THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Hospice Benefit, Section 8.550.1
Rule Number:	MSB 12-01-20-A
Division / Contact / Phone:	Medicaid Program Division / Guinevere Blodgett / 5927

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 12-01-20-A, Revision to the Medical Assistance Rule Concerning Hospice Benefit, Section 8.550.1
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.550.1 Hospice Benefit, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Please replace current text at § 8.550.1 DEFINITIONS, unnumbered paragraph 9 with the new text provided (change the word "six" to the word "nine." This change is effective 06/01/2012.

*to be completed by MSB Board Coordinator

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Rule Number:	MSB 12-01-20-A
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STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this rule amendment is to amend the definition of Terminal Illness by extending the medical prognosis of life expectancy from 6 months to 9 months. This allows clients to elect hospice with a medical prognosis of life expectancy of 9 months or less, to comply with 25.5-5-304(1)(a), C.R.S. (HB 10-1027).

2. An emergency rule-making is imperatively necessary

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

   ☐ for the preservation of public health, safety and welfare.

   Explain:

   N/A

3. Federal authority for the Rule, if any:

   Social Security Act §1906(o)
   42 CFR §418

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);
   25.5-5-304, C.R.S. (2011) and HB 10-1027

Initial Review	**03/09/2012**	Final Adoption	**04/13/2012**
Proposed Effective Date	**06/01/2012**	Emergency Adoption	

DOCUMENT # 01

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Hospice Benefit, Section 8.550.1
Rule Number:	MSB 12-01-20-A
Division / Contact / Phone:	Medicaid Program Division / Guinevere Blodgett / 5927

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   All Medicaid clients with a diagnosis of a terminal illness will be able to elect hospice services 3 months sooner than the current regulation allows (changing client's life expectancy from 6 months to 9 months).

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

   This rule change will allow clients with terminal illness to request hospice services 3 months earlier than they are allowed to under the current regulations. Allowing clients to elect hospice three months earlier will allow clients and their families to get access hospice care earlier in the disease process, which gives more time to create an optimal care plan.

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

   The Department's analysis of this proposed change shows that this change will not likely lead to increased hospice expenditures. Budget Analysis is attached.

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

   The quality of life that this proposed change is expected to make on the Medicaid clients eligible for hospice is the primary benefit to Medicaid clients.

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

   There are currently no less costly or less intrusive methods of extending hospice enrollment.

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

   This rule change brings the Department into compliance with 25.5-5-304, C.R.S., which states that clients are eligible for hospice services if they have a medical prognosis for life expectancy of 9 months or less.

8.550 HOSPICE BENEFIT

8.550.1 DEFINITIONS

Benefit Period means a period during which the client has made an Election to receive hospice care defined as one or more of the following:

(1) An initial 90-day period.

(2) A subsequent 90-day period.

(3) An unlimited number of subsequent 60-day periods.

The periods of care are available in the order listed and may be Elected separately at different times.

Certification means that the client's attending physician and/or the Hospice medical director have affirmed that the client is Terminally Ill.

Election/Elect means the client's written expression to choose Hospice care for Palliative and Supportive Medical Services. Home Care Services means Hospice Services that are provided primarily in the client's home but may be provided in a residential facility and/or licensed or certified health care facility.

Hospice means a centrally administered program of palliative, supportive, and Interdisciplinary Team services providing physical, psychological, sociological, and spiritual care to Terminally Ill clients and their families.

Hospice Services means counseling, home health aide, homemaker, nursing, physician, social services, physical therapy, occupational therapy, speech therapy, and trained volunteers.

Interdisciplinary Team or Interdisciplinary Group means a group of qualified individuals, consisting of at least a physician, registered nurse, clergy/counselors, volunteer director and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice clients/families.

Palliative and Supportive Medical Services means those services and/or interventions which are not curative but which produce the greatest degree of relief from the symptoms of the Terminal Illness.

Terminally Ill/Terminal Illness means a medical prognosis of life expectancy of ~~six~~nine months or less, should the illness run its normal course.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Premium Amounts for the Medicaid Buy-In Program
Rule Number:	MSB 12-03-02-A
Division / Contact / Phone:	Eligibility / Marivel Guadarrama / 3926

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 12-03-02-A, Revision to the Medical Assistance Rule Concerning Premium Amounts for the Medicaid Buy-In Program
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.6.O, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.100.6.O.1.f.3.c, d and e with the new text provided. All other text is for clarification purposes only. This change is effective 06/01/2012.

*to be completed by MSB Board Coordinator

Title of Rule:	Revision to the Medical Assistance Rule Concerning Premium Amounts for the Medicaid Buy-In Program
Rule Number:	MSB 12-03-02-A
Division / Contact / Phone:	Eligibility / Marivel Guadarrama / 3926

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule amends 10 CCR 2505-10, Section 8.100.6.O to comply with federal regulations. Specifically, CMS has required for the premium amounts to be decreased in order to comply with a premium no greater than 7.5% of income for a client. Decreasing these premiums amounts will allow for premium amounts commensurate with the client's income to increase affordability within the Medicaid Buy-In Program for Working Adults with Disabilities.

2. An emergency rule-making is imperatively necessary

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

   ☐ for the preservation of public health, safety and welfare.

   Explain:

   CMS has required for the premium amounts to be decreased in order to comply with a premium no greater than 7.5% of income for a client. The rules for the Medicaid Buy-In Program for Working Adults with Disabilities were previously approved with an effective date of 3/1/2012. These rules must be revised with the new premium amounts in order to comply with CMS.

3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

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

Initial Review		Final Adoption	**04/13/2012**
Proposed Effective Date	**06/01/2012**	Emergency Adoption	

DOCUMENT #03

Title of Rule:	Revision to the Medical Assistance Rule Concerning Premium Amounts for the Medicaid Buy-In Program
Rule Number:	MSB 12-03-02-A
Division / Contact / Phone:	Eligibility / Marivel Guadarrama / 3926

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The rule will affect working adults with disabilities income greater than or equal to 133% FPL but less than 450% of FPL regardless of resources.

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

   The rule will allow these persons owe a lesser premium amount than what is currently approved in rule. Anticipated caseload is 57 for fiscal year 2011-2012 and 1,695 for fiscal year 2012-2013.

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

   The probable costs to the Department will be the difference between the previously established premium amounts and the new premium amounts. These are total fund costs, and will be paid for exclusively from cash funds collected from hospital provider fees and federal matching funds. No General Fund will be required.

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

   The Department must implement the proposed rule pursuant to a CMS requirement and is necessary in order to obtain Federal financial participation (FFP) for the Medicaid Buy-In Program.

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

   N/A

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

   None

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

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

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

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

    c. Resources are not counted in determining eligibility.

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

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

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

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

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

        3. Premium amounts are as follows:

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

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

            c. A monthly premium of $~~100~~ 90 is applied to individuals with income above 133% of FPL but at or below 200% of FPL.

            d. A monthly premium of $~~225~~ 130 is applied to individuals with income above 200% of FPL but at or below 300% of FPL.

            e. A monthly premium of $~~400~~ 200 is applied to individuals with income above 300% of FPL but at or below 450% of FPL.

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

        5. A change in client net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of

the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

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