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 26-15-103, 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 any general hospital, birth center, 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., any 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 26-15-106(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the program, "general provider" includes associated physicians.

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 CICP 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 CICP 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 26-15-106 (5)(a)(I), C.R.S.

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 (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.

   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 CICP Funds

1. Using the information submitted in connection with an application to receive discounted health care services under available CICP funds, the provider shall determine whether the applicant meets all requirements to receive discounted health care services under available CICP funds. If the applicant is eligible to receive discounted health care services under available CICP funds, the qualified health care provider shall determine an appropriate rating and copayment for the client, using the current federal poverty levels (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 CICP 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 CICP 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 health care providers (providers) is limited by the annual legislative appropriation and funds will be proportionately allocated to providers based on the anticipated utilization of services. Payments made under this section to state-owned and local-owned hospital providers will consist of Certification of Public Expenditure (see 8.903.C.3) and federal funds, as determined by the federal financial participation (FFP) amount. Payments made under this section to private-owned hospital providers will consist of General Fund and federal funds, as determined by the FFP amount.

   Hospital providers who participate in the Colorado Indigent Care Program and whose percent of Medicaid-eligible inpatient days relative to total inpatient days is equal to 1% or greater, qualify to receive a Low-Income payment and a High-Volume payment. In addition, local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and those state-owned hospital providers whose percent of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association, qualify for a Bad Debt payment if funding exists.

   To receive a Low-Income payment, hospital providers must 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.

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 Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year. The basis for this calculation will be data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year.

3. Annually, state-owned and local-owned hospital providers shall submit a letter to the Department which states the cost not directly compensated by General Fund or Federal Funds for Medicaid inpatient hospital services and medically indigent services associated with the distribution of available funds. (Referred to as Certification of Public Expenditures.)

4. 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.

5. 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 CICP funding.

6. Providers shall deduct the full patient liability amount from total charges, which is the amount due from the client as identified in the CICP Copayment Table, as defined under Section 8.907 in these regulations. The summary information submitted to the Department concerning the use of CICP 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.

7. Beyond the distribution of available funds made by the CICP, allowable client copayments, and other third-party sources, a provider shall not seek payment from a client for the provider's CICP discounted health care services to the client.

8. High-Volume Payment. This payment is an allocation of the available Medicare Upper Payment Limit and is available only to hospital providers. As required by federal regulations, there would be three allotments of the upper payment limit: state-owned, local-owned, and private-owned hospital providers.

   The amount of available funds under the Medicare Upper Payment Limit is distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for qualified hospital providers. This calculation would be separate for state-owned, local-owned, and private-owned hospital providers, since the three groups are limited to unique pools of funds.

   The available funds under the Medicare Upper Payment Limit are multiplied by the

hospital provider specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for qualified hospital providers to calculate the High-Volume payment for the specific hospital provider. The available funds under the Medicare Upper Payment Limit by hospital provider category are:

a. Private-Owned Hospital Providers. The General Fund and FFP available and allocated by the Department under the Medicare Inpatient Upper Payment Limit for private-owned hospital providers.

b. Local-Owned Hospital Providers. The Certification of Public Expenditure and FFP available under the Medicare Inpatient Upper Payment Limit for local-owned hospital providers.

c. State-Owned Hospital Providers. The Certification of Public Expenditure and FFP available under the Medicare Inpatient Upper Payment Limit for state-owned hospital providers.

No payment (consisting of Federal Funds and General Fund or Certification of Public Expenditure) to a Local-Owned Hospital or State-Owned Hospital Provider will exceed 100% of uncompensated Medicaid inpatient hospital costs. Any amount of the calculated High-Volume payment that exceeds the calculated uncompensated Medicaid inpatient hospital costs will be added to the Low-Income payment calculation for that hospital provider. Uncompensated Medicaid inpatient hospital costs will be the maximum of the calculation of billed charges from inpatient claims paid in the most recently available State fiscal year multiplied by the cost-to-charge ratio available as of March 1 of each fiscal year minus the Medicaid reimbursement paid amount from inpatient claims paid in the same period, or the uncompensated Medicaid inpatient hospital costs from the prior State fiscal year, as reported under 8.903(C)(3) in these regulations, such that both figures will be inflated forward to the request budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

9. Low-Income payment. This payment is an allocation of the available Disproportionate Share Hospital Allotment imposed by the federal Centers for Medicare and Medicaid Services and is only available to hospital providers. The Disproportionate Share Hospital Allotment (or Cap) would be distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for hospital providers. This calculation is separate for public-owned (state-owned and local-owned) and private-owned hospital providers, since the two hospital provider categories have unique pools of General Fund appropriated each fiscal year.

