to the re-rating shall be discounted based on the client's initial rating.

If the client requests a re-rating and can document that relevant circumstances have changed since the initial rating, the qualified health care provider must re-rate the client. Reasons that justify the client to request or require the client to receive a re-rating include but are not limited to:

1. Family income has changed significantly;
2. Number of dependents has changed;
3. An error in the calculation; or
4. The eligibility year has expired.

8.907 CLIENT COPAYMENT

A. Client Copayments - General Policies

A client is responsible for paying a portion of his/her medical bills. The client's portion is called the "client copayment". Qualified health care providers are responsible for charging the client a copayment. The maximum allowable client copayments by service are shown below in the Client Copayment Table. Qualified health care providers may require clients to pay their copayment prior to receiving care (except for emergency care).

Client Copayment Table

CICP Rating	Inpatient Hospital, Ambulatory Surgery Copayment	Inpatient & Emergency Room - Physician Copayment	Outpatient Clinic Copayment	Hospital Emergency Room, Specialty Outpatient Clinic & Emergency Transportation Copayment	Prescription and Laboratory, Radiology, Imaging Copayment
N	\$15	\$7	\$7	\$15	\$5
A	\$65	\$35	\$15	\$25	\$10
B	\$105	\$55	\$15	\$25	\$10
C	\$155	\$80	\$20	\$30	\$15
D	\$220	\$110	\$20	\$30	\$15
E	\$300	\$150	\$25	\$35	\$20
F	\$390	\$195	\$25	\$35	\$20
G	\$535	\$270	\$35	\$45	\$30
H	\$600	\$300	\$35	\$45	\$30
I	\$630	\$315	\$40	\$50	\$35
.
Z	\$0	\$0	\$0	\$0	\$0

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related client copayments.

1. Hospital inpatient facility charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay of 24 hours or longer. The client is responsible for the corresponding Hospital Inpatient Copayment.
2. Ambulatory Surgery charges are for all operative procedures received by a client who is admitted to and discharged from the hospital setting on the same day. The client is responsible for the corresponding Inpatient Hospital Copayment for the non-physician (facility) services and the corresponding Physician Copayment for the physician services.
3. The Inpatient and Emergency Room Physician charges are for services provided to a client by a physician in the hospital setting, including inpatient and emergency room care. The client is responsible for the corresponding Physician Copayment.
4. Outpatient Clinic charges are for all non-physician (facility) and physician services received by a client while receiving care in the outpatient clinic setting, but does not include charges from outpatient services provided in the hospital setting (i.e. emergency room care, ambulatory surgery, radiology). Outpatient charges include primary and preventive medical care. The client is responsible for the corresponding Outpatient Clinic Copayment.

5. Hospital Emergency Room, charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care). The client is responsible for the corresponding Hospital Emergency Room Copayment.
 6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a client while receiving care in the specialty outpatient clinic setting, but do not include charges from outpatient services provided in the hospital setting (i.e., emergency room care, ambulatory surgery). Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. The client is responsible for the corresponding Specialty Outpatient Clinic Copayment. A qualified health care provider must receive written approval from the Department to charge the Specialty Outpatient Clinic Copayment.
 7. Emergency Transportation charges are for transportation provided by an ambulance. The client is responsible for the corresponding Emergency Transportation Copayment.
 8. Laboratory Service charges are for all laboratory tests received by a client not associated with an inpatient facility or hospital outpatient charge during the same period. The client is responsible for the corresponding Laboratory Services Copayment.
 9. Radiology and Imaging Service charges are for all radiology and imaging services received by a client while receiving care in the outpatient clinic setting, but does not include charges from outpatient or inpatient services provided in the hospital setting. The client is responsible for the corresponding Radiology and Imaging Copayment.
 10. Prescription charges are for prescription drugs received by a client at a qualified health care provider's pharmacy as an outpatient service. The client is responsible for the corresponding Prescription Copayment. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.
 11. Clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in an Outpatient setting are responsible for the Hospital Inpatient Facility copayment in addition to the Outpatient Specialty Clinic copayment.
- B. Z-Rating. These are homeless clients, clients living in transitional housing, clients residing with others, or recipients of Colorado's Aid to the Needy Disabled financial assistance program, who are at or below 40% of the Federal Poverty Level (qualify for an N-Rating). These clients are exempt from client copayments and are rated with the Z-rating.
- a. Homeless. A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

In addition, homeless clients are exempt from client copayments, the income verification requirement, and providing proof of residency when completing the CICP application.

