DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Enforcement Remedies Related to Survey Deficiencies; Medical Leave from Nursing Facility; and Management of Personal Needs Funds by Other than Resident, Sections 8.435, 8.443 & 8.482
Rule Number: MSB 24-09-03-A
Division / Contact / Phone: Policy Development and Implementation/ Erica Schaler/3195

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB24-09-03-A, Revision to the Medical Assistance Act Rule concerning Enforcement Remedies Related to Survey Deficiencies; Medical Leave from Nursing Facility; and Management of Personal Needs Funds by Other than Resident

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections 8.443.24; 8.435.2.C; 8.482.43; 8.482.55, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current language at 8.435.2.A with the proposed text beginning at 8.435.2.A through the end of 8.435.2.E.8.d. Replace the current text at 8.443.24 with the proposed text beginning at 8.443.24 through the end of 8.443.24.3. Replace the current text at 8.482.43 with the proposed text beginning at 8.482.43 through the end of 8.482.43.C.5. Replace the current text at 8.482.55 with the proposed text beginning at 8.482.55 through the end of 8.482.55.B. This rule is effective March 2, 2025.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Enforcement Remedies Related to Survey Deficiencies; Medical Leave from Nursing Facility; and Management of Personal Needs Funds by Other than Resident, Sections 8.435, 8.443 & 8.482
Rule Number: MSB 24-09-03-A
Division / Contact / Phone: Policy Development and Implementation/ Erica Schaler/3195

STATEMENT OF BASIS AND PURPOSE

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

   This rule amendment involves technical changes to rules 8.443.24, 8.435.2.C, 8.482.43, and 8.482.55. These changes include removing outdated language, correcting some grammatical and capitalization errors, and updating language to align with current practices. Additionally, the Department removed regulations that were moved under CDPHE's authority as a result of Senate Bill 21-128.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR § 488.330

4. State Authority for the Rule:

   CRS § 25.5-6-311
   CRS § 25.5-6-201-210
   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Enforcement Remedies Related to Survey Deficiencies; Medical Leave from Nursing Facility; and Management of Personal Needs Funds by Other than Resident, Sections 8.435, 8.443 & 8.482
Rule Number: MSB 24-09-03-A
Division / Contact / Phone: Policy Development and Implementation/ Erica Schaler/3195

REGULATORY ANALYSIS

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

   Individuals in nursing homes will benefit from the proposed rule. The rule will include language that aligns the rule with best practices, remove outdated language making the rule easier to understand for members, and will provide members with more current information. There are no costs associated with the proposed rule as these changes are technical in nature.

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

   The changes align the rule with state and federal regulations and are only technical in nature.

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

   There is no cost to the Department or any other agency because the changes are technical in nature.

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

   There are no costs of the proposed rule. The benefit of the proposed rule is in its alignment with state and federal regulations. There is no benefit of inaction.

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

   There are no less costly methods nor less intrusive methods for achieving the purpose of the proposed rule.

DO NOT PUBLISH THIS PAGE

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

   There were no alternative methods for achieving the purpose of the proposed rule that were considered.

8.435 ENFORCEMENT REMEDIES RELATED TO SURVEY DEFICIENCIES

8.435.2 GENERAL PROVISIONS

8.435.2.A. The Department enforces remedies for Class I Non-State-Operated Medicaid-Only Nursing Facilities. ~~and CMS enforces remedies for all other Class I nursing facilities,~~ Remedies for all other Class I nursing facilities are enforced pursuant to 42 C.F.R. section 488.330. Class I nursing facilities are subject to one or more of the following remedies when found to be in substantial non-compliance with program requirements:

1. Termination of the Medicaid provider agreement.

2. Civil Money Penalty (CMP).

3. Denial of payment for new admissions of Medicaid clients.

4. Temporary management.

5. Transfer of residents.

6. Transfer of residents in conjunction with facility closure.

7. The following three remedies with imposition delegated to CDPHE:

   a. State monitoring.

   b. Directed plan of correction.

   c. Directed in-service training.

8.435.2.C. The Class I non-State-operated Medicaid-only nursing facility will receive a Notice of Adverse Action from the Department. The appeal procedures set forth at Section 8.050 ~~will~~ apply. ~~Any other Class I nursing facilities shall be notified by CMS of any adverse action.~~

8.435.2.D. Enforcement Actions for Class I nursing facilities

1. Termination of the Medicaid provider agreement:

   a. Shall be effective within 23 days after the last day of the survey if the nursing facility has not removed the Immediate Jeopardy as determined by the Colorado Department of Public Health and Environment (CDPHE).

   b. May be rescinded by the Department when CDPHE notifies the Department that an Immediate Jeopardy is removed.

2. Denial of payment for new Medicaid admissions will end on the date CDPHE finds the nursing facility to be in substantial compliance with all participation requirements.

   a. If substantial compliance is achieved before the denial of payment effective date, the denial of payment will be rescinded.

   b. If substantial compliance is not achieved before the denial of payment effective date, the denial of payment will stop as of midnight on the date determined by CDPHE.

(1) Medicaid monies paid to the nursing facility for any resident admitted during the denial of payment effective period is subject to recoupment by the Department.

3. Civil Money Penalty (CMP)

a. CMPs are effective on the date the non-compliance began.

b. If the nursing facility waives its right to an appeal in writing within 60 calendar days from the date the CMP is imposed, the CMP shall be reduced by 35%, notwithstanding the provisions of Section 8.050.

c. The CMP shall be submitted to the Ddepartment or the federal Centers for Medicare and Medicaid Services (CMS) as defined by the adverse action notification.

d. Payment of CMP shall not be an allowable cost on the nursing facility's annual Med-13 cost reports as described in Section 8.441.

~~8.435.2.E. Nursing Home Penalty Cash Fund~~

~~1. All CMPs collected from Class I nursing facilities by the Department shall be transmitted to the state treasurer to be credited to the Nursing Home Penalty Cash Fund.~~

~~a. The Medicaid portions of CMPs imposed by CMS and transmitted to the State Treasurer shall be credited to the Nursing Home Penalty Cash Fund.~~

~~2. The Department and CDPHE have joint authority for administering the Nursing Home Penalty Cash fund, with final authority in the Department.~~

~~a. For measures aimed at improving the quality of life of residents of nursing facilities, the Nursing Facility Culture Change Accountability Board shall review and make recommendations to the departments regarding the use of the funds in the Nursing Home Penalty Cash Fund available for quality of life measures as specified in 10 CCR 2505-10 section 8.435.2.E.4.b.~~

~~3. The maximum amount of funds to be distributed from the Nursing Home Penalty Cash Fund each fiscal year for the purposes in 10 CCR 2505-10 section 8.435.2.E.4.b is specified in C.R.S. section 25-1-107.5.~~

~~4. As a basis for distribution of funds from the Nursing Home Penalty Cash Fund:~~

~~a. The Department and CDPHE shall consider the need to pay costs to:~~

~~1) Relocate residents to other facilities when a nursing facility closes~~

~~2) Maintain the operation of a nursing facility pending correction of violations;~~

~~3) Close a nursing facility;~~

~~4) Reimburse residents for personal funds lost.~~

b. The Nursing Facility Culture Change Accountability Board shall review and recommend distribution of funds for measures that will benefit residents of nursing facilities by improving their quality of life at the facilities, including:

1) Consumer education to promote resident-centered care in nursing facilities;

2) Training for state surveyors, supervisors and the state and local long term care ombudsman, established pursuant to C.R.S. section 26-11.5-104 et seq., regarding resident-centered care in nursing facilities;

3) Development of a newsletter and web site detailing information on resident-centered care in nursing facilities and related information;

4) Education and consultation for purposes of identifying and implementing resident-centered care initiatives in nursing facilities.

c. Expenses to administer and operate the accountability board, including reimbursement of expenses of accountability board members.

1) This expense shall not exceed 10 percent of the fiscal year amount authorized under 10 CCR 2505-10 section 8.435.2.E.3.

5. The Department and CDPHE shall consider the recommendations of the Nursing Facility Culture Change Accountability Board regarding the use of the funds available each fiscal year for quality of life improvement purposes specified in 10 CCR 2505-10 section 8.435.2.E.4.b.