   As required by the Social Security Act, Sec. 1923(g)(1)(A), no payment (consisting of Federal Funds and General Fund or Certification of Public Expenditure) to a hospital provider will exceed 100% of Medically Indigent costs. No hospital provider will receive a payment greater than hospital provider specific inflated medically indigent care costs or the uncompensated medically indigent costs as required under 8.903(C)(3). If the calculation generates a hospital provider specific payment beyond either of these amounts, the federal funds will remain under the Disproportionate Share Hospital Allotment.

   The available Disproportionate Share Hospital Allotment is multiplied by the hospital provider specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for hospital providers to calculate the Low-Income payment for the specific hospital provider category.

   a. Private-Owned Hospital Providers. The available Disproportionate Share Hospital

Allotment for private-owned hospital providers equals the General Fund and FFP available and allocated by the Department under the Disproportionate Share Hospital Allotment for private-owned hospital providers.

b. Public-Owned Hospital Providers. The available federal funds Disproportionate Share Hospital Allotment for public-owned (state-owned and local-owned) hospital providers equals the Disproportionate Share Hospital Allotment minus other federal funds designated as a Disproportionate Share Hospital payment under another payment and the amount of the federal funds distributed to the private-owned hospital providers.

10. Weighted Costs, High-Volume Payment and Low-Income Payment.

The hospital provider specific medically indigent costs are increased by the percent of Medicaid-eligible inpatient (fee-for-service and managed care) days relative to total inpatient days and percent of medically indigent days relative to total inpatient days to measure the relative Medicaid and low-income care to total care provided. For state-owned hospital providers, these percentages are not allowed to exceed one standard deviation above the mean for each weight.

The hospital provider specific medically indigent costs are further increased by the Disproportionate Share Hospital Factor, if the hospital provider qualifies, to account for disproportionately high volumes of Medicaid. To qualify for the Disproportionate Share Hospital Factor, the hospital provider's percent of Medicaid-eligible inpatient days relative to total inpatient days must equal or exceed one standard deviation above the mean. If the hospital provider does qualify, then the Disproportionate Share Hospital Factor would equal the hospital provider's specific percent of Medicaid-eligible inpatient days relative to total inpatient days. For local-owned hospital providers with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and private-owned hospital providers, the Disproportionate Share Hospital Factor is doubled. For local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers, the Disproportionate Share Hospital Factor is not allowed to exceed one standard deviation above the mean. If the hospital provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact.

The hospital provider specific medically indigent costs are further increased by the Medically Indigent Factor, if they qualify, to account for disproportionately high volumes of low-income care provided. To qualify for the Medically Indigent Factor, the hospital provider's percent of medically indigent days relative to total inpatient days must exceed the mean. If the hospital provider does qualify, then the Medically Indigent Factor equals the hospital provider specific percent of medically indigent days relative to total inpatient days. For local-owned hospital providers with less than or equal to 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and private-owned hospital providers, this factor is doubled. For local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers, the Medically Indigent Factor is not allowed to exceed one standard deviation above the mean. If the hospital provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact.

11. Bad Debt Payment. A Bad Debt payment is made only if federal funds remain available under the Disproportionate Share Hospital Allotment (or Cap) following the distribution of the Low-Income payment and the Low-Income Shortfall payment. This payment is available to local-owned hospital providers with more than 200 inpatient beds, as licensed by the Colorado Department of Public Health and Environment, and state-owned hospital providers whose percent of Medicaid-eligible inpatient days relative to total

inpatient days equal or exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association if funding exists.

The amount of available federal funds remaining under the Disproportionate Share Hospital Allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt costs for all hospital providers that qualified to receive the Bad Debt payment. Available Bad Debt charges are converted to Bad Debt costs using the most recent hospital provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the budget year using the most recently available Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year.

Available funds under the Disproportionate Share Hospital Allotment are multiplied by the hospital provider specific Bad Debt costs divided by the sum of all Bad Debt costs for all hospital providers that qualified to receive the Bad Debt payment to calculate the Bad Debt payment for the specific hospital provider.

