COLORADO
Department of Health Care Policy & Financing
Medical Services Board

NOTICE OF PROPOSED RULES

The Medical Services Board of the Colorado Department of Health Care Policy and Financing will hold a public meeting on Friday, January 14, 2022, beginning at 9:00 a.m., in the eleventh floor conference room at 303 East 17th Avenue, Denver, CO 80203. Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-4416 or chris.sykes@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting.

A copy of the full text of these proposed rule changes is available for review from the Medical Services Board Office, 1570 Grant Street, Denver, Colorado 80203, (303) 866-4416, fax (303) 866-4411. Written comments may be submitted to the Medical Services Board Office on or before close of business the Wednesday prior to the meeting. Additionally, the full text of all proposed changes will be available approximately one week prior to the meeting on the Department's website at www.colorado.gov/hcpf/medical-services-board.

This notice is submitted pursuant to § 24-4-103(3)(a) and (11)(a), C.R.S.

MSB 21-11-24-A, Revision to the Medical Assistance Act Rule Concerning Preferred Drug List (PDL) and New Drug Determinations, Section 8.800.16.B

Medical Assistance. This proposed rule change will clarify that when a new drug becomes available and falls into a Drug Class that is already on the PDL, that the Department will determine whether it's Preferred or Non-preferred within a specified timeframe.

The authority for this rule is contained in Section 25.5-1-108, C.R.S. (2021); Sections 25.5-1-301 through 25.5-1-303 (2021).

MSB 21-11-24-B, Revision to the Medical Assistance Eligibility Rules concerning General and Citizenship Eligibility Requirements, Section 8.100.3.G

Medical Assistance. On September 30, 2021, Congress singed the Extending Government Funding and Delivering Emergency Assistance Act (HR 5305) into law. Section 2502 of HR 5305 expanded eligibility to entitlement programs such as Medicaid, to include Afghan evacuees as qualified non-citizens not subject to the five-year bar. The resolution states that a citizen or national of Afghanistan who is paroled into the United States between July 31, 2021 and September 30, 2022; or is paroled into the United States after September 30, 2022 and is either a spouse or child (defined under section 101(b) of the Immigration and Nationality Act 8 U.S.C. 4 1101(b); or is the parent or legal guardian of an individual arriving from Afghanistan in the prescribed date range who was determined to be an unaccompanied child (under 6 U.S.C. 279(g)(2), will considered a qualified non-citizen not subject to the 5 year bar. The population is referred to as Afghan humanitarian parolees.

Currently, these statuses are already considered qualified non-citizens not subject to the five-year bar for children under the age of 19 and pregnant women. HR 5305 states that all humanitarian parolees arriving from Afghanistan during the specified date ranges should be considered qualified non-citizens not subject to the five-year bar, as long as their parole has not been terminated by the Department of Homeland Security. Individuals with these statuses are not automatically entitled for Medical Assistance, they will still need to apply and meet all categorical requirements to be

approved. Their status will also be verified electronically through the Verify Lawful Presence (VLP) interface with the Systematic Alien Verification for Entitlements (SAVE) program per current state and federal rule.

The authority for this rule is contained in HR 5305, Section 2502; Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021), Section 25.5-4-205, C.R.S. (2021) and Section 24.4-4-103(6)(a), C.R.S. (2021).

MSB 19-06-25-A, Revision to the Medical Assistance Eligibility Rule Concerning 10-Day Reporting, Section 8.100.3.A

Medical Assistance. The proposed rule will amend 10 CCR 2505-10 8.100.3.A to include requirements for reporting changes. Medical assistance recipients are required to report changes in circumstances that may potentially affect their eligibility for medical assistance programs. 42 C.F.R. §435.916(c) states that the Department must have a procedure in place to ensure that members make timely and accurate reports for any change in circumstance that may affect their eligibility. There is currently information regarding the 10-day reporting rule on the medical assistance application under the "What I Should Know" section, however, there is not an existing rule to reinforce this requirement as specified by 42 C.F.R. §435.916(c). The addition of this rule will better align the Department's policy with federal regulations, and it will ensure that the 10-day reporting rule is enforced.

