Colorado Revised Statutes 2017

TITLE 25.5

HEALTH CARE POLICY AND FINANCING

Cross references: For the legislative declaration contained in the 1993 act enacting this title, see section 1 of chapter 230, Session Laws of Colorado 1993.

ADMINISTRATION

ARTICLE 1

Department of Health Care Policy and Financing

PART 1

GENERAL PROVISIONS

25.5-1-101. Short title. This title shall be known and may be cited as the "State Health Care Policy and Financing Act".

Source: L. 93: Entire title added, p. 1097, § 15, effective July 1, 1994. **L. 2006:** Entire part amended, p. 1781, § 1, effective July 1.

25.5-1-102. Legislative declaration. (1) The general assembly declares that state and local policymakers and health and human services administrators recognize that the management of and the delivery system for health and human services have become complex, fragmented, and costly and that the health and human services delivery system in this state should be restructured to adequately address the needs of Colorado citizens.

(2) The general assembly further finds and declares that a continuing budget crisis makes it unlikely that funding sources will keep pace with the increasing demands of health and human services.

(3) Therefore, the general assembly finds that it is appropriate to restructure principal departments responsible for overseeing the delivery of health and human services and to reform the state's health and human services administration and delivery system, using guiding principles and within the time frames set forth in article 1.7 of title 24, C.R.S., as said article existed prior to July 1, 1997. It is the general assembly's intent that the departments of public health and environment, health care policy and financing, and human services be operational, effective July 1, 1994.

Source: L. 93: Entire title added, p. 1097, § 15, effective July 1, 1994. **L. 2006:** Entire part amended, p. 1781, § 1, effective July 1.

25.5-1-103. Definitions. As used in this title, unless the context otherwise requires:

(1) "County board" means the county or district board of social services; except that, in the city and county of Denver, "county board" means the department or agency with the responsibility for public assistance and welfare activities, and, in the city and county of Broomfield, "county board" means the city council or a board or commission with the responsibility for public assistance and welfare activities appointed by the city and county of Broomfield.

(2) "County department" means the county or district department of social services.

(3) "County director" means the director of the county or district department of social services.

(4) "Executive director" means the executive director of the department of health care policy and financing.

(5) "Medical assistance" means any program administered by the state department, including but not limited to the "Colorado Medical Assistance Act", as specified in articles 4, 5, and 6 of this title, the "Children's Basic Health Plan Act", article 8 of this title, the old age pension health and medical care program, and the supplemental old age pension health and medical care program; except that "medical assistance" for purposes of articles 4, 5, and 6 of this title shall have the meaning as defined in section 25.5-4-103 (13).

(5.5) "Medical home" means an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a child. A medical home may also be referred to as a health care home. If a child's medical home is not a primary medical care provider, the child must have a primary medical care provider to ensure that a child's primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following:

(a) Health maintenance and preventive care;

(b) Anticipatory guidance and health education;

(c) Acute and chronic illness care;

(d) Coordination of medications, specialists, and therapies;

(e) Provider participation in hospital care; and

(f) Twenty-four-hour telephone care.

(6) "Recipient" means any person who has been determined eligible to receive benefits or services under this title.

(7) "State board" or "board" means the medical services board created pursuant to section 25.5-1-301.

(8) "State department" means the department of health care policy and financing.

(9) "State designated agency" means an agency designated to perform specified functions that would otherwise be performed by the county departments, including the single entry point agencies and medical assistance sites.

Source: L. 93: Entire title added, p. 1098, § 15, effective July 1, 1994. **L. 95:** (2.5) added, p. 903, § 2, effective May 25. **L. 96:** (1) repealed, p. 1473, § 25, effective June 1. **L. 2006:** Entire part amended, p. 1782, § 1, effective July 1. **L. 2007:** (5.5) added, p. 1487, § 1, effective May 31.

25.5-1-104. Department of health care policy and financing created - executive director - powers, duties, and functions. (1) There is hereby created the department of health care policy and financing, the head of which shall be the executive director of the department of health care policy and financing, which office is hereby created. The executive director shall be appointed by the governor, with the consent of the senate, and shall serve at the pleasure of the governor. The reappointment of an executive director after an initial election of a governor shall be subject to the provisions of section 24-20-109, C.R.S. The executive director has those powers, duties, and functions prescribed for the heads of principal departments in the "Administrative Organization Act of 1968", article 1 of title 24, C.R.S., and any powers, duties, and functions set forth in this title.

(2) The department of health care policy and financing shall consist of an executive director of the department of health care policy and financing, the medical services board, and such divisions, sections, and other units as shall be established by the executive director pursuant to the provisions of subsection (3) of this section.

(3) The executive director may establish such divisions, sections, and other units within the state department as are necessary for the proper and efficient discharge of the powers, duties, and functions of the state department; except that such action by the executive director shall not conflict with the implementation requirements for the plan for restructuring the delivery of health and human services in this state, as set forth in article 1.7 of title 24, C.R.S.

(4) The department of health care policy and financing shall be responsible for the administration of the functions and programs as set forth in this title.

(5) (a) The executive director of the state department shall appoint an internal auditor who shall have the status of a division director and, as such, shall have the authority to appoint such personnel as may be necessary to carry out the duties of the internal auditor.

(b) The internal auditor appointed by the executive director pursuant to paragraph (a) of this subsection (5) shall:

(I) Conduct and supervise internal audits of the state department;

(II) Coordinate and facilitate external audits that are performed on the state department by state and federal entities;

(III) Conduct and supervise performance audits for the purpose of determining the efficiency and effectiveness of the state department's operation and administration of programs; and

(IV) Conduct such other audits and perform such other duties as may be specified by the executive director.

Source: L. 93: Entire title added, p. 1098, § 15, effective July 1, 1994. **L. 94:** (2) amended, p. 1559, § 4, effective July 1. **L. 96:** (2) amended, p. 1474, § 26, effective June 1. **L. 2006:** Entire part amended, p. 1783, § 1, effective July 1. **L. 2010:** (5) added, (SB 10-167), ch. 296, p. 1376, § 2, effective May 26.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "legislative Reports and Requirements" on the General Assembly's website.

25.5-1-105. Transfer of functions. (1) The state department shall, on and after July 1, 1994, execute, administer, perform, and enforce the rights, powers, duties, functions, and obligations vested prior to July 1, 1994, in the Colorado health data commission within the department of local affairs, the department of social services concerning the "Colorado Medical Assistance Act", and the university of Colorado health sciences center concerning health care for the medically indigent.

(2) All rules, regulations, and orders of the department of local affairs, the state department of social services, the state board of social services, the department of regulatory agencies, and the university of Colorado health sciences center adopted prior to July 1, 1994, in connection with the powers, duties, and functions transferred to the state department shall continue to be effective until revised, amended, repealed, or nullified pursuant to law. On and after July 1, 1994, the state board or the executive director, whichever is appropriate, shall adopt rules necessary for the administration of the state department and the administration of the programs set forth in this title.

(3) No suit, action, or other judicial or administrative proceeding lawfully commenced prior to July 1, 1994, or which could have been commenced prior to such date, by or against the department of local affairs, the state department of social services, the department of regulatory agencies, or the university of Colorado health sciences center, or any officer thereof in such officer's official capacity or in relation to the discharge of the official's duties, shall abate by reason of the transfer of duties and functions from said departments to the state department.

(4) The executive director, or a designee of the executive director, may accept, on behalf of and in the name of the state, gifts, donations, and grants for any purpose connected with the work and programs of the state department. Any property so given shall be held by the state treasurer, but the executive director, or the designee therefor, shall have the power to direct the disposition of any property so given for any purpose consistent with the terms and conditions under which such gift was created.

(5) The revisor of statutes is hereby authorized to change all references in the Colorado Revised Statutes to the department of local affairs, the state department of social services, the department of regulatory agencies, and the university of Colorado health sciences center from said references to the state department, as appropriate and with respect to the powers, duties, and functions transferred to the state department. In connection with such authority, the revisor of statutes is hereby authorized to amend or delete provisions of the Colorado Revised Statutes so as to make the statutes consistent with the powers, duties, and functions transferred pursuant to this section.

(6) On and after July 1, 2003, the powers, duties, and functions relating to the old age pension health and medical care program, as specified in section 25.5-2-101, are transferred by a **type 2** transfer to the department of health care policy and financing.

Source: L. 93: Entire title added, p. 1099, § 15, effective July 1, 1994. **L. 94:** (2) amended, p. 2610, § 12, effective July 1; (6) amended, p. 1559, § 5, effective July 1. **L. 2003:** (10) added, p. 2583, § 1, effective July 1. **L. 2005:** (1) amended, p. 772, § 50, effective June 1. **L. 2006:** Entire part amended, p. 1783, § 1, effective July 1. **L. 2011:** (6) amended, (SB 11-210), ch. 187, p. 721, § 6, effective July 15, 2012.

25.5-1-105.5. Chief medical officer - qualifications. (1) The executive director shall appoint a chief medical officer who shall:

(a) Have a degree of doctor of medicine or doctor of osteopathy and be licensed to practice medicine in the state of Colorado;

(b) Have at least two years of postgraduate experience in primary care; and

(c) Have at least two years of experience in an administrative capacity in a health care organization.

(2) The chief medical officer shall, with the assistance of advisory committees of the state department, provide medical judgment and advice regarding all medical issues involving programs administered by the state department.

(3) The chief medical officer shall receive a salary within the limits of moneys made available to the state department by appropriation of the general assembly or otherwise.

Source: L. 2007: Entire section added, p. 1492, § 3, effective July 1. **L. 2010:** (1) amended and (3) added, (SB 10-167), ch. 296, p. 1377, § 3, effective May 26.

Cross references: (1) For the legislative declaration contained in the 2007 act enacting this section, see section 1 of chapter 347, Session Laws of Colorado 2007.

(2) For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-1-106. Restructure of health and human services - development of plan - participation of department required. (Deleted by amendment)

Source: L. 93: Entire title added, p. 1101, § 15, effective July 1, 1994. **L. 2006:** Entire part amended, p. 1785, § 1, effective July 1.

25.5-1-107. Final agency action - administrative law judge - authority of executive director. (1) The executive director may appoint one or more persons to serve as administrative law judges for the state department pursuant to section 24-4-105, C.R.S., and pursuant to part 10 of article 30 of title 24, C.R.S., subject to appropriations made to the department of personnel. Except as provided in subsection (2) of this section, hearings conducted by the administrative law judge shall be considered initial decisions of the state department and shall be reviewed by the executive director or a designee of the executive director. In the event exceptions to the initial decision are filed pursuant to section 24-4-105 (14)(a)(I), C.R.S., such review shall be in accordance with section 24-4-105 (15), C.R.S. In the absence of any exception filed pursuant to

section 24-4-105 (14)(a)(I), C.R.S., the executive director shall review the initial decision in accordance with a procedure adopted by the state board. Such procedure shall be consistent with federal mandates concerning the single state agency requirement. Review by the executive director in accordance with section 24-4-105 (15), C.R.S., or the procedure adopted by the state board pursuant to this section shall constitute final agency action. The administrative law judge may conduct hearings on appeals from decisions of county departments of social services brought by recipients of and applicants for medical assistance and welfare which are required by law in order for the state to qualify for federal funds, and the administrative law judge may conduct other hearings for the state department. Notice of any such hearing shall be served at least ten days prior to such hearing.

(2) Hearings initiated by a licensed or certified provider of services shall be conducted by an administrative law judge for the state department and shall be considered final agency action and subject to judicial review in accordance with the provisions of section 24-4-106, C.R.S., for any party, including the state department, which shall be considered a person for such purposes.

Source: L. 93: Entire title added, p. 1101, § 15, effective July 1, 1994. **L. 95:** (1)(a) and (2) amended, p. 903, § 3, effective May 25; (1)(a) and (1)(c) amended, p. 664, § 101, effective July 1. **L. 97:** (1)(b) amended, p. 1190, § 10, effective July 1. **L. 2005:** (1)(c) amended, p. 859, § 25, effective June 1. **L. 2006:** Entire part amended, p. 1785, § 1, effective July 1.

Editor's note: Amendments to subsection (1)(a) by Senate Bill 95-78 and House Bill 95-1362 were harmonized.

Cross references: For the legislative declaration contained in the 1995 act amending subsections (1)(a) and (1)(c), see section 112 of chapter 167, Session Laws of Colorado 1995.

25.5-1-108. Executive director - rules. (1) The executive director shall have authority to promulgate rules in connection with the policies and procedures governing the administration of the department including, but not limited to, rules concerning the following:

(a) Matters of internal administration of the department, including organization, staffing, records, reports, systems, and procedures;

(b) Fiscal and personnel administration for the department;

(c) Accounting and fiscal reporting policies and procedures for disbursement of federal funds, contingency funds, and distribution of available appropriations;

(d) Such other rules relating to those functions the executive director is required to carry out pursuant to the provisions of this title.

(2) Nothing in this section shall be construed to affect any specific statutory provision granting rule-making authority in relation to a specific program to the executive director.

Source: L. 94: Entire section added, p. 1556, § 1, effective July 1. **L. 95:** (4) amended, p.1105, § 43, effective May 31. **L. 2006:** Entire part amended, p. 1786, § 1, effective July 1.

25.5-1-109. Department of health care policy and financing cash fund. All moneys collected by the state department as fees or otherwise shall be transmitted to the state treasurer,

who shall credit the same to the department of health care policy and financing cash fund, which fund is hereby created in the state treasury. Moneys in the fund shall be subject to annual appropriation by the general assembly for the direct and indirect costs of the state department's duties as provided by law.

Source: L. 94: Entire section added, p. 1941, § 3, effective July 1. **L. 2006:** Entire part amended, p. 1787, § 1, effective July 1.

25.5-1-109.5. Clinical standards - development. (1) The general assembly finds that:

(a) It is important to collect and analyze objective clinical standards to maximize the scarce dollars available for medical care; and

(b) The development of an ongoing, transparent measurement of health outcomes is essential to ensure quality health care for Coloradans.

(2) (a) The state department, following consultation with external clinical advisors, shall develop clinical standards and methods for collecting, analyzing, and disclosing information regarding clinical performance, including but not limited to immunization rates, medical home standards, clinical care guidelines, care coordination, case management, disease management, and coordination and integration of mental health services. The standards and methods shall be consistent with national guidelines and standards regarding the collection and analysis of health data, where feasible, and shall meet the federal reporting requirements established under Titles XIX and XXI of the federal "Social Security Act", 42 U.S.C. secs. 1396 and 1397.

(b) Repealed.

Source: L. 2007: Entire section added, p. 1495, § 9, effective July 1. **L. 2016:** (2)(b) repealed, (HB 16-1081), ch. 22, p. 50, § 1, effective August 10.

Cross references: For the legislative declaration contained in the 2007 act enacting this section, see section 1 of chapter 347, Session Laws of Colorado 2007.

25.5-1-110. Study of children's access to health care coverage - acceptance of donations - repeal. (Repealed)

Source: L. 2002: Entire section added, p. 1612, § 1, effective June 7. **L. 2003:** (4) amended, p. 2009, § 89, effective May 22. **L. 2006:** Entire part amended, p. 1787, § 1, effective July 1.

Editor's note: Subsection (6) provided for the repeal of this section, effective July 1, 2005. (See L. 2002, p. 1612.)

25.5-1-111. Waiver applications - authorization. (Deleted by amendment)

Source: L. 2002: Entire section added, p. 1308, § 27, effective June 7. **L. 2006:** Entire part amended, p. 1787, § 1, effective July 1.

25.5-1-112. Drug-purchasing pool - report - repeal. (Repealed)

Source: L. 2004: Entire section added, p. 1995, § 9, effective June 5. **L. 2006:** Entire part amended, p. 1787, § 1, effective July 1.

Editor's note: Subsection (3) provided for the repeal of this section, effective July 1, 2005. (See L. 2004, p. 1995.)

25.5-1-113. Federal authorization - repeal. (Deleted by amendment)

Source: L. 2005: Entire section added, p. 1230, § 9, effective June 3. **L. 2006:** Entire part amended, p. 1787, § 1, effective July 1.

25.5-1-113.5. Children's access to health care - reports. (Repealed)

Source: L. 2007: Entire section added, p. 1494, § 8, effective July 1. **L. 2017:** Entire section repealed, (HB 17-1060), ch. 6, p. 14, § 1, effective March 1.

25.5-1-114. Grants-in-aid - county supervision. (1) The state department shall consult with and coordinate with the counties before making any changes that affect county operations in the implementation of this section, when possible under state statutes and federal statutes and regulations.

(2) In administering any funds appropriated or made available to the state department for medical assistance administration, the state department has the power to:

(a) Require as a condition for receiving grants-in-aid that each county in this state shall bear the proportion of the total expense of furnishing medical assistance administration as is fixed by law relating to such assistance;

(b) Terminate any grants-in-aid to any county of this state if the laws and regulations providing such grants-in-aid and the minimum standards prescribed by rules of the state department thereunder are not complied with;

(c) Undertake forthwith the administration of any or all medical assistance within any county of this state which has had any or all of its grants-in-aid terminated pursuant to paragraph (b) of this subsection (2); but the county shall continue to meet the requirements of paragraph (a) of this subsection (2);

(d) Recover any moneys owed by a county to the state by reducing the amount of any payments due from the state in connection with the administration of medical assistance;

(e) Take any other action which may be necessary or desirable for carrying out the provisions of this title.

(3) The state department, under the supervision of the executive director, shall provide supervision of county departments for the effective administration of medical assistance as set out in the rules of the executive director and the rules of the state board pursuant to section 25.5-1-301; except that nothing in this subsection (3) shall be construed to allow counties to continue to receive an amount equal to the increased funding in the event the said funding is no longer available from the federal government.

Source: L. 2006: Entire part amended, p. 1787, § 1, effective July 1.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-114.5. Medicaid fraud detection - request for information. (1) In enacting this section, the general assembly intends to:

(a) Implement waste, fraud, and abuse detection, prevention, and recovery solutions to improve program integrity in the state's medicaid program and create efficiency and cost savings through a shift from a retrospective "pay and chase" model to a prospective prepayment model; and

(b) Invest in the most cost-effective technologies or strategies that yield the highest return on investment.

(2) By September 30, 2013, the state department shall issue a request for information to seek input from potential contractors on capabilities that the state department does not currently possess, functions that the state department is not currently performing, and the cost structures associated with implementing:

(a) Advanced predictive modeling and analytics technologies to provide a comprehensive and accurate view across all providers, recipients, and geographic locations within the medicaid program in order to:

(I) Identify and analyze those billing and utilization patterns that represent a high risk of fraudulent activity;

(II) Be easily integrated into the existing medicaid program claims operations;

(III) Undertake and automate such analysis before payment is made to minimize disruptions to state department operations and speed claim resolution;

(IV) Prioritize the identified transactions for additional review before payment is made based upon the likelihood of potential waste, fraud, or abuse;

(V) Obtain outcome information from adjudicated claims to allow for refinement and enhancement of the predictive analytics technologies based on historical data and algorithms with the system; and

(VI) Prevent the payment of claims for reimbursement that have been identified as potentially wasteful, fraudulent, or abusive until the claims have been automatically verified as valid;

(b) Provider and recipient data verification and screening technology solutions, which may use publicly available records, for the purposes of automating reviews and identifying and preventing inappropriate payments by:

(I) Identifying associations between providers, practitioners, and beneficiaries that indicate rings of collusive fraudulent activity; and

(II) Discovering recipient attributes that indicate improper eligibility, including but not limited to death, out-of-state residency, inappropriate asset ownership, or incarceration; and

(c) Fraud investigation services that combine retrospective claims analysis and prospective waste, fraud, or abuse detection techniques. These services must include analysis of historical claims data, medical records, suspect provider databases, and high-risk identification lists, as well as direct recipient and provider interviews. Emphasis must be placed on the state department providing education to providers and allowing them the opportunity to review and correct any problems identified prior to administrative proceedings.

(3) In addition to the information provided pursuant to subsection (2) of this section, a potential contractor responding to the request for information shall include information concerning:

(a) The extent to which the potential contractor will seek clinical and technical expertise from Colorado providers concerning the design and implementation of the medicaid fraud detection system described in this section and the method or methods for seeking that expertise; and

(b) The potential contractor's ability to create an education and outreach program that is widely available and easily accessible to Colorado providers for purposes of educating providers on issues relating to coverage and coding.

(4) (a) The state department is encouraged to use the results of the request for information to create formal requests for proposals to carry out the work identified in this section if the following conditions are met:

(I) The state department expects to generate state savings by preventing fraud, waste, and abuse;

(II) This work can be integrated into the state department's current medicaid operations without creating additional costs to the state; and

(III) The reviews or audits are not anticipated to delay or improperly deny the payment of legitimate claims to providers.

(b) Prior to awarding any contract pursuant to this section, the state department shall establish an appeal process for providers that minimizes the administrative burden placed on providers, limits the number of medical records requests, and provides adequate time for providers to respond to inquiries.

(5) It is the intent of the general assembly that the savings achieved through this section must more than cover the cost of implementation and administration. Therefore, to the extent possible, technology services used in carrying out this section must be secured using the savings generated by the program, with the state's direct cost funded through the actual savings achieved.

Source: L. 2013: Entire section added, (SB 13-137), ch. 285, p. 1501, § 1, effective August 7.

25.5-1-115. Locating violators - recoveries. (1) The executive director of the state department, or district attorneys may request and shall receive from departments, boards, bureaus, or other agencies of the state or any of its political subdivisions, and the same are authorized to provide, such assistance and data as will enable the state department and county departments properly to carry out their powers and duties to locate and prosecute any person who has fraudulently obtained medical assistance under this title. Any records established pursuant to the provisions of this section shall be available only to the state department, the department of human services, the county departments, the attorney general, and the district attorneys, county attorneys, and courts having jurisdiction in fraud or recovery proceedings or actions.

(2) (a) All departments and agencies of the state and local governments shall cooperate in the location and prosecution of any person who has fraudulently obtained medical assistance under this title, and, on request of the county board, the county director, the state department, or the district attorney of any judicial district in this state, shall supply all information on hand

relative to the location, employment, income, and property of such persons, notwithstanding any other provision of law making such information confidential, except the laws pertaining to confidentiality of any tax returns filed pursuant to law with the department of revenue. The department of revenue shall furnish at no cost to inquiring departments and agencies such information as may be necessary to effectuate the purposes of this article. The procedures whereby this information will be requested and provided shall be established by rule of the state department. The state department or county departments shall use such information only for the purposes of administering medical assistance under this title, and the district attorney shall use it only for the prosecution of persons who have fraudulently obtained medical assistance under this title, and shall not use the information, or disclose it, for any other purpose.

(b) (I) Whenever the state department, or a district attorney for the state department, or the state department on behalf of a county department, recovers any amount of fraudulently obtained medical assistance funds, the federal government shall be entitled to a share proportionate to the amount of federal funds paid unless a different amount is otherwise provided by federal law, the state shall be entitled to a share proportionate to the amount of state funds paid and such additional amounts of federal funds recovered as provided by federal law, and the county department shall be entitled to a share proportionate to the amount of county funds paid unless a different amount is provided pursuant to federal law or this section.

(II) (A) Whenever a county department, a county board, a district attorney, or a state department on behalf of a county department recovers any amount of fraudulently obtained public assistance funds in the form of assistance payments, it shall be deposited in the county social services fund, and the federal government is entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, the state is entitled to a share proportionate to one-half the amount of state funds paid, and the county is entitled to a share proportionate to the amount of county funds paid and, in addition, a share proportionate to one-half the amount of state funds paid.

(B) Whenever a county department, a county board, a district attorney, or a state department on behalf of a county department recovers any amount of fraudulently obtained medical assistance, it shall be deposited in the county social services fund, and the federal government is entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, and the county is entitled to the remaining funds.

(3) Whenever a county department, a county board, a district attorney, or the state department on behalf of the county recovers any amount of medical assistance payments that were obtained through unintentional client error, the federal government shall be entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, the state shall be entitled to a share proportionate to seventy-five percent of the amount of state funds paid, the county shall be entitled to a share proportionate to the amount of county funds paid, if any, and, in addition, a share proportionate to twenty-five percent of the amount of state funds paid.

(4) Actual costs and expenses incurred by the district attorney's office in carrying out the provisions of subsection (2) of this section shall be billed to counties or a county within the judicial district in the proportions specified in section 20-1-302, C.R.S. Each county shall make an annual accounting to the state department on all amounts recovered.

Source: L. 2006: Entire part amended, p. 1788, § 1, effective July 1. **L. 2012:** (2)(b)(II) amended, (SB 12-060), ch. 166, p. 578, § 3, effective August 8.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-115.5. Medical assistance fraud - report. (1) Notwithstanding the provisions of section 24-1-136 (11)(a)(I), on or before November 1, 2017, and on or before November 1 each year thereafter, the state department shall submit a written report to the joint budget committee; the judiciary committee and the public health care and human services committee of the house of representatives, or their successor committees; and to the judiciary committee and the health and human services committee of the senate, or their successor committees, concerning fraud in the medicaid program. The state department shall compile a single, comprehensive report that includes the information described in this subsection (1), as well as information that the attorney general provides to the state department pursuant to section 25.5-4-303.3. The state department shall report to the general assembly concerning the fraudulent receipt of medicaid benefits, including, at a minimum:

(a) Investigations of client fraud during the year;

(b) Termination of client medicaid benefits due to fraud;

(c) District attorney action, including, at a minimum, criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;

(d) Recoveries, including fines and penalties, restitution ordered, and restitution collected;

(e) Trends in methods used to commit client fraud, excluding law enforcement-sensitive information; and

(f) An estimate of the total savings, total cost, and net cost-effectiveness of fraud detection and recovery efforts.

Source: L. 2012: Entire section added, (SB 12-060), ch. 166, p. 577, § 1, effective August 8. **L. 2017:** IP(1) amended, (HB 17-1060), ch. 6, p. 14, § 2, effective March 1; IP(1), (1)(d), and (1)(e) amended and (1)(f) added, (SB 17-295), ch. 298, p. 1636, § 1, effective August 9.

Editor's note: Amendments to the introductory portion of subsection (1) by HB 17-1060 and SB 17-295 were harmonized.

25.5-1-116. Records confidential - authorization to obtain records of assets - release of location information to law enforcement agencies - outstanding felony arrest warrants. (1) The state department may establish reasonable rules to provide safeguards restricting the use or disclosure of information concerning applicants, recipients, and former and potential recipients of medical assistance to purposes directly connected with the administration of such medical assistance and related state department activities and covering the custody, use, and preservation of the records, papers, files, and communications of the state and county departments. Whenever, under provisions of law, names and addresses of applicants for, recipients of, or former and potential recipients of medical assistance are furnished to or held by

another agency or department of government, such agency or department shall be required to prevent the publication of lists thereof and their uses for purposes not directly connected with the administration of such medical assistance.

(2) (a) (I) Except as provided in subparagraphs (II) and (III) of this paragraph (a), it is unlawful for any person to solicit, disclose, or make use of or to authorize, knowingly permit, participate in, or acquiesce in the use of any lists or names of or any information concerning persons applying for or receiving public assistance and welfare directly or indirectly derived from the records, papers, files, or communications of the state or county departments or subdivisions or agencies thereof or acquired in the course of the performance of official duties. No financial institution or insurance company that provides the data, whether confidential or not, required by the state department, in accordance with the provisions of this subsection (2), shall be liable for the provision of the data to the state department nor for any use made thereof by the state department.

(II) The information described in subparagraph (I) of this paragraph (a) may be disclosed for purposes directly connected with the administration of medical assistance and in accordance with this paragraph (a) and paragraphs (b) and (c) of this subsection (2) and with the rules of the state department.

(III) (A) Notwithstanding any provision of state law to the contrary and to the extent allowable under federal law, at the request of the Colorado bureau of investigation, the state department shall provide the bureau with information concerning the location of any person whose name appears in the department's records who is the subject of an outstanding felony arrest warrant. Upon receipt of such information, it shall be the responsibility of the bureau to provide appropriate law enforcement agencies with location information obtained from the state department. Location information provided pursuant to this section shall be used solely for law enforcement purposes. The state department and the bureau shall determine and employ the most cost-effective method for obtaining and providing location information pursuant to this section. Neither the state department nor its employees or agents shall be liable in civil action for providing information in accordance with the provisions of this sub-subparagraph (A).

(B) As used in sub-subparagraph (A) of this subparagraph (III), "law enforcement agency" means any agency of the state or its political subdivisions that is responsible for enforcing the laws of this state. "Law enforcement agency" includes but is not limited to any police department, sheriff's department, district attorney's office, the office of the state attorney general, and the Colorado bureau of investigation.

(b) By signing an application or redetermination of eligibility form for medical assistance, an applicant authorizes the state department to obtain records pertaining to information provided in that application or redetermination of eligibility form from a financial institution, as defined in section 15-15-201 (4), C.R.S., or from any insurance company. The application or redetermination of eligibility form shall contain language clearly indicating that signing constitutes such an authorization.

(c) (I) In order to determine if applicants for or recipients of medical assistance have assets within eligibility limits, the state department may provide a list of information identifying these applicants or recipients to any financial institution, as defined in section 15-15-201 (4), C.R.S., or to any insurance company. This information may include identification numbers or social security numbers. The state department may require any such financial institution or insurance company to provide a written statement disclosing any assets held on behalf of

individuals adequately identified on the list provided. Before a termination notice is sent to the recipient, the county department or the medical assistance site in verifying the accuracy of the information obtained as a result of the match shall contact the recipient and inform the recipient of the apparent results of the computer match and give the recipient the opportunity to explain or correct any erroneous information secured by the match. The requirement to run a computerized match shall apply only to information that is entered in the financial institution's or insurance company's data processing system on the date the match is run and shall not be deemed to require any such institution or company to change its data or make new entries for the purpose of comparing identifying information. The cost of providing such computerized match shall be borne by the state department.