12. 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 payment will be made prior to the High-Volume payment and will equal the Major Teaching Hospital Rate multiplied by the available Medicare Upper Payment Limit for the hospital providers that qualified to receive the Pediatric Major Teaching Payment. Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

13. To calculate the distribution of available funds to hospital providers, hospital providers shall annually submit data relating to the number of Medicaid-eligible inpatient days and total inpatient days in a form specified by the Department by April 30 of each year.

14. Colorado Health Care Services Payment. Community Health Clinics and Primary Care Clinics operated by a licensed or certified health care facility providing primary care services to low-income adults qualify for this payment. To calculate the distribution of available funds to these providers, the providers must annually submit utilization data related to low-income adults in a form specified by the Department by April 30 of each year.

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. Be a U.S. citizen or a legal immigrant, within the meaning of 26-4-103(8.5), C.R.S.;

2. Be a resident of Colorado;

3. Meet all CICP eligibility requirements as defined by state law and procedures; and

4. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, where required by 8.904 (D) in these regulations.

B. Citizenship or Immigration Status

An applicant must be a U.S. citizen or a legal immigrant.

1. U.S. Citizen

A U.S. citizen is a person who meets one of the following criteria:

a. Born in the United States, Puerto Rico, Guam, Virgin Islands of the United States, American Samoa, and Swain's Island. A birth certificate will prove that a person was born a U.S. citizen, OR

b. Received citizenship through the naturalization process. A certificate of citizenship will prove that a person is an U.S. citizen.

2. Documented Legal Immigrant

A documented legal immigrant is a person who resides in the United States and who meets the definition of "legal immigrant" in 26-4-103(8.5), C.R.S., or who possesses acceptable documentation from the Immigration and Naturalization Service (INS).

A legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service during the pendency of such legal immigrant's receipt of discount health care services under available CICP funding.

3. Identification and Affidavit Requirements [Emer. Rule eff. 10/1/06; Perm. Rule eff. 10/30/06]

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

      I. A valid Colorado Driver's License or a Colorado Identification Card, issued pursuant to Article 2 of Title 42, C.R.S;

      II. A United States Military Card of a Military Dependents' Identification Card;

      III. A United States Coast Guard Merchant Mariner Card;

      IV. A Native American Tribal Document; OR

      V. 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 24-76.5-130(5)(a), C.R.S.

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

      I. That he or she is a United States Citizen or legal permanent resident; OR

      II. That he or she is otherwise lawfully present in the United States pursuant to Federal Law.

   c. For an applicant who has executed an affidavit stating that he or she is an alien lawfully present in the United States under 8.904.B.3.b.II, the following shall apply:

      I. 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.

      II. Until verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.

      III. The qualified health care provider shall perform the verification of lawful presence within 30 days of completing the application.

   d. Photocopies of the identification listed in 8.904.B.3.a shall be acceptable identification if the photocopies meet the following criteria:

      I. A notary public must have certified that he or she saw the original document

and that the photocopy is a true copy of that original; OR

II. Photocopies made by the qualified health care provider 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.

e. The qualified health care provider shall retain the documentation provided under section 8.904.B with the application.

C. 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 U.S. citizen or documented legal immigrant criteria, as defined in paragraph B of this section; and

3. Employed in Colorado.

D. 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.

E. Applicants Not Eligible

The following individuals are not eligible to receive discounted services under available CICP funds:

1. Undocumented immigrants.

2. 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.

3. 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.

4. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

5. 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 8.111.1 of these regulations;

b. SLMB benefits described at section 8.122, or

c. The QI1 benefits described at section 8.123.

6. 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.

F. 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 date of service in an emergency room. If the client receives any care other than the emergency room visit, the qualified health care provider must require 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 to receive discounted health care services under available CICP funding from the client.

c. In emergency circumstances, an applicant is not required to provide identification or

execute an affidavit as specified at 8.904.B.3.a and 8.904.B.3.b. [Emer. Rule eff. 10/1/06; Perm. Rule eff. 10/30/06]

G. 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/he r 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 CICP Manual. A minor is an individual under the age of 18.

H. 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.

I. Subsequent Insurance Payments

If a client receives discounted health care services under available CICP 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 CICP 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 CICP 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. CICP 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 CICP 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

CICP 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 CICP 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 CICP 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 CICP Rating.