6. For fiscal year 2009-2010 only, the Department shall contract with Colorado Health Care Education Foundation (CHCEF) to serve as the agent to disburse to grantees $194,997.00, the fiscal year 2009-2010 appropriation for measures that will benefit residents of nursing facilities by improving their quality of life.

a. This total amount of $194,997.00 is in accordance with the recommendations of the Nursing Facility Culture Change Accountability Board and approved by the Department and CDPHE, with final authority in the Department.

b. This appropriation of $194,997.00 from the Nursing Home Penalty Cash Fund is within the maximum appropriation of $200,000.00 authorized in C.R.S. section 25-1-107.5 for fiscal year 2009-2010.

c. If any grantee does not accept any portion of its approved disbursement amount, within thirty days of grantee notification to CHCEF, CHCEF shall return that portion to the Department to be credited to the Nursing Home Penalty Cash Fund.

7. For fiscal year 2010-2011 and successive fiscal years:

a. If any grantee does not accept any portion of its approved disbursement amount:

i. If funds are disbursed through an agent, the disbursement agent shall return that portion, within thirty days of grantee notification, to the Department to be credited to the Nursing Home Penalty Cash Fund.

ii. If funds are disbursed directly to the grantee, the grantee shall return that portion to the Department, within thirty days of disbursement, to be credited to the Nursing Home Penalty Cash Fund.

8. By October 1, 2010, and by each October 1 thereafter, the Department and CDPHE, with the assistance of the Nursing Facility Culture Change Accountability Board, shall jointly submit a report to the governor and the health and human services committees of the senate and house of representatives of the general assembly, or their successor committees, regarding the expenditure of moneys in the Nursing Home Penalty Cash Fund for the purposes described in 10 CCR 2505-10 section 8.435.2.E.4.b. The report shall detail the amount of moneys expended for such purposes, the recipients of the funds, the effectiveness of the use of the funds, and any other information deemed pertinent by the Department and CDPHE or requested by the governor or the committees.

a. The Nursing Facility Culture Change Accountability Board is responsible for monitoring grantee compliance in expending moneys for the approved measures.

b. If the total amount distributed to the grantee is not expended on the approved measure, the grantee shall return the remaining amount, within thirty days of completion of the measure, to the Department to be credited to the Nursing Home Penalty Cash Fund.

c. If the Department and CDPHE, based on the review of the Nursing Facility Culture Change Accountability Board, determine that any portions of the moneys received for the purposes described in 10 CCR 2505-10 section 8.435.2.E.4.b was not used appropriately, the grantee shall return that portion of the moneys, within thirty days of Nursing Facility Culture Change Accountability Board notification, to the Department to be credited to the Nursing Home Penalty Cash Fund.

d. Misuse of the funds by a grantee is subject to the false Medicaid claims provisions of C.R.S. sections 25.5-4-304 through 25.5-4-307.

8.443 NURSING FACILITY PROVIDER REIMBURSEMENT

8.443.24 NURSING FACILITY PAROLEES SUPPLEMENTAL MEDICAID PAYMENT

The Department shall make a supplemental Medicaid payment to Class I~~1~~ nursing facilities that admit residents directly from the Colorado Department of Corrections (DOC) who are released on parole~~, or~~ due to compassionate care or medical release.

1. Eligible population includes individuals discharged from the DOC whose medical, behavioral, or social needs are beyond the scope of what is provided in a typical nursing facility setting, which limits their access to care options under the standard nursing home reimbursement rate. The payment for each individual shall be prior authorized~~, as described in section 3 below,~~ for tiered reimbursement, based on their needs.

    a. Tiered reimbursement add-ons include:

        i. Tier I add-on for individuals who require one or more of the following:

            1) Enhanced staff training/education cost,

            2) Psychosocial supports,

            3) Community readjustment and reintegration supports/resources,

            4) A secure unit or neighborhood,

            5) Specialty intervention,

            6) Medically complex needs,

            7) Personal needs items,

            8) Psychiatry,

            9) Guardianship needs, and

            10) Sex offender treatment (if needed).

        ii. Tier II add-on for individuals who meet Tier I criteria and additionally meet one or more of the following criteria:

            1) 1:1 behavioral health support,

            2) High behavioral health needs that require a private room,

            3) Higher acuity needs, and

            4) High-cost medication or specialty equipment needs.

2. Quarterly, the Department shall complete a count of Medicaid patient days for the eligible population. Medicaid-covered patient days shall be pulled from the MMIS. The supplemental payment shall be calculated by multiplying the actual dates of care provided to the eligible

population by the applicable per-diem rate. Per-diem rates for Tier I and Tier II individuals shall be published in the Colorado Medicaid Provider Bulletin found on the Department's website at: www.Colorado.gov/hcpf/bulletins. The payment may be adjusted, subject to the following limitations:

a. The per diem rate shall not exceed fifty percent (50%) of the statewide average MMIS per diem reimbursement rate,

b. Payments shall be withheld or reduced subject to available UPL reimbursement, and

c. Payments may be adjusted to account for data corrections in previous payments.

3. The DOC will have a licensed physician review each eligible individual being discharged on~~from~~ parole to verify each individual meets ~~the~~ criteria ~~as outlined in Section 1 above~~. The licensed physician will document the services needed and submit a prior authorization request~~form~~ to the Department for approval. Both the Department and DOC administration will approve the prior authorization of each individual being discharged on~~from~~ parole prior to the Department authorizing payment to a nursing facility.

8.482 RESIDENT INCOME AND POSSESSIONS

8.482.4 NO DUPLICATE OR ADDITIONAL PAYMENTS

8.482.43 MEDICAL LEAVE FROM NURSING FACILITY

A. Definition. “Medical ~~l~~Leave” is defined as absence of the resident from the nursing facility due to ~~admittance~~ admission to a hospital or other institution.

B. Medical ~~l~~Leave~~d, as addressed in this section,~~ is subject to the following restrictions:

1. ~~Such absence of t~~The resident’s absence must be on the ~~specific~~ orders of a physician, as noted in the resident's chart;

2. ~~There must be a presumption by the doctor and by the resident that t~~The resident ~~will~~ plans to return to the nursing facility;

3. The nursing facility must prepare an AP-5615 showing the dates ~~such m~~the Medical L~~l~~eave commenced and ended. See ~~10 CCR 2505-10 s~~Section 8.482.34.

4. The resident, or the responsible party, must be advised, in writing, that payment for holding the nursing facility room cannot be made by Medicaid. In addition, the resident, or responsible party, must give written consent to the additional charge, including the daily rate and the anticipated number of days. If the resident is absent from the facility longer than the anticipated number of days shown on the consent form, the nursing facility must obtain agreement on another consent form before continuing to charge for medical leave. The consent form(s) must be retained with the resident’s records and be subject to audit.

C. Room reservation charges for Medical ~~l~~Leave:

1. The per diem charge for room reservations for ~~medical~~ Medical ~~leave~~ Leave cannot exceed the per diem rate currently authorized for the nursing facility, less total food and linen service costs. In no case shall the charge be greater than the current per diem rate less $2.

2. The specific bed which the resident had occupied prior to leave must be reserved. No other resident may occupy ~~a bed so reserved~~the reserved bed.

3. If no source of payment, other than the resident's funds, are available, and the nursing facility's current occupancy is less than 90 percent of capacity~~.~~, t~~T~~he room must be reserved at no charge to the resident.

4. Revenues to the nursing facility from room reservations must be used in reduction of related expenses, on the MED-13 form.

5. If no other funds are available, the room reservation charges may be deducted from the resident's personal needs account, subject to the restrictions in Section 8.482.42. However, the resident's personal needs account must ~~retain~~ maintain a balance of at least $10 at all times, if used for room reservations payment. In case of death of the resident, the entire resident personal needs account may be used, if necessary.

8.482.5 RESIDENT'S PERSONAL NEEDS ACCOUNTS

8.482.55 MANAGEMENT OF PERSONAL NEEDS FUNDS BY OTHER THAN RESIDENT

A. For residents unable to manage their own funds due to a physical or mental condition, a conservator, guardian, or other responsible person may carry out these acts for the resident.

B. Personal needs funds shall not be turned over to persons other than the resident's authorized agent when establishing the resident personal needs account.

1. With resident's written consent (if able and willing to give such consent) the administrator may authorize the purchase of specific items ~~for a close relative or friend~~on behalf of the resident.

2. An itemized, dated, and signed receipt is required for the purchase.

3. A copy or original itemized receipt must be submitted to facility at the time the purchase is delivered to the resident.