(II) For the fiscal year beginning July 1, 1984, and thereafter, all funds expended by the state department to pay the cost of providing such computerized matches shall be subject to an annual appropriation by the general assembly.

(III) The state department may expend funds appropriated pursuant to subparagraph (II) of this paragraph (c) in an amount not to exceed the amount of annualized general fund savings that result from the termination of recipients from medical assistance specifically due to disclosure of assets pursuant to this subsection (2).

(d) No applicant shall be denied nor any recipient discontinued due to the disclosure of their assets unless and until the county department or medical assistance site has assured that such assets taken together with other assets exceed the limit for eligibility of countable assets. Any information concerning assets found may be used to determine if such applicant's or recipient's eligibility for other medical assistance is affected.

(3) The applicant for or recipient of medical assistance, or his or her representative, shall have an opportunity to examine all applications and pertinent records concerning said applicant or recipient which constitute a basis for denial, modification, or termination of such medical assistance or to examine such records in case of a fair hearing.

(4) Any person who violates subsection (1) or (2) of this section is guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than five hundred dollars, or by imprisonment in the county jail for not more than three months, or by both such fine and imprisonment.

Source: L. 2006: Entire part amended, p. 1790, § 1, effective July 1.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-117. County departments - district departments. (1) Except as provided in subsection (2) of this section, there shall be established in each county of the state a county department of social services that shall consist of a county board of social services, a county director of social services, and any additional employees as may be necessary for the efficient performance of public assistance, as defined in section 26-2-103 (7), C.R.S., and medical assistance.

(2) Single entry point agencies established pursuant to part 1 of article 6 of this title, other than county departments acting as single entry point agencies, may act as state designated

agencies and are hereby authorized to carry out functions as specified in part 1 of article 6 of this title that are otherwise performed by county departments.

(3) With the approval of the department of human services, two or more counties may jointly establish a district department of social services. All duties and responsibilities for county departments set forth in this title shall also apply to district departments of social services.

Source: L. 2006: Entire part amended, p. 1792, § 1, effective July 1.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-118. Duties of county departments. (1) The county departments or other state designated agencies, where applicable, shall serve as agents of the state department and shall be charged with the administration of medical assistance and related activities in the respective counties in accordance with the rules of the state department.

(2) The county departments or other state designated agencies, where applicable, shall report to the state department at such times and in such manner and form as the state department may from time to time direct.

(3) The county department or other state designated agencies, where applicable, in each county shall submit quarterly and annually to the board of county commissioners a budget containing an estimate and supporting data setting forth the amount of money needed to carry out the provisions of this title.

Source: L. 2006: Entire part amended, p. 1793, § 1, effective July 1.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-119. County staff. The county director, with the approval of the county board, shall appoint such staff as may be necessary as determined by the state department rules to administer medical assistance within the county. The staff shall be appointed and shall serve in accordance with a merit system for the selection, retention, and promotion of county department employees as described in section 26-1-120, C.R.S. The salaries of the staff members shall be fixed in accordance with the rules and salary schedules prescribed by the state department or the department of human services, whichever is appropriate; except that, once a county transfers its county employees to a successor merit system as provided in section 26-1-120, C.R.S., the salaries shall be fixed by the county commissioners.

Source: L. 2006: Entire part amended, p. 1793, § 1, effective July 1.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-120. Appropriations. (1) (a) For carrying out the duties and obligations of the state department and county departments under the provisions of this title and for matching such

federal funds or meeting maintenance of effort requirements as may be available for public assistance and welfare activities in the state, including medical assistance administration and related activities, the general assembly, in accordance with the constitution and laws of the state of Colorado, shall make adequate appropriations for the payment of such costs, pursuant to the budget prepared by the executive director.

(b) If the federal law shall provide federal funds, in cash or in another form such as medical assistance, not otherwise provided for in this title, the state department is authorized to make such payments or offer such services in accordance with the requirements accompanying said federal funds within the limits of available state appropriations.

(c) When the executive director determines that adequate appropriations for the payment of the costs described in paragraph (a) of this subsection (1) have not been made and that an overexpenditure of an appropriation will occur based upon the state department's estimates, the state board may take actions consistent with state and federal law to bring the rate of expenditure into line with available funds. The general assembly declares that case load and utilization based on medical necessity are legitimate reasons for supplemental funding.

(2) The general assembly shall appropriate from the general fund to the state department moneys for the costs of administering medical assistance programs and the state's share of the costs of administering such functions by the county departments amounts sufficient for the proper and efficient performance of the duties imposed upon them by law, including a legal advisor appointed by the attorney general. The general assembly shall make two separate appropriations, one for the administrative costs of the state department and another for the administrative costs of the county departments. Any applicable matching federal funds shall be apportioned in accordance with the federal regulations accompanying such funds. Any unobligated and unexpended balances of appropriated state general funds remaining at the end of each fiscal year shall be credited to the state general fund.

(3) The expenses of training personnel for special skills relating to medical assistance, as such expenses shall be determined and approved by the state department, may be paid from state and federal funds available for such training purposes.

Source: L. 2006: Entire part amended, p. 1793, § 1, effective July 1.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-121. County expenditures - advancements - procedures. (1) For purposes of this article, under rules of the state department, administrative costs shall include: Salaries of the county director and employees of the county department staff engaged in the performance of medical assistance activities; the county's payments on behalf of such employees for old age and survivors' insurance or pursuant to a county officers' and employees' retirement plan and for any health insurance plan, if approved by the state department; the necessary travel expenses of the county board and the administrative staff of the county department in the performance of their duties; necessary telephone and other electronic means of communication; necessary equipment and supplies; necessary payments for postage and printing, including the printing and preparation of county warrants required for the administration of the county department; and such other administrative costs as may be approved by the state department; but advancements

for office space, utilities, and fixtures may be made from state funds only if federal matching funds are available.

(2) Notwithstanding any other provision of this article, the county department may spend in excess of twenty percent of actual costs for the purpose of matching federal funds for the administration of the child support enforcement program or for the administrative costs of activities involving food stamp, public assistance, or medical assistance fraud investigations or prosecutions.

(3) (a) Notwithstanding any other provision of this article, the county department may receive and spend federal funds to which it is entitled based on the county's certification of public expenditures for administrative costs made by other entities within the county, which expenditures:

(I) Are from sources other than the county social services fund;

(II) Are in excess of the county department's portion, as required pursuant to section 25.5-1-114 (2)(a), of the administrative costs; and

(III) Are for an administrative activity that has been approved by the state department as an activity that is eligible for reimbursement under a federal program.

(b) Acceptance and expenditure of federal funds pursuant to paragraph (a) of this subsection (3) shall not affect the state's share of and contribution to the administrative costs. The county shall be solely responsible for certifying the nonfederal share that is in excess of the county's required portion of the administrative costs. The state department may retain up to five percent of any federal funds received by a county department pursuant to this subsection (3). In addition, the state, in accordance with the provisions of section 26-1-109 (4)(d), C.R.S., shall recover any federal funds received by the county through the certification of public expenditures that are subsequently determined to be ineligible for federal reimbursement.

Source: L. 2006: Entire part amended, p. 1794, § 1, effective July 1. **L. 2011:** (3) added, (HB 11-1196), ch. 160, p. 555, § 6, effective August 10.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-122. County appropriation increases - limitations. (1) Beginning in calendar fiscal year 1994 and for each calendar fiscal year thereafter to and including calendar fiscal year 1997, the board of county commissioners in each county of this state shall annually appropriate funds for the county share of the administrative costs of medical assistance in the county in an amount equal to the actual county share for the previous fiscal year adjusted by an amount equal to the actual county share for the previous fiscal year multiplied by the percentage of change in property tax revenue.

(2) For the purposes of this section:

(a) "County share" means the actual amount of the county share for the previous fiscal year. "County share" shall not include:

(I) The amount expended by the county from the county contingency fund or the county tax base relief fund pursuant to section 26-1-126, C.R.S.;

(II) The amount expended by the county for general assistance pursuant to part 1 of article 17 of title 30, C.R.S.; and

(III) The amount expended by the county for programs or services provided by the county on its own, without requirements or funding from any other governmental agency.

(b) "Percentage of change in property tax revenue" means the difference between the total property tax levied for the previous fiscal year less the amount levied for debt service for the previous fiscal year and the total property tax levied for the year for which the percentage of change in tax revenue is being calculated less the amount levied for debt service for the year in which the percentage of change in tax revenue is being calculated divided by the total property tax levied for the previous fiscal year less the amount levied for debt service for the previous fiscal year.

(3) Notwithstanding the provisions of section 25.5-1-121, a county in the state shall not be required to contribute more than the amount set forth in subsection (1) of this section in any fiscal year. Nothing in this section shall be construed to limit the ability of a county to establish programs or services provided by the county on its own, without requirements or funding from any other governmental agency.

(4) (Deleted by amendment, L. 2008, p. 1812, § 3, effective June 2, 2008.)

(5) Any amounts remaining in the county social services fund created in section 26-1-123, C.R.S., at the end of any fiscal year shall remain in the county fund for expenditure as determined by the board of county commissioners for administrative costs of public assistance, medical assistance, and food stamps, and program costs of public assistance and food stamps.

(6) The limitation set forth in this section on the increase in the county share of the administrative costs of medical assistance will result in increased costs to the state. By making state funds available, the state is encouraging counties not to exercise any right a county may have pursuant to section 20 (9) of article X of the Colorado constitution to reduce or end its share of the costs of medical assistance administration for the county for three fiscal years following the fiscal year in which the state funds are received. If a county accepts funds from the state based on the limitation provided in this section for any fiscal year, the county agrees not to exercise any rights the county may have to reduce or end its share of the costs of medical assistance administration for the fiscal year in which the funds are accepted. Nothing in this subsection (6) or any agreement pursuant to this subsection (6) shall be construed to affect the existence or status of any rights accruing to the state or any county pursuant to section 20 (9) of article X of the Colorado constitution.

Source: L. 2006: Entire part amended, p. 1795, § 1, effective July 1. **L. 2008:** (2)(a)(I) and (4) amended, p. 1812, § 3, effective June 2.

Editor's note: This section was contained in a 2006 act that amended this part, resulting in the addition of this section.

25.5-1-123. Medical homes for children - legislative declaration - duties of the department. (1) The general assembly hereby finds and declares that:

(a) The best medical care for infants, children, and adolescents is provided through a medical home, as defined in section 25.5-1-103, and that is consistent with the joint principles of a patient-centered medical home. Those principles shall include a whole-person orientation, care that is coordinated and integrated across all elements of the complex health care system and the patient's community, and care that provides for quality and safety of the patient where qualified

health care practitioners provide primary care and help manage and facilitate all aspects of medical care.

(b) Infants, children, and adolescents and their families work best with a health care practitioner who knows the family and who develops a partnership of mutual responsibility and trust;

(c) Medical care provided through emergency departments, walk-in clinics, and other urgent-care facilities is often more costly and less effective than care given by a physician with prior knowledge of the child and his or her family; and

(d) The state department should strive to find a medical home for each child receiving services through the state medical assistance program, articles 4, 5, and 6 of this title, or the children's basic health plan, article 8 of this title.

(2) On or before July 1, 2008, the state department, in conjunction with the Colorado medical home initiative in the department of public health and environment, shall develop systems and standards to maximize the number of children enrolled in the state medical assistance program or the children's basic health plan who have a medical home. The systems and standards developed shall include, but need not be limited to, ways to ensure that a medical home shall offer family-centered, compassionate, culturally effective care and sensitive, respectful communication to a child and his or her family.

(3) Repealed.

Source: L. 2007: Entire section added, p. 1488, § 2, effective May 31. **L. 2017:** (3) repealed, (HB 17-1060), ch. 6, p. 15, § 3, effective March 1.

25.5-1-124. Early intervention payment system - participation by state department - rules. (1) The state department shall participate in the development and implementation of the coordinated system of payment for early intervention services authorized pursuant to part 7 of article 10.5 of title 27, C.R.S., and Part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq., as amended.

(2) The state department shall ensure that the early intervention services and payments for recipients of medical assistance under this title are integrated into the coordinated early intervention payment system developed pursuant to part 7 of article 10.5 of title 27, C.R.S. To the extent necessary to achieve the coordinated payment system and coverage of those early intervention services under this title, the state department shall amend the state plan for medical assistance or seek the necessary federal authorization, promulgate rules, and modify the billing system for medical assistance to facilitate the coordinated payment system.

(3) The state department shall also make any modifications necessary to the "Children's Basic Health Plan Act", article 8 of this title, including promulgating rules, to ensure that the children's basic health plan is integrated into the coordinated early intervention payment system developed pursuant to part 7 of article 10.5 of title 27, C.R.S.

(4) Repealed.

(5) (a) As used in this section, unless the context otherwise requires, "early intervention services" means those services defined as early intervention services by the department of human services in accordance with section 27-10.5-702 (7), C.R.S., that are determined, through negotiation between the state department and the department of human services, to be medically necessary under medical assistance and cost-effective. After negotiating the scope of early

intervention services to be covered under medical assistance, the state department and the department of human services shall submit to the joint budget committee of the general assembly, as part of each department's annual budget request, a proposal for the scope of coverage of early intervention services under medical assistance, including the anticipated costs of such coverage and whether the payment of such costs through medical assistance is cost-effective.

(b) "Early intervention services" shall not include the following:

(I) Nonemergency medical transportation;

(II) Respite care;

(III) Service coordination, as defined in 34 CFR 303.12 (d)(11); and

(IV) (A) Assistive technology.

(B) The exclusion of assistive technology shall not apply to durable medical equipment that is otherwise covered under the children's basic health plan, as defined in section 25.5-8-103 (2).

Source: L. 2007: Entire section added, p. 888, § 2, effective July 1. **L. 2008:** (5)(a) amended, p. 1468, § 14, effective August 5. **L. 2012:** (4) repealed, (HB 12-1247), ch. 53, p. 196, § 6, effective March 22.

25.5-1-125. Centennial care choices - value benefit plans - request for information - request for proposals - report to general assembly - definitions - legislative declaration. (Repealed)

Source: L. 2008: Entire section added, p. 2057, § 1, effective June 3. **L. 2010:** (2)(b)(VI) amended, (HB 10-1422), ch. 419, p. 2109, § 137, effective August 11. **L. 2013:** Entire section repealed, (HB 13-1139), ch. 120, p. 407, § 1, effective August 7.

25.5-1-126. Discounted prices for durable medical equipment and supplies. (1) The state department shall work with one or more nonprofit organizations to develop a link of approved vendors who are willing to sell durable medical equipment and medical supplies at discounted prices to persons who have applied for, but are not yet receiving, benefits under the "Colorado Medical Assistance Act". The state department shall provide the exclusive criteria for a nonprofit organization to use to approve a vendor for placement on the approved vendor list.

(2) The state department shall maintain a link of approved vendors developed pursuant to this section and shall:

(a) Make the link available on the state department's website; and

(b) Provide copies of the list to county departments and to sites authorized to accept medical assistance applications pursuant to section 25.5-4-205 (1), through the survey given to applicants.

Source: L. 2010: Entire section added, (HB 10-1029), ch. 219, p. 958, § 1, effective May 10.

25.5-1-127. Third-party benefit denials information. The state department shall provide information to recipients of benefits under this title concerning their right to appeal a

denial of benefits by a third party and shall post information on the state department's website concerning recipients' abilities to appeal a third party's denial of benefits, including but not limited to providing a link to information on the insurance commissioner's website regarding such appeals.

Source: L. 2010: Entire section added, (SB 10-002), ch. 366, p. 1727, § 2, effective June 7.

Cross references: For the legislative declaration in the 2010 act adding this section, see section 1 of chapter 366, Session Laws of Colorado 2010.

25.5-1-128. Provider payments - compliance with state fiscal requirements - definitions - rules. (1) (a) Notwithstanding any provision of law to the contrary, when the state department has regulatory authority over a program and when the provider has already signed a state department-approved provider application to provide a service or to bill the state department or its authorized contractor for a service, the state department-approved provider application shall serve to fulfill the requirements of a commitment voucher and the fiscal requirements of section 24-30-202 (1), C.R.S.

(b) The executive director may promulgate rules to exempt a provider who provides services through a program as described in paragraph (a) of this subsection (1) for any program the state department is authorized by law to administer, including but not limited to:

(I) The "Colorado Medical Assistance Act", articles 4 to 6 of this title;

(II) The "Children's Basic Health Plan Act", article 8 of this title;

(III) The "Colorado Indigent Care Program", part 1 of article 3 of this title;

(IV) The school health services program authorized by section 25.5-5-318;

(V) Programs that are funded through the primary care fund, created in section 24-22-117 (2)(b), C.R.S.; and

(VI) The state-funded old age pension health and medical care program pursuant to article 2 of this title.

(2) As used in this section, unless the context otherwise provides, "provider" means a health care provider, a mental health care provider, a pharmacist, a home health agency, a general provider as defined in section 25.5-3-103 (3), school district as defined in section 25.5-5-318 (1)(a), or any other entity that provides health care, health care coordination, outreach, enrollment, or administrative support services to recipients through fee-for-service, the primary care physician program, a managed care entity, a behavioral health organization, a medical home, or any system of care that coordinates health care or services as defined and authorized through rules promulgated by the state board or by the executive director.

Source: L. 2012: Entire section added, (HB 12-1054), ch. 14, p. 36, § 1, effective March 15.

PART 2

PROGRAMS TO BE ADMINISTERED BY THE DEPARTMENT

25.5-1-201. Programs to be administered by the department of health care policy and financing. (1) Programs to be administered and functions to be performed by the department of health care policy and financing shall be as follows:

(a) The "Colorado Medical Assistance Act", as specified in articles 4, 5, and 6 of this title;

(b) The "Colorado Indigent Care Program", as specified in part 1 of article 3 of this title;

(c) Effective July 1, 1996, school entry immunization, as specified in part 9 of article 4 of title 25, C.R.S. Commencing on and after the fiscal year beginning July 1, 1996, the state department is authorized to contract with the department of public health and environment for the purpose of enforcing the school entry immunization requirements.

(d) Repealed.

(e) The "Children's Basic Health Plan Act", as specified in article 8 of this title;

(f) The old age pension health and medical care program, as specified in section 25.5-2-101; and

(g) Programs, services, and supports for persons with intellectual and developmental disabilities, as specified in article 10 of this title.

Source: L. 93: Entire title added, p. 1102, § 15, effective July 1, 1994. **L. 94:** (1)(f) and (1)(g) amended and (1)(h) added, p. 1669, § 4, effective July 1. **L. 95:** (1)(g) and (1)(h)(II) amended and (1)(j) added, p. 511, § 4, effective May 16; (1)(j) added, p. 916, § 15, effective May 25. **L. 96:** (1)(b) and (1)(h)(I) repealed, p. 1474, § 27, effective June 1; (1)(i) and (1)(j) amended and (1)(k) added, p. 1437, § 7, effective July 1. **L. 99:** (1)(l) added, p. 700, § 6, effective July 1. **L. 2001:** (1)(m) added, p. 916, § 11, effective August 8. **L. 2002:** (1)(h) repealed, p. 427, § 5, effective July 1. **L. 2003:** (1)(l) and (1)(m) amended and (1)(n) added, p. 2583, § 3, effective July 1. **L. 2005:** (1)(a) repealed, p. 772, § 51, effective June 1. **L. 2006:** Entire part amended, p. 1796, § 2, effective July 1. **L. 2007:** (1)(d) repealed, p. 2042, § 70, effective June 1. **L. 2011:** (1)(f) amended, (SB 11-210), ch. 187, p. 721, § 7, effective July 15, 2012. **L. 2013:** (1)(e) and (1)(f) amended and (1)(g) added, (HB 13-1314), ch. 323, p. 1808, § 42, effective March 1, 2014.

25.5-1-202. Advisory committee on covering all children in Colorado - reports - definitions - repeal. (Repealed)

Source: L. 2007: Entire section added, p. 1491, § 2, effective July 1. **L. 2008:** (3)(b)(IV.5) added, p. 2027, § 3, effective June 3. **L. 2012:** Entire section repealed, (HB 12-1207), ch. 65, p. 229, § 1, effective March 24.

25.5-1-203. Prescription drug information and technical assistance program - expansion. The state department may expand the prescription drug information and technical assistance program created in section 25.5-5-507 to include persons receiving drug benefits pursuant to any program that is administered by the state department.

Source: L. 2008: Entire section added, p. 231, § 1, effective August 5.

25.5-1-204. Advisory committee to oversee the all-payer health claims database - creation - members - duties - legislative declaration - rules. (1) The general assembly hereby finds and declares that an advisory committee for the all-payer health claims database would support the database in its established mission of facilitating the reporting of health care and health quality data that results in transparent and public reporting of safety, quality, cost, and efficiency information; and analysis of health care spending and utilization patterns for purposes that improve the population's health, improve the care experience, and control costs.

(2) (a) No later than August 1, 2013, the executive director shall appoint an advisory committee to oversee the Colorado all-payer health claims database. The advisory committee shall include the following members:

(I) A member of academia with experience in health care data and cost efficiency research;

(II) A representative of:

(A) A statewide association of hospitals;

(B) An integrated multi-specialty organization;

(C) Physicians and surgeons;

(D) An organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity;

(E) A nonprofit organization that demonstrates experience working with employers to enhance value and affordability in health insurance;

(F) Dental insurers;

(G) Pharmacists or an affiliate society;

(H) Pharmacy benefit managers;

(I) A statewide association of ambulatory surgical centers;

(III) A representative, who is not a supplier or broker of health insurance, of:

(A) Small employers that purchase group health insurance for employees;

(B) Large employers that purchase health insurance for employees;

(C) Self-insured employers;

(IV) A representative from a community mental health center who has experience in behavioral health data collection;

(V) Three representatives with a demonstrated record of advocating health care issues on behalf of consumers;

(VI) Two representatives of health insurers, one who represents nonprofit insurers and one who represents for-profit insurers;

(VII) Two representatives of nonprofit organizations that facilitate health information exchange to improve health care for all Coloradans;

(VIII) The executive director or his or her designee, serving as an ex officio member;

(IX) The commissioner of insurance or his or her designee, serving as an ex officio member;

(X) A representative of the department of personnel, serving as an ex officio member;

(XI) The director of the office of information and technology or his or her designee, serving as an ex officio member; and

(XII) Two members of the general assembly, one appointed by the majority leader of the senate and one appointed by the majority leader of the house of representatives; except that, if the majority leaders are from the same political party, the minority leader of the house of

representatives shall appoint the second member. The two members of the general assembly shall serve as ex officio members.

(b) The advisory committee shall make recommendations to the executive director and the Colorado all-payer health claims database administrator related to the Colorado all-payer health claims database. The recommendations include the following:

(I) Procedures for the collection, retention, use, and disclosure of data from the Colorado all-payer health claims database, including procedures and safeguards to protect the privacy, integrity, confidentiality, and availability of any data;

(II) Guidelines for charging for custom reports from the Colorado all-payer health claims database;

(III) Procedures to ensure compliance with the "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended, and implementing federal regulations;

(IV) Procedures to ensure compliance with other state and federal privacy laws; and

(V) Procedures for data confidentiality and data disposal if the Colorado all-payer health claims database ceases to exist.

(c) The members of the advisory committee appointed pursuant to subparagraph (XII) of paragraph (a) of this subsection (2) are entitled to receive compensation and reimbursement of expenses as provided in section 2-2-326, C.R.S.

(3) (a) The administrator shall prepare and file annual reports to the legislature by March 1 of each year. The annual report must contain:

(I) The uses of the data in the all-payer health claims database;

(II) Public studies produced by the administrator;

(III) The cost of administering the Colorado all-payer health claims database, the sources of the funding, and the total revenue taken in by the database;

(IV) The recipients of the data, the purposes for the data requests, and whether a fee was charged for the data;

(V) A fee schedule displaying the fees for providing custom data reports from the Colorado all-payer health claims database.

(b) The executive director shall require an evaluation of the Colorado all-payer health claims database initiative every five years beginning in 2018, to ensure that the database accomplishes the goals of this section. The report must contain metrics that document and demonstrate the achievements or challenges of the program goals.

(4) The administrator shall seek funding for the creation of the all-payer health claims database and develop a plan for the financial stability of the database. If sufficient funding is received through gifts, grants, and donations on or before January 1, 2012, as determined by the executive director, the administrator shall, in consultation with the advisory committee, create the Colorado all-payer claims database. The Colorado all-payer claims database shall be operational no later than January 1, 2013.

(5) If sufficient funding is received, the executive director shall direct the administrator to create the database and the administrator shall:

(a) Determine the data to be collected from payers and the method of collection, including mandatory and voluntary reporting of health care and health quality data;

(b) Seek to establish agreements for voluntary reporting of health care claims data from health care payers that are not subject to mandatory reporting requirements in order to ensure availability of the most comprehensive and systemwide data on health care costs and quality;

(c) Seek to establish agreements or requests with the federal centers for medicare and medicaid services to obtain medicare health claims data;

(d) Determine the measures necessary to implement the reporting requirements in a manner that is cost-effective and reasonable for data sources and timely, relevant, and reliable for consumers, public and private purchasers, providers, and policymakers;

(e) Determine the reports and data to be made available to the public with recommendations from the advisory committee in order to accomplish the purposes of this section, including conducting studies and reporting the results of the studies;

(f) Collect, aggregate, distribute, and publicly report performance data on quality, health outcomes, health disparities, cost, utilization, and pricing in a manner accessible for consumers, public and private purchasers, providers, and policymakers;

(g) Protect patient privacy in compliance with state and federal medical privacy laws while preserving the ability to analyze data and share with providers and payers to ensure accuracy prior to the public release of information;

(h) Repealed.

(i) Provide leadership and coordination of public and private health care quality and performance measurements to ensure efficiency, cost-effectiveness, transparency, and informed choice by consumers and public and private purchasers.

(6) The administrator, with input from the advisory committee:

(a) Shall incorporate and utilize publicly available data other than administrative claims data if necessary to measure and analyze a significant health care quality, safety, or cost issue that cannot be adequately measured with administrative claims data alone;

(b) Shall require payer data sources to submit data necessary to implement the all-payer claims database;

(c) Shall determine the data elements to be collected, the reporting formats for data submitted, and the use and reporting of any data submitted. Data collection shall align with national, regional, and other uniform all-payer claims databases' standards where possible.

(d) May audit the accuracy of all data submitted;

(e) May contract with third parties to collect and process the health care data collected pursuant to this section. The contract shall prohibit the collection of unencrypted social security numbers and the use of the data for any purpose other than those specifically authorized by the contract. The contract shall require the third party to transmit the data collected and processed under the contract to the administrator or other designated entity.

(f) May share data regionally or help develop a multistate effort if recommended by the advisory committee.

(7) The all-payer health claims database shall:

(a) Be available to the public when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal law, as a resource to insurers, consumers, employers, providers, purchasers of health care, and state agencies to allow for continuous review of health care utilization, expenditures, and quality and safety performance in Colorado;

(b) Be available to state agencies and private entities in Colorado engaged in efforts to improve health care, subject to rules promulgated by the executive director;

(c) Be presented to allow for comparisons of geographic, demographic, and economic factors and institutional size;

(d) Present data in a consumer-friendly manner.

(8) The collection, storage, and release of health care data and other information pursuant to this section is subject to the federal "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended.

(9) The executive director shall promulgate rules as necessary to implement this section, which rules shall include the assessment of a fine for a payer required to submit data that does not comply with this section. Any fines collected shall be deposited in the all-payer health claims database cash fund, which is hereby created in the state treasury. The moneys in the fund shall be appropriated to the department of health care policy and financing for the purpose of maintaining the all-payer health claims database. The moneys in the fund shall remain in the fund and not revert to the general fund or any other fund at the end of any fiscal year.

(10) Repealed.

(11) If at any time, there is not sufficient funding to finance the ongoing operations of the database, the database shall cease operating and the advisory committee and administrator shall no longer have the duty to carry out the functions required pursuant to this section. If the database ceases to operate, the data submitted shall be destroyed or returned to its original source.

Source: L. 2010: Entire section added, (HB 10-1330), ch. 299, p. 1406, § 1, effective August 11. **L. 2013:** (1), (2), and (3) R&RE, (SB 13-149), ch. 152, p. 495, § 1, effective July 1; (10) repealed, (HB 13-1300), ch. 316, p. 1689, § 80, effective August 7; (5)(a) amended, (HB 13-1115), ch. 338, p. 1973, § 16, effective March 31, 2015. **L. 2014:** (2)(a)(X) amended, (HB 14-1363), ch. 302, p. 1269, § 29, effective May 31; (2)(c) amended, (SB 14-153), ch. 390, p. 1965, § 24, effective June 6. **L. 2017:** (4) amended and (5)(h) repealed, (HB 17-1060), ch. 6, p. 15, § 4, effective March 1.

25.5-1-205. Providing for the efficient provision of health care through state-supervised cooperative action - rules. (1) Cooperation among health care payors, including both private sector entities and federal and state-administered health care programs, has the potential to eliminate needless and costly complexity in the administration of the programs and to benefit patients, payors, and the government. Further, alignment of financial incentives among private and public entities may accelerate and reinforce improvements in health care quality and patient outcomes.

(2) The executive director shall facilitate departmental oversight of collaboration among providers, medicaid clients and advocates, and payors that is designed to improve health outcomes and patient satisfaction and support the financial sustainability of the medicaid program.

(3) The executive director may promulgate rules relating to the collaborative process set forth in this section.

Source: L. 2012: Entire section added, (HB 12-1281), ch. 246, p. 1182, § 1, effective June 4.