The CICP Rating determines a family's copayment and client copayment annual cap. CICP 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 CICP Rating on a temporary basis. The CICP 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 CICP Rating

The CICP Rating of an eligible client shall be determined by matching the family's net CICP 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. CICP 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 Copayment	Physician Copayment	Outpatient Clinic Copayment
N	$15	$7	$7
A	$65	$35	$15
B	$105	$55	$15
C	$155	$80	$20
D	$220	$110	$20
E	$300	$150	$25
F	$390	$195	$25
G	$535	$270	$35
H	$600	$300	$35
I	$630	$315	$40
.	.	.	.
Z	$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 longer than 24

hours. The client is responsible for the corresponding Hospital Inpatient Copayment.

2. Hospital outpatient 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.

3. 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 charges are for all non-physician (facility) and physician services received by a client while receiving care in the outpatient clinic setting, but do not include charges from outpatient services provided in the hospital setting (i.e., emergency room care, ambulatory surgery). Outpatient charges include primary and preventive medical care. The client is responsible for the corresponding Outpatient Clinic Copayment.

5. 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.

6. 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.

7. 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.

8. 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.

9. The client is responsible for the corresponding Hospital Inpatient Copayment for Magnetic Resonance Imaging (MRI), Computed Tomography (CT) and nuclear medicine services received by the client.

B. Z-Rating. These are homeless clients who are at or below 40% of the Federal Poverty Level (qualify for an N-Rating). Homeless clients are exempt from client copayments. Homeless patients are also exempt from the income verification requirement, verification of denied Medicaid benefits requirement and providing proof of residency when completing the CICP application.

General Definition: 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.

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 a calendar year (January 1 through December 31), even if a client's rating is for a different year (i.e., April 1 through March 31). Clients are responsible for any charges incurred prior to receiving their CICP Rating. Clients shall track their copayments and inform the provider in writing (including documentation) when they meet 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. The client's annual cap can change during the calendar year if the CICP Rating changes during the year. All copayments made toward the old annual cap during the calendar year apply to the new cap.

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 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 CICP 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 CICP 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 COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM

The Comprehensive Primary and Preventive Care Grant Program is authorized by the addition of Part 10 to the Medical Assistance Act, 26-4-1001 through 26-4-1007, C.R.S. This program was established to provide grants to health care providers in order to expand primary and preventive care services to Colorado's low-income, uninsured residents. Beginning with FY 00-01, the program shall be funded through the Comprehensive Primary and Preventive Care Fund established pursuant to the tobacco litigation settlement referred to as the Master Settlement Agreement as defined in 8.930.1 below.

.1 DEFINITIONS

A. Comprehensive Primary Care: The 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, comprehensive primary care 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.

B. Master Settlement Agreement: The Master Settlement Agreement, the Smokeless Tobacco Master Settlement Agreement, and the Consent Decree approved and entered by the court in the case denominated *State of Colorado, Ex Rel., Gale A. Norton, Attorney General V. R.J. Reynolds Tobacco Co.; American Tobacco Co., Inc.; Brown & Williamson Tobacco Corp.; Liggett Group Inc.; Lorillard Tobacco Company; Phillip Morris, Inc.; United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council for Tobacco Research-U.S.A., Inc.; and Tobacco Institute, Inc.* ; Case No. 97CV3432, in the District Court for the City and County of Denver.

C. Medically Underserved Area or Population: An area designated by the Secretary of the U.S. Department of Health and Human Services as an area with a shortage of health care professionals or health services or a population or group designated by the Secretary as having a shortage of such services.

D. Service Grant: A grant by the State Department to a qualified provider pursuant to 26-4-1003(6), C.R.S.

E. State Department: Unless otherwise specified, the State Department refers to the State Department of Health Care Policy and Financing.

.2 COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM CRITERIA

A. Clients to be Served

In order to be served under this program, clients must be receiving services from a qualified provider as defined in paragraph B. below. In addition, clients must also meet the following criteria:

1. Have a yearly family income below two hundred percent (200%) of the federal poverty level; and

2. Be ineligible for Medicaid, Medicare, the Children's Basic Health Plan, or any other type of governmental reimbursement for health care costs, such as through Social Security, the Veterans Administration, Military Dependency (CHAMPUS), or the United States Public Health Service; and

3. Cannot be receiving third-party payments for comprehensive and primary care from private resources including, but not limited to, a commercial or individual health insurance policy, a Health Maintenance Organization, an automobile or worker's compensation policy.