4. The facility must verify purchased items were delivered to the resident.

5. The Facility will only reimburse the responsible party for items the resident requested.

C. Refer to Section 8.482.51 for the account management policy and Section 8.440.2.A.2 for the acceptable purchases policy.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Hospital Discounted Care Rule Concerning Hospital Discounted Care Updates Per 24-116, Section 8.920.
Rule Number: MSB 24-09-24-A
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 24-09-24-A, Revision to the Hospital Discounted Care Rule Concerning Hospital Discounted Care Updates Per 24-116, Section 8.920.

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.920, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.920 with the proposed text beginning at 8.920 through the end of 8.928.A. This rule is effective March 2, 2025.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Hospital Discounted Care Rule Concerning Hospital Discounted Care Updates Per 24-116, Section 8.920.
Rule Number: MSB 24-09-24-A
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

STATEMENT OF BASIS AND PURPOSE

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

   During the 2024 session, the Colorado General Assembly passed Senate Bill (SB) 24-116 which made changes to Hospital Discounted Care, enacted under House Bill (HB) 21-1198. SB 24-116 allows hospitals to set payment plans at 6% of the patient's calculated household gross monthly income if the hospital bills for their employed or contracted health care professionals, adds definitions for Inpatient and Outpatient Hospital Services, excludes primary care services provided in clinics located in rural or frontier counties who have a sliding fee scale approved by the Department, requires licensed health care professionals to submit their own Hospital Discounted Care data to the Department, and allows for hospitals to disqualify patients from eligibility for Hospital Discounted Care if they determine the patient presumptively eligible for Health First Colorado (Colorado's Medicaid Program) or the Child Health Plan *Plus* (CHP+).

   This rule includes all the changes listed above except for the presumptive eligibility piece. There are multiple system changes that must be completed prior to that part of the statute being able to be enacted, and as such, a second rule change will be submitted in the fall of 2025, closer to those changes taking effect and after the Department has had time to collect feedback and input from stakeholders in order to develop rule language and policy. This rule also includes a change as recommended by the CICP Advisory Council to increase the number of days a hospital has to process a patient's application from 14 days to 21 days.

2. An emergency rule-making is imperatively necessary

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

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);
   Sections 25.5-3-501 through 25.5-3-507, C.R.S. (2024)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Hospital Discounted Care Rule Concerning Hospital Discounted Care Updates Per 24-116, Section 8.920.
Rule Number: MSB 24-09-24-A
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

REGULATORY ANALYSIS

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

   Health care facilities who bill for hospital and related professional services on a consolidated bill will be impacted because they will be able to bill and receive payments equivalent to health care facilities and professionals who bill separately instead of only being able to bill for their facility charges. Rural health care centers providing primary care services will benefit by being able to use their usual sliding fee scales to bill for primary care services without experiencing the undue regulatory burden of complying with requirements meant for hospital services. Stakeholders and policy makers will benefit from the proposed rule by receiving data from licensed health care professionals to evaluate their compliance with these regulations, in addition to data from hospitals. While patients may be billed more from a health care facility that provides a consolidated bill compared to the status quo, patients will benefit from consistent billing policies across health care facilities and from being able to receive primary care in rural health care centers on a sliding fee without having to apply for hospital discounted care.

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

   This rule change will increase the amount that health care facilities who bill for their employed or contracted licensed health care professionals can collect from their patients, which helps maintain the health care facility's cash flow and reduces the probability that facilities will have to limit availability of services provided to patients. This is especially important for the state’s safety net, rural, and critical access hospitals. This allows for consistent payment plan amounts for the hospital services and heath professional services, regardless of whether the patient receives a consolidated bill.

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

   There is no fiscal impact to the Department of Health Care Policy and Financing with this rule change. Funds for administering these requirements were appropriated by

the General Assembly to the Department and funding for hospitals will continue in accordance with rule 8.3000.

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

   The Department must implement these rules in accordance with the passage of Senate Bill 24-116. These rules will ensure that Health Care Facilities who bill for their employed or contracted licensed health care professionals are able to collect the 2% that the licensed health care professional could collect if they billed separately from the hospital. Health care systems that bill on a consolidated bill will benefit because they will be able to bill and receive payments equivalent to health care facilities and professionals who bill separately instead of only being able to bill for their facility charges. Patients will pay more than the status quo for care from those facilities but will benefit from consistent billing across providers. Rural health care centers will benefit by being able to use their own sliding fee scale for primary care services provided to patients without having to endure the undue burden of complying with requirements meant for hospital services, and patients receiving care at their facilities will not have to apply for discounted care unless they need to seek care at a hospital facility. Stakeholders and policy makers will benefit from receiving additional, more complete data from licensed health care professionals in addition to the data received from hospitals. Licensed health care professionals will have some additional information that will need to be reported directly to the Department, but this change makes it so the professionals will not have to coordinate with every facility they work with in order to report their data specific to each facility within the facility's data.

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

   There are no less costly methods to achieve the purpose of the proposed rule. The Department of Health Care Policy and Financing must comply with the provisions of Senate Bill 24-116 and has been appropriated funds to do so.

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

   No other alternative methods were considered because these changes are required by Senate Bill 24-116.

8.920 Hospital Discounted Care

~~PURPOSE AND LEGAL BASIS~~

The Health Care Billing for Indigent Patients Act of 2021, C.R.S. § 25-3-501, et. seq., referred to as Hospital Discounted Care, establishes the maximum rate a Health Care Facility and Licensed Health Care Professional may bill low-income patients for Discounted Care provided in the hospital, requires written description of patient's rights, establishes patient appeals and complaint processes, and imposes requirements on hospitals before assigning or selling patient debt to a medical creditor or before pursuing collection action. Senate Bill 24-116 added an increase in payment plan amounts for Health Care Facilities who bill for their own professionals, requires professionals who bill separately from the Health Care Facility to report their own data to the Department, and excludes primary care provided at rural or frontier clinics who have an approved sliding fee scale.

8.921 DEFINITIONS

A. Billing Statement means any patient-facing communication, whether electronic or in writing, that specifies an amount due for services and instructions for making payment.

B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in Title 25.5, Article 8, C.R.S.

C. Colorado Indigent Care Program or CICP means the safety net program established in Title 25.5, Article 3, Part 1, C.R.S.

D. Department means the Department of Health Care Policy and Financing established pursuant to section 25.5-1-104, C.R.S.

E. Discounted Care means the amount a Provider may charge a Qualified Patient for Medically Necessary Health Care Services rendered.

F. Emergency Medicaid means short-term Medicaid coverage for eligible people who do not meet immigration or citizenship requirements for Medicaid and need treatment for life- and/or limb-threatening emergencies.

G. Emergency Hospital Services means 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.

H. Federal Poverty Guidelines or FPG means a measure of income level issued annually by the United States Department of Health and Human Services. For Hospital Discounted Care, the FPG is updated annually every April 1.

I~~H~~. Health Care Facility means a hospital licensed as a general hospital pursuant to Title 25, Article 3, Part 1, C.R.S., a hospital established pursuant to section 23-21-503, C.R.S. or section 25-29-103, C.R.S., any freestanding emergency department licensed pursuant to section 25-1.5-114, C.R.S., or any outpatient health care facility that is licensed as an on-campus department or service of a hospital or that is listed as an off-campus location under a hospital's license~~,~~. Health Care Facility ~~but~~ does not include a federally qualified health center as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x(aa)(4), or a student-learning medical or dental clinic that is established for the purpose of student learning, offering Discounted Care as part of a program of student learning that is physically situated within a health sciences school, Health Care Facility does not apply to primary care services provided in a clinic located in a designated

rural or frontier county that offers a sliding-fee scale equal to the Medicare rural health clinic all inclusive rate payment established in accordance with 42 U.S.C. 1395l (f)(3)(B) or payment rate that is lower than usual and customary charges and considers a patient's household size and income size as approved by the Department.

~~I~~J. Health Care Services has the same meaning as set forth in section 10-16-102(33), C.R.S.

~~J~~K. Impermissible Extraordinary Collection Action means initiating foreclosure on an individual's primary residence or homestead, including a mobile home, as defined in section 38-12-201.5(5), C.R.S.

~~K~~L. Inpatient H~~h~~ospital ~~s~~Service has the same meaning as set forth in 42 C.F.R. § ~~-~~440.10.

