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Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Billing Clarification
Rule Number: MSB 24-10-30-B
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 24-10-30-B, Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Billing Clarification
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) 8.590.2.B. and 8.590.7.K., 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 8.590.2.B with the proposed text beginning at 8.590.2.B through the end of 8.590.2.B.3. Replace the current text at 8.590.7.K with the proposed text beginning at 8.590.7.K through the end of 8.590.7.3.d. This rule is effective May 15, 2025,

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Durable Medical Equipment Billing Clarification

Rule Number: MSB 24-10-30-B

Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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 makes two clarifications to the Durable Medical Equipment (DME) rule.

First, the proposed rule clarifies contradictory language in Section 8.590.2.B, which incorrectly states that DME provided to members residing in facilities, as part of the facility's payment, must be included in the facility's per diem rate. While it is accurate that the DME must be included in the facility's payment and not billed separately, not all facilities are paid a per diem. This language excludes inpatient hospitals, which are not paid a per diem rate but rather in accordance with the APR-DRG payment methodology. DME is included in the inpatient hospital payment, and always has been, which the proposed rule clarifies by removing "per diem" and simply references "the facility's payment methodology". The proposed rule also clarifies that repairs and modification to member-owned DME purchased prior to the admission to the facility may be provided and billed separately from the facility payment. Finally, the proposed rule clarifies that prosthetics and orthotics may only be provided during an admission to a facility when they are specifically excluded from the facility payment. If they are not excluded from the facility payment, they must not be billed separately.

Second, the proposed rule removes the percentages listed in Section 8.590.7.K for the billing of manually priced DME items. Manually priced items that do not have a fee schedule rate are reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP), less a percentage listed in the DME Billing Manual for such items. Manually priced items that do not have an assigned fee schedule rate and have no MSRP are reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider, plus a percentage listed in the Billing manual for such items. The percentages are updated each year in the State Plan Amendment for the across-the-board rate changes authorized in the Long Bill. Because these percentages are updated each year, it is cumbersome to list them in Department rule when they are already updated each year in the Billing Manual. Therefore, the proposed rule takes the percentages out of the rule and references the Billing Manual.

Initial Review

[date]

Final Adoption

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Proposed Effective Date

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Emergency Adoption

[date]

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These clarification reflect current Department policy, they do not change existing DME billing practices.

2. An emergency rule-making is imperatively necessary

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

Explain:N/A

3. Federal authority for the Rule, if any:

42 C.F.R. § 440.70(b)(3) (2024)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);
C.R.S. § 25.5-5-102(1)(f) (2024)

Initial Review
Proposed Effective Date

[date]
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Final Adoption
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Rule Number: MSB 24-10-30-B

Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

The proposed rule clarifies existing Durable Medical Equipment (DME) billing practices and reflects current Department policy. The billing clarification benefits facilities and DME providers by helping to ensure appropriate billing and avoiding confusion.

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 clarifies existing Durable Medical Equipment (DME) billing practices and reflects current Department policy. The qualitative impact is avoiding billing errors, possible audit findings, and recoupment efforts. The quantitative impact is helping to ensure Medicaid funding is spent efficiently and appropriately.

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 proposed rule clarifies existing Durable Medical Equipment (DME) billing practices and reflects current Department policy. Therefore, it does not have any probable costs or effect on state revenues.

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

There are no probable costs to the proposed rule. The benefits of the proposed rule are clarifying Department rule so it accurately reflects current Department policy. The costs of inaction are rules that do not accurately reflect Department policy and potentially lead to billing errors. There are no 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 or less intrusive methods for clarifying Department rule.

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

There are no alternative methods for clarifying Department rule.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.590.2 BENEFITS

8.590.2.B. DME and Supplies for Members Residing in Facilities

1. DME ~~and Supplies and Supplies~~ for members residing in a hospital, nursing facility or other facility, ~~may be included in the payment to the facility pursuant to the facility's payment methodology~~~~are provided by those facilities and reimbursed as part of the per diem rate~~. DME and Supplies shall not be separately billed, except under the following circumstances:
 - a. The member is within fourteen days of discharge, and
 - b. Prior authorization or training are needed to assist the member with equipment usage, and
 - c. The equipment is needed immediately upon discharge from the facility.
2. Repairs and modifications to member owned DME ~~that was purchased prior to the admission to the facility may be provided and billed separately, not required as part of the per diem reimbursement, shall be provided to members residing in a hospital, nursing facility or other facility receiving per diem Medicaid reimbursement.~~
3. Prosthetic or Orthotic Devices may be provided ~~at any time during admission in a hospital, nursing facility, or other facility only when prosthetic or orthotic devices are specifically excluded from the facility payment. If prosthetic and orthotic devices are not specifically excluded by the facility payment rule, contract, or methodology, they must not be billed separately to members residing in a hospital, nursing facility or other facility receiving per diem Medicaid reimbursement if Prosthetic or Orthotic benefits are not included in the facility's per diem rate.~~