B. Qualified Providers

In order to be eligible for the Comprehensive Primary and Preventive Care Grant Program, a health care provider must be an entity that provides comprehensive primary care services that:

1. Accepts all patients regardless of their ability to pay and uses a sliding fee schedule for payments or does not charge uninsured clients for services;

2. Serves a designated medically underserved area or population, as provided in Section 330(b) of the federal "Public Health Service Act", 42 U.S.C. Section 254b or demonstrates to the State Department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons. Copies of the Act are available for public inspection or shall be provided at cost by the Office of the Executive Director, Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library. No later amendments to or editions of the regulations are included in this reference.

3. Has a demonstrated track record of providing cost-effective care which can be assessed from information provided by the grantees that describes established processes that are in place to ensure the delivery of appropriate comprehensive primary and preventive care.

4. Provides or arranges for the provision of comprehensive primary care services to persons of all ages. Arranging for the provision of comprehensive primary care services means demonstrating established referral relationships with health care providers for any of the comprehensive primary care services not directly provided by an entity. 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 an initial screening evaluating eligibility for the State Medical Assistance Program, the Children's Basic Health Plan (CHP+), and the Colorado Indigent Care Program and refers potentially eligible patients to the appropriate agency for eligibility determination if they are not qualified to make such determinations.

8.930.3 APPLICATION AND GRANT AWARD PROCEDURES

8.930.31 Application

A. Grant awards shall be made through an application process. The Application Form shall be issued by the Department and posted for public access on the Department's website at least 30 days prior to the Application due date.

B. An advisory council appointed by the Executive Director of the Department shall review the draft Application Form prior to its issuance and make recommendations to the Department. The advisory council shall include a representative of the Department, a representative of the Department of Public Health and Environment, a representative of a qualified provider as defined in 8.930.2, B, two consumers who currently receive health care services from a qualified provider, a health care provider who is not affiliated with a qualified provider or an agency of the state, but who has training and expertise in providing comprehensive primary care services to medically underserved populations, and a representative of a nonprofit, community-based health care organization or business.

   In addition to the advisory council, other parties may also be asked by the Department to review the draft Application Form prior to its issuance and make recommendations to the Department.

8.930.32 Evaluation of Grants

A. An Application Evaluation Committee shall be established by the Department for the purpose of reviewing the grant applications and recommending which applications should receive awards directly to the Executive Director.

   No parties other than the Application Evaluation Committee shall be involved in evaluating applications and recommending awards. The Application Evaluation Committee may, at its option, call upon subject matter experts to review applications and provide analysis of those applications regarding their area of expertise. However, such experts shall not reveal the contents of those applications to any other parties, nor shall they participate in the formal evaluation or award recommendation processes of the committee. In no case shall a member of the Application Evaluation Committee or any subject matter experts have a conflict of interest, or the appearance of a conflict of interest, in the recommending of awards created by their participation.

B. The applications shall be evaluated in accordance with the terms stated in the Application From and as set by the Department. Criteria used to evaluate applications shall include, but not be limited to:

   1. Whether the applicant meets all criteria for qualified provider;

   2. The degree to which the work plan meets the "Conditions for Use of Grants" listed in Section 8.930.34;

   3. The technical and financial feasibility of the project;

   4 The appropriateness of the proposed program/services budget for the proposed project; and

   5. The plan presented for evaluating and reporting results.

6. The geographic distribution of funds among urban and rural areas in the State.

8.930.33 Awarding of Grants

A. The Executive Director, or his/her designee, shall make the final grant awards to applicants for the purpose of providing preventive and primary care services to Colorado's low-income, uninsured residents.

B. The Department reserves the right to change grant amounts, depending on the final number of grants awarded, the availability of funds and/or the goals stated in each grant application.

C. The Department will establish a process for applicants to appeal the Departments grant awards. This process will be outlined in the Application Form.

8.930.34 Conditions for Use of Grants

A. Grants shall be used:

1. To increase access to comprehensive primary care services for uninsured or medically indigent patients who are served by such providers;

2. To create new services or augment existing services provided to uninsured or medically indigent patients; or

3. To establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations.

4. To maintain increased access, capacity or services previously funded by Comprehensive Primary and Preventative Care (CPPC) Grants.

B. Grants shall NOT be used:

1. To supplant federal funds traditionally received by such qualified providers, but shall be used to supplement such funds;

2. For land or real estate investments;

3. To finance or satisfy any existing debt; or;

4. Unless the qualified provider specifically complies with the definition of qualified provider contained in Section 26-4-1003(5), C.R.S. and Section 8.930.2, B of these regulations.