The authority for this rule is contained in 42 C.F.R §435.916(c), 42 C.F.R §435.907(a), 20 C.F.R §416.708(h) and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021).

MSB 21-10-08-A, Revision to the Medical Assistance Eligibility Rules Concerning Definitions at Section 8.100.1, General Eligibility Transferring Requirements at Section 8.100.3.C, and Long-Term Care Medical Assistance Requirements at Sections 8.100.A&B

Medical Assistance. For the purposes of eligibility rules, language updates are needed to include the description and referencing of the level of care assessment and level of care determination. There will also be an update to the definition of a long-term care institution as the language is outdated. There will be no effective change to eligibility criteria (increased or decreased) as it is determined in 8.100. The rule change will only add language to more generally describe the level of care assessment and determination. All individuals applying for long-term care services will still need to meet the institutional level of care needed to be approved for services, in addition to all other categorical eligibility requirements such as income, assets, and a determination of disability.

The authority for this rule is contained 42 C.F.R. §§435.217 & 435.225; Section 25.5-4-205, C.R.S. (2021) and Sections 25.5-1-301 through 25.5-1-303, C.R.S..

MSB 21-10-19-B, Revision to the Medical Assistance Health Programs Office Rule Concerning Medicaid Statewide Managed Care System, Section 8.205, 8.209, 8.212 and 8.215

Medical Assistance. The rule establishes an operational component of managed care for Colorado Medicaid, including eligibility, enrollment/disenrollment, covered services, grievances and appeals, and rate setting. Multiple rule sections related to managed care have been revised to align with current statute for the statewide managed care system defined in C.R.S. 25.5-5 Part 4. The

changes also reflect the federally authorized waivers for the Accountable Care Collaborative Phase II and the new inpatient substance use disorder benefit.

The authority for this rule is contained in 42 CFR Part 438; Section 1915(b) waiver for the Colorado Medicaid Accountable Care Collaborative; Substance Use Disorder Continuum 1115(a) Waiver; Sections 25.5-1-301 through 25.5-1-303, C.R.S. 25.5 Article 5 Part 4 (2021).

CHP 21-06-03-B, Revision to the Medical Assistance Rule concerning Changes to the Revision of the Renewal process for Sections 140 and 430

Medical Assistance. The proposed rule change will amend 10 CCR 2505-3 sections 140 and 430 based on 42 C.F.R §457.315, §457.340, and §457.343 as this pertains to the renewal process for medical assistance. All policy revisions will align with federal regulations for the state to be in compliance with completing redeterminations. There will be new changes to the renewal process for both MAGI and Non-MAGI Programs which include the Child Health Plan Plus (CHP+) program. Updates will now allow members to receive an eligibility determination using up-to-date information, before initiating a renewal packet to the head of household. All members must be determined eligible at renewal if so, the household will not receive a renewal packet or be required to submit additional information. These members will receive an approval notice and only be directed to take action if the information used is not accurate. Members who are determined ineligible or if additional information is needed at renewal, will receive a renewal packet and be required to review, update, and sign the renewal. The signature form will be added to the renewal packet including the member's rights and responsibilities, penalty, and perjury language. Changes will also require members who are terminated at renewal to return the signed renewal form or failure to provide requested documentation, to complete a new application after ninety days from the termination date. The new application date will be the first of the month in which it is returned if returned within ninety days from the termination date. Members who are terminated at renewal and turn in their application or missing information within ninety days will have a new application date that starts the first of the month in which the renewal is returned. Members will also be given the option to request retro coverage within the 90-day period for any months in which coverage is reinstated. Policy will be updated to reflect these changes in the Colorado Benefits Management System (CBMS). These updates will be added for all Medical Assistance programs which include the Child Health Plan Plus (CHP+) program to increase accurate and timely eligibility redeterminations ensuring that Colorado provides medical assistance only to members who remain eligible and reduce enrollment of ineligible individuals. In addition, a new unearned income type of Earned Income tax Credits will be added to policy to align with MAGI rules. CBMS updates are not required for this new unearned income type. Lastly, an update to policy language will be made for the Reasonably Opportunity Period (ROP) for income verification that reduced the ROP from 90 days to 30 days. These updates were previously approved, and the updates are to align with policy with no CBMS updates required.