8.590.7 REIMBURSEMENT

- 8.590.7.K. Reimbursement rate for a purchased item shall be as follows:

1. Fee schedule items, with a HCPCS code, that have a maximum allowable reimbursement rate, shall be reimbursed at the lesser of submitted charges or the Department fee schedule rate.
2. Manually priced items that do not have an assigned fee schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less ~~a the~~ percentage listed in the Billing Manual for such items. ~~set forth below:~~
 - ~~a. July 1, 2018 to June 30, 2019, the percentage is 17.51.~~
 - ~~b. Pending federal approval, effective July 1, 2019, the percentage is 16.69.~~
3. Manually priced items that do not have an assigned fee schedule rate and have no MSRP shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus ~~a the~~ percentage listed in the Billing Manual for such items. ~~set forth below:~~
 - ~~c. July 1, 2018 to June 30, 2019, the percentage is 20.70.~~
 - ~~d. Pending federal approval, effective July 1, 2019, the percentage is 21.90.~~

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Out-of-State
Hospital and Physician Services Rate Negotiation
Rule Number: MSB 24-11-12-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 24-11-12-A, Revision to the Medical Assistance Act Rule
concerning Out-of-State Hospital and Physician Services Rate
Negotiation
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) 8.013, 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 8.013 with the proposed text beginning at 8.013.1 through
the end of 8.013.5.A.2.c. This rule is effective May 15, 2025.

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Out-of-State Hospital and Physician Services Rate Negotiation

Rule Number: MSB 24-11-12-A

Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

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 revision aligns Department rule with current policy, and federal State Plan authority, for out-of-state services and for the negotiation of single case agreements with out-of-state hospital and out-of-state physicians. When necessary, the Department may negotiate a higher reimbursement rate with an out-of-state provider to ensure access to care for members that require services not available in Colorado. For out-of-state hospitals to be eligible for single case agreements, the required services must not be available in Colorado and they must be prior authorized. For out-of-state physician services to be eligible for single case agreements, the physician services must either be part of an out-of-state hospital single case agreement or are provided by an out-of-state physician rendering services not available in Colorado. The authority to negotiate single case agreements in such circumstances ensures access to care for members that require hospital services or physician services not available in Colorado.

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 447.201(b) (2024)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);
Sections 25.5-5-102(1)(a-b), (d), C.R.S. (2024)

Initial Review

[date]

Final Adoption

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Proposed Effective Date

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Emergency Adoption

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Out-of-State Hospital and Physician Services Rate Negotiation

Rule Number: MSB 24-11-12-A

Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

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

Members who require out-of-state hospital services or physician services not otherwise available in Colorado will be affected by the proposed rule. Out-of-state hospitals and physicians who render such services will also be affected by the proposed rule. The Department will bear the cost of the rate negotiated in a single case agreement authorized under this rule.

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 qualitative impact to members requiring out-of-state services not available in Colorado will be access to care where a single case agreement is required to negotiate a rate the out-of-state provider will accept to render such services. The quantitative impact will be the rate negotiated in the single case agreement, which will be paid by the Department.

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

This rule is anticipated to be budget neutral because the Department already negotiates single case agreements with out-of-state providers when the required services are not available in Colorado. The proposed rule updates out-of-date rule language to align with the Department's policy for out-of-state services and for single case agreement negotiations, and with the federal authority for such negotiations in the State Plan.

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

The proposed rule has no probable costs because it aligns Department rule with current policy and federal State Plan authority, it does not add a new authority to negotiate single case agreements. The proposed rule benefit is aligning Department rule with existing policy and federal State Plan authority. The cost of inaction is

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continued misalignment between Department rule and the current Department policy and federal State Plan authority. There are no 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 or less intrusive methods to align Department rule with current policy and with federal State Plan authority.

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

There are no alternative methods for aligning Department rule with current policy and with federal State Plan authority.