25.5-1-206. School-based substance abuse prevention and intervention program - creation - reporting - legislative declaration - definitions - repeal. (1) (a) The general assembly finds and declares that:

(I) The 2011 healthy kids Colorado survey indicates that the top three substances that high school students report they use are alcohol, marijuana, and prescription drugs;

(II) With the legalization of marijuana by citizen initiative in Colorado, there is an increased availability of marijuana in the community and, at the same time, a decreased perception of harm related to marijuana use;

(III) Evidence-based prevention and intervention programs and education awareness programs targeted to school children who are twelve to nineteen years of age are needed to:

(A) Increase the perceived risk of harm associated with marijuana and alcohol use and prescription drug misuse;

(B) Decrease the rates of youth marijuana and alcohol use and prescription drug misuse and delay the age of first-time use; and

(C) Decrease the number of drug- and alcohol-related violations, suspensions, and expulsions reported by schools.

(b) Therefore, the general assembly declares that it is appropriate to award grants to schools, community-based organizations, and health organizations to provide school-based prevention and intervention programs that use evidence-based strategies, practices, and approaches to reduce the risk of marijuana and alcohol use and prescription drug misuse by school-aged children. Successful school-based programs will lead to increased overall health, behavioral health, and educational outcomes for Colorado's youth.

(2) As used in this section, unless the context otherwise requires:

(a) "Entity" means a school, school district, board of cooperative services, a nonprofit or not-for-profit community-based organization, or a community-based behavioral health organization.

(b) "Grant program" means the school-based substance abuse prevention and intervention grant program created in subsection (3) of this section.

(3) (a) The school-based substance abuse prevention and intervention grant program is created within the state department. The purpose of the grant program is to award competitive grants to entities to provide school-based prevention and intervention programs for youth twelve to nineteen years of age primarily focused on reducing marijuana use, but including strategies and efforts to reduce alcohol use and prescription drug misuse.

(b) To be considered for a competitive grant, the entity must demonstrate in the grant proposal that:

(I) The grant will be used to implement evidence-based programs and strategies delivered in the school setting that are designed to improve overall health, behavioral health, and educational outcomes for youth who are twelve to nineteen years of age;

(II) The entity is delivering the program and strategies to at-risk youth, regardless of the youths' eligibility for Colorado's medical assistance program; and

(III) The evidence-based programs and strategies are designed to achieve the following outcomes:

(A) An increase in the perceived risk of harm associated with marijuana use, prescription drug misuse, and underage alcohol use among youth who are twelve to nineteen years of age;

(B) A decrease in the rates of youth marijuana use, alcohol use, and prescription drug misuse;

(C) A delay in the age of first use of marijuana, alcohol, or prescription drug misuse;

(D) A decrease in the rates of youth who have ever used marijuana or alcohol or misused prescription drugs in their lifetime; and

(E) A decrease in the number of drug- and alcohol-related violations on school property, suspensions, and expulsions reported by schools.

(4) On or before September 1, 2014, the state department shall establish procedures and timelines for grant applications, criteria for determining grant amounts and grantee reporting requirements, and any other grant program policies. The state department may amend these policies at any time.

(5) Subject to available appropriations, the state department shall award grants for the 2014-15 academic year and for each academic year thereafter. There is no limit on the number of grants that the state department may award, and the same entity may receive more than one grant if the state department considers the needs of at-risk students in communities throughout the state for school-based substance abuse prevention and intervention programs.

(6) (a) On or before November 1 in any fiscal year in which the state department awards grants pursuant to this section, the state department shall submit a report to the joint budget committee; the public health care and human services and the health, insurance, and environment committees of the house of representatives, or any successor committees; and the health and human services committee of the senate, or any successor committee, summarizing all grants awarded pursuant to the grant program. At a minimum, the report must include the grant recipient and the amount of the grant, a description of the program or strategies delivered by the grant recipient, the outcomes achieved or proposed to be achieved by the program or strategies, and any other information relating to the success of the grant program in reducing or preventing the use of marijuana and alcohol and the misuse of prescription drugs by youth who are twelve to nineteen years of age.

(b) Pursuant to section 24-1-136 (11)(a)(I), this subsection (6) is repealed, effective November 2, 2017.

Source: L. 2014: Entire section added, (SB 14-215), ch. 352, p. 1612, § 6, effective July 1. **L. 2017:** (6) amended, (HB 17-1060), ch. 6, p. 15, § 5, effective March 1.

PART 3

MEDICAL SERVICES BOARD

25.5-1-301. Medical services board - creation. (1) There is hereby created in the state department a medical services board, referred to in this part 3 as the "board", which shall consist of eleven members appointed by the governor with the consent of the senate. The governor shall appoint persons to the board who have knowledge of medical assistance programs, and one or more of the appointments may include a person or persons who have received services through programs administered by the department within two years of the date of appointment. No more

than six members of the board shall be members of the same political party. Of the eleven members appointed to the board, at least one shall be appointed from each congressional district. In making appointments to the board, the governor shall include representation by at least one member who is a person with a disability, as defined in section 24-45.5-102 (2), C.R.S., a family member of a person with a disability, or a member of an advocacy group for persons with disabilities, provided that the other requirements of this subsection (1) are met.

(2) Members shall serve at the pleasure of the governor for a term of four years; except that, of the members first appointed, three shall serve for a term of two years and three shall serve for a term of three years. On July 1, 2001, the governor shall appoint one member from the private sector to the board who shall have experience with the delivery of health care, who shall be appointed for a term of two years, and one member who shall have experience or expertise in caring for medically underserved children, who shall be appointed for a term of three years.

(3) Members shall receive no compensation but shall be reimbursed for reasonable and necessary actual expenses incurred in the performance of their official duties as members of the board.

(4) Vacancies on the board shall be filled by appointment of the governor for the remainder of any unexpired term.

Source: L. 94: Entire part added, p. 1557, § 2, effective July 1. **L. 2001:** (1) and (2) amended, p. 916, § 12, effective August 8. **L. 2006:** Entire part amended, p. 1797, § 3, effective July 1. **L. 2009:** (1) amended, (HB 09-1281), ch. 399, p. 2154, § 4, effective August 5. **L. 2011:** (1) amended, (SB 11-183), ch. 132, p. 465, § 2, effective August 10.

25.5-1-302. Medical services board - organization. (1) The board shall elect from its members a president, a vice-president, and such other board officers as it shall determine. All board officers shall hold their offices at the pleasure of the board.

(2) Regular meetings of the board shall be held not less than once every three months at such times as may be fixed by resolution of the board. All meetings of the board, in every suit and proceeding, shall be considered to have been duly called and regularly held and all orders and proceedings of the board to have been authorized, unless the contrary is proven.

(3) The board shall adopt, and at any time may amend, bylaws in relation to its meetings and the transaction of its business. A majority shall constitute a quorum of the board. The vote of a majority of a quorum of the board shall constitute the action of the board. The board shall act only by resolution adopted at a duly called meeting of the board, and no individual of the board shall exercise any individual administrative authority with respect to the department.

Source: L. 94: Entire part added, p. 1557, § 2, effective July 1. **L. 2006:** Entire part amended, p. 1798, § 3, effective July 1.

25.5-1-303. Powers and duties of the board - scope of authority - rules. (1) The board shall have the authority set forth in subsection (3) of this section over the following programs administered by the state department:

(a) The "Colorado Medical Assistance Act", as specified in articles 4, 5, and 6 of this title;

(b) The "Colorado indigent care program", as specified in part 1 of article 3 of this title;

(c) Repealed.

(d) The "Children's Basic Health Plan Act", as specified in article 8 of this title;

(e) The old age pension health and medical care program, as specified in section 25.5-2-101;

(f) Programs, services, and supports for persons with intellectual and developmental disabilities, as specified in article 10 of this title.

(2) Nothing in this section shall be construed to affect any specific statutory provision granting rule-making authority to the board in relation to a specific program.

(3) The board shall adopt rules in connection with the programs set forth in subsection (1) of this section governing the following:

(a) The implementation of legislative and departmental policies and procedures for such programs; except that no rules shall be promulgated for any policy or procedure which governs the administration of the state department as specified in section 25.5-1-108 (1);

(b) The establishment of eligibility requirements for persons receiving services from the state department;

(c) The establishment of the type of benefits that a recipient of services may obtain if eligibility requirements are met, subject to the authorization, requirements, and availability of such benefits;

(d) The requirements, obligations, and rights of clients and recipients;

(e) The establishment of a procedure to resolve disputes that may arise between clients and the state department or clients and providers;

(f) The requirements, obligations, and rights of providers, including policies and procedures related to provider payments that may affect client benefits;

(g) The establishment of a procedure to resolve disputes that may arise between providers and between the state department and providers.

(4) At the request of the executive director, the board shall advise the executive director as to any proposed policies or rules governing programs administered by the state department that are not set forth in subsection (1) of this section.

(5) The board shall have no authority over the revenue of the state department.

(6) All rules and orders of the department of human services in connection with the old age pension health and medical care program shall continue to be effective until revised, amended, repealed, or nullified pursuant to law.

(7) The rules issued by the state board shall be binding upon the county departments. At any public hearing relating to a proposed rule-making, interested persons shall have the right to present their data, views, or arguments orally. Proposed rules of the state board shall be subject to the provisions of section 24-4-103, C.R.S.

(8) To the extent that rules are promulgated by the state board of human services for programs or providers that receive either medicaid only or both medicaid and nonmedicaid funding, the rules shall be developed in cooperation with the state department and shall not conflict with state statutes or federal statutes or regulations.

(9) The rules and orders of the department of human services and the state board of human services in connection with the programs, services, and supports specified in paragraph (f) of subsection (1) of this section shall continue to be effective until revised, amended, repealed, or nullified pursuant to law.

Source: L. 94: Entire part added, p. 1558, § 2, effective July 1. **L. 95:** (3)(e) to (3)(g) amended, p. 928, § 32, effective May 25. **L. 99:** (1)(c) amended and (1)(e) added, p. 701, § 7, effective July 1. **L. 2001:** (1)(f) and (7) added, pp. 916, 917, §§ 13, 14, effective August 8. **L. 2003:** (7) amended, p. 2009, § 90, effective May 22; (4) amended and (8) added, p. 2584, § 4, effective July 1. **L. 2006:** Entire part amended, p. 1798, § 3, effective July 1. **L. 2007:** (1)(c) repealed, p. 2042, § 71, effective June 1. **L. 2011:** (1)(e) and (6) amended, (SB 11-210), ch. 187, p. 722, § 8, effective July 15, 2012. **L. 2013:** (1)(f) and (9) added, (HB 13-1314), ch. 323, p. 1808, § 43, effective March 1, 2014.

Cross references: For the legislative declaration contained in the 1999 act amending subsection (1)(c) and enacting subsection (1)(e), see section 1 of chapter 203, Session Laws of Colorado 1999.

25.5-1-304. Repeal of part. (Deleted by amendment)

Source: L. 94: Entire part added, p. 1559, § 2, effective July 1. **L. 2000:** Entire section amended, p. 410, § 9, effective April 13. **L. 2006:** Entire part amended, p. 1800, § 3, effective July 1.

PART 4

HEALTH CARE COVERAGE COOPERATIVE
RULE-MAKING AUTHORITY

25.5-1-401. (Repealed)

Source: L. 2004: Entire part repealed, p. 1011, § 23, effective August 4.

Editor's note: This part 4 was added in 1994. For amendments to this part 4 prior to its repeal in 2004, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 5

COOPERATIVE HEALTH CARE AGREEMENTS
INVOLVING HOSPITALS

25.5-1-501 to 25.5-1-516. (Repealed)

Source: L. 2006: Entire part repealed, p. 1800, § 4, effective July 1.

Editor's note: This part 5 was added in 1995. For amendments to this part 5 prior to its repeal in 2006, consult the Colorado statutory research explanatory note and the table itemizing

the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 6

COMMISSION ON FAMILY MEDICINE

Editor's note: This part 6 was added with relocations in 2017. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

25.5-1-601. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) Physicians engaged in family medicine are in critically short supply in this state;

(b) Because of the distribution of such physicians, many rural and urban areas of the state are underserved;

(c) A significant portion of the state population is medically underserved because of indigency;

(d) Family physicians provide health care to all segments of the population;

(e) The provision of more competent family physicians is a public purpose of great importance; and

(f) The creation of the commission on family medicine is a desirable, necessary, and cost-effective means of addressing the needs described in this subsection (1).

Source: L. 2017: Entire part added, (HB 17-1024), ch. 7, p. 19, § 1, effective August 9.

Editor's note: This section is similar to former § 25-1-901 as it existed prior to 2017.

25.5-1-602. Commission created - composition - terms of office. (1) There is hereby created, in the department of health care policy and financing, the commission on family medicine, referred to in this part 6 as the "commission". No more than four members of the commission appointed by the governor pursuant to subsection (1)(d) of this section may be members of the same major political party. A vacancy on the commission occurs whenever any health care consumer member moves out of the congressional district from which he or she was appointed. A health care consumer member who moves out of the congressional district shall promptly notify the governor of the date of the move, but notice is not a condition precedent to the occurrence of the vacancy. The governor shall fill the vacancy by appointment for the unexpired term. The commission consists of the following members:

(a) The deans of accredited allopathic and osteopathic schools of medicine in the state or their designated representatives;

(b) The director of all family medicine programs in the state accredited by the accreditation council on graduate medical education of the American medical association or the American osteopathic association;

(c) A representative of the Colorado academy of family physicians; and

(d) A health care consumer to be appointed by the governor from each congressional district in the state.

(2) The members appointed under subsection (1)(d) of this section serve three-year terms. All members serve at the pleasure of the governor.

(3) The commission shall elect a chairperson and a vice-chairperson from among its members. Members of the commission serve without compensation, but members described in subsections (1)(b), (1)(c), and (1)(d) of this section are entitled to their actual and necessary expenses incurred in the performance of their duties. The commission shall meet on call of the chairperson, but not less than once every three months. A majority of the members of the commission constitutes a quorum for the transaction of business.

Source: L. 2017: Entire part added, (HB 17-1024), ch. 7, p. 20, § 1, effective August 9.

Editor's note: This section is similar to former § 25-1-902 as it existed prior to 2017.

25.5-1-603. Duties of commission - reporting. (1) The commission shall:

(a) Assure that family medicine residency program standards are equal to or more stringent than the standards established by the accreditation council on graduate medical education of the American medical association or the American osteopathic association for residency training in family medicine;

(b) In cooperation with the dean of the school of medicine, approve and recommend allocation of any funds which are identified and appropriated in the general appropriation bill as a line item for any community family medicine residency training program;

(c) Monitor the state's family medicine residency programs and recommend from time to time that the general assembly appropriate funds for said programs;

(d) Locate specific areas of the state which are underserved by family physicians and determine the priority of need among such areas;

(e) Offer to the general assembly alternative ideas on providing medical care to the medically indigent in the state; and

(f) (I) Support the development and maintenance of family medicine residency programs in rural and other underserved areas of the state for purposes of cultivating family medicine practitioners who are likely to continue practicing in rural and underserved areas of the state at the conclusion of their residency programs.

(II) On or before each November 1, the commission shall report to the office of state planning and budgeting and to the department of health care policy and financing concerning rural family medicine residency programs in the state and the role of the commission with respect to supporting the development and maintenance of those programs. In addition, notwithstanding section 24-1-136 (11), the commission shall present the report to the joint budget committee as part of its annual presentation to that committee.

Source: L. 2017: Entire part added, (HB 17-1024), ch. 7, p. 20, § 1, effective August 9.

Editor's note: This section is similar to former § 25-1-903 as it existed prior to 2017.

ARTICLE 2

State-funded Health and Medical Care

Editor's note: This article was added in 1994 and was repealed in 2002. This article was subsequently amended in 2006 resulting in the recreation of the article with relocated provisions. For amendments to this article prior to 2002, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

25.5-2-101. Old age pension health and medical care fund - supplemental old age pension health and medical care fund - cash system of accounting - legislative declaration - rules.

(1) (Deleted by amendment, L. 2011, (SB 11-210), ch. 187, p. 719, § 2, effective July 15, 2012.)

(2) Any money remaining in the state old age pension fund after full payment of basic minimum awards to qualified old age pension recipients and after establishment and maintenance of the old age pension stabilization fund in the amount of five million dollars shall be transferred to a fund to be known as the old age pension health and medical care fund, which is hereby created. The state board shall establish and promulgate rules for administration of a program to provide health and medical care to persons who qualify to receive old age pensions and who are not patients in an institution for tuberculosis or behavioral or mental health disorders. The costs of such program, not to exceed ten million dollars in any fiscal year, are defrayed from the health and medical care fund, but all money available, accrued or accruing, received or receivable, in said health and medical care fund in excess of ten million dollars in any fiscal year is transferred to the general fund of the state to be used pursuant to law. Money in the old age pension health and medical care fund is subject to annual appropriation by the general assembly.

(3) Repealed.

(4) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the state department relating to the financial administration of any nonadministrative expenditure for the health and medical care programs described in subsection (2) of this section.

Source: L. 2006: Entire article amended with relocations, p. 1800, § 5, effective July 1. **L. 2007:** (4) added, p. 465, § 1, effective July 1. **L. 2009:** (3) amended, (SB 09-261), ch. 201, p. 905, § 1, effective May 1. **L. 2010:** (3)(b)(III) amended and (3)(b)(IV) and (3)(b)(V) added, (HB 10-1380), ch. 215, p. 932, § 1, effective May 6. **L. 2011:** (3)(b)(VI) added, (SB 11-164), ch. 33, p. 93, § 5, effective March 18; (3) amended, (SB 11-210), ch. 187, p. 718, § 1, effective July 1; (1) and (4) amended, (SB 11-210), ch. 187, p. 719, § 2, effective July 15, 2012. **L. 2017:** (2) amended, (SB 17-242), ch. 263, p. 1326, § 197, effective May 25.

Editor's note: (1) This section is similar to former § 26-2-117 as it existed prior to 2006.

(2) Amendments to subsection (3) by Senate Bill 11-210 and Senate Bill 11-164 were harmonized.

(3) Subsection (3)(a)(II) provided for the repeal of subsection (3)(a), effective July 15, 2012. (See L. 2011, p. 718.) Subsection (3)(b)(V) provided for the repeal of subsection (3)(b), effective July 15, 2012. (See L. 2011, p. 718.)

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-2-102. Health and medical care program - aid to the needy disabled. (Repealed)

Source: L. 2006: Entire article amended with relocations, p. 1801, § 5, effective July 1. **L. 2007:** Entire section repealed, p. 2043, § 72, effective June 1.

Editor's note: This section was similar to former § 26-2-119.5 as it existed prior to 2006.

PRESCRIPTION DRUGS

ARTICLE 2.5

Colorado Cares
Prescription Drug Program

25.5-2.5-101. Short title. This article shall be known and may be cited as the "Colorado Cares Rx Act".

Source: L. 2007: Entire article added, p. 1, § 1, effective February 5.

25.5-2.5-102. Legislative declaration. (1) The general assembly finds that:

(a) Uninsured, underinsured, and older Coloradans pay a disproportionately greater share of their income for prescription drugs. In many cases, current drug prices have the effect of denying residents access to necessary medical care, thereby threatening their health and safety.

(b) Prescription drugs play an increasingly important role in improving or stabilizing a person's health and in reducing overall health care costs;

(c) Additionally, the new medicare prescription drug benefit restricts persons from purchasing insurance in order to fully cover their prescription drug needs. This restriction on a person's ability to purchase adequate coverage may threaten the person's health and safety.

(d) Currently, there is no limit on the amount that a pharmacy may charge for a generic or nonpatented drug, and, although some retail pharmacies are offering some generic and nonpatented drugs at discounted prices, there are no guarantees that the pharmacies will continue to do so.

(2) The general assembly, therefore, declares that it is important to make information available to the public concerning ways to purchase lower-cost generic and nonpatented prescription drugs through the "Colorado Cares Rx Act" in order to protect the health of uninsured, underinsured, and older Coloradans. The general assembly further declares that the

state should continue to actively research cost-effective mechanisms or programs that may provide additional options to address this need in Colorado.

Source: L. 2007: Entire article added, p. 1, § 1, effective February 5. **L. 2009:** Entire section amended, (SB 09-132), ch. 224, p. 1011, § 1, effective May 4.

25.5-2.5-103. Lower-cost prescription drugs - information - research - reporting. (1) The state department shall make information available to the public concerning lower-cost prescription drug programs. The information shall include, but need not be limited to:

(a) Ways in which low-income, uninsured persons can obtain lower-cost prescription drugs; and

(b) Contact information concerning programs for lower-cost prescription drugs.

(2) The state department shall research cost-effective programs or mechanisms by which low-income, uninsured persons may purchase lower-cost prescription drugs.

(3) The state department shall report annually to the health and human services committees of the house of representatives and the senate, or any successor committees, concerning the provisions of this article.

Source: L. 2007: Entire article added, p. 2, § 1, effective February 5. **L. 2009:** Entire section R&RE, (SB 09-132), ch. 224, p. 1012, § 2, effective May 4.

25.5-2.5-104. Program - rules - repeal. (Repealed)

Source: L. 2007: Entire article added, p. 2, § 1, effective February 5. **L. 2009:** Entire section repealed, (SB 09-132), ch. 224, p. 1012, § 3, effective May 4.

25.5-2.5-105. Cash fund. (Repealed)

Source: L. 2007: Entire article added, p. 4, § 1, effective February 5. **L. 2009:** Entire section repealed, (SB 09-132), ch. 224, p. 1012, § 3, effective May 4.

25.5-2.5-106. Repeal of article. (Repealed)

Source: L. 2007: Entire article added, p. 4, § 1, effective February 5. **L. 2009:** Entire section repealed, (SB 09-132), ch. 224, p. 1012, § 3, effective May 4.

INDIGENT CARE

ARTICLE 3

Indigent Care

Editor's note: This article was added in 2005. This article was amended in 2006, resulting in the relocation of provisions. For the text of this article prior to 2006, consult the 2005 Colorado Revised Statutes. Former C.R.S. section numbers are shown in editor's notes

following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

PART 1

COLORADO INDIGENT CARE PROGRAM

25.5-3-101. Short title. This part 1 shall be known and may be cited as the "Colorado Indigent Care Program".

Source: L. 2006: Entire article amended with relocations, p. 1802, § 6, effective July 1.

Editor's note: This section is similar to former § 26-15-101 as it existed prior to 2006.

25.5-3-102. Legislative declaration. (1) The general assembly hereby determines, finds, and declares that:

(a) The state has insufficient resources to pay for all medical services for persons who are indigent and must therefore allocate available resources in a manner that will provide treatment of those conditions constituting the most serious threats to the health of such medically indigent persons, as well as increase access to primary medical care to prevent deterioration of the health conditions among medically indigent people; and

(b) Such allocation of resources will require the prioritization of medical services by providers and the coordination of administration and delivery of medical services.

(2) The general assembly further determines, finds, and declares that the eligibility of medically indigent persons to receive medical services rendered under the conditions specified in subsection (1) of this section exists only to the extent of available appropriations, as well as to the extent of the individual provider facility's physical, staff, and financial capabilities. The general assembly also recognizes that the program for the medically indigent is a partial solution to the health care needs of Colorado's medically indigent citizens. Therefore, medically indigent persons accepting medical services from such program shall be subject to the limitations and requirements imposed in this part 1.

Source: L. 2006: Entire article amended with relocations, p. 1802, § 6, effective July 1.

Editor's note: This section is similar to former § 26-15-102 as it existed prior to 2006.

25.5-3-103. Definitions. As used in this part 1, unless the context otherwise requires:

(1) "Emergency care" 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.

(2) "Executive director" means the executive director of the state department.

(3) "General provider" means a general hospital, birth center, or community health clinic licensed or certified by the department of public health and environment pursuant to section 25-1.5-103 (1)(a)(I) or (1)(a)(II), C.R.S.; a federally qualified health center, as defined in section

1861 (aa)(4) of the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4); a rural health clinic, as defined in section 1861 (aa)(2) of the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(2); a health maintenance organization issued a certificate of authority pursuant to section 10-16-402, C.R.S.; and the health sciences center when acting pursuant to section 25.5-3-108 (5)(a)(I) or (5)(a)(II)(A). For the purposes of the program, "general provider" includes associated physicians.

(4) "Health sciences center" means the schools of medicine, dentistry, nursing, and pharmacy established by the regents of the university of Colorado under section 5 of article VIII of the Colorado constitution.

(5) "Program" means the program for the medically indigent established by section 25.5-3-104.

(6) "University hospital" means the university hospital operated pursuant to article 21 of title 23, C.R.S.

Source: L. 2006: Entire article amended with relocations, p. 1803, § 6, effective July 1. **L. 2011:** (3) amended, (HB 11-1101), ch. 94, p. 278, § 3, effective April 8; (3) amended, (HB 11-1323), ch. 265, p. 1199, § 3, effective June 2.

Editor's note: This section is similar to former § 26-15-103 as it existed prior to 2006.

25.5-3-104. Program for the medically indigent established - eligibility - rules. (1) A program for the medically indigent is hereby established, to commence July 1, 1983, which shall be administered by the state department, to provide payment to providers for the provision of medical services to eligible persons who are medically indigent. The state board may promulgate rules as are necessary for the implementation of this part 1 in accordance with article 4 of title 24, C.R.S.

(2) A client's eligibility to receive discounted services under the program for the medically indigent shall be determined by rule of the state board based on a specified percentage of the federal poverty line, adjusted for family size, which percentage shall not be less than two hundred fifty percent.

Source: L. 2006: Entire section amended, p. 1606, § 2, effective June 2; entire article amended with relocations, p. 1803, § 6, effective July 1. **L. 2010:** (2) amended, (HB 10-1422), ch. 419, p. 2109, § 138, effective August 11.

Editor's note: (1) This section is similar to former § 26-15-104 as it existed prior to 2006.

(2) Amendments to section 26-15-104 by Senate Bill 06-044 were harmonized with this section as it appeared in Senate Bill 06-219.

Cross references: For the legislative declaration contained in the 2006 act amending this section, see section 1 of chapter 323, Session Laws of Colorado 2006.

25.5-3-105. Eligibility of legal immigrants for services. A legal immigrant who is a resident of the state of Colorado shall be eligible to receive services under this part 1 so long as

he or she meets the eligibility requirements. As used in this section, "legal immigrant" has the same meaning as described in section 25.5-4-103 (10). As a condition of eligibility for services under this part 1, a legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service, or any successor agency, during the pendency of such legal immigrant's receipt of services under this part 1. Nothing in this section shall be construed to affect a legal immigrant's eligibility for services under this part 1 based upon such legal immigrant's responsibilities under an affidavit of support entered into before July 1, 1997.

Source: L. 2006: Entire article amended with relocations, p. 1804, § 6, effective July 1.

Editor's note: This section is similar to former § 26-15-104.3 as it existed prior to 2006.

25.5-3-106. No public funds for abortion - exception - definitions - repeal. (1) It is the purpose of this section to implement the provisions of amendment 3 to article V of the Colorado constitution, adopted by the registered electors of the state of Colorado at the general election November 6, 1984, which prohibits the use of public funds by the state of Colorado or its agencies or political subdivisions to pay or otherwise reimburse, directly or indirectly, any person, agency, or facility for any induced abortion.

(2) If every reasonable effort has been made to preserve the lives of a pregnant woman and her unborn child, then public funds may be used pursuant to this section to pay or reimburse for necessary medical services, not otherwise provided for by law.

(3) (a) Except as provided in paragraph (b) of this subsection (3), any necessary medical services performed pursuant to this section shall be performed only in a licensed health care facility by a provider who is a licensed physician.

(b) However, such services may be performed in other than a licensed health care facility if, in the medical judgment of the attending physician, the life of the pregnant woman or her unborn child is substantially threatened and a transfer to a licensed health care facility would further endanger the life of the pregnant woman or her unborn child. Such medical services may be performed in other than a licensed health care facility if the medical services are necessitated by a life-endangering circumstance described in subparagraph (II) of paragraph (b) of subsection (6) of this section and if there is no licensed health care facility within a thirty-mile radius of the place where such medical services are performed.

(4) (a) Any physician who renders necessary medical services pursuant to subsection (2) of this section shall report the following information to the state department:

(I) The age of the pregnant woman and the gestational age of the unborn child at the time the necessary medical services were performed;

(II) The necessary medical services which were performed;

(III) The medical condition which necessitated the performance of necessary medical services;

(IV) The date such necessary medical services were performed and the name of the facility in which such services were performed.

(b) The information required to be reported pursuant to paragraph (a) of this subsection (4) shall be compiled by the state department and such compilation shall be an ongoing public

record; except that the privacy of the pregnant woman and the attending physician shall be preserved.

(5) For purposes of this section, pregnancy is a medically diagnosable condition.

(6) For the purposes of this section:

(a) (I) "Death" means:

(A) The irreversible cessation of circulatory and respiratory functions; or

(B) The irreversible cessation of all functions of the entire brain, including the brain stem.

(II) A determination of death under this section shall be in accordance with accepted medical standards.

(b) "Life-endangering circumstance" means:

(I) The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term;

(II) The presence of a lethal medical condition in the unborn child, as determined by the attending physician and one other physician, which would result in the impending death of the unborn child during the term of pregnancy or at birth; or

(III) The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such case, unless the pregnant woman has been receiving prolonged psychiatric care, the attending licensed physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition. The attending physician shall report the findings of such consultation to the state department.

(c) "Necessary medical services" means any medical procedures deemed necessary to prevent the death of a pregnant woman or her unborn child due to life-endangering circumstances.

(7) If any provision of this section or application thereof is held invalid, such invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application and, to this end, provisions of this section are declared severable.

(8) Use of the term "unborn child" in this section is solely for the purposes of facilitating the implementation of section 50 of article V of the state constitution and its use shall not affect any other law or statute nor shall it create any presumptions relating to the legal status of an unborn child or create or affect any distinction between the legal status of an unborn child and the legal status of a fetus.

(9) This section shall be repealed if section 50 of article V of the Colorado constitution is repealed.

Source: L. 2006: Entire article amended with relocations, p. 1804, § 6, effective July 1.

