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, May 13, 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 21-01-06-A, Revision to the Medical Assistance Rule Concerning Changes to Expand the Postpartum Period to 12 months for Sections 8.100.1, 8.100.4.G., 8.100.6.P, and 8.100.6.Q

Medical Assistance. The proposed rule change will amend 10 CCR 2505-10 sections 8.100.1, 8.100.4.G, 8.100.6.P, and 8.100.6.Q, to include requirements to expand Postpartum coverage to 12 months from 60 days for members who are eligible and enrolled in Medicaid and Child Health Plan Plus (CHP+). These requirements are to expand coverage according to the new state plan option offered under Sections 9812 and 9822 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). The 12 months of the extended postpartum option will be available to all Medicaid or CHP+ members enrolled in the pregnant group defined under 42 C.F.R. § 435.116, including pregnant individuals enrolled in any other eligible Medicaid category. These changes require members who are within their 12 months of extended postpartum to receive continuous postpartum coverage, regardless of any changes in circumstances. Similar to the current 60-day postpartum period, the 12-month postpartum period will begin on the last day of a member's pregnancy ending and extends through the end of the month in which the 12-month period ends. The Department will be updating the Colorado Benefits Management System (CBMS) to reflect these changes. Lastly, updates to the rule will correct the listed federal poverty level (FPL) for the pregnant women category from 185% to 195% of the FPL, the Children category from 133% to 142% of the FPL, and for the Parents and Caretaker Relatives category updating the FPL from 60% to 68% to align with Colorado's current income eligibility levels. No System changes are needed for the FPL updates.

The authority for this rule is contained in 42 C.F.R §435.116 and §435.170(b); Sections 25.5-5-101(1)(c); C.R.S. 25.5-5-201 (4.5); C.R.S 25.5-8-109; 25.5-10 C.R.S. (2021) and Sections 25.5-1-301 through 25.5-1-303 (2021).

MSB 21-10-28-B, Revision to the HCBS Spinal Cord Injury Waiver Rules Concerning Statewide Expansion, Expanded Qualifying Diagnoses and Provider Definitions, Section 8.517

Medical Assistance. This rule revision will expand the SCI waiver eligibility requirements to include HCBS members statewide living with a spinal cord injury, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability for independent ambulation directly resulting from one of these diagnoses. Due to this expansion in qualifying conditions, the stakeholders requested an update to the name of the waiver to "HCBS for Complementary and Integrative Health (CIH) Waiver". The stakeholders voiced that they would prefer the name of the waiver not include the conditions they are living with and wanted to make sure the title was inclusive of members served. Additionally, the rule revision will remove references to a medical director and streamline the Complementary and Integrative Health Plan. The expansion of this waiver is statutorily required, and this rule revision will codify these statutory changes.
Lastly, we are requesting an update to provider definitions and qualifications. While not statutorily required, the updated provider definitions and qualifications are anticipated to allow for increased provider enrollment so members will have access to qualified providers in their counties.

The authority for this rule is 42 CFR 440.180; 25.5-6-1301 — 25.5-6-1304 (2021) and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021).

MSB 22-01-04-A, Revision to the Medical Assistance Act Rule concerning Prudent Layperson Standard for Emergency Care Services, Sections 8.300.1, 8.320.1, 8.754.2, 8.754.5

Medical Assistance. This rule revision will update the Emergency Care Services definition in the Hospital Services rule to include required language regarding the prudent layperson standard and reference that definition in the Client Co-Payment rule to align with federal regulations. In addition, it requires hospitals to comply with the requirements of federal law for assessing whether a member's services qualify as emergency care services and are therefore exempt from cost sharing.

The authority for this rule is contained in 42 CFR §§ 447.51, .54(d)(2), 42 CFR 438.114(a) and Sections 25.5-1-301 through 25.5-1-303, C.R.S..