8.013 OUT-OF-STATE MEDICAL CARE

8.013.1. COLORADO RESIDENTS TEMPORARILY OUT-OF-STATE

An eligible Colorado ~~recipient~~member, temporarily out of the state but still a resident of Colorado, ~~is entitled to receive the same Medicaid benefits to the same extent that Medicaid is furnished to members located in the state of Colorado residents in the state only~~ under ~~any one of the~~ following conditions:

A1). Medical services are needed because of a medical emergency.

For these services no prior authorization is needed. Whether an emergent condition exists is determined by the provider rendering service. ~~Documentation of the emergency must be submitted with the claim~~The emergency must be indicated on the claim submission.

B2). Medical services are needed because the ~~recipient's~~member's health would be endangered if he/she were required to ~~return~~travel to Colorado for medical care and treatment.

~~For these services no prior authorization is required.~~ The determination as to whether the ~~recipient's~~member's health would be endangered is made by the provider rendering service. ~~Documentation of why the recipient's health would be endangered must be submitted with the claim. However, the medical consultant of the Colorado Medicaid Program must be notified prior to the provision of services under this paragraph.~~

C3). The ~~State Medicaid Director~~Department determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available ~~in the state~~ where the ~~recipient~~member is temporarily located.

Prior authorization from the Medicaid Program's medical consultant must be obtained for services provided under this paragraph.

D4). It is the general practice for ~~recipients~~members in a particular locality to use medical resources in another state.

~~No prior authorization is necessary for services provided in accordance with this paragraph when the recipient of an area is obtaining services from a provider in a neighboring out of state locale.~~ Prior authorization from the Medicaid Program's medical consultant ~~is necessary~~may be required if the recipient is receiving services from any other out-~~of~~-state provider not in a neighboring locale.

E. ~~The Section 8.013.1.A-D. limitations on access to out-of-state medical care, for members temporarily out-of-state, do not apply to children who reside out of the state for whom Colorado makes adoption assistance payments or foster care maintenance payments.~~

8.013.2. COLORADO RESIDENTS SEEKING OUT-OF-STATE CARE

~~In addition, prior authorization from the Medicaid Program's medical consultant is required for all services which are only available out of state for Colorado Medicaid recipient's located in Colorado at the time services are necessary. If a member requires services that are only available out-of-state at the time services are medically necessary, then those services must will be approved by the Department.~~

~~C~~The above restrictions on out of state medical care shall not apply to children who reside out of the state for whom Colorado makes adoption assistance payments or foster care maintenance payments.

The county departments of social services shall advise all applicants and recipients of this policy.

8.013.3 PRIOR AUTHORIZATION

All services that require prior authorization in-state also require prior authorization out-of-state. Some services may require additional prior authorization to have the services rendered out-of-state, even if the underlying service does not require prior authorization.

8.013.4.4. PROVIDER ENROLLMENT PROCEDURES

To receive reimbursement, all out-of-state providers ~~shall be required to~~must enroll in the Colorado Medicaid Program. Out-of-state providers are subject to the same enrollment and screening rules, policies and procedures as in state providers, as specified in Section 8.125 Provider Screening. Some out-of-state providers are not eligible to enroll in Colorado Medicaid and cannot receive reimbursement.

8.013.25. REIMBURSEMENT PRINCIPLES

- ~~A. All claims except out of state nursing home claims must be submitted to the fiscal agent for the state with documentation showing that the above requirements have been met. (Out-of-state nursing home claims shall must be paid in accordance with the Section 8.443.19. Payment For Out Of State Nursing Home Care section of the Volume 8 staff manual.) All claims submitted to the fiscal agent must include:~~
- ~~B. 1) A copy of the provider's current Medicaid provider agreement with its state (if applicable);~~
- ~~C. 2) Its Colorado provider number; and~~
- ~~D. 3) Complete address, including zip code.~~
- ~~E. In addition, providers must sign a provider agreement in order to receive reimbursement. The claim form and the information contained in it shall constitute provider agreement. Except as provided elsewhere in the Volume 8 staff manual, reimbursement for out of state care shall be as follows:~~
- ~~F. Reimbursement for inpatient hospital services shall be 90% of the Colorado urban or rural DRG payment rate. Out of state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services (DHHS).~~
- ~~G. Reimbursement for physician services shall be the lower of the following:~~
- ~~H. A. HCFA Common Procedure Coding System (HCPCS) fee;~~
- ~~I. B. Provider's Actual Charge.~~
- ~~J. Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare. The foregoing procedures shall be in effect for all out of state providers, except as provided for elsewhere in the staff manual~~