Editor's note: This section is similar to former § 26-15-104.5 as it existed prior to 2006.

Cross references: For the text of "amendment 3 to article V of the Colorado constitution" referenced in subsection (1) of this section, see section 50 of article V of the state constitution.

25.5-3-107. Report concerning the program. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), the executive director shall prepare an annual report concerning the status of the medically indigent program to be submitted to the health and human services committees of the senate and the house of representatives, or any successor committees, no later than February 1 of each year. The report shall be prepared following consultation with providers in the program, state department personnel, and other agencies, organizations, or individuals as the executive director deems appropriate in order to obtain comprehensive and objective information about the program.

Source: L. 2006: Entire article amended with relocations, p. 1806, § 6, effective July 1. **L. 2017:** Entire section amended, (HB 17-1060), ch. 6, p. 16, § 6, effective March 1.

Editor's note: This section is similar to former § 26-15-105 as it existed prior to 2006.

25.5-3-108. Responsibility of the department of health care policy and financing - provider reimbursement. (1) The state department shall be responsible for:

(a) Execution of such contracts with providers for partial reimbursement of costs for medical services rendered to the medically indigent as the state department shall determine are necessary for the program;

(b) Promulgation of such reasonable rules as are necessary for the program;

(c) Submission of the report required in section 25.5-3-107; and

(d) Application for federal financial participation under the program.

(2) The contracts required by paragraph (a) of subsection (1) of this section shall be negotiated between the state department and the various general providers, as defined in section 25.5-3-103 (3), and shall include contracts with providers to provide tertiary or specialized services. The state department may award such contracts upon a determination that it would not be cost effective nor result in adequate quality of care for such services to be developed by the contract providers, or upon a determination that the contract providers are unable or unwilling to provide such services.

(3) The state department shall establish procedures requiring the provider to provide for proof of indigency to be submitted by the person seeking assistance, but the provider shall be responsible for the determination of eligibility.

(4) The state department shall establish procedures so that the providers of medical services rendered to the medically indigent cover geographic regions of the state.

(5) (a) The responsibilities of providers who provide medical care through the program for the medically indigent are as follows:

(I) Denver health and hospitals, including associated physicians, shall, up to its physical, staff, and financial capabilities as provided for under this program, be the primary providers of medical services to the medically indigent for the city and county of Denver.

(II) (A) University hospital and the physicians and other faculty members of the health sciences center shall, up to their physical, staff, and financial capabilities as provided for under this program, be the primary provider of medical services to the medically indigent for the Denver primary metropolitan statistical area.

(B) University hospital and the physicians and other faculty members of the health sciences center shall be the primary provider of such complex care as is not available or is not

contracted for in the remaining areas of the state up to their physical, staff, and financial capabilities as provided for under this program.

(b) Any two or more providers awarded contracts may, with the approval of the state department, redistribute their respective populations and associated funds.

(c) Every provider who provides medical care through the program for the medically indigent shall comply with all procedures established by the state department.

(6) The state department shall establish procedures that allocate funds to providers based on the anticipated utilization of services.

(7) A provider receiving reimbursement pursuant to this section shall transfer a medically indigent patient to another provider only with the prior agreement of the provider.

(8) (a) Every provider receiving reimbursement pursuant to this section shall prioritize for each fiscal year the medical services which it will be able to render, within the limits of the funds which will be made available by the state department.

(b) Such medical services shall be prioritized in the following order:

(I) Emergency care for the full year;

(II) Any additional medical care for those conditions the state department determines to be the most serious threat to the health of medically indigent persons;

(III) Any other additional medical care.

(9) A provider receiving reimbursement pursuant to this section shall not be liable in civil damages for refusing to admit for treatment or for refusing to treat any medically indigent person for a condition which the state department or the provider has determined to be outside of the scope of the program.

(10) (a) A medically indigent person who wishes to be determined eligible for assistance under this part 1 shall comply with the eligibility requirements set by the state department.

(b) A medically indigent person requesting assistance under this part 1 specifically authorizes the state department or provider to:

(I) Use any information required by the eligibility requirements set by the state department for the purpose of verifying eligibility; and

(II) Obtain records pertaining to eligibility from a financial institution, as defined in section 15-15-201 (4), C.R.S., or from any insurance company.

(c) A medically indigent person requesting assistance under this part 1 shall be provided language clearly explaining the provisions of this subsection (10).

(11) With the approval of the state department, any provider awarded a contract may enter into subcontracts or other agreements for services related to the program.

(12) Providers awarded contracts shall not be paid from funds made available for this program up to the extent, if any, of their annual financial obligation under the Hill-Burton act.

(13) When adopting or modifying procedures under this part 1, the state department shall notify each provider, who is contracted to provide medical care through the program for the medically indigent, at least thirty days prior to implementation of a new procedure. The state department shall hold a meeting for all providers at least thirty days prior to the implementation of a new procedure.

(14) The state department shall require any hospital provider who may receive payment under the program to annually submit data relating to the hospital's number of medicaid-eligible in-patient days and the hospital's total in-patient days in a form specified by the state department. The hospital provider shall verify the data to the state department through the program audit

procedures required by the state department. The state department shall include this information by hospital in the department's annual budget request to the joint budget committee of the general assembly and in the report required by section 25.5-3-107.

(15) To qualify for the program's payment formula disproportionate share hospital factor, as described in rule by the state board consistent with the provisions of this part 1, a hospital provider's percent of medicaid-eligible in-patient days relative to total in-patient days shall be equal to or exceed one standard deviation above the mean.

(16) After receiving approval by the state department, a community health clinic may utilize moneys received pursuant to this article, and any gifts, grants, and donations, for the development and implementation of demonstration projects that may include but need not be limited to coordination of care and disease management.

(17) Subject to adequate funding being made available under section 25.5-4-402.4, the Colorado healthcare affordability and sustainability enterprise created in section 25.5-4-402.4 (3) shall increase hospital reimbursements up to one hundred percent of hospital costs for providing medical care under the program.

(18) Repealed.

Source: L. 2006: (1) amended and (16) added, p. 1606, § 3, effective June 2; entire article amended with relocations, p. 1806, § 6, effective July 1. **L. 2009:** (18) added, (SB 09-264), ch. 204, p. 928, § 4, effective May 1; (17) added, (HB 09-1293), ch. 152, p. 644, § 3, effective July 1. **L. 2017:** (17) amended, (SB 17-267), ch. 267, p. 1447, § 13, effective July 1.

Editor's note: (1) This section is similar to former § 26-15-106 as it existed prior to 2006.

(2) (a) Amendments to section 26-15-106 (1) by Senate Bill 06-044 were harmonized with subsection (1) as it appeared in Senate Bill 06-219.

(b) Subsection (16) was enacted as § 26-15-106 (20) in Senate Bill 06-044 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

(3) Subsection (18)(b) provided for the repeal of subsection (18), effective July 1, 2011. (See L. 2009, p. 928.)

(4) Section 34 of chapter 267 (SB 17-267), Session Laws of Colorado 2017, provides that the section of the act changing this section does not take effect if the centers for medicare and medicaid services determine that the amendments do not comply with federal law. For more information, see SB 17-267. (L. 2017, p. 1478.) The executive director of the department of health care policy and financing did not notify the revisor of statutes by June 1, 2017, of such determination; therefore, the changes to this section took effect July 1, 2017.

Cross references: (1) For the legislative declaration contained in the 2006 act amending subsection (1) and enacting subsection (16), see section 1 of chapter 323, Session Laws of Colorado 2006. For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

(2) For the "Hill-Burton Act" referenced in subsection (12), also known as the "Hospital Survey and Construction Act", see Pub.L. 725, 79th Congress, 60 Stat. 1040.

25.5-3-109. Appropriations. The general assembly shall make annual appropriations to the state department to accomplish the purposes of this part 1.

Source: L. 2006: Entire article amended with relocations, p. 1809, § 6, effective July 1.

Editor's note: This section is similar to former § 26-15-110 as it existed prior to 2006.

25.5-3-110. Effect of part 1. This part 1 shall not affect the department of human services' responsibilities for the provision of mental health care in accordance with article 66 of title 27, C.R.S., and this part 1 shall not affect any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the university of Colorado psychiatric hospital.

Source: L. 2006: Entire article amended with relocations, p. 1809, § 6, effective July 1. **L. 2010:** Entire section amended, (SB 10-175), ch. 188, p. 800, § 64, effective April 29.

Editor's note: This section is similar to former § 26-15-111 as it existed prior to 2006.

25.5-3-111. Penalties. Any person who represents that any medical service is reimbursable or subject to payment under this part 1 when he or she knows that it is not and any person who represents that he or she is eligible for assistance under this part 1 when he or she knows that he or she is not commits a class 2 misdemeanor and shall be punished as provided in section 18-1.3-501, C.R.S.

Source: L. 2006: Entire article amended with relocations, p. 1809, § 6, effective July 1.

Editor's note: This section is similar to former § 26-15-112 as it existed prior to 2006.

25.5-3-112. Health care services fund - creation - state plan amendment - primary care special distribution fund. (1) (a) There is hereby created in the state treasury the Colorado health care services fund, referred to in this section as the "fund". The fund shall consist of moneys credited thereto pursuant to this section.

(b) In fiscal year 2005-06, the general assembly shall appropriate fourteen million nine hundred sixty-two thousand four hundred eight dollars from the general fund to the fund. Of the moneys in the general fund exempt account created in section 24-77-103.6 (2), C.R.S., the following amounts shall be appropriated by the general assembly to the fund:

(I) In fiscal year 2007-08, fifteen million dollars; and

(II) In fiscal year 2008-09, twelve million nine hundred eighteen thousand seven hundred fifty dollars.

(III) (Deleted by amendment, L. 2010, (HB 10-1321), ch. 48, p. 179, § 1, effective March 29, 2010.)

(b.5) In fiscal year 2009-10, the general assembly shall appropriate ten million three hundred ninety thousand dollars from the general fund to the fund.

(b.6) In fiscal year 2011-12, the treasurer shall transfer one million dollars from the general fund to the fund.

(c) All moneys appropriated to the fund shall be used as provided in this section and shall not be deposited in or transferred to the general fund of this state or to any other fund. Notwithstanding any provision of section 24-36-114, C.R.S., to the contrary, all interest derived from the deposit and investment of moneys in the fund shall be credited to the fund.

(1.5) Notwithstanding any provision of subsection (1) of this section to the contrary, on April 20, 2009, the state treasurer shall deduct five hundred thousand dollars from the fund and transfer such sum to the general fund.

(2) In fiscal year 2006-07, and each of the two fiscal years thereafter, notwithstanding the requirements of section 25.5-3-108 (8)(b), the moneys deposited into the fund shall be appropriated as follows:

(a) Of the moneys appropriated pursuant to this subsection (2), eighteen percent of the moneys annually appropriated shall be to Denver health and hospitals as the community health clinic provider for the city and county of Denver.

(b) (I) For fiscal year 2006-07, eighty-two percent of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be appropriated to community health clinics to provide primary care services pursuant to this article.

(II) For fiscal year 2006-07, eighteen percent of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be appropriated to primary care clinics operated by a licensed or certified health care facility to provide primary care services pursuant to this article.

(III) For fiscal years 2007-08 and 2008-09, the allocation of the moneys remaining after the appropriation pursuant to paragraph (a) of this subsection (2) shall be determined based on prior utilization as specified in rule by the state board.

(2.5) In fiscal year 2009-10, notwithstanding the requirements of section 25.5-3-108 (8)(b), the moneys deposited into the fund shall be appropriated as follows:

(a) Twenty percent of the moneys shall be appropriated to the state department for distribution to Denver health and hospitals as the community health clinic provider for the city and county of Denver;

(b) Eighty percent of the moneys shall be appropriated to the state department for distribution to community health clinics based upon prior utilizations as determined by the state department to mitigate reductions the clinics experience due to reductions in moneys available from the primary care fund created pursuant to section 24-22-117 (2)(b), C.R.S.

(2.7) In the 2010-11 fiscal year, notwithstanding the requirements of section 25.5-3-108 (8)(b), the moneys deposited into the fund shall be appropriated to the state department for distribution to Denver health and hospitals, as the community health clinic for the city and county of Denver, and to community health clinics. The state department shall develop a distribution formula specifying the distributions based upon prior utilizations and, to the extent possible, mitigation of the reductions in funding that the clinics experience due to reductions in moneys available from the primary care fund established pursuant to section 24-22-117 (2)(b), C.R.S.

(2.8) In the 2011-12 fiscal year, notwithstanding the requirements of section 25.5-3-108 (8)(b), the moneys deposited into the fund shall be appropriated to the state department for distribution to Denver health and hospitals, as the community health clinic for the city and county of Denver, to community health clinics, and to federally qualified health centers. The state department shall develop a distribution formula specifying the distributions based upon

prior utilizations and, to the extent possible, mitigation of the reductions in funding that the clinics experience due to reductions in moneys available from the primary care fund established pursuant to section 24-22-117 (2)(b), C.R.S.

(3) (a) The state department shall submit a state plan amendment for federal financial participation for moneys appropriated to primary care clinics operated by a licensed or certified health care facility. Upon approval of the state plan amendment, the state department is authorized to receive and expend all available federal moneys without a corresponding reduction in spending authority from the fund.

(b) To the extent possible under federal law, the state department shall pursue available federal financial participation for moneys appropriated to community health clinics.

(4) Repealed.

Source: L. 2006: Entire section added, p. 1606, § 4, effective June 2. **L. 2007:** (2) and (3) amended, p. 559, § 1, effective April 16; (2)(b)(III) amended, p. 2043, § 73, effective June 1. **L. 2008:** (3)(a) amended, p. 276, § 6, effective March 31. **L. 2009:** (1.5) added , (SB 09-208), ch. 149, p. 627, § 31, effective April 20; (1)(b) amended, (SB 09-264), ch. 204, p. 928, § 5, effective May 1. **L. 2010:** (1)(b), IP(2), and (2)(b)(III) amended and (1)(b.5), (2.5), and (4) added, (HB 10-1321), ch. 48, p. 179, §§ 1, 2, effective March 29; (4) amended and (2.7) added, (HB 10-1378), ch. 213, p. 927, § 3, effective May 27. **L. 2011:** (1)(b.6) and (2.8) added and (4) amended, (SB 11-219), ch. 188, p. 725, §§ 3, 4, 5, effective June 3.

Editor's note: (1) This section was originally numbered as § 26-15-114 in Senate Bill 06-044. Section 8 of the act provided for the renumbering and relocation of § 26-15-114 to this section. (See L. 2006, p. 1612.)

(2) Amendments to subsection (2) by House Bill 07-1258 and House Bill 07-1367 were harmonized.

(3) Subsection (4)(d) provided for the repeal of subsection (4), effective July 1, 2012. (See L. 2011, p. 725.)

Cross references: For the legislative declaration contained in the 2006 act enacting this section, see section 1 of chapter 323, Session Laws of Colorado 2006.

PART 2

COMPREHENSIVE PRIMARY AND
PREVENTIVE CARE GRANT PROGRAM

25.5-3-201. Short title. (Repealed)

Source: L. 2006: Entire article amended with relocations, p. 1809, § 6, effective July 1. **L. 2011:** Entire section repealed, (SB 11-216), ch. 149, p. 520, § 4, effective May 5.

25.5-3-202. Legislative declaration. (Repealed)

Source: L. 2006: Entire article amended with relocations, p. 1809, § 6, effective July 1. **L. 2010:** (3) amended, (HB 10-1422), ch. 419, p. 2109, § 139, effective August 11. **L. 2011:** Entire section repealed, (SB 11-216), ch. 149, p. 520, § 4, effective May 5.

25.5-3-203. Definitions. (Repealed)

Source: L. 2006: Entire article amended with relocations, p. 1810, § 6, effective July 1. **L. 2010:** (7)(a) amended, (HB 10-1422), ch. 419, p. 2109, § 140, effective August 11. **L. 2011:** Entire section repealed, (SB 11-216), ch. 149, p. 520, § 4, effective May 5.

25.5-3-204. Comprehensive primary and preventive care grant program - creation. (Repealed)

Source: L. 2006: Entire article amended with relocations, p. 1811, § 6, effective July 1. **L. 2011:** Entire section repealed, (SB 11-216), ch. 149, p. 520, § 4, effective May 5.

25.5-3-205. Grant-making process. (Repealed)

Source: L. 2006: Entire article amended with relocations, p. 1811, § 6, effective July 1. **L. 2011:** Entire section repealed, (SB 11-216), ch. 149, p. 520, § 4, effective May 5.

25.5-3-206. Reports. (Repealed)

Source: L. 2006: Entire article amended with relocations, p. 1812, § 6, effective July 1. **L. 2011:** Entire section repealed, (SB 11-216), ch. 149, p. 520, § 4, effective May 5.

25.5-3-207. Program funding - comprehensive primary and preventive care fund - creation - repeal. (Repealed)

Source: L. 2006: (1) and (3) amended, p. 1039, § 9, effective May 25; entire article amended with relocations, p. 1813, § 6, effective July 1. **L. 2007:** (4) added, p. 149, § 9, effective March 22. **L. 2008:** (4)(b) amended, p. 276, § 7, effective March 31. **L. 2009:** (3) amended, (SB 09-269), ch. 333, p. 1768, § 8, effective June 1. **L. 2010:** (4)(c) added, (HB 10-1323), ch. 35, p. 131, § 4, effective March 22. **L. 2011:** Entire section amended, (SB 11-216), ch. 149, p. 520, § 5, effective May 5.

Editor's note: Subsection (5) provided for the repeal of this section, effective September 15, 2011. (See L. 2011, p. 520.)

PART 3

COMPREHENSIVE PRIMARY CARE SERVICES

Editor's note: This part 3 was added in 2006. It was repealed in 2011 and was subsequently recreated and reenacted in 2012, resulting in the addition, relocation, or elimination

of sections as well as subject matter. For amendments to this part 3 prior to 2011, consult the 2010 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

25.5-3-301. Definitions. As used in this part 3, unless the context otherwise requires:

(1) "Comprehensive primary care" means the basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. "Comprehensive primary care", at a minimum, includes providing or arranging for the provision of the following services on a year-round basis: Primary health care; maternity care, including prenatal care; preventive, developmental, and diagnostic services for infants and children; adult preventive services; diagnostic laboratory and radiology services; emergency care for minor trauma; pharmaceutical services; and coordination and follow-up for hospital care. "Comprehensive primary care" may also include optional services based on a patient's needs. For the purposes of this subsection (1) and subsection (2) of this section, "arranging for the provision" means demonstrating established referral relationships with health care providers for any of the comprehensive primary care services not directly provided by an entity. An entity in a rural area may be exempt from this requirement if it can demonstrate that there are no providers in the community to provide one or more of the comprehensive primary care services.

(2) "Qualified provider" means an entity that provides comprehensive primary care services and that:

(a) Accepts all patients regardless of their ability to pay and uses a sliding fee schedule for payments or that provides comprehensive primary care services free of charge;

(b) Serves a designated medically underserved area or population, as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. sec. 254b, or demonstrates to the state department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;

(c) Has a demonstrated track record of providing cost-effective care;

(d) Provides or arranges for the provision of comprehensive primary care services to persons of all ages; and

(e) Completes initial screening for eligibility for the state medical assistance program, the children's basic health plan, and any other relevant government health care program and referral to the appropriate agency for eligibility determination.

(3) "Uninsured or medically indigent patient" means a patient receiving services from a qualified provider:

(a) Whose yearly family income is below two hundred percent of the federal poverty line; and

(b) Who is not eligible for medicaid, medicare, or any other type of governmental reimbursement for health care costs; and

(c) Who is not receiving third-party payments.

Source: L. 2012: Entire part RC&RE, (HB 12-1203), ch. 5, p. 15, § 1, effective March 1.

25.5-3-302. Annual allocation - primary care services - qualified provider - rules. (1) The state department shall annually allocate the moneys appropriated by the general

assembly to the primary care fund created in section 24-22-117 (2)(b), C.R.S., to all eligible qualified providers in the state who comply with the requirements of subsection (2) of this section. The state department shall allocate the moneys in amounts proportionate to the number of uninsured or medically indigent patients served by the qualified provider. For a qualified provider to be eligible for an allocation pursuant to this section, the qualified provider shall meet either of the following criteria:

(a) The qualified provider is a community health center, as defined in section 330 of the federal "Public Health Service Act", 42 U.S.C. sec. 254b; or

(b) At least fifty percent of the patients served by the qualified provider are uninsured or medically indigent patients, or patients who are enrolled in the medical assistance program, articles 4, 5, and 6 of this title, or the children's basic health plan, article 8 of this title, or any combination thereof.

(2) A qualified provider shall annually submit to the state department information sufficient to establish the provider's eligibility status. A qualified provider, except for a provider specified in paragraph (a) of subsection (1) of this section, shall provide an annual report that includes the total number of patients served, the number of uninsured or medically indigent patients served, and the number of patients served who are enrolled in the medical assistance program, articles 4, 5, and 6 of this title, or the children's basic health plan, article 8 of this title. A community health center specified in paragraph (a) of subsection (1) of this section shall annually provide to the state department the number of uninsured or medically indigent patients served. Each eligible qualified provider shall annually develop and submit to the state department documentation regarding the quality assurance program in place at the provider's facility to ensure that quality comprehensive primary care services are being provided. All qualified providers shall submit to the state department the information required under this section, as specified in rule by the state board. The data regarding the number of patients served shall be verified by an outside entity. For purposes of this part 3, the number of patients served is the number of unduplicated users of health care services and is not the number of visits by a patient.

(3) The state department shall make annual direct allocations of the total amount of money annually appropriated by the general assembly to the primary care fund pursuant to section 24-22-117 (2)(b), C.R.S., minus three percent for the administrative costs of the program, to all eligible qualified providers. An eligible qualified provider's allocation shall be based on the number of uninsured or medically indigent patients served by the provider in proportion to the total number of uninsured or medically indigent patients served by all eligible qualified providers in the previous calendar year. The state department shall establish a schedule for allocating the moneys in the primary care fund for eligible qualified providers. The disbursement of moneys in the primary care fund to eligible qualified providers under this part 3 are exempt from the provisions of the "Procurement Code", articles 101 to 112 of title 24, C.R.S.

(4) The state board shall adopt any rules necessary for the administration and implementation of this part 3.

Source: L. 2012: Entire part RC&RE, (HB 12-1203), ch. 5, p. 16, § 1, effective March 1.

25.5-3-303. Consultation. At least annually, the state department shall consult with representatives of federally qualified health centers, school-based health centers, family

residency directors, certified rural health clinics, other qualified providers, and consumer advocates regarding the implementation and administration of the allocation of moneys to qualified providers under this part 3.

Source: L. 2012: Entire part RC&RE, (HB 12-1203), ch. 5, p. 17, § 1, effective March 1.

Cross references: For the definition of "federally qualified health centers" in the federal "Social Security Act", see 42 U.S.C. sec. 1395x.

PART 4

COLORADO DENTAL HEALTH CARE PROGRAM
FOR LOW-INCOME SENIORS

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2016, see section 25.5-3-402 as enacted in section 1 of chapter 314 and section 7 of chapter 314, Session Laws of Colorado 2014. To obtain a copy of the review, once completed, view Colorado Legislative Council's web site. For the short title ("Colorado Dental Health Care Program for Low-income Seniors") and the legislative declaration in SB 14-180, see sections 25.5-3-401 and 25.5-3-402 as enacted in section 1 of chapter 314, Session Laws of Colorado 2014.

25.5-3-401. Short title. This part 4 is known as and may be cited as the "Colorado Dental Health Care Program for Low-income Seniors".

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1358, § 1, effective May 31.

25.5-3-402. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) The purpose of this part 4 is to promote the health and welfare of Colorado low-income seniors by providing access to patient-centered dental care and services to individuals sixty years of age or older whose income and resources are insufficient to meet the costs of such care and thereby support individuals and families to live independently with a good quality of life;

(b) By relocating and reorganizing the "Colorado Dental Care Act of 1977", which provided dental services to certain eligible seniors, the state department can align those dental health care services with adult dental benefits provided through other dental health care programs for seniors and thereby target the resources effectively to low-income seniors who may not qualify for those programs;

(c) The state department shall implement this part 4 through collaboration among various executive departments, agencies, and political subdivisions of the state; private individuals; and organizations, including but not limited to:

(I) The local area agencies on aging;

(II) Community health centers;

(III) Safety-net clinics;

(IV) Private practice dental providers; and

(V) Foundations; and

(d) The state department shall implement this part 4 as a grant program throughout all geographic regions of the state using best practices and experience from other grant programs operated by the state department to provide maximum flexibility to safety-net and private-practice dental providers in order to promote the health and welfare of low-income seniors.

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1358, § 1, effective May 31.

25.5-3-403. Definitions. As used in this part 4, unless the context otherwise requires:

(1) "Advisory committee" means the senior dental advisory committee created in section 25.5-3-406.

(2) "Covered dental care services" are to be defined by rules of the medical services board pursuant to section 25.5-3-404 and include but are not limited to diagnostic, preventive, and restorative care.

(3) "Dental health care services grant" means a grant awarded to a qualified grantee pursuant to section 25.5-3-404.

(4) "Eligible senior" means an adult who is sixty years of age or older and who is economically disadvantaged as specified by rule of the medical services board.

(5) "Program" means the Colorado dental health care program for low-income seniors created pursuant to section 25.5-3-404.

(6) "Qualified grantee" means an entity that can demonstrate that it can provide or arrange for the provision of comprehensive dental and oral care services and may include but is not limited to:

(a) An area agency on aging, as defined in section 26-11-203, C.R.S.;

(b) A community-based organization or foundation;

(c) A federally qualified health center, safety-net clinic, or health district;

(d) A local public health agency; or

(e) A private dental practice.

(7) "Qualified provider" means any person who is licensed to practice dentistry in Colorado or who employs a dentist licensed in Colorado and who is willing to accept reimbursement for covered dental services pursuant to this program.

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1359, § 1, effective May 31.

25.5-3-404. Colorado dental health care program for low-income seniors - rules. (1) (a) There is created in the state department the Colorado dental health care program for low-income seniors to provide covered dental care services for eligible seniors who are not eligible for dental services under medicaid, the old age pension health and medical care program, or private insurance.

(b) To ensure the continuity of dental health care to low-income seniors, the state department and the department of public health and environment shall ensure that any individual who meets, on June 30, 2014, the eligibility requirements for dental services under the "Colorado Dental Care Act of 1977", article 21 of title 25, C.R.S., prior to its repeal, remains eligible for

dental services after June 30, 2014, through the "Colorado Dental Care Act of 1977", medicaid, the old age pension health and medical care fund, or the program.

(2) The state department shall:

(a) In consultation with the advisory committee, develop a grant application under the program consistent with rules of the medical services board;

(b) Accept applications for dental health care services grants from any qualified grantee;

(c) On and after July 1, 2015, award dental health care services grants to qualified grantees to provide covered dental care services to eligible seniors;

(d) Pay dental health care services grants within thirty days after approval by the state department;

(e) Ensure that all eligible seniors have access to services through the program; and

(f) Consider geographic distribution of funds among urban and rural areas in the state when making funding decisions.

(3) (a) Qualified grantees shall:

(I) Submit an application for a dental health care services grant to the state department on the form developed by the state department;

(II) Provide outreach to targeted eligible seniors and dental care providers;

(III) Identify eligible seniors and qualified providers;

(IV) Demonstrate collaboration with community organizations;

(V) Ensure that eligible seniors receive covered dental care services efficiently without duplication of services;

(VI) Maintain records of eligible seniors served, dental care services provided, and moneys spent for a minimum of six years; and

(VII) Distribute grant funds to qualified providers in their service area or directly provide covered dental care services to eligible seniors in their service area.

(b) A qualified grantee may expend no more than seven percent of the amount of its grant for administrative purposes.

(c) A qualified grantee may also be a qualified provider if the person meets the qualifications of a qualified provider.

(4) Following recommendations of the state department and the advisory committee, the medical services board shall adopt rules pursuant to section 24-4-103, C.R.S., governing the program, including but not limited to:

(a) A definition of "economically disadvantaged" for purposes of eligibility;

(b) A description of dental services that may be provided to eligible seniors under the program; except that such services must include but not be limited to oral examination, diagnosis, treatment planning, emergency treatment, prophylaxis, X rays, partial and full dentures, replacement or repair of permanent teeth, removal of permanent teeth, fillings, periodontal treatment, and soft tissue treatment;

(c) Whether to require eligible seniors to make a co-payment and, if so, the circumstances and amount of the co-payment;

(d) A distribution formula for the availability of moneys to each area of the state; and

(e) Procedures, criteria, and standards for awarding dental health care services grants.

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1360, § 1, effective May 31.

25.5-3-405. Program reporting. (1) On or before September 1, 2015, and each September 1 thereafter, each qualified grantee receiving a dental health care services grant shall report to the state department concerning the number of eligible seniors served, the types of dental and oral health services provided, and any other information deemed relevant by the state department.

(2) Notwithstanding the provisions of section 24-1-136 (11)(a)(I), on or before November 1, 2016, and each November 1 thereafter, the state department shall submit a report to the joint budget committee of the general assembly and to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees, on the operation and effectiveness of the program, including an itemization of the department's administrative expenditures in implementing and administering the program and any recommendations for legislative changes to the program.

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1362, § 1, effective May 31. **L. 2017:** (2) amended, (HB 17-1060), ch. 6, p. 16, § 7, effective March 1.