The authority for this rule is contained in 42 C.F.R §457.315, §457.340, §457.343, and §457.380; Sections 25.5-1-301 through 25.5-1-303, C.R.S. § 25.5-6-1102 et seq (2021).

MSB 19-08-21-B, Revision to the Medical Assistance Rule concerning Changes to the renewal process for Sections 8.100.4.G, 8.100.3.K, and 8.100.3.P

Medical Assistance. The proposed rule change will amend 10 CCR 2505-10 sections 8.100.4.G, 8.100.3.K, and 8.100.3.P based on 42 C.F.R §435.915, §435.916, §435.917, and §435.948, and §435.949 as this pertains to the renewal process for medical assistance. All policy revisions will align with federal regulations for the state to be in compliance with completing redeterminations. There will be new changes to the renewal process for both MAGI and Non-MAGI Programs. Updates will now allow members to receive an eligibility determination using up-to-date information, before initiating a renewal packet to the head of household. When we are able to determine eligibility for all members of the home through interfaces or information within the eligibility system, the household will not receive a renewal packet or be required to submit additional information. These members will receive an approval notice and only be directed to take action if the information used is not accurate. Members who are determined ineligible or if additional verifications are needed at renewal, will receive a renewal packet and be required to review, update, sign the renewal. The signature form will be added to the renewal packet including the member's rights and responsibilities, penalty and perjury language. Changes will also require members who are terminated at renewal for failure to return the signed renewal form or failure to provide requested documentation, to complete a new application after ninety days from the termination date. Members who are terminated at renewal and turn in their application or missing information within ninety days will have a new application date that starts the first of the month in which the renewal is returned. Members will also be given the option to request retro coverage within the 90-day period for any gap in coverage when eligibility is reinstated. Policy will be updated to reflect these changes in the Colorado Benefits Management System (CBMS). These updates will be added for Medical Assistance programs to increase accurate and timely eligibility renewals ensuring that Colorado provides medical assistance only to members who remain eligible and reduce enrollment of ineligible individuals.

In addition, a new unearned income type of Earned Income tax Credits will be added to policy to align with Medicaid and Child Health Plan Plus rules, CBMS updates are not required for this new unearned income type. Lastly, an update to policy language will be made for the Reasonably Opportunity Period (ROP) for income verification that reduced the ROP from 90 days to 30 days. These updates were previously approved, and the updates are to align with policy, with no CBMS updates required.

The authority for this rule is contained in 42 C.F.R §435.915, §435.916, §435.917, §435.948, §435.949, and §457.380; Sections 25.5-1-301 through 25.5-1-303, C.R.S. § 25.5-6-1102 et seq (2021).

MSB 21-11-25-A, Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs, Section 8.765

Medical Assistance. Revises the rules for child-serving residential facilities to include the new Qualified Residential Treatment Program (QRTP) license type. The new license type will take effect October 1, 2021 in accordance with the federal Family First Prevention Services Act (FFPSA) and there will be a grace period until June 30, 2022 for all facilities enrolled with Medicaid to be in compliance. The revision will allow the Department to reimburse new QRTP facilities in compliance with the FFPSA and align Department rule with the Colorado Department of Human Services' new QRTP license type. QRTPs will provide a trauma-informed model of care to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

The authority for this rule is contained in Pub.L. 115-123, Div. E, Title VII, § 50734, Feb. 9, 2018, 132 Stat. 252, 42 CFR 440.160 (2021); Sections 25.5-1-301 through 25.5-1-303, CRS § 25.5-5-202(1)(i) (2021).

MSB 21-11-25-B, Revision to the Medical Assistance Act Rule concerning Long-Term Home Health and Private Duty Nursing Prior Authorization Requirements, Sections 8.520.8, 8.540.2 and 8.540.7

Medical Assistance. Update the long-term home health and private duty nursing rules to resume prior authorization on a tiered schedule over the course of ten months. These revisions are required to bring Department regulations in line with the Colorado State Plan. The Department otherwise risks deferral or disallowance from CMS for being out of compliance. A deferral or disallowance would impact the Department's ability to provide adequate services to members.

The authority for this rule is contained in Sections 25.5-1-301 through 25.5-1-303, (2021).