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

In addition, transitional housing clients are exempt from the income verification requirement when completing the CICP application.

- c. Residing with Others. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the client are considered residing with others. The individual allowing the client to reside with him or her may be asked to provide a written statement confirming that the client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.
- d. Recipient of Colorado's Aid to the Needy Disabled financial assistance program. A client who is eligible and enrolled to receive the monthly grant award from Colorado's Aid to the Needy Disabled financial assistance program.

In addition, recipients of Colorado's Aid to the Needy Disabled financial assistance program are exempt from client copayments, and the income verification requirement when completing the CICP application.

C. Client Annual Copayment Cap

- 1. For all CICP Ratings annual copayments for clients shall not exceed 10% of the family's net income and resources.
- 2. The client annual copayment cap (annual cap) is based on the client's date of eligibility. Clients are responsible for any charges incurred prior to receiving their CICP Rating. Clients shall track their CICP copayments and inform the provider in writing (including documentation) within 90 days after meeting their annual cap. However, if a client overpays the annual cap and informs the qualified health care provider of that fact in writing, the qualified health care provider shall reimburse the client for the overpayment.
- 3. A CICP client is eligible to receive a re-rating if his/her financial or family situation has changed since the initial rating. CICP copayments made under the prior rating will not count toward a new CICP rating cap and the client's annual copayment cap is resets when the client completes a new application.
- 4. An annual cap applies only to charges incurred after a client is eligible to receive discounted health care services, and applies only to discounted services incurred at a qualified CICP health care provider.

D. Determining Client Copayments

The client's copayment shall be determined by matching the client's CICP rating with the corresponding rate on the CICP copayment table.

- E. The patient must pay the lower of the copayment listed or actual charges.
- F. Clients shall be notified at or before time of services rendered of their copayment responsibility.
- G. Grants for Client Copayments

Grants from foundations to clients from non-profit, tax exempt, charitable foundations specifically for client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

8.908 APPEAL PROCESS

A. If an applicant or client feels that a rating or denial is in error, the applicant/client shall only challenge the rating or denial by filing an appeal with the qualified health care provider who completed the application to receive discounted health care services under available CICP funding pursuant to this section 8.908. There is no appeal process available through the Office of Administrative Courts.

B. Instructions for Filing an Appeal

The qualified health care provider shall inform the applicant or client that s/he has the right to appeal the rating or denial if s/he is not satisfied with the qualified health care provider's decision.

If the applicant or client wishes to appeal the rating or denial of the application, the applicant or client shall submit a written request for appeal, which includes any documentation supporting the reasons for the request.

C. Appeals

An applicant or client may file an appeal if the applicant or client wishes to challenge the accuracy of his or her initial rating.

A client or applicant shall have 15 calendar days from the date of the qualified health care provider's decision to request an appeal.

If the qualified health care provider does not receive the applicant's or client's appeal within the 15 days, the qualified health care provider shall notify the applicant or client in writing that the appeal was denied because it was not submitted timely. At the discretion of the qualified health care provider and for good cause shown, including a death in the applicant's or client's immediate family, the qualified health care provider may review an appeal received after 15 days.

An applicant or client can request an appeal for the following reasons:

1. The initial rating or denial was based on inaccurate information because the family member or representative was uninformed;
2. The applicant or client believes that the calculation is inaccurate for some other reason; or
3. Miscommunication between the applicant or client and the rating technician, cause incomplete or inaccurate data to be recorded on the application.

Each qualified health care provider shall designate a manager to review appeals and grant management exceptions. An appeal involves receiving a written request from the applicant or client, and reviewing the application completed by the rating technician, including all back-up documentation, to determine if the application to receive discounted health care services under available CICP funding is accurate.

If the manager finds that the initial rating or denial is not accurate, the designated manager shall correct the application to receive discounted health care services under available CICIP funding and assign the correct rating to the applicant or client. The correct rating is effective retroactive to the initial date of application, and charges incurred 90 days prior to the initial date of application must be discounted. The qualified health care provider shall notify the applicant or client in writing of the results of an appeal within 15 working days following receipt of the appeal request from the client.

D. Provider Management Exception

At the discretion of the qualified health care provider and for good cause shown, the designated manager may grant the applicant or client a provider management exception.