25.5-3-406. Senior dental advisory committee - creation - duties - repeal. (1) (a) There is created in the state department a senior dental advisory committee comprised of eleven members appointed by the executive director as follows:

(I) A member representing the state department;

(II) A dentist in private practice providing dental care to the senior population who represents a statewide organization of dentists;

(III) A dental hygienist providing dental care to seniors;

(IV) A representative of either an agency that coordinates services for low-income seniors or the office in the department of human services responsible for overseeing services to the elderly;

(V) A representative of an organization of Colorado community health centers, as defined in the federal "Public Health Service Act", 42 U.S.C. sec. 254b;

(VI) A representative of an organization of safety-net health providers that are not community health centers;

(VII) A representative of the university of Colorado school of dental medicine;

(VIII) Two consumer advocates;

(IX) A senior who is eligible for services under the program; and

(X) A representative of a foundation with experience in making dental care grants.

(b) Members of the committee shall serve three-year terms. Of the members initially appointed to the advisory committee, the executive director shall appoint six for two-year terms and five for three-year terms. In the event of a vacancy on the advisory committee, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

(c) (I) The executive director shall designate a member to serve as the chair of the advisory committee. The advisory committee shall meet as necessary at the call of the chair.

(II) Members of the advisory committee serve without compensation or reimbursement of expenses.

(III) Pursuant to section 24-18-108.5, C.R.S., a member of the advisory committee shall not perform an official act that may have a direct economic benefit on a business or other undertaking in which the member has a direct or substantial financial interest.

(d) Repealed.

(e) The state department shall provide staff assistance to the advisory committee.

(2) The advisory committee shall:

(a) Advise the state department on the operation of the program;

(b) Make recommendations to the medical services board regarding rules to be promulgated pursuant to section 25.5-3-404, including but not limited to:

(I) Defining covered dental care services;

(II) Whether to require eligible seniors to make a co-payment and, if so, the circumstances and amount of the co-payment;

(III) The distribution formula for the availability of funds to each area of the state;

(IV) Dental health care services grant procedures, criteria, and standards, including preference for qualified grantees who demonstrate collaboration with community organizations such as a local area agency on aging; and

(V) A maximum amount per procedure that can be spent by qualified grantees and qualified providers that shall not be less than the reimbursement schedule adopted by the state board of health pursuant to section 25-21-105, C.R.S., prior to its repeal.

(3) (a) This section is repealed, effective September 1, 2024.

(b) Prior to said repeal, the advisory committee must be reviewed as provided for in section 2-3-1203, C.R.S.

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1362, § 1, effective May 31. **L. 2016:** IP(2)(b) amended, (SB 16-189), ch. 210, p. 773, § 66, effective June 6.

Editor's note: Subsection (1)(d)(II) provided for the repeal of subsection (1)(d), effective July 1, 2016. (See L. 2014, p. 1362.)

COLORADO MEDICAL ASSISTANCE ACT

ARTICLE 4

Colorado Medical Assistance Act -
General Medical Assistance

Editor's note: This article was added with relocations in 2006 containing provisions of some sections formerly located in article 4 of title 26 or in article 1 of this title. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

PART 1

GENERAL PROVISIONS

25.5-4-101. Short title. This article and articles 5 and 6 of this title shall be known and may be cited as the "Colorado Medical Assistance Act".

Source: L. 2006: Entire article added with relocations, p. 1815, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-101 as it existed prior to 2006.

25.5-4-102. Legislative declaration. It is the purpose of the "Colorado Medical Assistance Act" to promote the public health and welfare of the people of Colorado by providing, in cooperation with the federal government, medical and remedial care and services for individuals and families whose income and resources are insufficient to meet the costs of such necessary services and to assist such individuals and families to attain or retain their capabilities for independence and self-care, as contemplated by the provisions of Title XIX of the social security act. The state of Colorado and its various departments, agencies, and political subdivisions are authorized to promote and achieve these ends by any appropriate lawful means, through cooperation with and the utilization of available resources of the federal government and private individuals and organizations.

Source: L. 2006: Entire article added with relocations, p. 1815, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-102 as it existed prior to 2006.

25.5-4-103. Definitions. As used in this article 4 and articles 5 and 6 of this title 25.5, unless the context otherwise requires:

(1) Repealed.

(1.5) "Accountable care collaborative" means a medicaid care delivery system established pursuant to section 25.5-5-419.

(2) "Applicant" means an individual who is seeking an eligibility determination for himself or herself under this article and articles 5 and 6 of this title through an application submission or a transfer from another agency or insurance affordability program.

(3) "Case management services" means services provided by community-centered boards, as defined by section 25.5-10-202, and community mental health centers and community mental health clinics, as defined by section 27-66-101, to assist persons with intellectual and developmental disabilities, as defined by section 25.5-10-202, and persons with mental health disorders, as defined by section 27-65-102 (11.5), by case management agencies, as defined in section 25.5-6-303 (5), providing case management services, as defined in sections 25.5-6-104 (2)(b) and 25.5-6-303 (6), to persons with a disability, persons who are elderly or blind, and long-term care clients, in gaining access to needed medical, social, educational, and other services.

(4) "Categorically needy" means those persons who are eligible for medical assistance under this article and articles 5 and 6 of this title due to their eligibility for one or more of the federal categories of public assistance. A person may be categorically needy and eligible for medical assistance under mandatory provisions as provided under section 25.5-5-101 or may be categorically needy under optional provisions as provided under section 25.5-5-201.

(5) "Clinic services" means those services as defined in section 25.5-5-301.

(6) "Essential person" means a person who meets the requirements of section 26-2-103 (5), C.R.S.

(7) "Home health services" is synonymous with "home health care" and includes the following services provided to an eligible person through a certified home health agency, pursuant to a home health plan of care:

(a) Nursing services;

(b) Home health aide services;

(c) Provision of medical supplies, equipment, and appliances suitable for use in the home;

(d) Physical therapy, occupational therapy, or speech and hearing therapy.

(8) "Hospice care" means services provided by a public agency or private organization, or any subdivision thereof, which entity shall be known as a hospice and shall be primarily engaged in providing care to an individual for whom a certified medical prognosis has been made indicating a life expectancy of six months or less and who has elected to receive such care in lieu of other medical benefits available under this article and articles 5 and 6 of this title.

(9) "Intermediate nursing facility for persons with intellectual and developmental disabilities" means a tax-supported, state-administered intermediate nursing facility, or a distinct part of such facility, which meets the state nursing home licensing standards set forth in section 25-1.5-103 (1)(a)(I), C.R.S., and the requirements in 42 U.S.C. sec. 1396d and which:

(a) Is maintained primarily to provide health-related care on a regular basis for persons with intellectual and developmental disabilities, as defined in section 27-10.5-102 (11), C.R.S., and section 25.5-10-202, C.R.S., who do not require the degree of services and supports that a hospital or skilled nursing facility can provide but who, because of their mental or physical condition, require care and services above the level of room and board, which can be made available only through institutional facilities; and

(b) May provide care which includes but is not limited to moderate assistance or therapy functions; occasional direction, supervision, or therapy; moderate assistance or therapy for loss of mobility; routine, nonskilled nursing services; and monitoring of the drug regimen.

(10) "Legal immigrant" means an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the immigration and naturalization service, or any successor agency, as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by the immigration and naturalization service, or any successor agency.

(11) "Liable" or "liability" means the legal liability of a third party, either by reason of judgment, settlement, compromise, or contract, as the result of negligent acts or other wrongful acts or otherwise for all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of medical assistance.

(12) "Managed care system" means a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care.

(13) "Medical assistance" means payment on behalf of recipients eligible for and enrolled in the program established in articles 4, 5, and 6 of this title, which is funded through Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396u-1, to enrolled providers under the state medical assistance program of medical care, services, goods, and devices rendered or provided to recipients under this article and articles 5 and 6 of this title, and other related payments, pursuant to this article and articles 5 and 6 of this title and the rules of the state department.

(13.5) "Modified adjusted gross income" or "MAGI" means an amount of income, as determined pursuant to section 1902 (e)(14) of the federal "Social Security Act", that is used to establish eligibility for medical assistance.

(14) "Nursing facility" means a facility, or a distinct part of a facility, that meets the state nursing home licensing standards in section 25-1.5-103 (1)(a)(I), is maintained primarily for the care and treatment of inpatients under the direction of a physician, and meets the requirements in 42 U.S.C. sec. 1396r for certification as a qualified provider of nursing facility services. The patients in such a facility require supportive, therapeutic, or compensating services and the availability of a licensed nurse for observation or treatment on a twenty-four-hour basis. Nursing care may include terminal care; extensive assistance or therapy in the activities of daily living; continual direction, supervision, or therapy; extensive assistance or therapy for loss of mobility; nursing assessment and services that involve assessment of the total needs of the patient, planning of patient care, and observing, monitoring, and recording the patient's response to treatment; and monitoring, observing, and evaluating the drug regimen. "Nursing facility" includes private, nonprofit, or proprietary intermediate nursing facilities for persons with intellectual and developmental disabilities.

(15) "Overpayment" means the amount paid by an agency administering the medical assistance program to an enrolled provider under the state medical assistance program participating in the program, which amount is in excess of the amount that is allowable for services furnished and which is required by Title XIX of the social security act to be refunded to the appropriate medicaid agencies.

(16) "Patient personal needs trust fund" means any fund or account established by the nursing care facility or intermediate care facility or its agents, employees, or designees to manage the personal needs funds of the facility's patients.

(17) "Personal needs funds" means moneys received by any person admitted to a nursing care facility or intermediate care facility, which moneys are received by said person to purchase necessary clothing, incidentals, or other personal needs items which are not reimbursed by any federal or state program, or items of value, which moneys or items of value are in any way surrendered to the management or control of said facility, its agents, employees, or designees.

(18) "Pilot program", as used in section 25.5-5-319, means the family planning pilot program established in section 25.5-5-319, which is carried out by all medicaid providers who provide family planning services and which shall be repealed, effective July 1 five years after the issuance of the federal waiver or July 1 in the year in which the waiver is terminated, whichever occurs first.

(19) (a) "Provider" means any person, public or private institution, agency, or business concern providing medical care, services, or goods authorized under this article and articles 5 and 6 of this title and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods and enrolled under the state medical assistance program. These services must be provided and goods must be dispensed only if performed, referred, or ordered by a doctor of medicine or a doctor of osteopathy. Services of dentists, podiatrists, and optometrists or services provided by a school district under section 25.5-5-318 need not be referred or ordered by a doctor of medicine or a doctor of osteopathy.

(b) "Provider" includes a laboratory certified under the federal "Clinical Laboratories Improvement Act of 1967", as amended, 42 U.S.C. sec. 263a, to perform high complexity testing.

(19.5) "Psychiatric residential treatment facility" means a facility that is licensed as a residential child care facility, as defined in section 26-6-102 (33), C.R.S., that is not a hospital, and that provides inpatient psychiatric services for individuals who are less than twenty-one years of age under the direction of a physician licensed pursuant to article 36 of title 12, C.R.S., and that meets any other requirement established in rule by the state board.

(20) "Qualified alien" shall have the meaning ascribed to that term in section 431 (b) of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended.

(21) "Recipient" means any person who has been determined eligible to receive benefits under this article and articles 5 and 6 of this title, whose need for medical care has been professionally established, and for whose care less than full payment is available through the legal obligation of a contractor, public or private, to pay for or provide such care.

(22) "Recovery" or "amount recovered" means the amount payable to the applicant or recipient or his heirs, assigns, or legal representatives as the result of any liability of a third party.

(23) "Rehabilitative services" means any medical or remedial services recommended by a physician which may reduce physical or mental disability and which may improve functional level.

(24) "Resident" means any individual who is living, other than temporarily, within the state. "Resident" includes any unemancipated child whose parent, or other person entitled to custody, lives within the state. The state board shall adopt rules for making this determination. Temporary absences from the state shall not cause an individual to lose his status as a resident of this state.

(25) "Social security act" means the federal "Social Security Act" and amendments thereto.

(25.5) "State university teaching hospital" means a hospital licensed or certified pursuant to section 25-1.5-103 (1)(a), C.R.S.:

(a) That provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education as defined in section 23-18-102 (10), C.R.S.; and

(b) In which more than fifty percent of its credentialed physicians are members of the faculty at a state institution of higher education as defined in section 23-18-102 (10), C.R.S.

(26) "Third party" means an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of medical assistance.

(27) "Title XIX" means Title XIX of the social security act, as amended, administered by the federal department of health and human services, or any successor agency, and includes amendments thereto and other federal social security laws replacing said title, in whole or in part.

(28) "Transitional medicaid" means the medical assistance provided to recipients eligible pursuant to section 25.5-5-101 (1)(b).

Source: L. 2006: (19.5) added, p. 1202, § 1, effective May 26; entire article added with relocations, p. 1815, § 7, effective July 1; (3) amended, p. 1389, § 18, effective August 7. **L. 2007:** (19.5) amended, p. 2043, § 74, effective June 1. **L. 2008:** (25.5) added, p. 1184, § 2,

effective May 22. **L. 2010:** (3) amended, (SB 10-175), ch. 188, p. 800, § 65, effective April 29. **L. 2011:** (10) amended, (HB 11-1303), ch. 264, p. 1168, § 65, effective August 10. **L. 2013:** (3), IP(9), and (9)(a) amended, (HB 13-1314), ch. 323, p. 1808, § 44, effective March 1. **L. 2014:** (1) repealed, (2) amended, and (13.5) added, (SB 14-067), ch. 12, p. 109, § 1, effective February 27. **L. 2016:** (19.5) amended, (SB 16-189), ch. 210, p. 773, § 67, effective June 6. **L. 2017:** IP(1) and (14) amended, (HB 17-1046), ch. 50, p. 159, § 13, effective March 16; IP amended and (1.5) added, (HB 17-1353), ch. 231, p. 895, § 1, effective May 23; IP and (3) amended, (SB 17-242), ch. 263, p. 1327, § 198, effective May 25; IP and IP(7) amended, (SB 17-091), ch. 321, p. 1731, § 1, effective June 5.

Editor's note: (1) This section is similar to former § 26-4-103 as it existed prior to 2006.

(2) Subsection (3) was originally numbered as § 26-4-103 (2), and the amendments to it in House Bill 06-1277 were harmonized with subsection (3) as it appeared in Senate Bill 06-219.

(3) Subsection (19.5) was enacted as § 26-4-103 (13.6) in House Bill 06-1395 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-4-104. Program of medical assistance - single state agency. (1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is hereby designated as the single state agency to administer such program in accordance with Title XIX and this article and articles 5 and 6 of this title. Such program shall not be required to furnish recipients under sixty-five years of age the benefits that are provided to recipients sixty-five years of age and over under Title XVIII of the social security act; but said program shall otherwise be uniform to the extent required by Title XIX of the social security act.

(2) The state department may review any decision of a county department and may consider any application upon which a decision has not been made by the county department within a reasonable time to determine the propriety of the action or failure to take timely action on an application for medical assistance. The state department shall make such additional investigation as it deems necessary and shall, after giving the county department an opportunity to rebut any findings or conclusions of the state department that the action or delay in taking action was a violation of or contrary to state department rules, make such decision as to the granting of medical benefits and the amount thereof as in its opinion is justifiable pursuant to the provisions of this article and articles 5 and 6 of this title and the rules of the state department. Applicants or recipients affected by such decisions of the state department, upon request, shall be given reasonable notice and opportunity for a fair hearing by the state department.

Source: L. 2006: Entire article added with relocations, p. 1819, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-104 as it existed prior to 2006.

25.5-4-105. Federal requirements under Title XIX. Nothing in this article or articles 5 and 6 of this title shall prevent the state department from complying with federal requirements for a program of medical assistance in order for the state of Colorado to qualify for federal funds under Title XIX of the social security act and to maintain a program within the limits of available appropriations.

Source: L. 2006: Entire article added with relocations, p. 1820, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-105 as it existed prior to 2006.

25.5-4-106. Cooperation with federal government - grants-in-aid - cooperation with the department of human services in delivery of services. (1) The state department shall be the sole state agency for administering the state plans for health and medical assistance pursuant to this title, and any other state plan relating to medical assistance that requires state action which is not specifically the responsibility of some other state department, division, section, board, commission, or committee under the provisions of federal or state law.

(2) (a) The state department may accept on behalf of the state of Colorado the provisions and benefits of acts of congress designed to provide funds or other property for particular medical assistance within the state, which funds or other property are designated for such purposes within the function of the state department, and may accept on behalf of the state any offers which have been or may from time to time be made of funds or other property by any persons, agencies, or entities for particular medical assistance activities within the state, which funds or other property are designated for such purposes within the function of the state department; but, unless otherwise expressly provided by law, such acceptance shall not be manifested unless and until the state department has recommended such acceptance to and received the written approval of the governor and the attorney general. Such approval shall authorize the acceptance of the funds or property in accordance with the restrictions and conditions for the purpose for which funds or property are intended.

(b) The state treasurer is designated as ex officio custodian of all medical assistance funds received by the state from the federal government and from any other source, if the approval provided for in paragraph (a) of this subsection (2) has been obtained.

(c) The state treasurer shall hold each such fund separate and distinct from state funds and is authorized to make disbursements from such funds for the designated purpose or for administrative costs, which may be provided in such grants upon warrants issued by the state controller upon the voucher of the state department.

(3) The state department shall cooperate with the federal department of health and human services and other federal agencies in any reasonable manner, in conformity with the laws of this state, which may be necessary to qualify for federal financial participation, including the preparation of state plans, the making of reports in such form and containing such information as any federal agency may from time to time require, and the compliance with such provisions as the federal government may from time to time find necessary to assure the correctness and verification of the reports.

(4) The rules of the state department may include provisions to accommodate requirements of contracts entered into between the state department and the federal department of health and human services, or any successor agency, for studies of guaranteed annual income

or other forms of income maintenance research projects; and for such purpose, the requirements of this title as to eligibility for medical assistance shall not apply for the term of and in accordance with the contract for such purpose.

(5) The state department is responsible for administering the delivery of medical assistance by county departments of social services or any other public or private entities participating in the delivery of medical assistance pursuant to this article and articles 5 and 6 of this title.

Source: L. 2006: Entire article added with relocations, p. 1820, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-110 as it existed prior to 2006.

25.5-4-107. Retaliation definition. (1) For purposes of any rules promulgated by the state department or state board and any action taken by the state department against any person, "retaliation" means taking any of the following actions against a recipient or someone acting on behalf of a recipient after the recipient or someone acting on behalf of the recipient files a complaint concerning services provided or not provided to the recipient:

(a) Indicating to a recipient that the recipient cannot have an advocate, family member, or other authorized representative assist the recipient; or

(b) (I) An adverse action that negatively affects a recipient's level of eligibility for or receipt of services received at the time of the complaint without verification of a change in the recipient's income, resources, or health care needs that justifies the adverse action.

(II) No adverse action shall be taken against a recipient after a complaint has been filed until the recipient is notified of the proposed action, informed of the reason for the proposed action, and provided an opportunity to appeal the proposed action.

(2) "Retaliation" shall not include instances where a recipient is not eligible for a service or program or where a provider documents a problem with a recipient and shares the documentation with the recipient or a third party prior to the recipient filing a complaint.

Source: L. 2006: Entire section added, p. 1019, § 1, effective May 25.

Editor's note: This section was originally numbered as § 26-4-402.5 in House Bill 06-1211. Section 2 of the act provided for the renumbering and relocation of § 26-4-402.5 to this section. (See L. 2006, p. 1020.)

PART 2

ADMINISTRATION

25.5-4-201. Cash system of accounting - financial administration of medical services premiums - medical programs administered by department of human services - federal contributions - rules. (1) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the state department relating to the financial administration of any nonadministrative expenditure that qualifies for federal financial participation under Title XIX of

the federal "Social Security Act", except for expenditures under the program for the medically indigent, article 3 of this title.

(1.5) (a) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, for the contributions required by 42 U.S.C. sec. 1396u-5 (c).

(b) The contributions required by 42 U.S.C. sec. 1396u-5 (c) shall be made in the manner required by the federal centers for medicare and medicaid services, or any successor agency. Nothing in this paragraph (b) shall require the state department to make the contribution before the contribution is due.

(2) The executive director shall promulgate rules to identify the programs utilizing the cash system of accounting.

Source: L. 2006: Entire section amended, p. 917, § 1, effective May 11; entire article added with relocations, p. 1821, § 7, effective July 1. **L. 2007:** (1.5) added, p. 465, § 2, effective July 1. **L. 2009:** (1.5) amended, (SB 09-265), ch. 205, p. 935, § 1, effective May 1.

Editor's note: (1) This section is similar to former § 26-4-110.7 as it existed prior to 2006.

(2) Amendments to section 26-4-110.7 by Senate Bill 06-129 were harmonized with this section as it appeared in Senate Bill 06-219.

25.5-4-202. Comprehensive plan for other services and benefits. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1821, § 7, effective July 1. **L. 2016:** Entire section repealed, (HB 16-1081), ch. 22, p. 52, § 6, effective August 10.

Editor's note: This section is similar to former § 26-4-107 as it existed prior to 2006.

25.5-4-203. Advisory council established. There is hereby created a state medical assistance and services advisory council, referred to in this article as the "advisory council", consisting of sixteen members. Ex officio members of the advisory council shall be the executive directors of the state department and the department of health or their successors in function. The remaining members of the advisory council shall be appointed by the governor and shall be chosen by him to represent the various areas of medical services and the public. Specifically included shall be two members who are doctors of medicine licensed in this state, one doctor of osteopathy licensed in this state, one dentist licensed in this state, one optometrist licensed in this state, one owner or operator of a licensed nursing facility in this state, one member who shall represent licensed hospitals in this state, one pharmacist licensed in this state, one professional nurse licensed in this state, one member who has provided home health care services for three years, and three members who are not directly associated with the areas of medical services to represent the public. The remaining member may represent any other area of medical services not specifically enumerated but shall not be limited thereto. Members shall serve at the pleasure of the governor and shall receive no compensation but shall be reimbursed for their actual and necessary expenses. The advisory council shall advise the state department on the provision of health and medical care services to recipients.

Source: L. 2006: Entire article added with relocations, p. 1822, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-108 as it existed prior to 2006.

25.5-4-204. Automated medical assistance administration. (1) The general assembly hereby finds and declares that the agency responsible for the administration of the state's medical assistance program would be more effective in its ability to streamline administrative functions of program administrators and providers under the program through the implementation of an automated system that will provide for the following:

(a) Electronic claim submittals;

(b) Online eligibility determinations;

(c) Electronic remittance statements;

(d) Electronic fund transfers; and

(e) Automation of other administrative functions associated with the medical assistance program.

(2) Therefore, the general assembly declares that it is appropriate to enact legislation, as set forth in subsection (3) of this section, that authorizes the state department to develop and implement an automated system for processing claims and payments under the medical assistance program, as well as for other administrative functions associated with the program.

(3) The executive director of the state department shall develop and implement an automated system through which medical assistance claims and payments and eligibility determinations or other related transactions may be processed. The system shall provide for the use of automated electronic technologies. The automated system may be implemented in phases if deemed necessary by the executive director. The automated system shall be implemented only after the executive director determines that:

(a) Technology is available and proven to perform satisfactorily in a production environment;

(b) Adequate financing is available to facilitate the implementation and maintenance of the system. Financing may include, but is not limited to, federal funds, appropriations from the general fund, provider transaction fees, or any other financing mechanisms which the state department may impose, and grants or contributions from public or private entities.

(c) The system has been successfully installed and fully tested; and

(d) Adequate provider training has been provided for an orderly implementation.

Source: L. 2006: Entire article added with relocations, p. 1822, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-403.7 as it existed prior to 2006.

25.5-4-205. Application - verification of eligibility - demonstration project - rules. (1) (a) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for medicaid benefits at the same time they determine eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and hospitals, a

hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4)(f), C.R.S., and other medical assistance sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine presumptive eligibility. When the state department determines that it is necessary to designate an additional medical assistance site, the state department shall notify the county in which the medical assistance site is located that an additional medical assistance site has been designated. Any person who is determined to be eligible pursuant to the requirements of this article and articles 5 and 6 of this title shall be eligible for benefits until such person is determined to be ineligible. Upon determination that any person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason therefor. When an applicant is found ineligible for medical assistance eligibility programs, the applicant's application data and verifications shall be automatically shared with the state insurance marketplace through a system interface. Separate determination of eligibility and formal application for benefits under this article and articles 5 and 6 of this title for persons eligible as provided in sections 25.5-5-101 and 25.5-5-201 shall be made in accordance with the rules of the state department.

(a.5) Repealed.

(a.7) As part of the medicaid eligibility modernization, the department is authorized to create a universal application for single point of entry for home- and community-based services waivers for children.

(b) The state department shall develop training safeguards to prevent actions taken by staff of medical assistance sites from affecting food and cash assistance eligibility.

(2) (a) Any married couple, at the beginning of a continuous period of institutionalization of one spouse, may request the county department to assess and document the total value of the resources of the couple, if the couple supplies to the county department the necessary information and documentation which is needed to make such an assessment.

(b) Any assessment prepared by the county department and provided to a couple shall contain a procedure for appealing any determinations which have been made.

(c) If a request for assessment and documentation is not part of an application for medical assistance, the county department may establish a fee not exceeding the reasonable expenses of the county department of providing and documenting such assessment.

(3) (a) The state department shall promulgate rules to simplify the processing of applications in order that medical benefits are furnished to recipients as soon as possible, including rules that:

(I) Provide for initial processing of applications and determination of eligibility for medical assistance only at locations other than the county departments, at locations used for processing applications for the Colorado works program, or at the location used by the private service contractor that administers the children's basic health plan for determining eligibility of children for the plan; and

(II) May make provision for the payment of medical benefits for a period not to exceed three months prior to the date of application in cases where the applicant did not make application prior to his or her need for said medical benefits.

(b) (I) The state department shall promulgate rules that:

(A) To the extent authorized under federal law, require an applicant to state only the applicant's income and require the state department to verify the applicant's income through federally approved electronic data sources; except that, if electronic data is not available, or the information obtained from an electronic data source is not reasonably compatible with information provided by or on behalf of an applicant, the rules shall require an individual to provide documentation in order to verify the applicant's income; and

(B) Require the state department at least annually to verify a recipient's income eligibility at reenrollment through federally approved electronic data sources and, if the recipient meets all eligibility requirements, permit the recipient to remain enrolled in the program. The rules shall only require an individual to provide documentation verifying income if electronic data is not available, or the information obtained from electronic data sources is not reasonably compatible with information provided by or on behalf of an applicant.

(C) and (D) (Deleted by amendment, L. 2009, (SB 09-292), ch. 369, p. 1974, § 96, effective August 5, 2009.)

(I.5) (A) If the state department determines that a recipient was not eligible for medical benefits solely based upon the recipient's income after the recipient had been determined to be eligible based upon electronic data obtained through a federally approved electronic data source, the state department shall not pursue recovery from a county department for the cost of medical services provided to the recipient, and the county department is not responsible for any federal error rate sanctions resulting from such determination.

(B) Notwithstanding any other provision in this paragraph (b), for applications that contain self-employment income, the state department shall not implement this paragraph (b) until it can verify self-employment income through federally approved electronic data sources as authorized by rules of the state department and federal law.

(II) Repealed.

(c) Adequate safeguards shall be established by the state department to ensure that only eligible persons receive benefits under this article and articles 5 and 6 of this title.

(d) (I) In addition, an applicant who is eighteen years of age or older shall be required to supply a form of personal photographic identification either by providing a valid Colorado driver's license or a valid identification card issued by the department of revenue pursuant to section 42-2-302, C.R.S. The state department may adopt rules that exempt applicants from the requirement of supplying a form of personal photographic identification if the requirement causes an unreasonable hardship or if the requirement is in conflict with federal law.

(II) The state department shall also adopt rules that allow for assistance to be provided until the applicant is able to obtain or qualify for a driver's license or identification card; however, a county department or an entity designated by the state department pursuant to subsection (1) of this section is not required to pursue recovery of assistance from an applicant who fails, upon recertification, to meet the photographic identification requirement.

(e) (I) In collaboration with and to augment the state department's efforts to simplify eligibility determinations for benefits under the state medical assistance program and the children's basic health plan, the state department shall establish a process so that a recipient, enrollee, or the parent or guardian of a recipient or enrollee may apply for reenrollment either over the telephone or through the internet.

(II) (A) Subject to receipt of federal authorization and spending authority, the state department may implement a pilot program that allows a limited number of recipients or

enrollees to apply for reenrollment either over the telephone or through the internet during a transition to a process that will serve recipients and enrollees statewide. The pilot program shall not serve as a replacement for a statewide process.

(B) Notwithstanding any other provision in this paragraph (e), the state department shall not implement this paragraph (e) until it can verify the eligibility of a recipient or enrollee over the telephone or through the internet as authorized by rules of the state department and federal law.

(C) Notwithstanding any other provision in this paragraph (e), the state department shall not implement or administer any portion of this paragraph (e) until spending authority has been received in the general appropriation act or any supplemental appropriation and shall only implement and administer this paragraph (e) to the extent of such spending authority.

(III) The state department may solicit and accept gifts, grants, and donations from public or private sources for the development or implementation of reenrollment either over the telephone or through the internet process described in this paragraph (e); except that the state department may not accept a gift, grant, or donation that is subject to conditions that are inconsistent with this paragraph (e) or any other law. Any gifts, grants, or donations received by the state department shall be transmitted to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund created pursuant to section 25.5-1-109.

(4) (a) By signing an application for medical assistance, a person assigns to the state department, by operation of law, all rights the applicant may have to medical support or payments for medical expenses from any other person on the applicant's own behalf or on behalf of any other member of the applicant's family for whom application is made. For purposes of this subsection (4), an assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant meets the requirements of subsection (3) of this section and shall remain in effect so long as an individual is eligible for and receives medical assistance benefits. The application shall contain a statement explaining this assignment.

(b) An applicant for medical benefits upon initial application and each redetermination shall disclose any third party who may be responsible for the payment of medical expenses on behalf of the applicant or any other member of the applicant's family for whom application is made. As part of its medicaid eligibility modernization, the state department shall require the county department or other entity designated to accept applications for medical benefits to enter the third-party information into the automated system developed pursuant to section 25.5-4-204.