~~L~~M. Licensed Health Care Professional means any health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. or who provides services under the supervision of a health care professional who is registered, certified, or licensed pursuant to Title 12, C.R.S. and who provides Health Care Services in a Health Care Facility.

~~M~~N. Medicaid means the Colorado Medical Assistance Act set forth in Title 25.5, Articles 4, 5, and 6, C.R.S.

~~N~~O. Medical Creditor means any entity that attempts to collect on a medical debt, including a Provider or Provider's billing office, a collection agency as defined in section 5-16-103(3), a debt buyer as defined in section 5-16-103(8.5), C.R.S. and a debt collector as defined in 15 U.S.C. sec. 1692a(6).

~~O~~P. ~~Non-CICP Health Care Services means Health Care Services provided in a Health Care Facility for which reimbursement under the Colorado Indigent Care Program, established in Title 25.5, Article 3, Part 1, C.R.S. is not available.~~

~~P~~. Outpatient Hospital ~~s~~Service has the same meaning as set forth in 42 C.F.R. § 440.20.

~~Q~~Q. Patient Contact Best Efforts means the process of communication efforts completed by the Provider to contact a patient. This includes phone calls, SMS messages, emails, and portal messages.

~~R~~P. Permissible Extraordinary Collection Action means an action other than an Impermissible Extraordinary Collection Action that requires a legal or judicial process, including but not limited to placing a lien on an individual's real property, attaching or seizing an individual's bank account or any other personal property, or garnishing an individual's wages. A Permissible Extraordinary Collection Action does not include the attachment of a hospital lien pursuant to section 38-27-101, C.R.S.

~~S~~Q. Provider means any Health Care Facility or Licensed Health Care Professional subject to Title 25.5, Article 3, Part 5, C.R.S.

~~T~~R. Qualified Patient means an individual ~~who resides in Colorado~~ who attests to residing in Colorado, whose household income is not more than two hundred fifty percent of the Federal Poverty ~~Level,~~Guidelines and who received ~~a Health Care Service at a Health Care Facility.~~an Inpatient ~~h~~Hospital ~~s~~Service or Outpatient ~~h~~Hospital ~~s~~Service at a ~~h~~Health ~~c~~Care ~~f~~Facility.

~~U~~S. Screen or Screening means a process identified in rule by the Department whereby Health Care Facilities assess a patient's circumstances related to eligibility criteria and determine whether the patient is likely to qualify for public health care coverage or Discounted Care, inform the patient of

the Health Care Facility's determination, and provide information to the patient about how the patient can enroll in public health care coverage.

~~T~~V. SMS means short messaging service messages, commonly referred to as text messages.

~~U~~W. Uninsured means an uninsured individual, as defined in section 10-22-113(5)(d), C.R.S.

8.922 SCREENING AND APPLICATION

A. Screening, Application, and Determination Notice

1. Beginning September 1, 2022, using the single uniform application developed and distributed by the Department, a Health Care Facility shall screen each uninsured patient and any insured patients who request to be screened for:

a. Public health insurance programs including but not limited to Medicare, Medicaid, Emergency Medicaid, and the Children's Basic Health Plan.

b. Eligibility for the CICP, if the patient receives or is scheduled to receive a service eligible for reimbursement through the CICP.

c. Discounted Care, as described in section 25.5-3-503, C.R.S.

2. Uninsured Patients

a. Health Care Facilities must complete the screening process using the uniform application within 45 days from the uninsured patient's date of service or date of discharge, whichever is later.

b. The screening process consists of completing the first page of the uniform application using self-attested information provided by the patient or their guardian.

c. If the self-attested screening process results in a determination that the patient may be eligible for Discounted Care, then, at the time of the screening, the Health Care Facility must provide the patient or their guardian with a list of information and documents required to complete the application process. The patient is permitted 45 days to provide the documentation required to complete the application. When all necessary documentation has been received from the patient, the Health Care Facility must determine the patient's eligibility for Discounted Care and send written notice of the determination to the patient or guardian within ~~14~~ 21 days.

d. If the self-attested screening process results in a determination that a patient likely is ineligible for Discounted Care, the patient must be informed that the screening results are not an official determination and that they have the right to complete the application and receive an official determination of eligibility for Discounted Care if they choose. If the patient requests to complete the application process for Discounted Care, the Health Care Facility must complete the application process and provide an official determination of eligibility for Discounted Care.~~.~~

e. If the self-attested screening process results in a determination that the patient may be eligible for one or more public health coverage options, the Health Care Facility must inform the patient of those options and provide information on how

the patient may apply for them, including any application deadlines the patient should be aware of.

3. Insured Patients

   a. If the insured patient or their guardian requests to be screened for public health insurance programs, CICP, and Discounted Care, Health Care Facilities must screen insured patients within 45 days of their date of service or date of discharge, or within 45 days of the date of their first bill after their insurance adjustment, whichever is later.

   b. The request to be screened may be made in person, by telephone, email, or by using the portal, if available. Health Care Facilities must contact the insured patient or their guardian to schedule the screening within three business days after receiving the insured patient's request.

   c. Patients believed to have health insurance coverage when services were rendered and who are subsequently determined to be uninsured on their date of service are considered Uninsured. Within 45 days from the date of the notification that the patient was not insured on the date of service, the Health Care Facility must complete the screening.

4. Health Care Facility Determination Notice

   a. The Health Care Facility must provide the patient written notice of the determination within ~~14~~ 21 days of receiving all required documentation to complete the patient's application for Discounted Care. A copy of the determination must be sent to any and all applicable Licensed Health Care Professionals.

   b. The determination shall be written in plain language and in the patient or their guardian's preferred language.

   c. If a Health Care Facility fails to issue written notice of the determination to the patient within ~~14~~ 21 days of receiving all required documentation to complete the patient's application, the patient may file an appeal. If the appeal is filed within 60 calendar days of the patient submitting all required documentation, the Health Care Facility must review the appeal and respond to the patient or their guardian and the Department within 15 calendar days of the date of the appeal.

   d. For patients determined to be eligible for Discounted Care, the determination notice must include but is not limited to:

      1. The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, Hospital Discounted Care, and CICP, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined potentially eligible for.

         i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply for to that program for their services to be covered, that date must be included in the determination notice.

2. The dates for which the Discounted Care determination is valid.

3. The household size and income used to determine eligibility and the household calculated FPG.

4. The patient's ~~4%, and 6%, and 2%~~monthly installment amounts ~~limits based on their~~ calculated on their gross household income pursuant to 8.923.A.2.

5. If the patient was applying and approved for CICP, the patient's CICP rating.

6. If the patient was applying and approved for CICP, the patient's CICP copay cap.

7. If the Health Care Facility is not a CICP Provider, information on where the patient may obtain CICP services.

8. Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department.

e. The determination notice for patients determined not eligible for Discounted Care must include but is not limited to:

1. The basis for denial of Discounted Care.

2. The programs and discounts for which the patient was determined likely eligible for, including but not limited to Medicaid, Emergency Medicaid, CHP+, Medicare, and the availability of subsidies through Connect for Health Colorado. This must also include where to find additional information and how to apply for each program the patient was determined potentially eligible for.

i. If the patient appears likely eligible for a program, and there is a deadline by which the patient must apply to that program for their services to be covered, that date must be included in the determination notice.

3. The service date the Discounted Care denial covers and an explanation that the household may qualify for coverage of future services if there is a change in household size or income.

4. The household size and income used to determine eligibility and the household calculated FPG.

5. Information on how to file a complaint and how to file an appeal with the Health Care Facility and the Department.

5. A Health Care Facility is no longer obligated to screen an uninsured patient for past dates of service if the patient or their guardian signs the ~~D~~decline ~~S~~screening ~~F~~form developed by the Department that notes those specific dates of service or a past date range that includes those specific dates of service except when a patient or guardian who opted out of screening subsequently requests to complete the screening, if the subsequent request is made prior to starting Permissible Extraordinary Collections Actions.

a. The Health Care Facility must keep on file a ~~D~~decline ~~S~~screening ~~F~~form signed by the patient, or their guardian until June 30 of the seventh state fiscal year after the patient's date of service or date of discharge, whichever is later.