A client may request and a qualified health care provider may grant a provider management exception if the client can demonstrate that there are unusual circumstances that may have affected his or her initial rating. Provider Management Exceptions shall always result in a lower client rating. Provider Management Exceptions shall not be used for applicants who do not qualify to receive discounted health care services under available CICIP funding due to being over-resourced.

A client may request a provider management exception within 15 calendar days of the qualified health care provider's decision regarding an appeal, or simultaneously with an appeal.

The facility shall notify the client in writing of the qualified health care provider's findings within 15 working days of receipt of the written request.

Designated managers may authorize a three-month exception to a client's rating based on unusual circumstances. After the 90 day period ends, the client shall be re-rated. The qualified health care provider must note provider management exceptions on the application. Qualified health care providers shall treat clients equitably in the provider management exception process.

A rating from a provider management exception is effective as of the initial date of application. Charges incurred 90 days prior to the initial date of application must be discounted. Qualified health care providers are not required to honor provider management exceptions granted by other qualified health care providers.

8.930 Repealed effective 8/12/2011.

8.940 OLD AGE PENSION HEALTH CARE PROGRAM

8.941 EXTENT AND LIMITATIONS OF MEDICAL CARE

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM

In accordance with the Constitution of Colorado, Article XXIV, Section 7, and the Colorado Social Services Act, an Old Age Pension Health Care Program is established to provide necessary medical care for the Old Age Pension recipients who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. The State Department is designated as the single State agency to administer the program.

- A. The Old Age Pension Health Care Program provides optional benefits to clients who qualify for (State only) OAP-A and (State only) OAP-B pensions who do not qualify for Federal Financial Participation in the Colorado Medicaid Program. These cases are coded with Supplemental Income Status Code (SISC) C.

- B. Under the Old Age Pension Health Care Program, only the following State funded benefits are provided: physician and practitioner services, inpatient hospital, outpatient services, lab and x-ray, emergency transportation, emergency dental, dental, pharmacy, home health services and supplies, and Medicare cost sharing.

Effective January 1, 2006, Medicare Part D prescription drugs provided pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (defined at 42 U.S.C. Sections 1395w-102 and 141 and 42 C.F.R. Section 423, et seq.) shall not be a benefit for those individuals who are eligible for both Medicare and the Old Age Pension Health Care Program. The pharmacy drug benefit under the Old Age Pension Health Care Program shall follow Medicaid regulations, as specified under 10 CCR 2505-10, Section 8.800.

For the benefits listed above, the Old Age Pension Health Care Program shall only be used to provide clients with health care services determined to be medically necessary by the health care provider.

- C. All other medical benefits not listed in paragraph B are excluded under the Old Age Pension Health Care Program. Inpatient care in an institution for tuberculosis or mental diseases, skilled and intermediate nursing facility services, and home and community based services are also excluded.
- D. The Old Age Pension Health Care Program eligibility shall not be retroactive. Eligibility shall begin with the date of application or date eligibility is established, whichever is later.
- E. The Executive Director of the Department of Health Care Policy and Financing, under the direction of the State Medical Services Board, shall manage the Old Age Pension Health and Medical Care fund to assure that utilization controls and other mechanisms are in place in order to hold expenditures within the constitutional and statutory limits.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will exceed the available funds, he/she shall take action to reduce expenditures as needed by reducing, suspending, or eliminating payments for covered benefits.

The Executive Director shall consider reducing, suspending or eliminating benefits, individually or in any combination, based upon the shortest duration of time and considering the least impact on the client. The Executive Director shall report to the Board whenever such action is required, specifying the dollar impact, length of time for the reduction, and the number of clients and providers affected. In addition, the Executive Director shall report to the Board on the feasibility of other cost reduction options.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will be less than the available funds, he/she may take action to increase expenditures up to constitutional and statutory limits by modifying the reimbursement methodology for covered benefits. In addition, the Executive Director shall report to the Board whenever such action is taken.

- F. Counties shall provide information to Old Age Pension Health Care Program clients regarding the disposal of excess resources in order to qualify for the Medicaid program. Such information shall include advisements concerning the prohibition of transfer of assets without fair consideration.
- G. If Medicare pays for a medical service that is a non-benefit for this group, the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program.