(5) (a) The state department shall not pursue recovery from a county for the cost of medical services provided to a person who has been incorrectly determined eligible for medical assistance by that county or any other entity.

(b) (Deleted by amendment, L. 2008, p. 2024, § 1, effective June 3, 2008.)

Source: L. 2006: (1)(a.5) added, p. 1592, § 2, effective June 2; entire article added with relocations, p. 1823, § 7, effective July 1. **L. 2008:** (3) and (5)(b) amended, p. 2024, § 1, effective June 3. **L. 2009:** (3)(e) added, (HB09-1020), ch. 298, p. 1595, § 1, effective May 21; (3)(b)(I)(C) and (3)(B)(I)(D) amended and (3)(b)(I.5) added, (SB 09-292), ch. 369, p. 1974, § 96, effective August 5. **L. 2010:** (4) amended, (SB 10-002), ch. 366, p. 1727, § 3, effective June 7; (1)(a.7) added, (HB 10-1041), ch. 25, p. 100, § 1, effective August 11. **L. 2012:** (3)(b)(I)(A), (3)(b)(I)(B), and (3)(b)(I.5)(A) amended, (HB 12-1120), ch. 27, p. 108, § 25, effective June 1. **L.**

2014: (1)(a), (3)(b)(I)(A), (3)(b)(I)(B), (3)(b)(I.5), and (3)(d)(II) amended, (SB 14-067), ch. 12, p. 109, § 2, effective February 27.

Editor's note: (1) This section is similar to former § 26-4-106 as it existed prior to 2006.

(2) Subsection (1)(a.5) was enacted as § 26-4-106 (1)(b.5) in House Bill 06-1270 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

(3) Subsection (3)(b)(II)(B) provided for the repeal of subsection (3)(b)(II), effective July 1, 2009. (See L. 2008, p. 2024.)

(4) Subsection (1)(a.5)(VIII) provided for the repeal of subsection (1)(a.5), effective July 1, 2010. (See L. 2006, p. 1592.)

(5) The effective date for amendments to subsections (3)(b)(I)(A), (3)(b)(I)(B), and (3)(b)(I.5)(A) of this section by House Bill 12-1120 (chapter 27, Session Laws of Colorado 2012) was changed from August 8, 2012, to June 1, 2012, by House Bill 12S-1002 (First Extraordinary Session, chapter 2, p. 2432, Session Laws of Colorado 2012.)

Cross references: (1) For the legislative declaration contained in the 2006 act enacting subsection (1)(a.5), see section 1 of chapter 320, Session Laws of Colorado 2006.

(2) For the legislative declaration in the 2010 act amending subsection (4), see section 1 of chapter 366, Session Laws of Colorado 2010.

25.5-4-205.5. Confined persons - suspension of benefits. (1) For purposes of this section, unless the context otherwise requires, "confined person" means a person who is:

(a) An inmate confined to a correctional institution operated by or under contract with the department of corrections;

(b) Confined in a jail;

(c) Committed to a juvenile commitment facility;

(d) Committed to a department of human services facility pursuant to part 1 of article 8 of title 16, C.R.S.; or

(e) A patient placed in a department of human services facility pursuant to court order or certification.

(2) Notwithstanding any other provision of law, a person who, immediately prior to becoming a confined person, was a recipient of medical assistance pursuant to this article 4 or article 5 or 6 of this title 25.5 remains eligible for medical assistance while a confined person; except that no medical assistance may be furnished pursuant to this article 4 or article 5 or 6 of this title 25.5 while the person is a confined person unless federal financial participation is available for the cost of the assistance, including but not limited to juveniles held in a facility operated by or under contract to the division of youth services established pursuant to section 19-2-203 or the department of human services. Once a person is no longer a confined person, the person continues to be eligible for receipt of medical benefits pursuant to this article 4 or article 5 or 6 of this title 25.5 until the person is determined to be ineligible for the receipt of the assistance. To the extent permitted by federal law, the time during which a person is a confined person is not included in any calculation of when the person must recertify his or her eligibility for medical assistance pursuant to this article 4 or article 5 or 6 of this title 25.5.

Source: L. 2008: Entire section added, p. 903, § 1, effective May 20. **L. 2017:** (2) amended, (HB 17-1329), ch. 381, p. 1983, § 59, effective June 6.

25.5-4-206. Reimbursement to counties - costs of administration. The state department shall reimburse the county departments for costs of administration incurred by the counties under this article and articles 5 and 6 of this title in accordance with the provisions of section 26-1-122 (5), C.R.S.

Source: L. 2006: Entire article added with relocations, p. 1825, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-411 as it existed prior to 2006.

25.5-4-207. Appeals - rules - applicability. (1) (a) (I) If an application for medical assistance is not acted upon within a reasonable time after filing of the same, or if an application is denied in whole or in part, or if medical assistance benefits are suspended, terminated, or modified, the applicant or recipient, as the case may be, may appeal to the state department in the manner and form prescribed by the rules of the state department. Except as permitted under federal law, state department rules must provide for at least a ten-day advance notice before the effective date of any suspension, termination, or modification of medical assistance. The county or designated service agency shall notify the applicant or recipient in writing of the basis for the county's decision or action and shall inform the applicant or recipient of the right to a county or service agency conference under the dispute resolution process described in paragraph (b) of this subsection (1) and of the right to a state-level appeal and the process for appeal.

(II) The applicant or recipient has sixty days after the date of the notice to file an appeal. If the recipient files an appeal prior to the effective date of the intended action, existing medical assistance benefits must automatically continue unchanged until the appeal process is completed, unless the recipient requests in writing that medical assistance benefits not continue during the appeal process; except that, to the extent authorized by federal law, the state department rules may permit existing medical assistance benefits to continue until the appeal process is completed even if the recipient's appeal is filed after the effective date of the intended action. The state department shall promulgate rules consistent with federal law that prescribe the circumstances under which the county or designated service agency may continue benefits if an appeal is filed after the effective date of the intended action. At a minimum, the rules must allow for continuing benefits when the recipient's health or safety is impacted, the recipient was not able to timely respond due to the recipient's disability or employment, the recipient's caregiver was unavailable due to the caregiver's health or employment, or the recipient did not receive the county's or designated service agency's notice prior to the effective date of the intended action.

(III) Either prior to appeal or as part of the filing of an appeal, the applicant or recipient may request the dispute resolution process described in paragraph (b) of this subsection (1) through the county department or service delivery agency.

(b) Every county department or service delivery agency shall adopt procedures for the resolution of disputes arising between the county department or the service delivery agency and any applicant for or recipient of medical assistance. Such procedures are referred to in this section as the "dispute resolution process". Two or more counties may jointly establish the dispute resolution process. The dispute resolution process must be consistent with rules

promulgated by the state board pursuant to article 4 of title 24, C.R.S. The dispute resolution process shall include an opportunity for all clients to have a county conference, upon the client's request, and such requirement may be met through a telephonic conference upon the agreement of the client and the county department. The dispute resolution process need not conform to the requirements of section 24-4-105, C.R.S., as long as the rules adopted by the state board include provisions specifically setting forth expeditious time frames, notice, and an opportunity to be heard and to present information. If the dispute is resolved through the county or service delivery agency's dispute resolution process and the applicant or recipient has already filed an appeal, the county shall inform the applicant or recipient of the process for dismissing the appeal.

(c) The state board shall adopt rules setting forth what other issues, if any, may be appealed by an applicant or recipient to the state department. A hearing need not be granted when either state or federal law requires or results in a reduction or deletion of a medical assistance benefit unless the applicant or recipient is arguing that his or her case does not fit within the parameters set forth by the change in the law. In notifying the applicant or recipient that an appeal is being denied because of a change in state or federal law, the state's notice must inform the applicant or recipient that further appeal should be directed to the appropriate state or federal court.

(d) Upon receipt of an appeal, the office of administrative courts shall give the appellant at least ten days' notice of the hearing date and an opportunity for a fair hearing in accordance with the rules of the state department. The fair hearing must comply with section 24-4-105, C.R.S., and the state department's administrative law judge shall preside.

(d.5) (I) At the commencement of a hearing that concerns the termination or reduction of an existing benefit, the state department's administrative law judge shall review the legal sufficiency of the notice of action from which the recipient is appealing. If the administrative law judge determines that the notice is legally insufficient, the administrative law judge shall inform the appellant that the termination or reduction may be set aside on the basis of insufficient notice without proceeding to a hearing on the merits. The appellant may affirmatively waive the defense of insufficient notice and agree to proceed with a hearing on the merits or may ask the administrative law judge to decide the appeal on the basis of his or her finding that the notice is legally insufficient. The administrative law judge shall also inform the appellant that the state department may issue legally sufficient notice in the future and that the state department may seek recoupment of benefits if a basis for denial or reduction of benefits is subsequently determined.

(II) This subsection (1)(d.5) applies to hearings conducted on and after January 1, 2018.

(e) The appellant shall have an opportunity to examine all applications and pertinent records concerning the appellant that constitute a basis for the denial, suspension, termination, or modification of medical assistance benefits. The person or persons involved in the decision denying, suspending, terminating, or modifying medical assistance benefits or, if the person or persons are not reasonably available, a person familiar with the facts underlying the basis for the decision, shall be available for cross-examination if requested by the appellant.

(2) All decisions of the state department shall be binding upon the county department involved and shall be complied with by such county department.

Source: L. 2006: Entire article added with relocations, p. 1825, § 7, effective July 1. **L. 2016:** (1) amended, (HB 16-1277), ch. 198, p. 698, § 1, effective September 1. **L. 2017:** (1)(d.5) added, (HB 17-1126), ch. 123, p. 427, § 1, effective April 6.

Editor's note: This section is similar to former § 26-4-402 as it existed prior to 2006.

25.5-4-208. County duties - transitional medicaid. County departments shall assist families in completing the reporting requirements for transitional medicaid. This shall include informing families of the transitional medicaid eligibility requirements and the required reporting calendar.

Source: L. 2006: Entire article added with relocations, p. 1826, § 7, effective July 1. **L. 2014:** Entire section amended, (SB 14-067), ch. 12, p. 116, § 11, effective February 27.

Editor's note: This section is similar to former § 26-4-106.5 as it existed prior to 2006.

25.5-4-209. Payments by third parties - copayments by recipients - review - appeal - children's waiting list reduction fund. (1) (a) Any recipient receiving benefits under this article or article 5 or 6 of this title who receives any supplemental income, available for medical purposes under rules of the state department, or who receives proceeds from sickness, accident, health, or casualty insurance shall apply the supplemental income or insurance proceeds to the cost of the benefits rendered, and the rules may require reports from providers of other payments received by them from or on behalf of recipients.

(b) Subject to any limitations imposed by Title XIX and the requirements set forth in subsection (1)(c) of this section, a recipient must pay at the time of service a portion of the cost of any medical benefit rendered to the recipient or to the recipient's dependents pursuant to this article 4 or article 5 or 6 of this title 25.5, as determined by rules of the state department.

(c) (I) Except as otherwise provided in subsection (1)(c)(II) of this section, on and after January 1, 2018, for pharmacy and for hospital outpatient services, including urgent care centers and facilities and emergency services, the rules of the state department required by subsection (1)(b) of this section must require the recipient to pay:

(A) For pharmacy, at least double the average amount paid by recipients in state fiscal year 2015-16; or

(B) For hospital outpatient services, at least double the amount required to be paid as specified in the rules as of January 1, 2017.

(II) For both pharmacy and hospital outpatient services, the amount required to be paid by the recipient shall not exceed any specified maximum dollar amount allowed by federal law or regulations as of January 1, 2017.

(d) The state department shall evaluate options to exempt individuals who are qualified for institutional care but are instead enrolled in home- and community-based service waivers from the increased payment requirements specified in subsection (1)(c) of this section.

(2) (a) Notwithstanding the provisions of section 26-1-114, C.R.S., the state department is authorized to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available, including the collection of sufficient information from individuals who are eligible for medical assistance to pursue claims against the third parties. The

state department shall collect the information at the time of any determination or redetermination of eligibility for medical assistance. A knowing or willful failure of an individual to provide the information may result in the termination of the individual's eligibility for medical assistance.

(b) A third party, as a condition of doing business in the state, shall:

(I) (A) Provide on a monthly basis to the state department or its business associate eligibility records identifying all persons covered by the third party in a manner prescribed by rule to allow the state department or its business associate to perform an analysis and determine which persons are eligible for medical assistance;

(B) The eligibility record data elements provided by the third party shall be the minimum necessary to achieve a satisfactory data match. The third party shall provide, upon request of the state department or its business associate, additional data elements as needed to confirm eligibility matches as determined by the initial analysis, including, but not limited to, the name, address, and identifying number of the third party's plan.

(II) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the third party for an item or service for which payment has been made under the medical assistance plan to the extent that such service is covered by the third party;

(III) Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service; and

(IV) Agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if:

(A) The claim is submitted by the state within the three-year period beginning on the date that the item or service is furnished; and

(B) Any action by the state to enforce its rights with respect to the claim is commenced within six years after the state's submission of the claim.

(c) The cost to a third party of providing data, including eligibility records, shall be borne by the state department.

(d) A third party that provides data required by the state department, whether confidential or not, shall not be held liable for the provision of such data to the state department or for any use made thereof.

(e) (I) The state department's business associate shall not use, transfer, extract, copy, revise, or store any data required to be provided to the state department and its business associate, including the eligibility records, social security numbers, coverage, nature of coverage, period provided, or any other data elements, for purposes other than:

(A) The identification of persons eligible to receive medical assistance, as defined by section 25.5-1-103 (5);

(B) Cost avoidance;

(C) The remuneration of the state department for services provided or paid for;

(D) Any record retention requirements;

(E) Audit requirements; and

(F) Purposes related to litigation and testimony.

(II) The state department's business associate shall destroy all data once the functions specified in subparagraph (I) of this paragraph (e) have been accomplished.

(f) (I) A Colorado resident shall have a private right of action against the state department's business associate if the business associate negligently uses the data specified in paragraph (e) of this subsection (2) for purposes other than those stated in paragraph (e) of this subsection (2). The right of action shall be enforceable in the courts of Colorado and limited to the actual damages incurred by the individual bringing the action.

(II) A third party may bring an action on behalf of a Colorado resident for injunctive relief against the state department's business associate to prevent the business associate from intentionally using the data for purposes other than those specified in paragraph (e) of this subsection (2).

(g) As used in this section:

(I) "Business associate" shall have the same meaning as provided in 45 CFR 160.103.

(II) "Third party" means a health insurer, self-insured plan, group health plan as defined in 29 U.S.C. sec. 1167 (1), service benefit plan, managed care organization, pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(3) (a) The rights assigned by a recipient of medical assistance to the state department pursuant to section 25.5-4-205 (4) shall include the right to appeal an adverse coverage decision by a third party for which the medical assistance program may be responsible for payment, including but not limited to the internal and external reviews provided for in sections 10-16-113 and 10-16-113.5, C.R.S., and a third party's reasonable appeal procedure under state and federal law. The state department or the independent contractor retained pursuant to paragraph (b) of this subsection (3) shall review and, if necessary, may appeal at any level an adverse coverage decision, except an adverse coverage decision relating to medicare, Title XVIII of the federal "Social Security Act", as amended.

(b) The state department shall enter into one or more agreements with an independent contractor to pursue recoveries from third parties pursuant to paragraph (a) of this subsection (3). Any such agreement shall provide that the independent contractor's only compensation shall be a prudent and reasonable percentage of the amount recovered on behalf of the state department as determined by the state department.

(c) (I) An independent contractor retained pursuant to paragraph (b) of this subsection (3) shall maintain a contemporaneous record of the hours of services provided and any costs incurred. When the matter is resolved, the independent contractor shall provide to the state department a statement of the hours of services provided, the amount of costs incurred, the total amount of the contingent fee, and the hourly rate for the services provided. The hourly rate for the services provided shall be determined by dividing the amount of the contingent fee, less the amount of costs incurred, by the number of hours of services provided by the independent contractor. The statement required by this subparagraph (I) shall be available for inspection and copying at reasonable times at the state department.

(II) Compliance with this paragraph (c) does not relieve a contracting attorney of any obligation or legal responsibility imposed by the Colorado rules of professional conduct or any provision of law.

(d) Nothing in this subsection (3) shall be construed to authorize the denial of or delay of payment to a provider by the state department or the delay or interference with the provision of services to a medical assistance recipient.

(e) Repealed.

(4) With respect to programs administered by the state department, the state department shall access available data from the public assistance reporting information system for the purpose of identifying persons who are receiving certain public benefits from other states. The state department shall ensure that duplicate benefits are not being paid improperly to persons identified pursuant to the public assistance reporting information system.

Source: L. 2006: Entire article added with relocations, p. 1826, § 7, effective July 1. **L. 2008:** (1)(a), (2), and (3)(a) amended, p. 1768, § 1, effective June 2. **L. 2010:** (4) added, (SB 10-167), ch. 296, p. 1378, § 5, effective May 26; (3)(a) amended and (3)(e) added, (SB 10-002), ch. 366, p. 1727, § 4, effective June 7. **L. 2017:** (1)(b) amended and (1)(c) and (1)(d) added, (SB 17-267), ch. 267, p. 1447, § 14, effective May 30.

Editor's note: (1) This section is similar to former § 26-4-518 as it existed prior to 2006.

(2) Subsection (3)(e)(IV) provided for the repeal of subsection (3)(e), effective July 1, 2013. (See L. 2010, p. 1727.)

Cross references: (1) For the legislative declaration in the 2010 act amending subsection (3)(a) and adding (3)(e), see section 1 of chapter 366, Session Laws of Colorado 2010.

(2) For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

(3) For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-4-210. Purchase of health insurance for recipients. (1) (a) The state department shall purchase group health insurance for a medical assistance recipient who is eligible to enroll for such coverage if enrollment of such recipient in the group plan would be cost-effective. In addition, the state department may purchase individual health insurance for a medical assistance recipient who is eligible to enroll in a health insurance plan if enrollment of such recipient would be cost-effective to this state. A determination of cost-effectiveness shall be in accordance with federal guidelines established by the secretary of the United States department of health and human services.

(b) Notwithstanding any provision of paragraph (a) of this subsection (1) to the contrary, the state department, in purchasing health insurance for medical assistance recipients who are eligible to enroll for private coverage, shall not purchase such health insurance for more than two thousand individuals.

(2) Enrollment in a group health insurance plan shall be required of recipients for whom enrollment has been determined to be cost-effective as a condition of obtaining or retaining medical assistance. A parent shall be required to enroll a dependent child recipient, but medical assistance for such child shall not be discontinued if a parent fails to enroll the child.

(3) The state department shall pay any premium, deductible, coinsurance, or other cost-sharing obligation required under the group plan for services covered under the state medical assistance plan. In addition, the state department shall pay any premium, deductible, coinsurance, or other cost-sharing obligation required under an individual plan purchased by the state department for a medical assistance recipient pursuant to subsection (1) of this section. Payment of said services shall be treated as payment for medical assistance. Coverage provided by the purchased health insurance plan shall be considered as third-party liability for the purposes of section 25.5-4-209.

(4) Services not available to a recipient under the purchased plan shall be provided to the recipient if such services would otherwise be provided as medical assistance services pursuant to this article or article 5 or 6 of this title. Nothing in this section shall be construed to require that services provided under a group health insurance plan for medical assistance recipients shall be made available to recipients not enrolled in the plan. Enrollment in a group health insurance plan pursuant to this section shall not affect the eligibility of a recipient who otherwise qualifies for medical assistance pursuant to this article or article 5 or 6 of this title.

Source: L. 2006: Entire article added with relocations, p. 1828, § 7, effective July 1. **L. 2010:** (1) amended, (SB 10-167), ch. 296, p. 1378, § 6, effective May 26.

Editor's note: This section is similar to former § 26-4-518.5 as it existed prior to 2006.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-211. Medicaid management information system - appropriation in annual general appropriation act - expenditure in next fiscal year - repeal. (1) Subject to the limitation in subsection (2) of this section, unexpended and unencumbered moneys from an appropriation in the annual general appropriation act to the state department for the medicaid management information system remain available for expenditure by the state department in the next fiscal year without further appropriation. This section applies to appropriations made by the general assembly for fiscal years beginning on and after July 1, 2013.

(2) On or before June 30, 2014, and on or before June 30 of each year thereafter, the state department shall notify the state controller of the amount of the appropriation from the annual general appropriation act for the medicaid management information system for the current fiscal year that the state department needs to remain available for expenditure in the next fiscal year. The state department may not expend more than the amount notified under the authority granted in this section.

(3) (a) On or before January 2, 2015, and on or before January 2 of each year thereafter, the state department shall report to the joint budget committee the amount of the appropriation from the prior fiscal year that remains available for the current fiscal year and the purpose for which the money is being used.

(b) Pursuant to section 24-1-136 (11)(a)(I), this subsection (3) is repealed, effective January 3, 2018.

Source: L. 2013: Entire section added, (HB 13-1281), ch. 205, p. 851, § 1, effective May 11. **L. 2017:** (3) amended, (HB 17-1060), ch. 6, p. 16, § 8, effective March 1.

25.5-4-212. Medicaid client correspondence improvement process - legislative declaration - definition. (1) (a) The general assembly finds and declares that:

(I) Accurate, understandable, timely, informative, and clear correspondence from the state department is critical to the life and health of medicaid recipients, and, in some cases, is a matter of life and death for our most vulnerable populations;

(II) Unclear, confusing, and late correspondence from the state department causes an increased workload for the state, counties administering the medicaid program, and nonprofit advocacy groups assisting clients; and

(III) Government should be a good steward of taxpayers' money, ensuring that it is spent in the most cost-effective manner.

(b) Therefore, the general assembly finds that improving medicaid client correspondence is critical to the health and safety of medicaid clients and will reduce unnecessary confusion that requires clients to call counties and the state department or file appeals.

(2) As used in this section, unless the context otherwise requires, "client correspondence" means any communication, the purpose of which is to provide notice of an approval, denial, termination, or change to an individual's medicaid eligibility; to provide notice of the approval, denial, reduction, suspension, or termination of a medicaid benefit; or to request additional information that is relevant to determining an individual's medicaid eligibility or benefits. "Client correspondence" does not include communications regarding the state department's review of trusts or review of documents or records relating to trusts.

(3) The state department shall improve medicaid client correspondence by ensuring that client correspondence revised or created after January 1, 2018:

(a) Is written using person-first, plain language;

(b) Is written in a format that includes the date of the correspondence and a client greeting;

(c) Is consistent, using the same terms throughout to the extent practicable including commonly used program names;

(d) Is accurately translated into the second most commonly spoken language in the state if a client indicates that this is the client's written language of preference or as required by law;

(e) Includes a statement translated into the top fifteen languages most commonly spoken by individuals in Colorado with limited English proficiency informing an applicant or client how to seek further assistance in understanding the content of the correspondence;

(f) Clearly conveys the purpose of the client correspondence, the action or actions being taken by the state department or its designated entity, if any, and the specific action or actions that the client must or may take in response to the correspondence;

(g) Includes a specific description of any necessary information or documents requested from the applicant or client;

(h) Includes contact information for client questions; and

(i) Includes a specific and plain language explanation of the basis for the denial, reduction, suspension, or termination of the benefit if applicable.

(4) Subject to the availability of sufficient appropriations and receipt of federal financial participation, on and after July 1, 2018, the state department shall make electronically available to a client specific and detailed information concerning the client's household composition, assets, income sources, and income amounts, if relevant to a determination for which client correspondence was issued. If implemented, the state department shall notify clients in the written correspondence of the option to access this information.

(5) The state department is encouraged to promote the receipt of client correspondence electronically or through mobile applications for clients who choose those methods of delivery as allowed by law.

(6) As part of its ongoing process to create and improve client correspondence, the state department may engage with experts in written communication and plain language to test client correspondence against the criteria set forth in subsection (3) of this section with a geographically diverse and representative sample of medicaid clients relevant to the client correspondence being revised. The state department shall also develop a process to review and consider feedback from stakeholders including client advocates and counties prior to implementing significant changes to correspondence.

(7) The state department shall ensure that client correspondence that may only affect a small number of clients, but may, nonetheless, have a significant impact on the lives of those clients, is appropriately prioritized for revision.

(8) As part of its annual presentation made to its legislative committee of reference pursuant to section 2-7-203, the state department shall present information concerning:

(a) Its process for ongoing improvement of client correspondence;

(b) Client correspondence revised pursuant to criteria set forth in subsection (3) of this section during the prior year and client correspondence improvements that are planned for the upcoming year; and

(c) A description of the results of testing of new or significantly revised client correspondence pursuant to subsection (6) of this section, including a description of the stakeholder feedback.

Source: L. 2017: Entire section added, (SB 17-121), ch. 303, p. 1651, § 1, effective August 9.

25.5-4-213. Audit of medicaid client correspondence - definition. (1) As used in this section, unless the context otherwise requires, "client correspondence" has the same meaning as defined in section 25.5-4-212.

(2) During the 2020 calendar year and the 2023 calendar year, the office of the state auditor shall conduct or cause to be conducted a performance audit of client correspondence. Thereafter, the state auditor, in the exercise of his or her discretion, may conduct or cause to be conducted additional performance audits of client correspondence pursuant to this section. The audit shall include correspondence generated through the Colorado benefits management system, as well as correspondence that is not generated through the Colorado benefits management system.

(3) The performance audit conducted pursuant to this section shall include:

(a) A review of available data from counties, the department's customer service contract center, and from assistors within the health benefit exchange, created in article 22 of title 10, regarding customer service contacts that are related to client confusion regarding correspondence received by medicaid clients or applicants;

(b) A review of the accuracy of client correspondence at the time it is generated;

(c) A review of whether client correspondence satisfies the requirements of any state or federal law, rule, or regulation relating to the sufficiency of any notice;

(d) A review of any client correspondence testing process conducted by the department and whether testing is done prior to implementing new or significantly revised client communications;

(e) A review of the results of any client correspondence testing, including client comprehension of the intended purpose or purposes of the correspondence; and

(f) A review of the accuracy of client income and household composition information that is communicated electronically, if applicable.

(4) If audit findings include findings that information contained in client correspondence is inaccurate at the time the correspondence was generated, the audit shall identify, if possible, the source of the inaccurate information, which may include but is not limited to computer system or interface issues, county input error, or applicant error.

(5) Based on the findings and conclusions identified during the performance audit conducted pursuant to this section, the office of the state auditor shall make recommendations to the state department for improving client correspondence. On or before December 30, 2020, December 30, 2023, and December 30 in any calendar year in which an audit is conducted pursuant to this section, the office of the state auditor shall submit the findings, conclusions, and recommendations from the performance audit in the form of a written report to the legislative audit committee, which shall hold a public hearing for the purposes of a review of the report. The report shall also be submitted to the joint budget committee, the public health care and human services committee of the house of representatives, the health and human services committee of the senate, and the joint technology committee, or any successor committees.

Source: L. 2017: Entire section added, (HB 17-1143), ch. 67, p. 211, § 1, effective August 9; (1) amended, (SB 17-121), ch. 303, p. 1653, § 2, effective August 9.

25.5-4-214. Feasibility study - residential and inpatient substance use disorder treatment - report - repeal. (1) On or before November 1, 2017, the state department shall prepare a written report with assistance from the department of human services' office of behavioral health concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the medicaid program. In addition, the report must also include an analysis of providing residential and inpatient substance use disorder treatment as a state-funded benefit rather than through the medicaid program. The state department shall submit the report to the joint budget committee, the public health care and human services committee of the house of representatives, the health and human services committee of the senate, or any successor committees, and to any legislative study committee addressing substance use disorder treatment that meets during the 2017 legislative interim. The state department shall prepare a comprehensive report, including within the report information provided by the department of

human services, as well as any other sources of information as determined by the state department.

(2) The state department shall consider and report on the following:

(a) The prevalence of opioid addiction and other substance use disorders in Colorado, including demographic and geographic information;

(b) Evidence-based best practices for the treatment of substance use disorders;

(c) A description of residential and inpatient substance use disorder treatment and a comparison of the treatment costs and administrative costs of providing the service utilizing medicaid dollars or with state funding;

(d) The eligibility criteria for publicly funded residential and inpatient substance use disorder treatment;

(e) Residential and inpatient substance use disorder treatment that is not currently included in Colorado's state medicaid plan but that may be provided by the state as an optional benefit or through a federal waiver;

(f) Any federal authorization necessary to include residential and inpatient substance use disorder treatment as a benefit under the medicaid program or waiver of federal rules that would allow for expansion of residential and inpatient treatment;

(g) An estimate of the number of medicaid clients who may be eligible for the benefit if the benefit were included as part of the medicaid program;

(h) Whether facilities currently providing residential and inpatient substance use disorder treatment in Colorado would be able to provide those services under the medicaid program;

(i) An estimate of state costs associated with providing residential and inpatient substance use disorder treatment as part of the medicaid program;

(j) Published research relating to other state costs incurred for the medicaid program and other public assistance program expenses that may be avoided if residential and inpatient substance use disorder treatment is included as part of the medicaid program;

(k) If known, other states providing residential and inpatient substance use disorder treatment as part of the medicaid program and the experiences of those states relating to implementation, cost, savings, and efficacy of residential and inpatient treatment;

(l) If known, the number and cost of emergency room visits or hospital stays by medicaid clients in Colorado relating to substance use disorders;

(m) If known, the number of county law enforcement contacts related to persons using drugs or alcohol and the percentage of persons entering county jails who have substance use disorders; and

(n) If known, state and national research on how access to residential and inpatient substance use disorder treatment impacts recidivism and law enforcement resources.