6. For patients who are discharged without being screened or signing the ~~D~~decline ~~S~~screening ~~F~~form, the Health Care Facility must attempt to contact the patient by at least one method of contact that the patient indicates is their preferred method, which can include phone call, SMS message, email, and portal message at least once a month for six months after the patient's date of discharge with the first contact sent prior to the expiration of 45 days after screening. The Health Care Facility may commence billing 46 days after the patient's date of service or date of discharge, whichever is later. If the patient requests that the Health Care Facility cease contacting them by phone, SMS message, or email, the provider may consider those requirements as fulfilled. The Health Care Facility must document the patient's request and maintain the request as part of the patient record.

7. If a Health Care Facility has attempted to contact the patient in accordance with Patient Contact Best Efforts, and the patient does not respond within 182 days of their date of service or date of discharge, whichever is later, the Facility may conclude that the patient has made an informed decision to decline screening. Patient Contact Best Efforts, at a minimum, must include:

   a. Notice that the failure to respond may result in the loss of their right to be screened for cost saving options.

   b. Calling any phone numbers provided by the patient and leaving voice messages with allowable information under the Health Insurance Portability and Accountability Act as defined at 45 C.F.R. sec. 164.502 and the Telephone Consumer Protection Act as defined at 47 U.S.C. sec. 227 if the calls are unanswered,

   c. SMS messages to any of the patient's phone numbers identified by the patient as a mobile number if the Health Care Facility has the ability to send SMS messages,

   d. Sending emails to any email address provided by the patient, and

   e. Sending messages through any appropriate patient portal.

8. If a patient does not indicate their preferred method of contact, the Provider shall contact patients in accordance with their internal patient communication policies. Documentation of the communication attempts for patients must be kept in their patient records and the communication policy must be kept on file until the June 30 of the seventh state fiscal year past the patient's date of service.

9. Documentation of the attempts to contact the patient or guardian to complete the screening must be maintained as part of the patient record. This may include call logs, message logs, copies of sent emails, portal messages sent, and copies of bills.

10. Providers shall maintain all Discounted Care-related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the creation of the documentation.

B. Patients

1. Any patient or patient's guardian aged 18 and older may apply to receive Discounted Care.

2. The decision regarding eligibility for Discounted Care applies to both the patient and the members of the patient's household.

3. If a patient is deceased, the personal representative of the estate or a family member may complete the screening and application on behalf of the patient.

4. The application to receive Discounted Care shall include the names, birth dates, and relationship to the patient of all members of the patient's household who are included on the application.

    a. A patient must include their spouse or civil union partner in their household for the application.

    b. Any additional person living at the same address as the patient may also be included in the household.

    c. A patient may include household members who live in other states or countries if the patient attests to the fact that they provide at least 50% of the household member's support.

5. A minor shall not be screened separately from his or her parents or guardians unless they are emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Household Income

1. Using the information submitted by a patient or patient's guardian, the Health Care Facility shall determine whether the patient meets all requirements to receive Discounted Care. Health Care Facilities must follow the income counting methodology determined by the Department. Health Care Facilities shall determine Qualified Patient financial eligibility based on income from each household member 18 and older and household size. The Health Care Facility may not consider assets in determining eligibility.

2. Eligibility shall be determined at the time of application, unless required documentation is not available, in which case the patient or patient's guardian will be notified of the missing documentation within three business days after receipt of the application. An eligibility determination shall be made within ~~14~~ 21 calendar days after the application is complete.

3. Patients may establish household income by providing documents that satisfy documentation guidelines established by the Department. Acceptable forms of documentation may include but is not limited to pay stubs, employer letter, tax returns, and business financial statements. The Health Care Facility may not require more than the minimum amount of documentation to substantiate declared income.

    a. Patients who are experiencing homelessness are exempt from the documentation requirements related to establishing income and may self-attest to their household income.

8.923 HEALTH CARE SERVICE DISCOUNTS

A. Beginning September 1, 2022, if a patient screened pursuant to section 8.922 is determined to be a Qualified Patient, a Health Care Facility and a Licensed Health Care Professional shall~~:~~ for E~~e~~mergency ~~h~~Hospital and other H~~h~~ealth~~-~~ ~~c~~Care S~~s~~ervices:

1. Limit the amounts billed for Health Care Services to no more than the rate established in Department rule pursuant to section 8.929.

2. Enter into a payment plan with the Qualified Patient in which the Qualified Patient pays for care in monthly installments. For services provided by a Health Care Facility, monthly installments shall not exceed four percent of the patient's gross monthly household income on a bill from a Health Care Facility that contains only facility charges and shall not exceed~~. and not paying more than~~ six percent of the patient's gross monthly household income on a bill from a Health Care Facility containing both facility and Licensed Health Care Professional charges. For services provided by each Licensed Health Care Professional who bills separately from the Health Care Facility, monthly installments shall not exceed two percent of the patient's gross monthly household income; and

3. After a cumulative thirty-six months of payments, the Health Care Facility shall treat the Qualified Patient's bill as paid in full and must permanently cease collection activities on any balance that remains unpaid.

4. Providers shall not suggest or require that patients obtain loans that include fees, interest, or payment plans that exceed 36 payments to pay for services in lieu of setting up a payment plan directly with the Health Care Facility or Licensed Health Care Professional.

    a. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section. If a patient defaults on a loan from the Provider, the same rules apply related to any collection actions taken by the Provider as apply for payment plans under this section..

B. A Health Care Facility shall not:

1. Deny Discounted Care on the basis that the patient has not applied for any public benefits program; or

2. Adopt or maintain any policies that result in the denial of admission or treatment of a patient because the patient may qualify for Discounted Care.

8.924 PATIENT RIGHTS

A. Beginning September 1, 2022, a Health Care Facility shall make available to the public and to each patient information developed by the Department about patient's rights pursuant to Part 5 of Article 3 of Title 25.5 C.R.S. (2021) and the uniform application developed by the Department pursuant to section 25.5-3-505 (2)(i), C.R.S.

B. At a minimum, the Health Care Facility shall:

1. Post the information in all languages spoken by ten percent or more of the population in any Colorado county conspicuously on the Health Care Facility's website, including a link to the information on the Health Care Facility's main landing page;

2. Make the information available in patient waiting areas;

3. Make the information available to each patient, or the patient's legal guardian, before the patient is discharged from the Health Care Facility, verbally or in writing in the patient's or legal guardian's preferred language, which may include using professional interpretation and/or translation services; and

4. Inform each patient on the patient's Billing Statement of the patient's rights pursuant to Part 5 of Article 3 of Title 25.5, C.R.S. (2021) including the right to apply for Discounted Care, and provide the website, email address, and telephone number where the information may be obtained in the patient's preferred language.

C. Providers shall not present the patient's rights in a format that differs from the format in which the material is distributed by the Department without Department approval.

1. Providers may not make any part of the patient's rights information part of a footnote or use any other format that may minimize its importance.

8.925 REPORTING REQUIREMENTS

A. Beginning September 1, 2023 for Health Care Facilities and beginning September 1, 2025 for Licensed Health Care Professionals, and each September 1 thereafter, each Health Care Facility and Licensed Health Care Professional shall report to the Department data that the Department determines is necessary to evaluate compliance across race, ethnicity, age, and primary-language-spoken patient groups with the screening, Discounted Care, payment plan, and collections practices required by Title 25.5, Article 3, Part 5, C.R.S. . The Department shall distribute a compliance data reporting template to each Health Care Facility.

1. If a Health Care Facility or Licensed Health Care Professional is not capable of disaggregating the required data by race, ethnicity, age, and primary language spoken, the Health Care Facility or Licensed Health Care Professional shall report to the Department the steps the Health Care Facility or Licensed Health Care Professional is taking to improve race, ethnicity, age, and primary language spoken data collection and the date by which the facility or Licensed Health Care Professional will be able to disaggregate the reported data.

B. Beginning September 1, 2023 for Health Care Facilities and beginning September 1, 2025 for Licensed Health Care Professionals, and each September 1 thereafter, each Health Care Facility and Licensed Health Care Professional shall submit Discounted Care utilization and charge data in a format and timeline determined by the Department.

8.926 COLLECTIONS

A. Beginning September 1, 2022, before assigning or selling patient debt to a collection agency or a debt buyer, or before pursuing, either directly or indirectly, any Permissible Extraordinary Collection Action:

1. A Health Care Facility shall meet the screening requirements in section 8.922;

2. A Provider shall provide Discounted Care to a Qualified Patient pursuant to section 8.920;

3. A Provider shall provide a plain language explanation of the health care services and fees and notify the patient or their guardian of potential collection actions in their preferred language on the timeline developed by the Department; and

4. A Provider shall bill any third-party payer that is responsible for providing health care coverage to the patient. If a Licensed Health Care Professional is an out-of-network provider under a Qualified Patient's health insurance plan, the Licensed Health Care Professional and health insurance carrier shall comply with the out-of-network billing requirements described in sections 10-16-704 (3) and 12-30-113, C.R.S.