8.930.4 EVALUATION AND REPORTING

Provider Annual Reports to Department

Each qualified provider who receives a grant under this program shall provide an annual report to the Department which must include, at a minimum:

1. The number of additional uninsured and medically indigent patients served;

2. The types of services provided;

3. Results achieved, and the criteria used to measure their effectiveness in achieving stated goals.

4. Other information that may be required by the Colorado Department of Public Health and Environment.

5. Cost reports may also be requested.

8.930.5 AUDIT PROCEDURE

The Department shall develop audit procedures to assure that grants awarded under this program are used to provide services to uninsured and medically indigent patients. Each qualified provider who receives a grant under this program must agree to abide by the audit procedures developed by the Department.

8.940 OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

8.941 EXTENT AND LIMITATIONS OF MEDICAL CARE

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

In accordance with the Constitution of Colorado, Title 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.

The Old Age Pension Health Care Supplemental Program is authorized by Colorado Revised Statues, Section 26-2-117, C.R.S. The funding for this program cannot be accessed until all funds in the Old Age Pension Health Care Program are exhausted.

A. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program provide 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 and the Old Age Pension Health Care Supplemental 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, pharmacy, home health services and supplies, and Medicare cost sharing. As of January 1, 2004 the inpatient hospital benefit is suspended until October 15, 2004.

   Effective October 15, 2004, the inpatient hospital benefit is restored at those hospitals which participate under the Colorado Indigent Care Program. Services to the clients covered under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program are limited to those inpatient services available under the Colorado Indigent Care Program.

   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 or the Old Age Pension Health Care Supplemental Program. The

pharmacy drug benefit under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program shall follow Medicaid regulations, as specified under 8.830.

For the benefits listed above, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental 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 and the Old Age Pension Health Care Supplemental 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 and the Old Age Pension Health Care Supplemental 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 and the supplemental 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.

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 or the Old Age Pension Health Care Supplemental Program.

8.941.2 DEFINITION

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

8.941.3 GROUPS ASSISTED UNDER THE OLD AGE PENSION HEALTH CARE PROGRAM AND THE OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

Old Age Pension Health Care Program and the Old Age Pension Health Supplemental 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 and the Old Age Pension Health Care Supplemental 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 2503-1) shall to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program.

8.941.5 CERTIFICATION OF PAYMENT FOR PROVIDERS

All providers of medical services in their submission of claim to the Old Pension Health Care Program and the Old Age Pension Health Care Supplemental 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 or the Old Age Pension Health Care Supplemental Program."

8.941.6 GENERAL EXCLUSIONS

In addition to any specific exclusion defined in this manual, the general exclusions from coverage of the Old Pension Health Care Program and the Old Age Pension Health Care Supplemental Program defined by the rules of the Department of Human Services (9 CCR 2503-1) are also excluded. *[Eff 03/02/2007]*

8.941.7 OUT-OF-STATE MEDICAL CARE

All requirements for out of state medical care as defined by the rules in this manual apply to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program for covered services with the exception that any reduction, suspension or elimination of benefits must be applied. *[Eff 03/02/2007]*

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 this manual apply to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program for covered services with the exception that any reduction, suspension or elimination of benefits provided must also be applied. *[Eff 03/02/2007]*

8.941.9 REIMBURSEMENT TO PROVIDERS

As of October 15, 2004, the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program will reimburse inpatient hospital services, which are only a covered benefit at those hospitals that participate under the Colorado Indigent Care Program, at 10% of the appropriate Medicaid reimbursement. *[Eff 03/02/2007]*

As of September 1, 2006, providers of physician and practitioner services; outpatient services (including outpatient hospitals, federal qualified health centers, rural health centers and dialysis centers); emergency dental services; independent laboratory and x-ray services; medical supply services; hospice and home health services; and emergency transportation services will be reimbursed at 40% of the appropriate Medicaid reimbursement. *[Eff 03/02/2007]*

As of November 1, 2006, pharmacy claims are reimbursed at 70% of the appropriate Medicaid reimbursement. *[Eff 03/02/2007]*

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. *[Eff 03/02/2007]*

8.941.10 CLIENT CO-PAYMENT

Recipients of benefits under the OAP Health Care Program or Old Age Pension Health Care Supplemental 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 section 8.754 of this manual. This charge to the recipient will be called co-payment. *[Eff 08/30/2006]*

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. *[Eff 08/30/2006]*

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. *[Eff 08/30/2006]*

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. *[Eff 08/30/2006]*

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 data 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

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.