8.941.2 DEFINITION

Throughout this section of the rules, all references to “medical” shall mean the Old Age Pension Health Care Program. Exceptions will be noted in the specific rule. All forms of communication to providers, counties and recipients (Provider bulletins, claim forms, authorization forms, Medicaid Authorization Card (MAC etc.), shall include Colorado Medical Assistance Program, and Old Age Pension Health Care Program.

8.941.3 GROUPS ASSISTED UNDER THE OLD AGE PENSION HEALTH CARE PROGRAM

Old Age Pension Health Care Program benefits are provided to persons receiving OAP A, OAP-B, and OAP refugees who do not meet SSI eligibility criteria, but do meet the State eligibility criteria for the Old Age Pension Health Care Program. These persons qualify for a SISC Code C.

- A. SISC Code C – this code is for persons eligible to receive financial assistance under OAP-A, OAP-B, or OAP Refugee Assistance, who do not receive an SSI payment, and do not otherwise qualify for the Colorado Medicaid Program. Code C signifies that no FFP is available in medical assistance program expenditures.
- B. Recipients of financial assistance under State AND, State AB or OAP “C” are not eligible for assistance under the Old Age Pension Health Care Program.

8.941.4 FINANCIAL ASSISTANCE

All rules applicable to Old Age Pension financial assistance program payments (as set forth in the Department of Human Services rules at 9 CCR 2503-3 shall apply to the Old Age Pension Health Care Program.

8.941.5 CERTIFICATION OF PAYMENT FOR PROVIDERS

All providers of medical services in their submission of claim to the Old Age Pension Health Care Program certify that, “I will accept as payment in full, payment made under the Old Age Pension Health Care Program, and certify that no supplemental charges have been, or will be, billed to the patient, except for those non-covered items, or services, if any, which are not reimbursable under the Old Age Pension Health Care Program.”

8.941.6 GENERAL EXCLUSIONS

In addition to any specific exclusion defined in this manual, the general exclusions from coverage of the Old Age Pension Health Care Program defined by the rules of the Department of Human Services (9 CCR 2503-1) are also excluded.

8.941.7 OUT-OF-STATE MEDICAL CARE

All requirements for out- of- state medical care as defined by 10 CCR 2505-10, Section 8.013 apply to the Old Age Pension Health Care Program for covered services with the exception that any reduction, suspension or elimination of benefits must be applied.

8.941.8 SUBMISSION OF CLAIMS

Rules governing the submission or payment of claims, provider or recipient appeals, third party liability, overpayment, fraud and abuse, and State identification numbers as defined in 10 CCR 2505-10, Section 8.000, et seq. apply to the Old Age Pension Health Care Program for covered services with the exception that any reduction, suspension or elimination of benefits provided must also be applied.

8.941.9 REIMBURSEMENT TO PROVIDERS

In accordance with 8.941.1(E), the Executive Director may alter the reimbursement for any service with the condition that expenditures remain within the constitutional and statutory limits. Reimbursement rates shall be published on the Department's website. When reimbursement rates are modified, notification will be published in the Provider Bulletin.

8.941.10 CLIENT CO-PAYMENT

Recipients of benefits under the OAP Health Care Program shall be responsible for paying directly to providers a set portion of the cost of services according to the regulations and fee schedule as defined for the Medical Assistance and described in 10 CCR 2505-10, Section 8.754.1. This charge to the recipient will be called co-payment.

Those recipients whose co-payments reach a limit of \$300.00 within a January 1 through December 31 calendar year will be exempted from further co-payments during that year. The exemption will begin on the date of payment for the claim, which indicates that the cumulative maximum has been reached.

It will be a recipient responsibility to present the Medical ID Card to the provider at the time a service is rendered in order to claim exemption from copayment for that service.

8.942 CHANGE OF SUPPLEMENTAL INCOME STATUS CODE (SISC) TO MEDICAID

8.942.1 MEDICAID QUALIFICATION

When a recipient of OAP-A or OAP-B and the OAP Health Care Program or Old Age Pension Health Care Supplemental Program subsequently qualifies for Medicaid, his/her SISC code must be changed to indicate Medicaid benefits. Additionally, the county must backdate the Medicaid benefits to the date the individual became eligible for Medicaid even if the recipient was eligible for the OAP Health Care Program or the Old Age Pension Health Care Supplemental Program at the time. Some reasons for Medicaid eligibility are: receipt of Supplemental Security Income, receipt of Social Security disability benefits, attainment of age 65, changes in alien status or reduction of resources that caused the individual to be ineligible for Medicaid.