B. A Health Care Facility must complete the Patient Contact Best Efforts in their attempts to contact a patient who has not signed a Decline Screening Form or who has not been screened as described in Section 8.922 prior to starting Permissible Extraordinary Collections Actions.

C. Documentation of Patient Contact Best Efforts communication attempts with the patient as outlined in section 8.922 satisfies the screening requirements for Health Care Facilities.

D. For a Qualified Patient with an established payment plan, Permissible Extraordinary Collections Actions may not be started until the patient has failed to remit three consecutive payments and has not communicated with the Provider asking for a deferment or to be redetermined prior to or during those three months of missed payments. Providers must notify Qualified Patients with established payment plans at least 30 days prior to the commencement of Permissible Extraordinary Collections Actions.

E. Providers shall not commence collection proceedings against a patient for any amount in excess of the rates established at Section 8.923.A.2, and must reduce the amount owed by the amount of any payments received from the patient or a third-party payer.

8.927 APPEALS AND COMPLAINTS

A. If a patient is determined ineligible for Discounted Care after the uniform application has been completed, the patient may appeal the decision as follows:

1. No later than 30 calendar days from the date on the Health Care Facility's eligibility determination letter, the patient or their guardian may submit an appeal in writing via U.S. Mail, email, or patient portal message if available to the Health Care Facility that made the determination.

2. Within 15 calendar days from the date of the appeal, the Health Care Facility shall complete a redetermination of eligibility and respond to the patient or guardian and the Department.

3. If the Health Care Facility upholds its initial eligibility determination, the patient or guardian may proceed to the next step of the appeals process as described in Section 8.927.A.4.

4. No later than 15 calendar days from the date of the Health Care Facility's initial appeal decision, the patient shall submit a written appeal to the Department. Email submissions must be addressed to hcpf_HospDiscountCare@state.co.us. Letters must be mailed to:

Department of Health Care Policy and Financing
~~Attention: Hospital Discounted Care~~
~~c/o State Programs Unit, Special Financing Division~~
~~1570 Grant Street~~
~~Denver, CO 80203~~
Attention: State Programs Unit, Special Financing Division
% Hospital Discounted Care
303 E. 17th Avenue- Suite 1100

Denver, CO 80203

5. Within 15 calendar days from date of receipt of the appeal, the Department shall issue a final determination letter to both the patient and the Health Care Facility. If the Department deems that the redetermination was inaccurate, the Health Care Facility must resend a determination letter to the patient and the Department stating the patient is/was eligible for Discounted Care on the date of service.

B. A patient or guardian who believes a Health Care Facility has improperly calculated a payment plan based on inaccurate income information may appeal the payment plan offered by the Facility to the Department using the process described in Section 8.927.A.1.

C. The Department shall maintain records of all appeals and its final determinations for each Health Care Facility. If the Department determines a Health Care Facility has a repeated pattern of errors in patient eligibility determinations, the Department will require the Health Care Facility to attend training with the Department. The Health Care Facility may be subject to random application checks for 12 months following the training to ensure that the errors have been corrected.

D. Patients and their guardians may file complaints against Providers directly with the Department. Patients are not required to file a complaint with the Provider prior to filing a complaint with the Department.

1. Patients may submit complaints via U.S. Mail, email, or phone as follows:

Phone: 303-866-2580
Email: hcpf_HospDiscountCare@state.co.us
U.S. Mail: Department of Health Care Policy and Financing
~~Attention: Hospital Discounted Care~~
~~c/o State Programs Unit, Special Financing Division~~
~~1570 Grant Street~~
~~Denver, CO 80203~~
Attention: State Programs Unit, Special Financing Division
% Hospital Discounted Care
303 E. 17th Avenue~~-~~ Suite 1100
Denver, CO 80203

2. The Department shall review complaints within 30 calendar days of receipt.

3. The Department shall maintain records of all complaints for each Provider. If the Department determines there is a repeated pattern in the complaints filed against the Provider, the Provider may be subject to a corrective action plan.

a. Providers will have 90 days to submit a corrective action plan. Extensions may be made at the Department's discretion up to no more than 120 days.

8.928 REVIEW OF PROVIDERS FOR NONCOMPLIANCE

A. The Department shall periodically review Providers to ensure compliance with Part 5 of Article 3 of Title 25.5, C.R.S. (2024~~1~~) and these rules. If the Department finds that a Provider is not in compliance with these rules, the Department shall notify the Provider.

B. The Provider will have 90 days to file a corrective action plan with the Department that must include measures to inform impacted patients about the noncompliance and provide financial corrections consistent with these rules.

1. At the Department's discretion, a Provider may be permitted up to 120 days to submit a corrective action plan upon request.

2. The Department may require a Provider that is not in compliance with Title 25.5, Article 3, Part 5, C.R.S. or these rules to develop and operate under a corrective action plan until the Department determines the Provider is in compliance.

C. If a Provider's noncompliance with these rules is determined by the Department to be knowing or willful or there is a repeated pattern of noncompliance, the Department may fine the Provider no more than $5,000. If the Provider fails to take corrective action or fails to file a corrective action plan with the Department pursuant to this section, the Department may fine the Provider no more than $5,000 per week until the Provider takes corrective action. The Department shall consider the size of the Health Care Facility and the seriousness of the violation in setting the fine amount.

D. The Department shall make the information reported pursuant to this section and any corrective action plans for which fines were imposed pursuant to this section available to the public and shall annually report the information as part of its presentation to its committees of reference at a hearing held pursuant to section 2-7-203 (2)(a), C.R.S. of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act".

E. For audit purposes, Providers shall maintain all Discounted Care related records, including but not limited to, documentation to support screenings and determinations, service data including dates of service for Qualified Patients and services provided to them on those dates, and expenditures until June 30 of the seventh state fiscal year following the screening or determination.

8.929 RATES

The Department shall annually establish rates for Discounted Care. The rates will approximate and not be less than one hundred percent of the Medicare rate or one hundred percent of the Medicaid rate, whichever is greater. The Department shall publicly post the established rates on the Department's website pursuant to section 25.5-3-505, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000
Rule Number: MSB 24-10-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.3000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.3000 with the proposed text beginning at 8.3001.48 through the end of 8.3001.48. Replace the current text at 8.3003.A.3 through the end of 8.3003.B.4.a.ii. Replace the current text at 8.3004.D.3.g. This rule is effective March 2, 2025.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Healthcare Affordability and Sustainability Provider Fees and Supplemental Payments, Section 8.3000
Rule Number: MSB 24-10-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule achieves two purposes. These are 1) make necessary adjustments to MSB 24-02-06-A and 2) establish a one-time provider fee increase to fund supplemental payment increases for federal fiscal year (FFY) 22-23 and FFY 23-24.

   1) MSB 24-02-06-A Adjustment - The adjustments to MSB 24-02-06-A, originally presented to the Medical Services Board in July 2024, modifies the calculation of the HAS provider fees and supplemental payments. Since then, it was identified that two minor rule revisions are necessary for HAS calculations. These include:

      a. Reinclusion of the "Urban Center Safety Net Specialty Hospital" definition in Section 8.3001 DEFINITIONS. This definition was erroneously removed and needs to be a defined hospital for certain hospital reimbursement calculations.

      b. Change the hospital-specific Disproportionate Share Hospital (DSH) limit for low Medicaid inpatient utilization rate (MIUR) hospitals from "equal to 10.00%" to "greater than or equal to 10.00%" in Section 8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENTS. This is necessary to allow for increased HAS supplemental payments to low MIUR hospitals, aligning with HAS supplemental payment calculations.

   Both listed changes are minor and have negligible impacts. The Urban Center Safety Net Specialty Hospital definition makes no changes to hospital reimbursement. The low MIUR DSH limit change increases HAS supplemental payments to low MIUR hospitals by $50k.

