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, June 14, 2024, beginning at 9:00 a.m., at 1735 S Public Rd 1st Floor, Lafayette, CO 80026, USA. 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, 303 E. 17th Ave, Ste 1100, 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 24-02-29-A, Revision to the Medical Assistance Eligibility Rules concerning Redetermination of Eligibility, Section 8.100.3.P (Ana Bordallo, Office of Medicaid Operations)

Medical Assistance. The proposed rule will amend 10 CCR 2505-10 8.100.3.P to incorporate updates to clarify that a member will receive at least 30 days at renewal to return and provide updated documents identified during the ex-parte review as detailed in 42 CFR §435.916(3)(i) which states we must provide the individual at least 30 days from the date of the renewal date form to respond and provide missing information. The Department has complied with this regulation, and we are improving the ex-parte process to give additional time and streamline the process. Going forward members will receive the renewal packet along with the request for documents at the same time instead of sending it separately. These changes are also reflected in the Colorado Benefits Management System (CBMS).
The Department expects that including the renewal packet and the verification checklist in one envelope, rather than two, will have no costs to the Department. The Department does not expect this to impact the eligibility of current Medicaid members because this will just improve the renewal process for members. There is no cost to the Department associated with this policy. The probable benefit of this policy is to improve the renewal process to ensure members are notified earlier about missing verifications. The cost of inaction is that members will be notified of missing verifications separately from receiving the renewal packet, which may lead to delays in renewals. There are no obvious benefits to inaction.

The authority for this rule is contained in 42 CFR §435.916(a)(3)(i)(B) (2023) and Sections 25.5-1-301-303 (2023).

MSB 24-01-03-C, Revision to the Medical Assistance Rule Concerning the Hospital Community Benefit Accountability, 8.5000 (James Johnston, Special Financing Division)

Medical Assistance. A new section to the Medical Assistance Act Rule Concerning Hospital Community Benefit Accountability, Section 8.5000. With recently enacted legislation, House Bill 23-1243: Hospital Community Benefit, non-profit, general, acute care hospital including University of Colorado Hospital and Denver Health and Hospital Authority are required to conduct an annual public meeting to discuss the hospital's previous year's community benefit activities and investments; complete a community health needs implementation plan; and to submit annual documentation around the annual public meeting and discrete community benefit investment amounts directly to the Colorado Department of Health Care Policy & Financing (HCPF). This rule will define best practices for hospitals to engage and solicit stakeholder feedback during the annual public meeting; establish standard accommodation practices for the public meetings; outline annual submission requirements for hospitals; and establish corrective plans for non-compliant hospitals with community benefit reporting requirements.

The authority for this rule is contained in Title 26 of the Code of Federal Regulation § 1.501(r); Sections 25.5-1-702 through 25.5-1-704, C.R.S (2023) and 25.5-1-301-303 (2023).

MSB 23-12-13-A, Case Management Redesign (CMRD) Outdated Language Repeal, Sections 8.300. 8.400, 8.500, & 8.600 (Tiffani Domokos and Cassandra Keller, Office of Community Living)

Medical Assistance. The Office of Community Living is restructuring and revising certain rules to come into alignment with federal requirements for conflict free case management under Colorado's Case Management Redesign. Case Management Redesign (CMRD) refers to several initiatives aimed at simplifying access to long-term services and supports, creating stability for the case management system, increasing and standardizing quality requirements, ensuring accountability, and achieving federal compliance. Updates to rule language are necessary to mirror the policies created for CMRD and to be able to hold agencies accountable to the CMRD requirements outside of contracts. The purpose of the outdated language repeal is to remove language that conflicts with or is repetitive to the newly implemented 8.7000 regulations.

The authority for this rule is contained in 42 CFR § 441.301(c)(1)(vi); C.R.S. 25.5-6.701- 706; C.R.S. 25.5-6-601- 607; C.R.S. 25.5-6-13.01- 13.04; C.R.S. 27-10.5-101- 103; C.R.S. 25.5-6-301-313; C.R.S. 7-10.5-101-103; C.R.S. 27-10.5-401; C.R.S. 25.5-6-401-411; C.R.S. 25.5-6-901; C.R.S. 25.5-5-306(1) and C.R.S. 27-10.5-102(11); C.R.S. 25.5-5-305; C.R.S 25.5-6-17 and 25.5-1-301-303 (2023).