MSB 22-01-10-B, Revision to the Medical Assistance Rule Concerning allowing individuals ages 65 and older to qualify for the Medicaid Buy-In Program for Working Adults with Disabilities, Section 8.100.6.P.1.a

Medical Assistance. The rule change amends 10 CCR 2505-10 Section 8.100.6.P. 1. to remove the upper age limit of 65 currently on the Medicaid Buy-In Program for Working Adults with Disabilities (program) to comply with Senate Bill 20-033.

The authority for this rule is contained in Balanced Budget Act of 1997, Public Law 105-33,111, as amended which provides individuals an opportunity to buy into Medicaid consistent with the Social Security Act, 42 U.S.C. Sec. 1396a (a)(10)(A)(ii)(XIII), as amended, to permit the Department to provide Medical Assistance Eligibility to individuals in the Work Incentives Eligibility group, age

sixty-five and older, after they are no longer eligible under the Ticket to Work and Work Incentives Improvement Act of 1999, Pub. L. 106-170. C.R.S. 25.5-6-1402.2(6), C.R.S. 25.5-6-1403(5), C.R.S. 25.5-6-1404, C.R.S. 25.5-6-1405 (2021) and Sections 25.5-1-301 through 25.5-1-303 (2021).

MSB 22-01-12-A, Revision to the Medical Assistance programs Rule Concerning updates to add Family Planning Services for Sections 8.100.3.F, 8.100.4.E, 8.100.4.F, and 8.100.4.G

Medical Assistance. The proposed rule change will amend 10 CCR 2505-10 sections 8.100.3.F, 8.100.4.E, 8.100.4.F, and 8.100.4.G, to include requirements to add a new limited family planning medical assistance program per Senate Bill 21-025. The updates to add the limited family planning services will allow Colorado to align with Federal requirements described at 42 CFR §435.214 and §435.603(k), which codifies the statutory provisions in sections 1902(a)(10)(A)(ii)(XXI) and 1902(ii) of the Social Security Act (the Act). This limited family planning medical assistance category covers individuals of any age or gender who are not pregnant, not eligible for a Medicaid eligibility category that provides full coverage, and whose income is no more than 260% of the federal poverty level. The department will also add a new category for the presumptive eligibility program for the limited family planning services to allow members to receive immediate services. This category will be called family planning presumptive eligibility. Family planning presumptive eligibility will provide services while their application is processed to determine eligibility for medical assistance. The department eligibility policy will be updated to reflect these changes in the Colorado Benefits Management System (CBMS). Updates to the rule will correct the listed federal poverty level (FPL) of 185% to 195% of the FPL to align with Colorado's current FPL limit of 195% for presumptive eligibility for pregnant women and 60% to 68% for parent and caretaker relatives. No System changes will be made for the FPL updates.

The authority for this rule is contained in 42 CFR §435.214 and §435.603(k); C.R.S. 25.5-5-102(1)(h) and C.R.S. 25.5-5-329 and Sections 25.5-1-301 through 25.5-1-303 (2021).

MSB 22-01-12-B, Revision to the Medical Assistance programs Rule Concerning updates to add Reproductive Health Care services for sections 8.100.3.G and 8.100.3.I

Medical Assistance. The proposed rule change will amend 10 CCR 2505-10 8.100.3.G and 8.100.3.I, to include requirements to add reproductive health care services according to Senate bill 21-009. The updates to add the reproductive health care services will allow specific individuals who are not eligible for coverage under any other Medicaid program due to their citizenship or immigration status to receive reproductive health services. The Department will also make changes to the medical-only application and the online PEAK application to allow members to declare the need for reproductive health services. Individuals eligible for reproductive health services will now be offered family planning services that include contraceptive methods and counseling services to qualified individuals.

The authority for this rule is contained in Sections 25.5-2-103, 25.5-5-102 (1)(h), & 25.5-1-201 (1)(f.5) (2021) and Sections 25.5-1-301 through 25.5-1-303 (2021).