(3) As part of the report, the state department and the department of human services shall include recommendations to the general assembly concerning:

(a) The time frame for implementation of residential and inpatient substance use disorder treatment as a benefit under the medicaid program, as well as any other benefit planning or implementation considerations;

(b) Effective use of state and federal funding and the improvement of coordination among state agencies in administering all substance use disorder programs and treatment options in Colorado;

(c) Changes to state law necessary to implement the residential and inpatient substance use disorder treatment benefit as part of the medicaid program; and

(d) Changes, if any, to training requirements for certified addiction counselors necessary to implement effective substance use disorder treatment and to meet federal requirements for medicaid providers.

(4) In preparing the report, the state department and the department of human services may use national data from recognized sources if state-level data is unavailable and may solicit information and research from state agencies and other organizations regarding the social and financial impacts of substance use disorders in Colorado and effective options for treatment.

(5) This section is repealed, effective July 1, 2019.

Source: L. 2017: Entire section added, (HB 17-1351), ch. 288, p. 1600, § 2, effective June 2.

Cross references: For the legislative declaration in HB 17-1351, see section 1 of chapter 288, Session Laws of Colorado 2017.

PART 3

RECOVERY

25.5-4-300.4. Last resort for payment - legislative intent. It is the intent of the general assembly that medicaid be the last resort for payment for medically necessary goods and services furnished to recipients and that all other sources of payment are primary to medical assistance provided by medicaid.

Source: L. 2008: Entire section added, p. 1771, § 2, effective June 2.

25.5-4-300.7. Prevention of coding errors - prepayment review of claims. (1) The state department shall implement and maintain a system for reducing medical services coding errors in medicaid claims submitted to the state department for reimbursement. The system shall include automatic, prepayment review of medicaid claims through the use of nationally recognized correct coding methods in the medicaid management information system, in accordance with 42 U.S.C. sec. 1396b (r) and regulations thereunder, as amended by Pub.L. 111-148, and any other subsequent acts of congress. The state department shall acquire and maintain any information technology necessary to implement the automated, prepayment review of medicaid claims.

(2) Repealed.

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1379, § 8, effective May 26. **L. 2016:** (2) repealed, (HB 16-1081), ch. 22, p. 50, § 2, effective August 10.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To

obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-300.9. Explanation of benefits - medicaid recipients - legislative declaration. (1) (a) The general assembly finds and declares that:

(I) Colorado's medicaid program provides critical medical services to the state's poorest and most vulnerable residents;

(II) Funding for these services is provided through a financial partnership between Colorado and the federal government;

(III) For the 2015-16 state budget year, the general assembly appropriated $8,891,000,000 for Colorado's medicaid program, of which $2,508,000,000 is from the general fund and $677,000,000 is from the hospital provider fee, with the remainder from federal money;

(IV) It is in the best interest of Colorado to do everything possible to minimize error, inefficiency, and fraud in providing medicaid services to ensure the long-term viability of this safety net program;

(V) In the private sector, as well as the medicare program, insurers routinely provide an explanation of benefits to their clients, listing claims submitted by providers for services rendered to the client even when the insurer is not seeking a co-payment for the service and the provider is not claiming an amount due from the client;

(VI) While creating an explanation of benefits is not without cost to the health care system, only the client receiving medical services or his or her authorized representative is in the position to verify whether the claimed medical services were actually provided and for whom they were provided, which is a necessary first step in containing health care costs;

(VII) While medicaid clients may not appear to be affected financially by billing errors or fraudulent claims, medicaid clients who rely on these services for survival and independence are most severely affected by the inappropriate use of scarce resources; and

(VIII) Further, medicaid clients and medicaid advocates for low-income and vulnerable Coloradans want the opportunity to partner with the state department and providers to ensure a well-run and fraud-free medicaid program in Colorado.

(b) Therefore, the general assembly declares that creating an explanation of benefits for recipients of medicaid-funded services is a necessary step in managing the state's medicaid program and in safeguarding the significant public investment, both state and federal, in meeting the health care needs of low-income and vulnerable Coloradans.

(2) By or before July 1, 2017, the state department shall develop and implement an explanation of benefits for recipients of medical services pursuant to articles 4 to 6 of this title. The purpose of the explanation of benefits is to inform a medicaid client of a claim for reimbursement made for services provided to the client or on his or her behalf, so that the client may discover and report administrative or provider errors or fraudulent claims for reimbursement.

(3) The explanation of benefits is required for all acute and long-term care services for which a provider is seeking reimbursement under a fee-for-service model.

(4) The explanation of benefits must include, at a minimum:

(a) The name of the medicaid client receiving the service;

(b) The name of the service provider;

(c) A description of the service provided;

(d) The billing code for the service;

(e) The date of service, or range of dates for services, if multiple services are provided in a set period of time, such as personal care services;

(f) A clear statement to the medicaid client that the explanation of benefits is not a bill, but is only provided for the client's information and to make sure that a provider is being reimbursed only for services actually provided;

(g) Information regarding at least one verbal and one written method for the medicaid client to report errors in the explanation of benefits that are relevant to provider reimbursement; and

(h) Any other information that the state department determines is useful to the medicaid client or for purposes of discovering administrative or provider error or fraud.

(5) The state department shall develop the form and content of the explanation of benefits in conjunction with medicaid clients and medicaid advocates to ensure that medicaid clients understand the information provided and the purpose of the explanation of benefits. The state department shall also work with medicaid clients and medicaid advocates to develop educational materials for the state department's website and for distribution by advocacy and nonprofit organizations that explain the process for reporting errors and encourage clients to take responsibility for reporting errors.

(6) The state department shall provide the explanation of benefits to a medicaid client not less frequently than once every two months, if services have been provided to or on behalf of the client during that time period. The state department shall determine the most cost-effective means for producing and distributing the explanation of benefits to medicaid clients, which may include e-mail or web-based distribution, with mailed copies by request only. Further, the state department may include the explanation of benefits with an existing mailing or existing electronic or web-based communication to medicaid clients.

(7) Nothing in this section requires the state department to produce an explanation of benefits form if the information required to be included in the explanation of benefits pursuant to subsection (4) of this section is already included in another format that is understandable to the medicaid client.

Source: L. 2016: Entire section added, (SB 16-120), ch. 254, p. 1044, § 1, effective August 10.

25.5-4-301. Recoveries - overpayments - penalties - interest - adjustments - liens - review or audit procedures. (1) (a) (I) Except as provided in section 25.5-4-302 and subparagraph (III) of this paragraph (a), no recipient or estate of the recipient shall be liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the social security act, by this title, or by rules promulgated by the state board, which benefits are rendered to the recipient by a provider of medical services authorized to render such service in the state of Colorado, except those contributions required pursuant to section 25.5-4-209 (1). However, a recipient may enter into a documented agreement with a provider under which the recipient agrees to pay for items or services that are nonreimbursable under the medical assistance program. Under these circumstances, a recipient is liable for the cost of such services and items.

(II) The provisions of subparagraph (I) of this paragraph (a) shall apply regardless of whether medicaid has actually reimbursed the provider and regardless of whether the provider is enrolled in the Colorado medical assistance program.

(II.5) (A) A provider of medical services who bills or seeks collection through a third party from a recipient or the estate of a recipient for medical services authorized by Title XIX of the social security act in an amount in violation of subsection (1)(a)(I) of this section is liable for and subject to the following: A refund to the recipient of any amount unlawfully received from the recipient, plus statutory interest from the date of the receipt until the date of repayment; a civil monetary penalty of one hundred dollars for each violation of subsection (1)(a)(I) of this section; and all amounts submitted to a collection agency in the name of the medicaid recipient. When determining income or resources for purposes of determining eligibility or benefit amounts for any state-funded program under this title 25.5, the state department shall exclude from consideration any money received by a recipient pursuant to this subsection (1)(a)(II.5). The imposition of a civil monetary penalty by the state department may be appealed administratively.

(A.5) A provider of medical services who, within thirty days of notification by the state department, or longer if approved by the state department, voids the bill, returns any amount unlawfully received, and makes every reasonable effort to resolve any collection actions so that the recipient or the estate of the recipient has no adverse financial consequences is not subject to the provisions of subsection (1)(a)(II.5)(A) of this section.

(B) In order to establish a claim for the civil monetary penalty established by subsection (1)(a)(II.5)(A) of this section, a recipient or the estate of a recipient, or a person acting on behalf of a recipient or the estate of a recipient, shall notify the state department.

(C) The provisions of this subparagraph (II.5) shall not apply to a long-term care facility licensed pursuant to section 25-3-101, C.R.S.

(D) The provisions of subsection (1)(a)(II.5)(A) of this section shall not apply if a recipient knowingly misrepresents his or her medicaid coverage status to a provider of medical services and the provider submits documentation to the state department that the recipient knowingly misrepresented his or her medicaid coverage status and the documentation clearly establishes a good cause basis for granting an exception to the provider.

(III) (A) When a third party is primarily liable for the payment of the costs of a recipient's medical benefits, prior to receiving nonemergency medical care, the recipient shall comply with the protocols of the third party, including using providers within the third party's network or receiving a referral from the recipient's primary care physician. Any recipient failing to follow the third party's protocols is liable for the payment or cost of any care or services that the third party would have been liable to pay; except that, if the third party or the service provider substantively fails to communicate the protocols to the recipient, the items or services are nonreimbursable under this article and articles 5 and 6 of this title and the recipient is not liable to the provider.

(B) A recipient may enter into a written agreement with a third party or provider under which the recipient agrees to pay for items provided or services rendered that are outside of the network or plan protocols. The recipient's agreement to be personally liable for such nonemergency, nonreimbursable items shall be recorded on forms approved by the state board and signed and dated by both the recipient and the provider in advance of the services being rendered.

(b) Recipient income applied pursuant to section 25.5-4-209 (1) shall not disqualify any recipient, as defined in section 26-2-103 (8), C.R.S., from receiving benefits under this article, article 5 or 6 of this title, or public assistance under article 2 of title 26, C.R.S. If, at any time during the continuance of medical benefits, the recipient becomes possessed of property having a value in excess of that amount set by law or by the rules of the state department or receives any increase in income, it is the duty of the recipient to notify the county department thereof, and the county department may, after investigation, either revoke such medical benefits or alter the amount thereof, as the circumstances may require.

(c) Any medical assistance paid to which a recipient was not lawfully entitled shall be recoverable from the recipient or the estate of the recipient by the county as a debt due the state pursuant to section 25.5-1-115, but no lien may be imposed against the property of a recipient on account of medical assistance paid or to be paid on the recipient's behalf under this article or article 5 or 6 of this title, except pursuant to the judgment of a court of competent jurisdiction or as provided by section 25.5-4-302.

(d) If any such medical assistance was obtained fraudulently, interest shall be charged and paid to the county department on the amount of such medical assistance calculated at the legal rate and calculated from the date that payment for medical services rendered on behalf of the recipient is made to the date such amount is recovered.

(2) Any overpayment to a provider, including those of personal needs funds made pursuant to section 25.5-6-206, shall be recoverable regardless of whether the overpayment is the result of an error by the state department, a county department of social services, an entity acting on behalf of either department, or by the provider or any agent of the provider as follows:

(a) (I) If the state department makes a determination that such overpayment has been made as a result of the provider's false representation, the state department may collect the overpayment, plus a civil monetary penalty equal to one-half the amount of the overpayment, and interest on the sum of the two amounts accruing at the statutory rate from the date the overpayment is identified, by the means specified in this subsection (2). Such sum may be collected for up to the amount of time prescribed in section 13-80-103.5, C.R.S., after the overpayment is identified. Amounts remaining uncollected for more than the time period prescribed in section 13-80-103.5, C.R.S., after the last repayment was made may be considered uncollectible. For the purposes of this subparagraph (I), "false representation" means an inaccurate statement that is relevant to a claim for reimbursement and is made by a provider who has actual knowledge of the truth of false nature of the statement or by a provider acting in deliberate ignorance of or with reckless disregard for the truth of the statement. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the department, board, or the department's fiscal agent.

(II) If the state department makes a determination that such overpayment has been made for some other reason than a false representation by the provider specified in subparagraph (I) of this paragraph (a), the state department may collect the amount of overpayment, plus interest accruing at the statutory rate from the date the provider is notified of such overpayment, by the means specified in this subsection (2). Pursuant to the criteria established in rules promulgated by the state board, the state department may waive the recovery or adjustment of all or part of the overpayment and accrued interest specified in this subparagraph (II) if it would be inequitable, uncollectible or administratively impracticable; except that no action shall be taken

against a recipient of medical services initially determined to be eligible pursuant to section 25.5-4-205 if the overpayment occurred through no fault of the recipient. Amounts remaining uncollected for more than five years after the last repayment was made may be considered uncollectible.

(b) In order to collect the amounts specified in paragraph (a) of this subsection (2), the state department may withhold subsequent payments to which the provider is or becomes entitled and apply the amount withheld as an offset. The state board shall establish in rules the rate at which an overpayment may be offset, with provision for a reduction of such rate upon a good cause shown by the provider that the rate at which payment will be withheld will result in an undue hardship for the provider. In determining whether to grant a good cause reduction, the state department shall consider the impact of collecting the amount provided by state board rules on the quality of patient care and the financial viability of the provider. The state department may also take such other steps administratively as are available for the collection of the amounts specified in paragraph (a) of this subsection (2).

(c) If a provider defaults on repayment of the amounts specified in paragraph (a) of this subsection (2), the state department may bring a suit against the provider in the appropriate court. Court costs shall not be assessed against the state department but shall be assessed against the provider if the court finds in favor of the state department. Any costs collected by the state department shall be paid into the registry of the court. Once the amount has been reduced to judgment, the state department may proceed with all available postjudgment remedies.

(d) Notwithstanding the provisions of section 24-30-202.4, C.R.S., an amount specified in paragraph (a) of this subsection (2) that the state department has determined to be uncollectible may be referred to the controller for collection. Net proceeds of debts collected by the controller pursuant to this paragraph (d) shall be paid into the fund from which the overpayment was made.

(e) Any provider adversely affected by actions taken pursuant to this subsection (2), except when a suit is filed against the provider pursuant to paragraph (c) of this subsection (2), may appeal the determination of the state department pursuant to the provisions in section 24-4-105, C.R.S.

(f) If the state department, either directly or through a contracting agent, undertakes a review or an audit of a provider to determine whether an overpayment has been made to that provider, the review or audit shall be subject to the procedures required in subsection (3) of this section.

(3) (a) A review or audit of a provider shall be subject to the following procedures:

(I) The reviewer or auditor shall conduct a review or audit in accordance with applicable state and federal law.

(II) The reviewer or auditor shall apply uniform standards and procedures to each class of providers subject to a review or an audit to determine an overpayment.

(III) The reviewer or auditor shall prepare findings for the entire period under review or audit, and a provider shall be subject to only one demand for repayment in connection with the review or audit.

(IV) The reviewer or auditor shall initiate each review or audit requiring an inspection of the provider's records by delivering to the provider not less than ten business days prior to the commencement of the audit a written request describing in detail such records and offering the provider the option of providing either a reproduction of such records or inspection by the

reviewer or auditor at the provider's site. The request shall also clearly define milestone dates pertaining to records' requested due dates, permissible extensions of dates, the timelines for informal reconsideration, and deadlines for requesting a formal appeal. The records subject to the request shall be limited to records directly related to claims for reimbursement submitted by the provider. In the event such records are available from a county department of social services or another agency, subdivision, or contractor of the state, the reviewer or auditor shall request such records from such other agencies as may be appropriate prior to making a request to the provider. The reviewer or auditor shall conduct on-site inspections at reasonable times during regular business hours, and the reviewer or auditor shall make arrangements necessary for the reproduction of such records on site. If the provider chooses to provide a reproduction of the records requested by the reviewer or auditor instead of on-site inspection, the reviewer or auditor shall give the provider a reasonable period of time, that shall be not less than forty-five days, to provide such records taking into account the scope of the request, the time frame covered, and the reproduction arrangements available to the provider.

(IV.5) At the request of the provider, the reviewer or auditor shall conduct an in-person or telephonic interview with the provider prior to the preparation of a preliminary draft of the report of the reviewer or auditor at which the reviewer or auditor and the provider shall discuss:

(A) The findings of the reviewer or auditor;

(B) Any documentation useful for the provider to refute the findings of the reviewer or auditor; and

(C) The next steps in the review or audit process.

(V) A physician's record or other order for health care services, drugs, or medicinal supplies in a form transmitted electronically shall be sufficient to validate the provider's records regarding the ordering of the health care services, drugs, or medicinal supplies.

(VI) Whenever possible, the reviewer or auditor shall base a determination of an overpayment to a provider upon a review of actual records of the department, its agents, or the provider. In the event sufficient records are not available to the reviewer or auditor, an overpayment determination may be based upon a sampling of records so long as the sampling and any extrapolation therefrom is reasonably valid from a statistical standpoint and is in accordance with generally accepted auditing standards.

(VII) If a reviewer or auditor determines that there has been an overpayment to the provider, then, at the time demand for repayment is made, the state department shall offer the provider an informal reconsideration of the review or audit findings. The state department shall notify the provider in writing of the right to an informal reconsideration prior to implementing any recovery of an overpayment and give the provider an opportunity to request an informal reconsideration. In the event informal reconsideration is requested or a formal appeal is filed pursuant to subparagraph (VIII) of this paragraph (a), the state department shall not implement recovery of the overpayment until such informal reconsideration or formal appeal has been completed. Within forty-five days after the request for an informal reconsideration, the state department shall render a decision on the request and notify the provider of the decision. The notification shall include information concerning requesting a formal appeal, including informing the provider that the request must be filed within thirty days after the date of the state department's decision on the request for an informal reconsideration. If the state department is unable to render a decision on the request for informal reconsideration within forty-five days after the request, within forty-five days after the request, the state department shall notify the

provider of its inability to complete the decision and shall include information concerning requesting a formal appeal, including informing the provider that the request must be filed within thirty days after the receipt of the notification that the state department is unable to render a decision. For purposes of this subparagraph (VII), an informal reconsideration shall be considered final thirty days after the earlier of the date on which the provider withdraws its request or the date on which the state department issues a written decision on the request.

(VIII) In accordance with paragraph (e) of subsection (2) of this section, any provider adversely affected by the actions of the state department or its contracting agent in connection with a review or an audit, including whether the state department or its contracting agent adhered to the provisions of this subsection (3) in making an overpayment determination, may appeal such actions pursuant to the provisions of section 24-4-105, C.R.S.

(a.5) Any additional review or audit procedures shall be adopted by rule of the state board and shall be specifically referenced in any contract with a provider.

(b) The state department is authorized to engage the services of a qualified agent through a competitive contract issued pursuant to the state's procurement code for the purpose of conducting a review or audit of a provider to assist in determining whether there has been an overpayment to a provider and the amount of that overpayment. In addition to such terms and conditions as the state department may deem necessary, any contract shall be subject to the requirements for conducting a review or an audit in accordance with paragraph (a) of this subsection (3). The state department is further authorized to enter into a contract with a qualified agent for the purpose of conducting a review or an audit of a provider that provides that the compensation of the contracting agent shall be contingent and based upon a percentage of the amount of the recovery collected from the provider. A contract issued by the state department for the purpose of conducting a review or an audit of a provider to determine whether the provider has received an overpayment shall also be subject to the following conditions:

(I) The compensation paid to the contracting agent under a contingency-based contract shall not exceed eighteen percent of the amount finally collected from the provider overpayment, and the state department may establish a limit on the amount of annual compensation that may be paid to a contracting agent under a contingency-based contract and may further establish a limit on the amount that may be paid to a contracting agent under a contingency-based contract for recovery from any one provider.

(II) Reimbursement of the contracting agent's costs in performing the review or audit under a contingency-based contract shall be deemed included in the percentage compensation due the agent under the contract.

(III) No employee or agent of the contracting agent involved in the performance of a contingency-based contract shall be compensated by the contracting agent based upon the amount recovered under the contract.

(IV) The state department shall retain all authority for providing notice and otherwise making demand upon a provider for recovery of an overpayment, and the state department shall review and approve any written demand, request, or determination by the contracting agent regarding a review or an audit of a provider under this subsection (3).

(V) In any contingency-based contract authorized pursuant to this paragraph (b), the state of Colorado shall not be obligated to pay the contracting agent for amounts not actually collected from the provider.

(3.5) (a) Prior to the start of a contract to review or audit providers, the state department is encouraged to meet with organizations or associations of providers to educate providers on the review or audit process and the responsibilities of both the providers and the state department throughout the review or audit process. The state department is also encouraged to prepare an annual report on common findings following a contract to review or audit providers and distribute the report to organizations or associations of providers. The annual report should include information to prevent similar findings in future reviews or audits and should direct providers to resource information.

(b) Repealed.

(4) If medical assistance is furnished to or on behalf of a recipient pursuant to the provisions of this article and articles 5 and 6 of this title for which a third party is liable, the state department has an enforceable right against such third party for the amount of such medical assistance, including the lien right specified in subsection (5) of this section. Whenever the recipient has brought or may bring an action in court to determine the liability of the third party, the state department, without any other name, title, or authority to enforce the state department's right, may enter into appropriate agreements and assignments of rights with the recipient and the recipient's attorney, if any. Any such agreement shall be filed with the court in which such an action is pending. The attorney named in such an agreement upon designation as a special assistant attorney general by the attorney general shall have the right to prove both the recipient's claim and the state department's claim. The state department, without any other name, title, or authority, may take any necessary action to determine the existence and amount of the state department's claims under this section, whether such claims are founded on judgment, contract, lien, or otherwise, and take any other action that is appropriate to recover from such third parties. To enforce such right, the attorney general, pursuant to section 24-31-101, C.R.S., on behalf of the state department may institute and prosecute, or intervene of right in legal proceedings against the third party having legal liability, either in the name of the state department or in the name of the recipient or his or her assignee, guardian, personal representative, estate, or survivors. When the state department intervenes in legal proceedings against the third party, it shall not be liable for any portion of the attorney fees or costs of the recipient.

(5) (a) When the state department has furnished medical assistance to or on behalf of a recipient pursuant to the provisions of this article, and articles 5 and 6 of this title, for which a third party is liable, the state department shall have an automatic statutory lien for all such medical assistance. The state department's lien shall be against any judgment, award, or settlement in a suit or claim against such third party and shall be in an amount that shall be the fullest extent allowed by federal law as applicable in this state, but not to exceed the amount of the medical assistance provided.

(b) No judgment, award, or settlement in any action or claim by a recipient to recover damages for injuries, where the state department has a lien, shall be satisfied without first satisfying the state department's lien. Failure by any party to the judgment, award, or settlement to comply with this section shall make each such party liable for the full amount of medical assistance furnished to or on behalf of the recipient for the injuries that are the subject of the judgment, award, or settlement.

(c) Except as otherwise provided in this article, the entire amount of any judgment, award, or settlement of the recipient's action or claim, with or without suit, regardless of how characterized by the parties, shall be subject to the state department's lien.

(d) Where the action or claim is brought by the recipient alone and the recipient incurs a personal liability to pay attorney fees, the state department will pay its reasonable share of attorney fees not to exceed twenty-five percent of the state department's lien. The state department shall not be liable for costs.

(e) The state department's right to recover under this section is independent of the recipient's right.

(6) When the applicant or recipient, or his or her guardian, executor, administrator, or other appropriate representative, brings an action or asserts a claim against any third party, such person shall give to the state department written notice of the action or claim by personal service or certified mail within fifteen days after filing the action or asserting the claim. Failure to comply with this subsection (6) shall make the recipient, legal guardian, executor, administrator, attorney, or other representative liable for the entire amount of medical assistance furnished to or on behalf of the recipient for the injuries that gave rise to the action or claim. The state department may, after thirty days' written notice to such person, enforce its rights under subsection (5) of this section and this subsection (6) in the district court of the city and county of Denver; except that liability of a person other than the recipient shall exist only if such person had knowledge that the recipient had received medical assistance or if excusable neglect is found by the court. The court shall award the state department its costs and attorney fees incurred in the prosecution of any such action.

(7) When a legally responsible relative of the recipient agrees or is ordered to provide medical support or health insurance coverage for his or her dependents or other persons, and such dependents are applicants for, recipients of, or otherwise entitled to receive medical assistance pursuant to this article and articles 5 and 6 of this title, the state department shall be subrogated to any rights that the responsible persons may have to obtain reimbursement from a third party or insurance carrier for the cost of medical assistance provided for such dependents or persons. Where the state department gives written notice of subrogation, any third party or insurance carrier liable for reimbursement for the cost of medical care shall accord to the state department all rights and benefits available to the responsible relative that pertain to the provision of medical care to any persons entitled to medical assistance pursuant to this article and articles 5 and 6 of this title for whom the relative is legally responsible.

(8) All recipients of medical assistance under the medicaid program shall be deemed to have authorized their attorneys, all third parties, including but not limited to insurance companies, and providers of medical care to release to the state department all information needed by the state department to secure and enforce its rights under subsections (4) and (5) of this section.

(9) Nothing in part 6 of article 4 of title 10, C.R.S., shall be construed to limit the right of the state department to recover the medical assistance furnished to or on behalf of a recipient as the result of the negligence of a third party.

(10) No action taken by the state department pursuant to subsection (4) of this section or any judgment rendered in such action shall be a bar to any action upon the claim or cause of action of the applicant or recipient or his or her guardian, personal representative, estate, dependent, or survivors against the third party having legal liability, nor shall any such action or judgment operate to deny the applicant or recipient the recovery for that portion of his or her medical costs or other damages not provided as medical assistance under this article or article 5 or 6 of this title.

(11) (a) The state department shall have a right to recover any amount of medical assistance paid on behalf of a recipient because:

(I) The trustee of a trust for the benefit of the recipient has used the trust property in a manner contrary to the terms of the trust;

(II) A person holding the recipient's power of attorney has used the power for purposes other than the benefit of the recipient.

(b) To enforce the right under this subsection (11), the county or state department may institute or intervene in legal proceedings against the trustee or person holding the power of attorney. Any amount of medical assistance recovered pursuant to this subsection (11) shall be distributed between the state and county in proportion to the amount of medical assistance paid by each respectively, if any.

(c) No action taken by the county or state department pursuant to this subsection (11) or any judgment rendered in such action or proceeding shall be a bar to any action upon the claim or cause of action of the recipient or his or her guardian, personal representative, estate, dependent, or survivors against the trustee or person holding the power of attorney.

(12) (a) An entity that provides managed care, as defined in section 25.5-5-403, that has entered into a risk contract with the state department shall have the same rights of the department set forth in this section except with respect to the rights described in subsections (5) and (6) of this section. In addition, the attorney general may not enforce the rights set forth in this subsection (12). Venue for an action brought by or on behalf of an entity pursuant to this subsection (12) shall be governed by the Colorado rules of civil procedure.

(b) Within fifteen days after filing an action or asserting a claim against a third party, a recipient under a managed care plan or a guardian, executor, administrator, or other appropriate representative of the recipient shall provide to the entity that administers the managed care plan written notice of the action or claim. Notice shall be by personal service or certified mail.

(c) In cases where the state department has recovery rights against a third party pursuant to subsections (4) and (5) of this section and an entity that provides managed care has subrogation rights against the same party pursuant to paragraph (a) of this subsection (12), the recovery rights of the state department shall take precedence over the rights of the managed care plan.

(13) To the extent allowable under federal law, the state department shall recover from a legal immigrant's sponsor all medical assistance paid on behalf of a sponsored legal immigrant who is enrolled in the medical assistance program.

(14) Notwithstanding any provision of this section to the contrary:

(a) (I) The state department, or the state department's designated agent, shall conduct pre-enrollment and post-enrollment site visits of providers who are designated as moderate or high categorical risks to the medicaid program. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements.

(II) As established in rules promulgated by the state board, the state department may waive pre-enrollment and post-enrollment site visits of providers if the site visits are conducted by medicare or other federally designated entities.

(III) A provider is designated as a limited, moderate, or high categorical risk pursuant to the medicare program and federal regulations. If a provider is not designated in a risk category

pursuant to the medicare program and federal regulations, the provider's risk category shall be established pursuant to rules promulgated by the state board.

(b) A provider enrolled in the medicaid program shall permit the centers for medicare and medicaid services or its agent or designated contractors and the state department or its agent to conduct unannounced, on-site inspections of any and all provider locations. Payment for any agent designated by the state department to perform on-site inspections shall not be based on any recoveries paid to the state department by a provider for violations discovered as a result of the on-site inspection.

(15) (a) The state department may request a written response from any provider who fails to comply with the rules, manuals, or bulletins issued by the state department, state board, or the state department's fiscal agent, or from any provider whose activities endanger the health, safety, or welfare of medicaid recipients. The written response must describe how the provider will come into and ensure future compliance. If a written response is requested, a provider has thirty days, or longer if approved by the state department, to submit the written response.

(b) If the provider does not agree with the state department's findings that resulted in the request issued pursuant to subsection (15)(a) of this section, then the provider's written response must include an explanation and specific reasons for the provider's disagreement.

Source: L. 2006: Entire article added with relocations, p. 1829, § 7, effective July 1; (1)(a)(II.5) added, p. 107, § 1, effective January 1, 2007. **L. 2007:** (3)(a)(IV) and (3)(a)(VII) amended and (3)(a)(IV.5), (3)(a.5), and (3.5) added, pp. 1467, 1469, 1468, §§ 1, 3, 2, effective May 30. **L. 2009:** (5)(a) and (5)(c) amended, (HB 09-1191), ch. 100, p. 372, § 1, effective August 5. **L. 2010:** (2)(a)(II) amended, (SB 10-167), ch. 296, p. 1378, § 7, effective May 26. **L. 2013:** (14) added, (HB 13-1068), ch. 119, p. 405, § 1, effective April 8. **L. 2017:** (1)(a)(II.5)(A) and (1)(a)(II.5)(B) amended and (1)(a)(II.5)(A.5), (1)(a)(II.5)(D), and (15) added, (HB 17-1139), ch. 376, p. 1942, § 2, effective June 6.

Editor's note: (1) This section is similar to former § 26-4-403 as it existed prior to 2006.