   2) HAS Provider Fee Increase - In the subsequent months, HAS supplemental payments for FFY 22-23 and FFY 23-24 will be increased from 97.00% to 99.25% of the Inpatient/Outpatient Upper Payment Limits (UPLs), equaling a $85 million payment increase. Both years are still within the two-year federal filing requirements, allowing for federal financial participation for any supplemental payment increases. The state's funding obligation for this payment increase will come from an additional $31 million in provider fees to be collected from hospitals at the same time the supplemental payments are made. The calculation methodology for the one-time fee increase is included in Section 8.3003.A. OUTPATIENT SERVICES FEE and Section 8.3003.B. INPATIENT

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SERVICES FEE. No changes are required to Section 8.3000 for the payment increase for either year.

The Department worked extensively with the Colorado Hospital Association (CHA) and the general hospital provider community over the last several months on this project. The HAS provider fee and supplemental payment increases were both presented to the Colorado Healthcare Affordability & Sustainability Enterprise (CHASE) Board at their October 2024 meeting. The CHASE Board approved the fees and payments at the board meeting and makes recommendations for the MSB to approve the proposed rule.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

   25.5-4-402.4(4)(b), (g), C.R.S.

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REGULATORY ANALYSIS

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

   MSB 24-02-06-A Adjustment - Low MIUR hospitals will experience a limited supplemental payment increase. Hospitals will bear the cost through increased provider fees used to fund this funding obligation increase.

   HAS Provider Fee Increase - Hospitals will bear the cost through increased provider fees. Hospitals though, will also experience greater supplemental payments with the increased provider fees.

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

   MSB 24-02-06-A Adjustment - The proposed rule will increase HAS supplemental payments to low MIUR hospitals by $50k.

   HAS Provider Fee Increase - The supplemental payment, provider fee, and net reimbursement increases for FFY 22-23 and FFY 23-24 are provided in the table below. Net reimbursement equals supplemental payments minus provider fees.

FFY	FFY 22-23	FFY 23-24	Total
Provider Fees	$21.2M	$9.9M	$31.1M
Supplemental Payments	$55.9M	$29.2M	$85.1M
Net Reimbursement	$34.7M	$19.3M	$54.0M

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

   There are no costs to the Department with the proposed rule.

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

   MSB 24-02-06-A Adjustment - If no action is taken, low MIUR hospitals do not experience the $50k payment increase.

   HAS Provider Fee Increase – If no action is taken, the $31 million in state funding obligation cannot be collected and the $85 million supplemental payments cannot be made to hospitals.

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

   No other methods are available to achieve the purpose of the proposed rule.

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

   No other alternatives are available.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

8.3001: DEFINITIONS

1. "Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.

2. "CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).

3. "CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

4. "CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

5. "CMS" means the federal Centers for Medicare and Medicaid Services.

6. "Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and licensed or certified as a critical access hospital by the Colorado Department of Public Health and Environment.

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

8. "Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).

9. "Essential Access Hospital" means a Critical Access Hospital or General Hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget and having 25 or fewer licensed beds.

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

11. "Fund" means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).

12. "General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

13. "High Volume Medicaid and CICP Hospital" means a hospital with at least 30,000 Medicaid Days per year that provides over 35% of its total days to Medicaid and CICP clients.

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

15. “High Medicaid Utilization Hospital” means a hospital with a Medicaid payer mix greater than or equal to twenty-five percent (25%) and a Medicaid non-managed care patient days utilization rate greater than or equal to forty percent (40%).

16. “Heart Institute Hospital” means a hospital recognized as a HeartCARE Center by the American College of Cardiology (ACC) with at least 25,000 Medicaid Non-Managed Care Days per year.

17. “Hospital-Specific Disproportionate Share Hospital Limit” or “Hospital-Specific DSH Limit” means a hospital’s maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

18. “Hospital Transformation Program Supplemental Medicaid Payments” or “HTP Supplemental Medicaid Payments” means the:

    1. Outpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.B.,

    2. Inpatient Hospital Supplemental Medicaid Payment described in Section 8.3004.C., and

    3. Essential Access Hospital Supplemental Medicaid Payment described in Section 8.3004.E.

19. The HTP Supplemental Medicaid Payments do not include the Hospital Quality Incentive Payment described in Section 8.3004.F. or Rural Support Program Hospital Supplemental Medicaid Payment described in Section 8.3004.G.

20. “Independent Metropolitan Hospital” means an independently owned and operated hospital located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget with at least 1,500 Medicaid Days per year.

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

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

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

24. “Managed Care Day” means an inpatient hospital day for which the primary payer is a managed care health plan, including HMO, PPO, POS, and EPO days.

25. “Medicaid Day” means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

26. “Medicaid Managed Care Day” means a Managed Care Day for which the primary payer is Medicaid.

27. “Medicare Cost Report” means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

28. “MMIS” means the Medicaid Management Information System, the Department’s Medicaid claims payment system.

29. “MIUR” means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospital days.

30. “Neonatal Intensive Care Unit Hospital” or “NICU Hospital” means a hospital with a NICU classification of Level III or IV according to guidelines published by the American Academy of Pediatrics (AAP).

31. “Non-Managed Care Day” means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.

32. “Non-State-Owned Government Hospital” means a hospital that is either owned or operated by a local government.

33. “Outpatient Services Fee” means an assessment on hospitals based on outpatient hospital charges.

34. “Outpatient Upper Payment Limit” means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

35. “Pediatric Specialty Hospital” means a hospital that provides care exclusively to pediatric populations.

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

37. “PPO” or “Preferred Provider Organization” means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.

38. “Privately-Owned Hospital” means a hospital that is privately owned and operated.

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

40. “Rehabilitation Hospital” means an inpatient rehabilitation facility.

41. “Respiratory Hospital” means a hospital that primarily specializes in respiratory related diseases.

42. “Rural Hospital” means a hospital not located within a Metropolitan Statistical Area (MSA) designated by the United States Office of Management and Budget.

43. “Safety Net Metropolitan Hospital” means a hospital that provides services within the Pueblo, Colorado Metropolitan Statistical Area designated by the United States Office of Management and Budget (Pueblo MSA) with no less than 15,000 Days per year reported on its Medicare Cost Report, Worksheet S-3, Part 1, Column 7 (Title XIX), lines 1-18, and 28 (adult, pediatrics, intensive care, and subunits).

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

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

46. “Supplemental Medicaid Payments” means the:

1. Outpatient Hospital Supplemental Medicaid Payment described in 8.3004.B.,

2. Inpatient Hospital Supplemental Medicaid Payment described in 8.3004.C.,

3. Essential Access Hospital Supplemental Medicaid Payment described in 8.3004.E.,

4. Hospital Quality Incentive Payment described in 8.3004.F., and

5. Rural Support Program Hospital Supplemental Medicaid Payment described in 8.3004.G.

47. "Uninsured Cost" means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

48. "Urban Center Safety Net Specialty Hospital" means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days per year, rounded to the nearest percent, equals, or exceeds 65%.

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

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

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.6625% of total hospital outpatient charges, with the following exception:

   a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to 1.6485% of total hospital outpatient charges.

4. A one-time Outpatient Services Fee shall be collected from hospitals to increase Inpatient Hospital Supplemental Medicaid Payments and Outpatient Hospital Supplemental Medicaid Payments to 99.25% of the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit for federal fiscal year 2022-23 and federal fiscal year 2023-24.

   a. The Outpatient Services Fee is calculated as .0359% of a hospital's cost report year-end (CRYE) 2022 total hospital outpatient charges, with the following exception:

      i. High Volume Medicaid and CICP Hospital's Outpatient Services Fee is discounted to .0356% of CRYE 2022 total hospital outpatient charges.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

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

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $106.01 per day for Managed Care Days and 473.90 per day for ~~all~~ Non-Managed Care Days, with the following exceptions:

   a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $55.35 per day for Managed Care Days and $247.42 per day for ~~all~~ Non-Managed Care Days, and

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to 42.40 per day for Managed Care Days and $189.56 per day for Non-Managed Care Days.

4. A one-time Inpatient Services Fee shall be collected from hospitals to increase Inpatient Hospital Supplemental Medicaid Payments and Outpatient Supplemental Medicaid Payments to 99.25% of the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit for federal fiscal year 2022-23 and federal fiscal year 2023-24.

a. The Inpatient Services Fee is calculated as $2.68 per CRYE 2022 Managed Care Day and $11.96 per CRYE 2022 Non-Managed Care Day, with the following exceptions:
   i. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $1.40 per CRYE 2022 Managed Care Day and $6.24 per CRYE 2022 Non-Managed Cared Day, and
   ii. Essential Access Hospitals' Inpatient Services Fee is discounted to $1.07 per CRYE 2022 Managed Care Day and $4.78 per CRYE 2022 Non-Managed Care Day.