~~Volume 8 regulations. Individual cases which are adversely affected by these procedures shall be presented to the Bureau of Medical Services, Director, Program Operations Division, Colorado Department of Social Services. Individual consideration shall be given to such cases.~~

A. The Department may ~~utilize single case agreements to~~ negotiate a higher reimbursement rate ~~for the following services:~~

1. Hospital services

a. The Department may negotiate a single case agreement with an ~~for~~ out-of-state hospital ~~services that are prior authorized under the following circumstances:-~~

i. ~~A. These are cases which require procedures~~ The hospital services ~~are~~ not available in Colorado;

~~ii. -and which~~ The hospital services must be prior authorized; and,-

iii. ~~B. The patient~~member's physician may suggest where the ~~patient member~~ should be sent, but the medical consultant for the Department is responsible for making the final determination based on the most cost effective institution consistent with quality of care.

b. The reimbursement rate for out-of-state hospital services in accordance with single case agreements will be negotiated between the Department and the out-of-state facility providing the services. When negotiating the rate, the Department will take into consideration the following:

i. The actual costs of the facility;

ii. The Medicare rate for the same or similar services, if any; and,

iii. The Medicaid rate for the same or similar services in the state where the facility is located, when available.

c. The reimbursement rate for out-of-state hospital services in accordance with single case agreements may not exceed the usual and customary charges of the facility for such services.

2. Physician services

a. The Department may negotiate a higher reimbursement rate for out-of-state physician services in accordance with single case agreements under the following circumstances:

i. The physician services are either:

I. Included in an approved single case agreement with a hospital in accordance with Section 8.013.2.D.1.; or

II. Provided by an out-of-state physician rendering services not available in Colorado.

ii. The member's physician may suggest where the member should be sent, but the medical consultant for the Department is responsible for making the final determinations based on the most cost-effective physician consistent with quality of care.

b. The reimbursement rate for out-of-state physician services in accordance with single case agreements will be negotiated between the Department and the out-of-state physician providing the services. When negotiating the rate, the Department will take into consideration the following:

i. The actual costs of the facility or the physician;

ii. The Medicare rate for the same or similar services, if any; and,

iii. The Medicaid rate for the same or similar services in the state where the facility or physician is located, when available.

~~b.~~c. The reimbursement rate for out-of-state physician services in accordance with single case agreements may not exceed the usual and customary charges for the facility or physician for such services.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning The Medicaid Buy-In Program for Children with Disabilities, Section 8.100.5.

Rule Number: MSB 24-07-08-A

Division / Contact / Phone: Eligibility Policy Unit / Nancy Brenes / 303-866-2897

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 24-07-08-B, Revision to the Medical Assistance Eligibility Rules Concerning the Medicaid Buy-In Program for Children with Disabilities, Section 8.100.5.
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) 8.100.5.Q.1.b.iv, 8.100.5.Q.1.f and 8.100.5.H.1, 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 8.100.5.H with the proposed text beginning at 8.100.5.H through the end of 8.100.5.H.4.e. Replace the current text at 8.100.6.Q with the proposed text beginning at 8.100.6.Q through the end of 8.100.6.Q.4. This rule is effective May 15, 2025.

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Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning The Medicaid Buy-In Program for Children with Disabilities, Section 8.100.5.

Rule Number: MSB 24-07-08-A

Division / Contact / Phone: Eligibility Policy Unit / Nancy Brenes / 303-866-2897

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 8.100.6.Q.1.f to incorporate changes to the Medicaid Buy-In Program for Children with Disabilities that would require families to enroll in medical family coverage offered through an employer-based group health plan if they are eligible and if the employer contributes at least 50% towards the plan premiums.

The proposed rule change will also amend 10 CCR 2505-10 8.100.5.H.1 and 8.100.6.Q.1.b.iv to correct and include the Medicaid Buy-In Program for Children with Disabilities under the income allocations and disregards currently applied to the Aged, Blind, and Disabled programs.

The benefit of changing the rule is to align policy with The Family Opportunity Act 1902(cc)(2)(A). The previous income disregards were not in alignment and as such resulted in an audit finding. This correction will allow appropriate income disregard calculations to be utilized, which will improve the eligibility determination process.

The Department will be updating the Colorado Benefits Management System (CBMS) to reflect these changes. A new memo explaining the disregards and employer sponsored insurance requirements changes will also be published.

2. An emergency rule-making is imperatively necessary

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

Explain: N/A

3. Federal authority for the Rule, if any:

42 U.S.C. 1396a(cc)(2)(A)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);
10 CCR 2505-10 Sections 8.100.5.Q and 8.100.5.H

Initial Review

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Final Adoption

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Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning The Medicaid Buy-In Program for Children with Disabilities, Section 8.100.5.