MSB 22-02-08-A, Revision to the Medical Assistance Rule Concerning the Family Support Services Program, Sections 8.613.C

Medical Assistance. The purpose of this rule amendment is to achieve programmatic alignment between Family Support Services Program (FSSP) rules at section 8.613.C and new statutory changes outlined in SB 21-199 regarding verification of lawful presence in the United States. Effective July 1, 2022, SB21-199 repeals current laws that require a person to demonstrate the person's lawful presence in the United States to be eligible in Colorado for certain public benefits. SB 21-199 states that lawful presence is not a requirement of eligibility for state or local public benefits. This amendment will remove the lawful presence requirement for enrollment into FSSP.

The authority for this rule is contained in C.R.S. § 25.210-303 (2021) and Sections 25.5-1-301 through 25.5-1-303 (2021).

MSB 22-03-21-A, Revision to the Special Financing Division Colorado Indigent Care Program rules concerning HB21-1198 Implementation and CICP Alignment, Section 8.900

Medical Assistance. During the 2021 session, the Colorado General Assembly passed House Bill (HB) 21-1198 which moved the Health Care Billing Requirements for indigent patients from the Department of Public Health and Environment to the Department of Health Care Policy and Financing for creation and implementation. HB 21-1198, also known as Hospital Discounted Care, allows uninsured individuals the opportunity to apply for financial assistance or charity care programs through the Health Care Facility where they receive treatment. Health Care services covered include any services received in a general acute care or critical access hospital or free-standing emergency department.

HB21-1198 requires designated providers to establish a monthly payment plan for indigent patients under which payments for health care facility charges may not exceed 4% of the patient's monthly household income, and payments for each licensed health care professional charges may not exceed 2% of the patient's monthly household income. After 36 cumulative payments, the patient's bill is considered paid in full. The Department determines the rates used by all health care providers which cannot be less than 100% of the Medicare rate or 100% of the Medicaid base rage, whichever is greater. This rulemaking process will simultaneously create rules for Hospital Discounted Care and update the Colorado Indigent Care Program (CICP) rules in order to minimize administrative burden for participating CICP hospital providers. Hospital Discounted Care must be implemented by April 1, 2022 per HB21-1198.

The authority for this rule is contained in Sections 25.5-3-501 through 25.5-3-506, C.R.S.; Sections 25.5-3-101 through 25.5-3-112 and Sections 25.5-1-301 through 25.5-1-303 (2021).

MSB 22-03-29-A, Revision to the Medical Assistance Act Rule concerning Long-Term Home Health Prior Authorization, Section 8.520.8.C

Medical Assistance. The proposed rule removes prior authorization reinstatement requirements for long-term home health (LTHH). The Department of Health Care Policy & Financing (the Department) met with Health First Colorado (Colorado's Medicaid program) members and families, providers, and other stakeholders about concerns related to the pediatric long-term home health (LTHH) benefit prior authorization request (PAR) reinstatement process. Based on these conversations, the Department has made the decision to temporarily pause the PAR process effective November 1, 2021 until at least March 2024.
This allows the Department and partners time to robustly engage with stakeholders, train providers on operational changes, evaluate benefit policy, and notify Health First Colorado members before the pause is lifted. This also gives the Department time to ensure full compliance with federal and state policy while keeping Health First Colorado members and their needs front and center.

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

MSB 22-02-10-A, Revision to the Medical Assistance Act Rule concerning Qualified Residential Treatment Programs and Residential Child Care Facilities, Sections 8.212.1, 8.765.8, and 8.765.13

Medical Assistance. In order to comply with the Family First Prevention Services Act, the Department will not reimburse for Residential Child Care Facilities after June 2022, except for Early and Periodic Screening, Diagnostic, and Treatment services. The proposed rule also adds Qualified Residential Treatment Programs to the list of providers in Section 8.212.1.A.13, which exempts Regional Accountable Entity coverage under the Community Behavioral Health Services program for children in the custody of the Colorado Department of Human Services' Division of Child Welfare or Division of Youth Corrections who are placed into Psychiatric Residential Treatment Facilities, Residential Child Care Facilities, or—under the proposed rule—Qualified Residential Treatment Programs.

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); CRS § 25.5-5-202(1)(i) (2021) and Sections 25.5-1-301 through 25.5-1-303 (2021).