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

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

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

   c. Critical Access Hospitals with at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

   a. Total funds for the payment shall equal $257,231,668.

   b. No qualified hospital shall receive a payment greater than 100% of their Hospital-Specific DSH Limit.

   c. A qualified hospital with CICP write-off costs greater than 700% of the state-wide average shall receive a payment equal to a minimum of 96.00% of their Hospital-Specific DSH Limit.

   d. A qualified Critical Access Hospital or Rural Hospital shall receive a payment equal to a minimum of 86.00% of their Hospital Specific DSH Limit.

   e. A qualified hospital not owned/operated by a healthcare system network within a Metropolitan Statistical Area and having less than 2,700 Medicaid Days shall receive a payment equal to a minimum of 80.00% of their Hospital-Specific DSH Limit.

   f. All remaining qualified hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining funds.

   g. A Low MIUR hospital shall ~~have their~~ receive a payment greater than or equal to 10.00% of their Hospital-Specific DSH Limit ~~equal 10.00%~~.

      i. A low MIUR hospital is a hospital with a MIUR less than or equal to 22.50%.

   h. The payment percentage of the hospital specific DSH limit shall be published in provider bulletin

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Title of Rule: Revision to the Medical Assistance Act Rule concerning updates to the Continuous Eligibility for Medical Assistance programs for section 8.100.3.Q
Rule Number: MSB 24-09-05-A
Division / Contact / Phone: Eligibility Policy Section / Melissa Torres-Murillo / 5052

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 24-09-05-A, Revision to the Medical Assistance Act Rule concerning updates to the Continuous Eligibility for Medical Assistance programs for section 8.100.3.Q

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.3.Q.1 and 8.100.3.Q.2, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.3.Q with the proposed text beginning at 8.100.3.Q.1 through the end of 8.100.3.Q.3.c. This rule is effective March 2, 2025.

*to be completed by MSB Board Coordinator

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Rule Number: MSB 24-09-05-A
Division / Contact / Phone: Eligibility Policy Section / Melissa Torres-Murillo / 5052

STATEMENT OF BASIS AND PURPOSE

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

The proposed rule change will amend 10 CCR 2505-10 Section 8.100.3.Q.1 and 8.100.3.Q.2 to update requirements to expand the 12 months of continuous eligibility (CE) for children under the age of 19 in Medicaid and Child Health Plan Plus (CHP+). These requirements are to expand coverage according to Section 5112 of the Consolidated Appropriations Act, 2023 (CAA, 2023), which amended titles XIX and XXI of the Social Security Act (the Act). The updates to amend the requirements for continuous eligibility for children under the age of 19 will allow continuous coverage for children enrolled in the limited Family Planning Medical Assistance programs, as well as ensure that children who become incarcerated and who are later released will still be eligible for the remainder of their CE period if they have any of their 12 months of coverage left. These changes will also eliminate the 14-day no-fault period that applied at the initial application and eliminate the termination of children under 19 years of age for not meeting the reasonable compatibility income check after the child's initial eligibility determination has been made. In addition, a child who moves to a higher benefit category during the CE period when changes are reported will start a new 12-month CE period (such as moving from CHP+ to Medicaid if the income decreases within Medicaid income levels). Changes will also allow a child's eligibility to be terminated during a CE period for the allowable exception of when the Department determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error, fraud, or perjury attributed to the child or the child's representative. Lastly, the Department will update the Colorado Benefits Management System (CBMS) to reflect and align these changes with these proposed rule updates.

2. An emergency rule-making is imperatively necessary

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

3. Federal authority for the Rule, if any:

   42 C.F.R. § 435.926

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

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C.R.S. 25.5-5-204.5

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REGULATORY ANALYSIS

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

   The rule update will benefit all children under the age of 19 who are found eligible and enrolled in Medicaid or CHP+ coverage. By updating these rules and requirements, we can expand continuous eligibility coverage to children under the Limited Family Planning Medical assistance program and children who are released from incarceration who received Medical Assistance coverage prior to incarceration. And the department can maintain enrollment for children who may have had a change in circumstance after their eligibility determination. These proposed rule changes have no projected negative impacts on any class of persons.

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

   The proposed rule to provide Medical Assistance continuously to eligible members, regardless of their change in circumstances will help keep children on medical assistance so they can continue to receive necessary health care leading to healthier Medicaid and CHP+ eligible children.

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

   The Department expects that adding CE coverage to the limited Family Planning medical assistance aid code as well as the adjustments to the Reasonable Opportunity Period (ROP) and CHP+ rule updates will have no impact on state revenues because this will not lead to an increase in the number of eligible members; instead, it will merely apply continuous eligibility for those members already eligible for Family Planning. The Department also assumes minimal implications for the movement between the Medicaid and CHP+ programs, but acknowledges that this policy change may result in a slight dip in CHP+ enrollment but expects this potential change to be imperceptible given the current post PHE movement trend from Medicaid to CHP+.

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

   There is no cost to the Department associated with this policy.

   The probable benefit of this policy is to align the state rules with the State Plan with CMS.

   The cost of inaction is that the current rules will not align with the State Plan.

   There are no obvious benefits to inaction.

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

   There are no less costly methods then making these policy alignments.

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

   There were no alternative methods considered for the proposed rule.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.Q. Continuous Eligibility (CE) for Medical Assistance programs

1. Continuous eligibility applies to children under age 19, who through an eligibility determination, reassessment or redetermination, are found eligible for a Medical Assistance program. The continuous eligibility period may last for up to 12 months.

   a. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

   ~~i)~~ ~~A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, any changes to income or other factors made to the child's case during the 14-day no fault period may change his or her eligibility for Medical Assistance.~~

   b. Exception: A child's continuous eligibility period will end effective the earliest possible month if any of the following occur:

      i) Child is deceased;

      ii) Becomes an inmate of a public institution;

         1. Incarcerated children receiving a full medical assistance program will move to a limited Incarceration benefit. If the child is released within the initial 12 months of the CE period, full coverage will be reinstated for the remaining 12-month CE period, unless any of the other exceptions apply;~~.~~

      iii) The child is no longer part of the Medical Assistance required household;

      iv) Is no longer a Colorado resident;

      v) Is unable to be located; based on evidence or reasonable assumption;

      vi) Requests to be withdrawn from continuous eligibility;

      vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.G.3 and 8.100.3.H.9; or

      viii) ~~Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 30-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial~~

~~eligibility determination or an annual redetermination.~~Eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error, or a finding of fraud or perjury attributed to the child or the child's ~~representative~~responsible party.

2. The continuous eligibility period will begin on the first day of the month the application is received, or from the date all criteria are~~is~~ met. For a child transitioning from CHP+ to the MAGI Medical Assistance program specified in section 8.100.4.G.2, a new 12-month continuous eligibility period will begin on the first day of the month of the transition. Continuous eligibility ~~is applicable~~ applies to children enrolled in the following Medical Assistance programs:

   a. MAGI-Medical Assistance, program as specified in section 8.100.4.G.2;

   b. SSI Mandatory, as specified in section 8.100.6.C

      i.) When a child is no longer eligible for SSI Mandatory they will be categorized as eligible within the MAGI-Child category for the remainder of the eligibility period;~~-~~

   c. Long- Term Care services

      i.) When a child is no longer eligible for Long-Term Care services they will be categorized as eligible within the MAGI- Child category for the remainder of the eligibility period;~~-~~

   d. Medicaid Buy-In program specified in section 8.100.6.Q

      i) Exception: Enrollment will be discontinued if there is a failure to pay premiums;

   e. Pickle (Title II COLA/Pickle Amendment of 1977);

   f. Disabled Adult Child (DAC); and

   g. Limited Family Planning Medical Assistance.

3. Children, under the age of 19, no longer enrolled in Foster Care Medicaid will be eligible for the MAGI-Medical Assistance program. The continuous eligibility period will begin the month the child is no longer enrolled in Foster Care Medicaid as long as they meet one of the following conditions:

   a. Begin living with other Relatives;

   b. Are reunited with Parents; or

   c. Have received guardianship.