Rule Number: MSB 24-07-08-A

Division / Contact / Phone: Eligibility Policy Unit / Nancy Brenes / 303-866-2897

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.

With the proposed rule, families will be required to enroll in medical family coverage offered through an employer-based group health plan if they are eligible and if the employer contributes at least 50% towards the plan premiums. With the proposed rule there would also be an increase in income disregards that can help more families qualify for the program or stay in the program if they report an increase in income. This proposed change aligns the current rule with the Social Security Act, § 1902(cc)(2)(A).

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

With the proposed rule, applicants and/or recipients of the Medicaid Buy-In Program for Children with Disabilities would have higher income disregards which could help expand access to the program as well as allow current members with increased income changes to stay enrolled in the program.

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 requiring families to enroll in medical family coverage offered through an employer-based group health plan if they are eligible and if the employer contributes at least 50% towards the plan premiums could have a minor dampening effect on the number of individuals eligible for this program.

The Department expects that replacing the current income allocations and disregards with those found in 8.100.5.H, which are applied to the Aged, Blind, and Disabled programs, could produce a slight increase in the number of individuals who are eligible for this program.

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When the two components of this rule change are considered together, the Department expects the upward and downward pressures on caseload will yield no net change.

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 reduce pressure on state revenue by requiring families to enroll in employer-based health group plans, and to expand access to medical assistance coverage for a larger number of individuals based on higher income disregards.

The cost of inaction is that some people would have to forego coverage due to lower income disregards, and some would have an excess of coverage due to qualifying for, but not using, medical family coverage offered through an employer-based group health plan.

There are no known 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 of altering the eligibility criteria associated with this policy, given that there is no expected cost to the Department.

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

8.100.5. Aged, Blind, and Disabled, Long Term Care, and Medicare Savings Plan Medical Assistance General Eligibility

8.100.5.H. Income Allocations and Disregards

1. The following income allocations and disregards are only applicable to SSI related, OAP, Medicare Savings Programs (MSP), [the Medicaid Buy-In Program for Children with Disabilities](#) and the Medicaid Buy-In Program for Working Adults with Disabilities.

These allocations and disregards are not applicable to the HCBS waivers or the LTC programs.

For the Medicaid Buy-In Program for Working Adults with Disabilities, the applicant's spouse's income does not count toward the applicant.

- a. Income of spouses living together is considered mutually available for SSI related, OAP, and Medicare Savings Programs (MSP).
 - b. For a person living in the household of another and not paying shelter costs, one third of the Federal Benefit Rate (FBR) is counted as in-kind income and is added to the countable income. This does not apply to unemancipated children.
2. For the purposes of this rule, the following definitions apply:
 - a. unemancipated child is:
 - i) a child under age 18 who is living in the same household with a parent or spouse of a parent, or
 - ii) a child under age 21 who is living in the same household with a parent or spouse of a parent, if the child is regularly attending a school, college, or university, or is receiving technical training designed to prepare the child for gainful employment.
 - b. Ineligible child is a child who is not applying or eligible for SSI.
 - c. Ineligible parent/spouse is a parent or spouse who is not applying or eligible for SSI.
 3. Countable income is calculated by reducing the gross income by the following allocations and disregards.
 - a. Income allocations are the part of the gross income that is allocated to individuals in the home who are not eligible for Supplemental Security Income or Old Age Pension. The allocation reduces the gross income that is deemed available to the applicant/client. The allocation is deducted from the gross income prior to applying the other disregards.

The allocations are:

- i) An Ineligible Child Allocation is an amount equal to one half the current year's SSI FBR that is disregarded from the ineligible parents' gross income. This allocation is used to meet the needs of ineligible children in the household. This allocation is available for each ineligible child in the home. The amount of the allocation is reduced by any of the ineligible child's own income.
 - ii) An Ineligible Parent(s) Allocation is an amount equal to the current year's SSI FBR for a single individual or a couple, as applicable. This amount is used to meet the needs of the ineligible parent(s) in the home with an applicant/client child.
 - iii) No allocations are allowed for applicant/recipient spouses who do not have children in the home.
- b. Allocations are applied to the income in the following manner:
 - i) Allocation disregards are deducted from unearned income before earned income.
 - ii) Ineligible child allocation disregards are deducted from parents' income before any standard disregards are applied.
 - iii) Ineligible parent(s) allocation disregards are deducted after any ineligible child allocation disregards and after the standard income disregards.