8.943 IDENTIFICATION AND AFFIDAVIT REQUIREMENTS [Emer. Rule eff. 10/1/06; Perm. Rule eff. 10/30/06]

8.943.1 Effective August 1, 2006, each applicant eighteen (18) years of age or older shall produce the following identification:

- A. A valid Colorado Driver's License or a Colorado Identification Card, issued pursuant to Article 2 of Title 42, C.R.S.;
- B. A United States Military Card or a Military Dependents' Identification Card;
- C. A United States Coast Guard Merchant Mariner Card;
- D. A Native American Tribal Document; OR
- E. Other forms of identification or a waiver process to ensure that an individual proves lawful presence in the United States as authorized by the Executive Director of the Colorado Department of Revenue pursuant to Section 24-76.5-130(5)(a), C.R.S.

8.943.2 Effective August 1, 2006, each applicant eighteen (18) years of age or older shall execute an affidavit stating:

- A. That he or she is a United States Citizen or legal permanent resident; OR
- B. That he or she is otherwise lawfully present in the United States pursuant to Federal Law.

8.943.3. For an applicant who has executed an affidavit stating that he or she is an alien lawfully present in the United States under 8.943.2.B, the following shall apply:

- A. Verification of lawful presence shall be made through the Federal Systematic Alien Verification of Entitlement Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security.
- B. Until such verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.
- C. The county or medical assistance site shall perform the verification of lawful presence no more than 30 days after receipt of the affidavit stating that the applicant is otherwise lawfully present in the United States pursuant to Federal Law.

8.943.4 Photocopies of the identification listed in 8.943.1 shall be acceptable identification if the photocopies meet the following criteria:

- A. A notary public must have certified on the photocopy or an attachment that individually identifies the original document that he or she saw the original document and that the photocopy is a true copy of that original; OR
- B. Photocopies made by a county caseworker or medical assistance site worker who attests in writing on the photocopy that he or she saw the original documentation and that the photocopy is a true copy of that original.

8.943.5 The county shall retain a photocopy of the documentation required under section 8.943.

8.943.6.A. If an applicant does not have the required documentation, he or she must be given a reasonable opportunity period of up to ten (10) business days to provide the required documentation. If the applicant does not provide the required documentation within those ten (10) business days, then the application shall be denied.

8.943.6.B. If an applicant whose benefits are terminated on the basis of not having the documents required by 8.943.1 provides such documentation within ten (10) weeks of the date of denial, the denial shall be rescinded, and the client made eligible back to the date of application, provided he or she meet all other eligibility requirements.

8.950 PRIMARY CARE FUND

8.950.1 GENERAL DESCRIPTION

8.950.1.A. In accordance with Section 21 of Article X (Tobacco Taxes for Health Related Purposes) of the State Constitution, an increase in Colorado's tax on cigarettes and tobacco products became effective January 1, 2005, and created a cash fund that was designated for health related purposes. House Bill 05-1262 divided the tobacco tax cash fund into separate funds, assigning 19% of the moneys to establish the Primary Care Fund, set forth how the funds will be allocated and designated the Department of Health Care Policy and Financing (the Department) as the administrator of the Primary Care Fund.

8.950.1.B. The Primary Care Fund provides an allocation of moneys to health care providers that make basic health care services available in an outpatient setting to residents of Colorado who are considered medically indigent. Moneys shall be allocated based on the number of medically indigent patients in an amount proportionate to the total number of medically indigent patients served by all health care providers who qualify for moneys from this fund.

8.950.2 DEFINITIONS

8.950.2.A. Arranges For - Demonstrating Established Referral Relationships with health care providers for any of the Comprehensive Primary Care services not directly provided by the provider.

8.950.2.B. Children's Basic Health Plan also known as Child Health Plan Plus (CHP+) - As specified in Article 19 of Title 26, C.R.S.

8.950.2.C. Colorado Indigent Care Program (CICP) - As specified in Article 15 of Title 26, C.R.S.

8.950.2.D. Comprehensive Primary Care - Basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. At a minimum, this includes providing or arranging for the provision of the following services on a Year-Round Basis: primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services, diagnostic laboratory and radiology services; emergency care for minor trauma; Pharmaceutical Services; and coordination and follow-up for hospital care. It may also include optional services based on a patient's needs such as dental, behavioral health and eyeglasses.

8.950.2.E. Cost-Effective Care - Provides or Arranges For Comprehensive Primary Care that is appropriate and at a reasonable average cost per patient Visit/Encounter.

8.950.2.F. Eligible Qualified Provider - A qualified Provider who is identified by the Department to receive funding from the Primary Care Fund.

8.950.2.G. Established Referral Relationship - A formal, written agreement in the form of a letter, a memorandum of agreement or a contract between two entities which includes:

1. The Comprehensive Primary Care and/or products (e.g., pharmaceuticals, radiology) to be provided by one entity on behalf of the other entity;
2. Any applicable policies, processes or procedures;
3. The guarantee that referred Medically Indigent Patients shall receive services on a Sliding Fee Schedule or at no charge; and
4. Signatures by representatives of both entities.

8.950.2.H. Medical Assistance Program (Medicaid) - As specified in Article 4 of Title 26, C.R.S.

8.950.2.I. Medically Indigent Patient - A patient receiving medical services from a Qualified Provider and:

1. Whose yearly family income is below two hundred percent (200%) of the Federal Poverty Level (FPL);

2. Who is not eligible for the Medical Assistance Program, , the Children’s Basic Health Plan, Medicare or any other governmental reimbursement for health care costs such as through Social Security, the Veterans Administration, Military Dependency (TRICARE or CHAMPUS), or the United States Public Health Service. (Payments received from the Colorado Indigent Care Program are not considered a governmental reimbursement for health care costs related to a specific patient); and
 3. There is no Third Party Payer.
- 8.950.2.J. Medically Underserved Area - A federal government designation given to a geographical area based on the ratio of medical personnel (physicians, dentists, behavioral health workers, etc.) to the population. These areas have fewer than a generally accepted minimum number of medical personnel per thousand population resulting in insufficient health resources (personnel and/or facilities) to meet the medical needs of the resident population. Such areas are also defined by measuring the health status of the resident population; an area with an unhealthy population being considered underserved.
- 8.950.2.K. Medically Underserved Population - A federal government designation given to a human population that does not receive adequate medical attention or have access to health care facilities.
- 8.950.2.L. Outside Entity - A business or professional that is not classified as an employee of the provider or the Department and does not have a direct or indirect financial interest with the provider. The business or professional shall have auditing experience or experience working directly with the Medical Assistance Program or similar services or grants for Medically Indigent Patients.
- 8.950.2.M. Pharmaceutical Services - Provides prescription drugs, or coordinates access to or Arranges For client to receive prescription drugs prescribed by the Qualified Provider on a Sliding Fee Schedule or at no charge.
- 8.950.2.N. Qualified Provider - An entity that provides Comprehensive Primary Care in Colorado and that:
1. Accepts all patients regardless of their ability to pay and uses a Sliding Fee Schedule for payments or does not charge Medically Indigent Patients for services;
 2. Serves a designated Medically Underserved Area or Medically Underserved Population as provided in section 330(b) of the federal “Public Health Service Act”, 42 U.S.C. sec. 254b, or demonstrates to the Department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;
 3. Has a demonstrated Track Record of providing Cost-Effective Care;
 4. Provides or Arranges For the provision of Comprehensive Primary Care to persons of all ages. An entity in a rural area may be exempt from this requirement if they can demonstrate that there are no providers in the community to provide one or more of the Comprehensive Primary Care services;
 5. Completes a screening that evaluates eligibility for the Medical Assistance Program, the Children’s Basic Health Plan, and the Colorado Indigent Care Program and refers patients potentially eligible for one of the programs to the appropriate agency (e.g., county departments of human/social services) for eligibility determination if they are not qualified to make eligibility determinations; and