4. Income disregards

a. \$20 General Income Disregard

If there is unearned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied, a General Income Disregard of \$20 shall be applied as follows:

- i) The first \$20 of total available unearned income (except for SSI income) must be disregarded. The remaining amount of unearned income is countable.
 - ii) If the client has less than \$20 of unearned income, the difference between the gross unearned income and the \$20 deduction shall be applied as an earned income disregard, if applicable.
 - iii) Only one \$20 general income disregard is allowed per couple and is divided between the two spouses. If one of the spouses has no income the other spouse shall get the full \$20 disregard.
- b. \$65 Plus One Half Remainder Earned Income Disregard
 - i) If there is earned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied:
 - 1) Deduct the first \$65 of all earned income.
 - 2) Divide the remaining income in half.
 - 3) The result is the amount of earned income used for determining eligibility.

- c. Child support received by an applicant/recipient child is reduced by one third of the total child support payment. This reduction does not apply to ineligible children when calculating the ineligible child allocation disregard.
- d. The first \$400 of the gross monthly earned income is exempt for a blind or disabled child who is a student that is regularly attending school. The exemption cannot exceed \$1,620 in a calendar year.
- e. Title 20 of the Code of Federal Regulations, § 416.1112 (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 303 E 17th Ave, Denver, CO 80203~~1570 Grant Street, Denver, CO 80203~~. Certified copies of incorporated materials are provided at cost upon request.

8.100.6 Aged, Blind, and Disabled Medical Assistance Eligibility

8.100.6.Q. Medicaid Buy-In Program for Children with Disabilities

1. To be eligible for the Medicaid Buy-In Program for Children with Disabilities:
 - a. Applicants must be age 18 or younger.
 - b. Household income will be considered and must be less than or equal to 300% of FPL after income disregards. The following rules apply:
 - i) 8.100.4.E - MAGI Household Requirements
 - ii) 8.100.5.F - Income Requirements
 - iii) 8.100.5.F.6 - Income Exemptions
 - iv) 8.100.5.H. Income Allocations and Disregards~~An earned income of \$90 shall be disregarded from the gross wages of each individual who is employed~~
 - ~~v) A disregard of a 33% (-.3333) reduction will be applied to the household's net income.~~
 - c. Resources are not counted in determining eligibility.
 - d. Individuals must have a disability as defined by Social Security Administration medical listing.
 - e. Children age 16 through 18 cannot be employed. If employed, children age 16 through 18 shall will be determined for eligibility through the Medicaid Buy-In Program for Working Adults with Disabilities.

f. Families are required to enroll in medical family coverage offered through an employer-based group health plan if they are eligible and if the employer contributes at least 50% towards the plan premiums.

gf. Families will be required to pay monthly premiums on a sliding scale based on household size and income.

- i) For families whose income does not exceed 200% of FPL, the amount of premiums and cost-sharing charges cannot exceed 5% of the family's adjusted gross income. For families whose income exceeds 200% of FPL but does not exceed 300% of FPL, the amount of premiums and cost-sharing charges cannot exceed 7.5% of the family's adjusted gross income.
- ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.
- iii) For households with two or more children eligible for the Medicaid Buy-In Program for Children with Disabilities, the total premium shall be the amount due for one eligible child.
- iv) Premium amounts are as follows:
 - 1) There is no monthly premium for households with income at or below 133% of FPL.
 - 2) A monthly premium of \$70 is applied to households with income above 133% of FPL but at or below 185% of FPL.
 - 3) A monthly premium of \$90 is applied to individuals with income above 185% of FPL but at or below 250% of FPL.
 - 4) A monthly premium of \$120 is applied to individuals with income above 250% of FPL but at or below 300% of FPL.
- v) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by \$10 or more.
- vi) A change in household net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in a member's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due. The Department will waive premiums for the Children with Disabilities Program members who are within their 12 months postpartum period.
- vii) Due to the federal COVID-19 Public Health Emergency, the Department will waive premiums for the Department's Children with Disabilities Program during the federal emergency declaration. Effective May 11, 2023 the COVID -19 Public Health Emergency has ended. The Department will continue to waive premiums until the last day of the twelfth month following the end of the COVID - 19 Public Health Emergency. The Department will notify all members as to when required premiums will resume.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation.
3. Verification requirements will follow the MAGI Category Verification Requirements found at 8.100.4.B.
- 4, Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Children with Disabilities. This is also called “opt out.”