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6. Is a community health center, as defined in Section 330 of the federal “Public Health Services Act” , 42 U.S.C. Section 254b; or at least 50% of the patients served by the provider are Medically Indigent Patients or patients who are enrolled in the Medical Assistance Program, the Children’s Basic Health Plan, or any combination thereof.
- 8.950.2.O. Quality Assurance Program - Formalized plan and processes designed to ensure the delivery of quality and appropriate Comprehensive Primary Care in a defined medical setting. This can be demonstrated by obtaining a certification or accreditation through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). If such certification or accreditation is not available, then at a minimum, the Quality Assurance Program shall be comprised of elements that meet or exceed the following components:
1. Establishment of credentialing/re-credentialing requirements for medical personnel;
 2. Surveying and monitoring of patient satisfaction;
 3. Establishment of a grievance process for patients, including documentation of grievances and resolutions;
 4. Development of clinic operating policies and scheduled performance monitoring;
 5. Review of medical records to check for compliance with established policies and to monitor quality of care;
 6. Assessment of state and federal regulations to ensure compliance;
 7. Establishment of patient safety procedures; and
 8. Establishment of infection control practices.
- 8.950.2.P. Sliding Fee Schedule - A tiered co-payment system that determines the level of patient’s financial participation and guarantees that the patient financial participation is below usual and customary charges. Factors considered in establishing the tiered co-payment system shall only be financial status and the number of members in the patient’s family unit.
- 8.950.2.Q. Third Party Payments or Third Party Payer - Any individual, entity or program with a legal obligation to pay for some or all health-related services rendered to a patient. Examples include the Medical Assistance Program; the Children’s Basic Health Plan; Medicare; commercial, individual or employment-related health insurance; court-ordered health insurance (such as that required by non-custodial parents); workers' compensation; automobile insurance; and long-term care insurance. The Colorado Indigent Care Program is not considered a Third Party Payer and payments received from the Colorado Indigent Care Program are not considered Third Party Payments.
- 8.950.2.R. Track Record - Evidence of providing Comprehensive Primary Care covering at least a consecutive 52-week period prior to the submission of the application.

8.950.2.S. Unduplicated User/Patient Count - The sum of patients who have had at least one Visit/Encounter and received at least one of the services under the Comprehensive Primary Care definition during the applicable calendar year, but does not include the same patient more than once. The sum shall be calculated on a specific point-in-time occurring between the end of the applicable calendar year and prior to the submission of the application. Each patient shall be counted once under only one payment source designation (Third Party Payer or Medically Indigent Patient). The patient's payment source designation shall be the payment source designation listed for the patient at the specific point-in-time in which the calculation is made. The sum shall not include:

1. Counting a patient more than once if the same patient returns for additional services (e.g., medical or dental) and/or products (e.g., pharmaceuticals) during the applicable calendar year;
2. Counting a patient more than once if the payment source designation changed during the applicable calendar year;
3. Persons who have only received services through an outreach event, community education program, nurse hotline, or other types of community-based events or programs and were not documented on an individual basis;
4. Persons who have only received services from large-scale efforts such as mass immunization programs, screening programs, and health fairs; or
5. Persons whose only contact with the provider is to receive Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) counseling and vouchers are not users and the contact does not generate an encounter.

8.950.2.T. Visit/Encounter - A face-to-face appointment with medical personnel (physicians, physician assistants, dentists, behavioral health workers, etc.) in which the patient received health related services and/or products (e.g., pharmaceuticals or radiology) and the appointment is customarily billable to a Third Party Payer.

8.950.2.U. Year-Round Basis - Comprehensive Primary Care provided in a consecutive 52-week period directly by the provider and/or through an established referral relationship with other providers. If an organization is closed for four consecutive weeks or longer in a calendar year on a regularly scheduled basis, it is not considered to directly provide services on a year-round basis.

8.950.3 PROVIDER ELIGIBILITY

8.950.3.A. Providers who provide Comprehensive Primary Care to Medically Indigent Patients and who meet all of the requirements established for the Primary Care Fund as of the date the application form is submitted to the Department shall receive moneys appropriated to the Primary Care Fund. Specifically, the provider shall:

1. Meet all of the requirements of a Qualified Provider as specified in 8.950.2.N;
2. Have a Quality Assurance Program in place as specified in 8.950.2.O; and
3. Submit a completed application form according to stated guidelines as specified under 8.950.4.

8.950.4 APPLICATION

- 8.950.4.A. The application form shall be available to providers annually and posted for public access on the Department's website at least 30 calendar days prior to the response due date.
- 8.950.4.B. At a minimum, the application form shall require responses that:
1. Demonstrate how the provider meets the criteria of a Qualified Provider as defined in 8.950.2.N;
 2. Provide an Unduplicated User/Patient Count covering the applicable calendar year which, at a minimum, shall include the number of patients eligible for the Medical Assistance Program and the Children's Basic Health Plan and the number of patients considered to be Medically Indigent Patients;
 3. Provide certification that the Unduplicated User/Patient Count identified in 8.950.4.B.2 has been verified by an Outside Entity; and
 4. Provide documentation that the provider has a Quality Assurance Program as defined in 8.950.2.O.
- 8.950.4.C. Providers shall complete and provide a response annually. The response shall be made in compliance with all specifications in the application form, including format, data and documentation. Responses to the application form shall be submitted directly to the Department by the required response deadline.
- 8.950.4.D. All providers who submit a response to the application form shall be notified within 45 days of the response deadline if the provider met or did not meet the requirements to become an Eligible Qualified Provider.

8.950.5 DISBURSEMENT

- 8.950.5.A. Eligible Qualified Providers are determined on a state fiscal year basis and shall receive only those moneys appropriated to the Primary Care Fund for that same state fiscal year, subject to the tax amount actually collected for that state fiscal year.
- 8.950.5.B. Payments shall be based on the number of Medically Indigent Patients in each Eligible Qualified Provider's Unduplicated User/Patient Count in an amount proportionate to the total number of Medically Indigent Patients from all Eligible Qualified Providers' Unduplicated User/Patient Counts.
- 8.950.5.C. The schedule for the disbursement of moneys to all Eligible Qualified Providers shall be dependent on actual tax collections allocated to the Primary Care Fund such that:
1. Tax collections for sales in July, August, and September shall be distributed to Eligible Qualified Providers prior to the end of October.
 2. Tax collections for sales in October, November, and December shall be distributed to Eligible Qualified Providers prior to the end of January.
 3. Tax collections for sales in January, February, and March shall be distributed to Eligible Qualified Providers prior to the end of April.
 4. Tax collections for sales in April, May, and June shall be distributed to Eligible Qualified Providers prior to the end of July.

5. For State Fiscal Year 2005-06 only, tax collections for sales in January 2005 through December 2005, shall be distributed to Eligible Qualified Providers prior to the end of February 2006.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.1 Definitions

Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.

Covered Dental Care Services mean the Current Dental Terminology (CDT) procedure codes and descriptions for the Colorado Dental Health Care Program for Low-Income Seniors as published on the Department's website at <https://www.colorado.gov/hcpf/research-data-and-grants>.

C.R.S. means the Colorado Revised Statutes.

Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2014).

Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.

Eligible Senior means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is able to demonstrate lawful presence in the state in accordance with 1 CCR 201-17, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance.

Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).

Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.

Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors. The Max Allowable Fee is the sum of the Program Payment and the Max Patient Co-Pay.

Max Patient Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.

Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2014).

Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2014)

Program Payment means the maximum amount by procedure listed for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors.

Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:

1. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2014);
2. A community-based organization or foundation;
3. A Federally Qualified Health Center, safety-net clinic, or health district;
4. A local public health agency; or
5. A private dental practice.

Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.

Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2014).

8.960.2 Legal Basis

The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2014).

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at <https://www.colorado.gov/hcpf/research-data-and-grants> at least 30 days prior to the due date.

8.960.3.B Evaluation of Grant Proposals

Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1. The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any particular applicant.
2. The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.
3. Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:

- a. Outreach to and identify Eligible Seniors;
 - b. Collaborate with community-based organizations; and
 - c. Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.
4. The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

8.960.3.C Grant Awards

The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.3.D Qualified Grantee Responsibilities

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

1. Identify and outreach to Eligible Seniors and Qualified Providers;
2. Demonstrate collaboration with community-based organizations;
3. Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;
4. Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;
5. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;
6. Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and
7. Submit an annual report as specified under 8.960.3.F.

8.960.3.E Invoicing

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

1. Invoices shall include the number of Eligible Seniors served, the types of Covered Dental Care Services provided, and any other information required by the Department.
2. The Department will pay no more than the established Program Payment per procedure rendered.

3. It is up to the discretion of Qualified Providers whether to charge a co-payment. Under no circumstance shall Eligible Seniors be charged more than the Max Patient Co-Pay per procedure rendered.
4. Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

8.960.3.F Annual Report

On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

The annual report shall be completed in a format specified by the Department and shall include:

1. The number of Eligible Seniors served;
2. The types of Covered Dental Care Services provided;
3. An itemization of administrative expenditures; and
4. Any other information deemed relevant by the Department.

EDITOR'S NOTES

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 03/04/2007, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 03/04/2007, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]