(2) Subsection (1)(a)(II.5) was enacted as § 26-4-403 (1)(a)(II.5) in House Bill 06-1079 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

(3) Subsection (3.5)(b)(II) provided for the repeal of subsection (3.5)(b), effective July 1, 2011. (See L. 2007, p. 1468.)

Cross references: (1) For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

(2) For the legislative declaration in HB 17-1139, see section 1 of chapter 376, Session Laws of Colorado 2017.

25.5-4-302. Recovery of assets. (1) The general assembly hereby finds, determines, and declares that the cost of providing medical assistance to qualified recipients throughout the state has increased significantly in recent years; that such increasing costs have created an increased

burden on state revenues while reducing the amount of such revenues available for other state programs; that recovering some of the medical assistance from the estates of medical assistance recipients would be a viable mechanism for such recipients to share in the cost of such assistance; and that such an estate recovery program would be a cost-efficient method of offsetting medical assistance costs in an equitable manner. The general assembly also declares that in order to ensure that medicaid is available for low-income individuals reasonable restrictions consistent with federal law should be placed on the ability of persons to become eligible for medicaid by means of making transfers of property without fair and valuable consideration.

(2) (a) Medical assistance paid on behalf of any individual who was fifty-five years of age or older when the individual received such assistance may be recovered by the state department from the estate of such individual in accordance with paragraph (c) of this subsection (2).

(b) Medical assistance paid on behalf of any individual who is institutionalized may be recovered by the state department from the estate of such individual in accordance with paragraph (c) of this subsection (2).

(c) The state department shall establish an estate recovery program only insofar as such program is in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended, and shall not take any action to recover medical assistance when the amount of assistance to be recovered is economically inappropriate in relation to expenses of recovery.

(3) The state department is authorized to file liens against any property of an individual who is institutionalized and from whom the state department may recover medical assistance pursuant to paragraph (b) of subsection (2) of this section.

(4) The state department may compromise, settle, or waive any recovery of medical assistance authorized pursuant to subsection (2) of this section upon good cause shown.

(5) Subject to any limitation concerning estate recovery in Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended, the amount of any medical assistance paid pursuant to the provisions of this article and articles 5 and 6 of this title is a claim against the estate pursuant to the provisions of section 15-12-805 (1), C.R.S.

(6) The state board shall promulgate rules to implement the provisions of this section, including rules limiting the eligibility for medical assistance if the person made a voluntary assignment or transfer of property without fair and valuable consideration prior to applying for medical assistance. A contract for an exempt burial fund for an individual shall include a provision restricting the full amount to the cost of the burial and stating that any portion not expended for the burial costs shall be refunded to the state department by the mortuary as reimbursement for the cost of medical assistance provided to the individual. Said rules shall be in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended.

(7) Effective upon the implementation of a private-public partnership program for financing long-term care pursuant to section 25.5-6-110, this section shall apply to participants of such program only after excluding from the amount that may otherwise be recovered from such person's estate an amount allowed by rules adopted by the state board in accordance with section 25.5-6-110.

Source: L. 2006: Entire article added with relocations, p. 1836, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-403.3 as it existed prior to 2006.

25.5-4-303. State income tax refund intercept - garnishment of earning - failure to provide medical support for child. (1) (a) At any time prescribed by the department of revenue, but not less frequently than annually, the state department may certify to the department of revenue information regarding any person who:

(I) Is obligated to the state agency responsible for administering medical assistance in this state for medical support based on medical assistance provided to the obligor's dependent child; and

(II) Has received payment from a third party to cover the health care costs of the child but has neither applied such payment to cover the child's health care costs nor to reimburse the state department, the custodial parent of the child, or the provider of medical care.

(b) The information provided to the department of revenue shall include the name and the social security number of the person described in paragraph (a) of this subsection (1), the amount of medical assistance provided to the child during the period for which medical support was ordered but not provided as described in subparagraph (II) of paragraph (a) of this subsection (1), and any other identifying information required by the department of revenue.

(2) Prior to a final certification of the information described in subsection (1) of this section to the department of revenue, the state department shall notify the obligated person, in writing, that the state intends to refer the person's name to the department of revenue in an attempt to offset the person's medical support obligation against the person's state income tax refund. Such notification shall include information on the parent's right to object to the offset.

(3) Upon notification by the department of revenue of amounts deposited with the state treasurer pursuant to section 39-21-108 (3), C.R.S., the state department may recover the amount of the medical assistance described in paragraph (b) of subsection (1) of this section.

(4) The state department may garnish the wages and other earnings of a person described in paragraph (a) of subsection (1) of this section. The garnishment of wages and earning shall be in accordance with articles 54 and 54.5 of title 13, C.R.S.

(5) The state board shall adopt rules as are necessary for the implementation of this section.

Source: L. 2006: Entire article added with relocations, p. 1838, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-403.4 as it existed prior to 2006.

25.5-4-303.3. Provider fraud - attorney general report. (1) No later than October 1, 2017, and no later than October 1 each year thereafter, the attorney general shall submit a written report to the state department for inclusion in a single, comprehensive report to the general assembly concerning medicaid fraud pursuant to section 25.5-1-115.5. The attorney general shall provide information relating to medicaid provider fraud including, at a minimum:

(a) Investigations of provider fraud during the year;

(b) Criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;

(c) Recoveries, including fines and penalties, restitution ordered, and restitution collected;

(d) Civil claims;

(e) Trends in methods used to commit provider fraud, excluding law enforcement-sensitive information; and

(f) An estimate of the total savings, total cost, and net cost-effectiveness of fraud detection and recovery efforts.

Source: L. 2012: Entire section added, (SB 12-060), ch. 166, p. 578, § 2, effective August 8. **L. 2017:** IP(1), (1)(d), and (1)(e) amended and (1)(f) added, (SB 17-295), ch. 298, p. 1637, § 2, effective August 9.

25.5-4-303.5. Short title. This section and sections 25.5-4-304 to 25.5-4-310 shall be known and may be cited as the "Colorado Medicaid False Claims Act".

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1379, § 10, effective May 26.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-304. Definitions. As used in sections 25.5-4-303.5 to 25.5-4-309, unless the context otherwise requires:

(1) (a) "Claim" means a request or demand for money or property, whether under a contract or otherwise, and regardless of whether the state has title to the money or property, under the "Colorado Medical Assistance Act" that is:

(I) Presented to an officer, employee, or agent of the state; or

(II) Made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the state's behalf or to advance a program or interest of the state and if the state:

(A) Provides or has provided any portion of the money or property requested or demanded; or

(B) Will reimburse the contractor, grantee, or other recipient for any portion of the money or property that is requested or demanded.

(b) "Claim" does not include a request or demand for money or property that the state has paid to an individual as compensation for employment by the state or as an income subsidy with no restriction on that individual's use of the money or property.

(2) "Colorado Medical Assistance Act" means this article and articles 5 and 6 of this title.

(3) (a) "Knowing" or "knowingly" means that a person, with respect to information:

(I) Has actual knowledge of the information;

(II) Acts in deliberate ignorance of the truth or falsity of the information; or

(III) Acts in reckless disregard of the truth or falsity of the information.

(b) "Knowing" or "knowingly" does not require proof of specific intent to defraud.

(4) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(5) "Obligation" means a fixed or contingent duty arising from an express or implied contractual, quasi-contractual, grantor-grantee, licensor-licensee, statutory, fee-based, or similar relationship, or the retention of overpayment.

Source: L. 2006: Entire article added with relocations, p. 1838, § 7, effective July 1. **L. 2010:** Entire section R&RE, (SB 10-167), ch. 296, p. 1379, § 11, effective May 26. **L. 2013:** (5) amended, (SB 13-205), ch. 276, p. 1441, § 3, effective August 7.

Editor's note: This section is similar to former §§ 26-4-1102 and 26-4-1103 (3) as they existed prior to 2006.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-305. False medicaid claims - liability for certain acts. (1) Except as otherwise provided in subsection (2) of this section, a person is liable to the state for a civil penalty of not less than five thousand five hundred dollars and not more than eleven thousand dollars; except that these upper and lower limits on liability shall automatically increase to equal the civil penalty allowed under the federal "False Claims Act", 31 U.S.C. sec. 3729, et seq., if and as the penalties in such federal act may be adjusted for inflation as described in said act in accordance with the federal "Civil Penalties Inflation Adjustment Act of 1990", Pub. L. No. 101-410, plus three times the amount of damages that the state sustains because of the act of that person, if the person:

(a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(b) Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;

(c) Has possession, custody, or control of property or money used, or to be used, by the state in connection with the "Colorado Medical Assistance Act"and knowingly delivers, or causes to be delivered, less than all of the money or property;

(d) Authorizes the making or delivery of a document certifying receipt of property used, or to be used, by the state in connection with the "Colorado Medical Assistance Act" and, intending to defraud the state, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(e) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state in connection with the "Colorado Medical Assistance Act" who lawfully may not sell or pledge the property;

(f) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act", or knowingly conceals or knowingly and improperly avoids

or decreases an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act";

(g) Conspires to commit a violation of paragraphs (a) to (f) of this subsection (1).

(2) Notwithstanding the amount of damages authorized in subsection (1) of this section, for a person who violates subsection (1) of this section, the court may assess not less than twice the amount of damages that the state sustains because of the act of the person if the court finds that:

(a) The person who committed the violation of subsection (1) of this section furnished to the officials of the state responsible for investigating false claims violations all information about the violation known to the person and furnished said information within thirty days after the date on which the person first obtained the information;

(b) At the time the person furnished the information about the violation to the state, a criminal prosecution, civil action, or administrative action had not commenced with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation; and

(c) The person fully cooperated with any investigation of the violation by the state.

(3) A person violating this section shall also be liable to the state for the costs of a civil action brought to recover any penalty or damages.

(4) Any information furnished pursuant to subsection (2) of this section shall be exempt from disclosure under part 2 of article 72 of this title.

Source: L. 2006: Entire article added with relocations, p. 1839, § 7, effective July 1. **L. 2010:** Entire section R&RE, (SB 10-167), ch. 296, p. 1380, § 12, effective May 26. **L. 2011:** IP(1) amended, (HB 11-1303), ch. 264, p. 1168, § 66, effective August 10. **L. 2013:** IP(1) and (1)(a) amended, (SB 13-205), ch. 276, p. 1441, § 4, effective August 7.

Editor's note: This section is similar to former § 26-4-1103 (1) and (2) as they existed prior to 2006.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-306. Civil actions for false medicaid claims. (1) **Responsibility of attorney general.** The attorney general shall diligently investigate a violation under section 25.5-4-305. If the attorney general finds that a person has violated or is violating section 25.5-4-305, the attorney general may bring a civil action under this section against the person.

(2) **Actions by private persons.** (a) A relator may bring a civil action for a violation of section 25.5-4-305 on behalf of the relator and the state. The action shall be brought in the name of the state. The action may be dismissed only if the court and the attorney general give written consent to the dismissal and their reasons for consenting.

(b) A copy of the complaint and written disclosure of substantially all material evidence and information the relator possesses shall be served on the state pursuant to rule 4 of the

Colorado rules of civil procedure. The complaint shall be filed in camera, shall remain under seal for at least sixty days, and shall not be served on the defendant until the court so orders. The state may elect to intervene and proceed with the action within sixty days after it receives both the complaint and the material evidence and information.

(c) The state may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (b) of this subsection (2). Any such motion may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to a complaint filed under this section until twenty days after the complaint is unsealed and served upon the defendant pursuant to rule 4 of the Colorado rules of civil procedure.

(d) Before the expiration of the sixty-day period pursuant to paragraph (b) of this subsection (2) or any extensions obtained under paragraph (c) of this subsection (2), the state shall:

(I) Proceed with the action, in which case the state shall conduct the action; or

(II) Notify the court that it declines to take over the action, in which case the relator shall have the right to conduct the action.

(e) When a relator brings an action under this subsection (2), no person other than the state may intervene or bring a related action based on the facts underlying the pending action.

(3) **Rights of parties to private actions.** (a) If the state proceeds with an action brought under subsection (2) of this section, it shall have the primary responsibility for prosecuting the action and shall not be bound by an act of the relator. The relator shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (b) of this subsection (3).

(b) (I) The state may dismiss the action notwithstanding the objections of the relator if the relator has been notified by the state of the filing of the motion and the court has provided the relator with an opportunity for a hearing on the motion.

(II) The state may settle the action with the defendant notwithstanding the objections of the relator if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, the hearing may be held in camera.

(III) Upon a showing by the state that unrestricted participation during the course of the litigation by the relator would interfere with or unduly delay the state's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the relator's participation, including but not limited to:

(A) Limiting the number of witnesses the relator may call;

(B) Limiting the length of the testimony of the witnesses;

(C) Limiting the relator's cross-examination of witnesses; or

(D) Otherwise limiting the participation by the relator in the litigation.

(IV) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the relator would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the relator in the litigation.

(c) If the state elects not to proceed with the action, the relator who initiated the action shall have the right to conduct the action. If the state so requests, it shall be served with copies of all pleadings filed in the action and, at the state's expense, shall be supplied with copies of all deposition transcripts. When a relator proceeds with the action, the court, without limiting the

status and rights of the relator, may nevertheless permit the state to intervene at a later date upon a showing of good cause.

(d) Regardless of whether the state proceeds with the action, upon a showing by the state that certain actions of discovery by the relator would interfere with the state's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay the discovery for a period of not more than sixty days. The showing shall be conducted in camera. The court may extend the sixty-day period upon a further showing in camera that the state has pursued the criminal or civil investigation or proceedings with reasonable diligence and that any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(e) Notwithstanding the provisions of subsection (2) of this section, the state may elect to pursue its claim through any alternate remedy available to the state, including any administrative proceeding to determine a civil money penalty. If an alternate remedy is pursued in another proceeding, the relator shall have the same rights in the proceeding as the relator would have had if the action had continued under this section. Any finding of fact or conclusion of law made in another proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of this paragraph (e), a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the state, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(4) **Award to private persons.** (a) (I) If the state proceeds with an action brought by a relator under subsection (2) of this section, the relator shall, subject to subparagraph (II) of this paragraph (a), receive at least fifteen percent but not more than twenty-five percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the relator substantially contributed to the prosecution of the action.

(II) If the court finds the action to be based primarily on disclosures of specific information, other than information provided by the relator, relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative, administrative, or state auditor's report, hearing, audit, or investigation, or from the news media, the court may award to the relator such sums as it considers appropriate, but in no case more than ten percent of the proceeds, taking into account the significance of the information and the role of the relator in advancing the case to litigation.

(III) Any payment to a relator under subparagraph (I) or (II) of this paragraph (a) shall be made from the proceeds. The relator shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred plus reasonable attorney fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(b) If the state does not proceed with an action brought under subsection (2) of this section, the relator bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than twenty-five percent and not more than thirty percent of the proceeds of the action or settlement and shall be paid out of the proceeds. The relator shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(c) Regardless of whether the state proceeds with an action brought under subsection (2) of this section, if the court finds that the action was brought by a relator who planned and initiated the violation of section 25.5-4-305 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action that the relator would otherwise receive under paragraph (a) or (b) of this subsection (4), taking into account the role of the relator in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the relator is convicted of criminal conduct arising from his or her role in the violation of section 25.5-4-305, the relator shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the state to continue the action.

(d) If the state does not proceed with an action brought under subsection (2) of this section and the relator bringing the action conducts the action, the court may award to the defendant its reasonable attorney fees and expenses if the defendant prevails in the action and the court finds that the claim of the relator was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(5) **Certain actions barred.** (a) A court shall not have jurisdiction over an action brought under this section against a member of the general assembly, a member of the state judiciary, or an elected official in the executive branch of the state of Colorado if the action is based on evidence or information known to the state when the action was brought.

(b) A relator shall not bring an action under subsection (2) of this section that is based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the state is already a party.

(c) (I) A court shall dismiss an action or claim brought under subsection (2) of this section unless opposed by the state, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed in a state criminal, civil, or administrative hearing in which the state or its agent is a party, in a legislative, administrative, or state auditor's report, hearing, audit, or investigation, or by the news media, unless the action is brought by the state or the relator is an original source of the information.

(II) For purposes of this paragraph (c), "original source" means an individual who, prior to a public disclosure under subparagraph (I) of this paragraph (c), has voluntarily disclosed to the state the information on which the allegations or transactions in a claim are based, or who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and has voluntarily provided the information to the state before filing an action under subsection (2) of this section.

(6) **State not liable for certain expenses.** The state is not liable for expenses that a relator incurs in bringing an action under this section.

(7) **Private action for retaliation.** (a) An employee, contractor, or agent shall be entitled to all relief necessary to make the employee, contractor, or agent whole, if the employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the defendant or by any other person because of lawful acts done by the employee, contractor, or agent, or associated others in furtherance of an action under this section or in furtherance of an effort to stop any violations of section 25.5-4-305.

(b) (I) An employee, contractor, or agent who seeks relief pursuant to this subsection (7) shall be entitled to all relief necessary to make the employee, contractor, or agent whole. Such relief shall include:

(A) Reinstatement with the same seniority status the employee, contractor, or agent would have had but for the discrimination, twice the amount of back pay, and interest on the back pay; and

(B) Compensation for any special damages sustained as a result of the discrimination or retaliation, including litigation costs and reasonable attorney fees.

(II) An employee, contractor, or agent may bring an action in the appropriate court of the state for the relief provided in this subsection (7).

Source: L. 2006: Entire article added with relocations, p. 1840, § 7, effective July 1. **L. 2009:** IP(1)(b), IP(1)(c), and (4) amended, (SB 09-292), ch. 369, p. 1974, § 97, effective August 5. **L. 2010:** Entire section R&RE, (SB 10-167), ch. 296, p. 1382, § 13, effective May 26. **L. 2013:** (2)(e), (5), and (7) amended, (SB 13-205), ch. 276, p. 1441, § 5, effective August 7.

Editor's note: This section is similar to former § 26-4-1104 as it existed prior to 2006.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-307. False medicaid claims procedures - statute of limitations. (1) A civil action under section 25.5-4-306 (1) or (2) may not be brought after the later of:

(a) More than six years after the date on which the violation of section 25.5-4-305 is committed; or

(b) More than three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the state charged with responsibility to act in the circumstances, but in no event more than ten years after the date on which the violation of section 25.5-4-305 is committed.

(2) If the state elects to intervene and proceed with an action brought under section 25.5-4-306, the state may file its own complaint or amend the relator's complaint to clarify or add detail to the claims in which the state is intervening and to add any additional claims with respect to which the state contends it is entitled to relief. For statute of limitations purposes, any such pleadings by the state shall relate back to the filing date of the relator's complaint, to the extent that the state's claim arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of the relator.

(3) In an action brought under section 25.5-4-306, the state or relator must prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(4) Notwithstanding any other provision of law, the Colorado rules of criminal procedure, or the Colorado rules of evidence, a final judgment rendered in favor of the state in a criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon

a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action that involves the same transaction as in the criminal proceeding and that is brought under section 25.5-4-306.

(5) A private action for retaliation under section 25.5-4-306 (7) may not be brought more than three years after the date when the retaliation occurred.

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1386, § 14, effective May 26. **L. 2013:** (5) added, (SB 13-205), ch. 276, p. 1442, § 6, effective August 7.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-308. False medicaid claims jurisdiction. An action under section 25.5-4-306 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, or transacts business or in which an act proscribed by section 25.5-4-305 occurred. A summons as required by the Colorado rules of civil procedure shall be issued by the appropriate district court and served at any place.

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1387, § 14, effective May 26.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-309. False medicaid claims civil investigation demands. (1) **General.** (a) (I) Whenever the attorney general has reason to believe that a person may be in possession, custody, or control of documentary material or information relevant to a false medicaid claims law investigation, the attorney general may, before commencing a civil proceeding under section 25.5-4-306 or other false medicaid claims law or making an election under section 25.5-4-306 (2)(d), issue in writing and cause to be served upon the person a civil investigative demand requiring the person to:

(A) Produce the documentary material for inspection and copying;

(B) Answer in writing written interrogatories with respect to the documentary material or information;

(C) Give oral testimony concerning the documentary material or information; or

(D) Furnish any combination of such material, answers, or testimony.

(II) The attorney general may not delegate the authority to issue civil investigative demands under this subsection (1). Whenever a civil investigative demand is an express demand for any product of discovery, the attorney general, the deputy attorney general, or an assistant

attorney general shall cause to be served, in any manner authorized by this section, a copy of the demand upon the person from whom the discovery was obtained and shall notify the person to whom the demand is issued of the date on which the copy was served.

(b) (I) Each civil investigative demand issued under this subsection (1) shall state the nature of the conduct constituting the alleged violation of a false medicaid claims law that is under investigation and the applicable provision of law alleged to be violated.

(II) If the demand is for the production of documentary material, the demand shall:

(A) Describe each class of documentary material to be produced with such definiteness and certainty as to permit the material to be fairly identified;

(B) Prescribe a return date for each such class that will provide a reasonable period of time within which the material so demanded may be assembled and made available for inspection and copying; and

(C) Identify the false medicaid claims law investigator to whom the material shall be made available.

(III) If the demand is for answers to written interrogatories, the demand shall:

(A) Specify the written interrogatories to be answered;

(B) Prescribe dates on which answers to written interrogatories shall be submitted; and

(C) Identify the false medicaid claims law investigator to whom the answers shall be submitted.

(IV) If the demand is for the giving of oral testimony, the demand shall:

(A) Prescribe a date, time, and place at which oral testimony shall be commenced and notify the deponent if the oral testimony is to be video or audio recorded;

(B) Identify a false medicaid claims law investigator who shall conduct the examination and the custodian to whom the transcript of the examination shall be submitted;

(C) Specify that such attendance and testimony are necessary to the conduct of the investigation;

(D) Notify the person receiving the demand of the right to be accompanied by an attorney and any other representative; and

(E) Describe the general purpose for which the demand is being issued and the general nature of the testimony, including the primary areas of inquiry, that will be taken pursuant to the demand.

(V) A civil investigative demand issued under this section that is an express demand for any product of discovery shall not be returned or returnable until twenty days after a copy of the demand has been served upon the person from whom the discovery was obtained.

(VI) The date prescribed for the commencement of oral testimony pursuant to a civil investigative demand issued under this section shall be a date that is not less than seven days after the date on which the demand is received, unless the attorney general or an assistant attorney general designated by the attorney general determines that exceptional circumstances are present that warrant the commencement of the testimony within a lesser period of time.

(VII) The attorney general shall not authorize the issuance under this section of more than one civil investigative demand for oral testimony by the same person unless the person requests otherwise or unless the attorney general, after investigation, notifies that person in writing that an additional demand for oral testimony is necessary. Notwithstanding section 24-31-103, C.R.S., the attorney general shall not authorize the performance, by any other officer,

employee, or agency, of any function vested in the attorney general under this subparagraph (VII).

(2) **Protected material or information.** (a) A civil investigative demand issued under subsection (1) of this section shall not require the production of documentary material, the submission of answers to written interrogatories, or the giving of oral testimony if the material, answers, or testimony would be protected from disclosure under:

(I) The standards applicable to subpoenas or subpoenas duces tecum issued by a court of this state to aid in a grand jury investigation; or

(II) The standards applicable to discovery requests under the Colorado rules of civil procedure, to the extent that the application of the standards to any such demand is appropriate and consistent with the provisions and purposes of this section.

(b) A demand that is an express demand for a product of discovery supersedes any inconsistent order, rule, or provision of law, other than this section, preventing or restraining disclosure of the product of discovery to a person. Disclosure of a product of discovery pursuant to an express demand does not constitute a waiver of any right or privilege that the person making the disclosure may be entitled to invoke to resist discovery of trial preparation materials.

(3) **Service and jurisdiction.** (a) A civil investigative demand issued under subsection (1) of this section or a petition brought pursuant to subsection (10) of this section may be served by a false medicaid claims law investigator, a sheriff, or a deputy sheriff at any place within the state.

(b) A civil investigative demand issued under subsection (1) of this section or a petition filed under subsection (10) of this section may be served upon a person who is not found within the state in the manner prescribed by the Colorado rules of civil procedure for service in another state or a foreign country. To the extent that the courts of this state can assert jurisdiction over any such person consistent with due process, the district court for the city and county of Denver shall have the same jurisdiction to take an action respecting compliance with this section by any such person that the court would have if the person were personally within the jurisdiction of the court.

(4) **Service on legal entities and natural persons.** (a) Service of a civil investigative demand issued under subsection (1) of this section or of a petition filed under subsection (10) of this section may be made upon a partnership, corporation, association, or other legal entity by:

(I) Delivering an executed copy of the demand or petition to a partner, executive officer, managing agent, or general agent of the partnership, corporation, association, or entity, or to an agent authorized by appointment or by law to receive service of process on behalf of the partnership, corporation, association, or entity;

(II) Delivering an executed copy of the demand or petition to the principal office or place of business of the partnership, corporation, association, or entity; or

(III) Depositing an executed copy of the demand or petition in the United States mail by registered or certified mail, with a return receipt requested, addressed to the partnership, corporation, association, or entity at its principal office or place of business.

(b) Service of a civil investigative demand issued under subsection (1) of this section or of a petition filed under subsection (10) of this section may be made upon a natural person by:

(I) Delivering an executed copy of the demand or petition to the person; or

(II) Depositing an executed copy of the demand or petition in the United States mail by registered or certified mail, with a return receipt requested, addressed to the person at the person's residence, principal office, or place of business.

(5) **Proof of service.** A verified return by the individual serving a civil investigative demand issued under subsection (1) of this section or a petition filed under subsection (10) of this section setting forth the manner of the service shall be proof of the service. In the case of service by registered or certified mail, the return shall be accompanied by the return post office receipt of delivery of the demand.

(6) **Documentary material.** (a) (I) The production of documentary material in response to a civil investigative demand issued under subsection (1) of this section shall be made under a sworn certificate, in the form as the demand designates, by:

(A) In the case of a natural person, the person to whom the demand is directed; or

(B) In the case of a person other than a natural person, a person having knowledge of the facts and circumstances relating to the production and authorized to act on behalf of the person.

(II) The certificate shall state that all of the documentary material required by the demand and in the possession, custody, or control of the person to whom the demand is directed has been produced and made available to the false medicaid claims law investigator identified in the demand.

(b) A person upon whom a civil investigative demand for the production of documentary material has been served under this section shall make the material available for inspection and copying to the false medicaid claims law investigator identified in the demand at the principal place of business of the person, or at such other place as the false medicaid claims law investigator and the person thereafter may agree and prescribe in writing, or as the court may direct under subsection (10) of this section. The material shall be made so available on the return date specified in the demand, or on such later date as the false medicaid claims law investigator may prescribe in writing. The person may, upon written agreement between the person and the false medicaid claims law investigator, substitute copies for originals of all or any part of the material.

(7) **Interrogatories.** (a) Each interrogatory in a civil investigative demand issued under subsection (1) of this section shall be answered separately and fully in writing under oath and shall be submitted under a sworn certificate, in the form the demand designates, by:

(I) In the case of a natural person, the person to whom the demand is directed; or

(II) In the case of a person other than a natural person, the person or persons responsible for answering each interrogatory.

(b) If an interrogatory is objected to, the reasons for the objection shall be stated in the certificate instead of an answer. The certificate shall state that all information required by the demand and in the possession, custody, control, or knowledge of the person to whom the demand is directed has been submitted. To the extent that any information is not furnished, the information shall be identified and reasons set forth with particularity regarding the reasons why the information was not furnished.

(8) **Oral examinations.** (a) The examination of a person pursuant to a civil investigative demand for oral testimony issued under subsection (1) of this section shall be taken before an officer authorized to administer oaths and affirmations by the laws of the United States, the state of Colorado, or the place where the examination is held. The officer before whom the testimony is to be taken shall put the witness on oath or affirmation and shall,

personally or with the assistance of someone acting under the direction of the officer and in the officer's presence, record the testimony of the witness. The testimony shall be taken stenographically and shall be transcribed. When the testimony is fully transcribed, the officer before whom the testimony is taken shall promptly transmit a copy of the transcript of the testimony to the custodian. This subsection (8) shall not preclude the taking of testimony by any means authorized by, and in a manner consistent with, the Colorado rules of civil procedure.

(b) The false medicaid claims law investigator conducting the examination shall exclude from the place where the examination is held all persons except the person giving the testimony, the attorney for and any other representative of the person giving the testimony, the attorney for the state, any person who may be agreed upon by the attorney for the state and the person giving the testimony, the officer before whom the testimony is to be taken, and the stenographer who is recording the testimony.

(c) The oral testimony of a person taken pursuant to a civil investigative demand served under this section shall be taken in the judicial district of the state within which the person resides, is found, or transacts business, or in another place as may be agreed upon by the false medicaid claims law investigator conducting the examination and the person.

(d) When the testimony is fully transcribed, the false medicaid claims law investigator or the officer before whom the testimony is taken shall afford the witness, who may be accompanied by counsel, a reasonable opportunity to examine and read the transcript, unless the witness waives the examination and reading. Any changes in form or substance that the witness desires to make shall be entered and identified upon the transcript by the officer or the false medicaid claims law investigator, with a statement of the reasons given by the witness for making the changes. The transcript shall then be signed by the witness, unless the witness in writing waives the signing, is ill, cannot be found, or refuses to sign. If the witness does not sign the transcript within thirty days after being afforded a reasonable opportunity to examine it, the officer or the false medicaid claims law investigator shall sign it and state on the record the fact of the waiver, illness, absence of the witness, or refusal to sign, together with the reasons, if any, given therefor.

(e) The officer before whom the testimony is taken shall certify on the transcript that the witness was sworn by the officer and that the transcript is a true record of the testimony given by the witness, and the officer or false medicaid claims law investigator shall promptly deliver the transcript, or send the transcript by registered or certified mail, to the custodian.

(f) Upon payment of reasonable charges therefor, the false medicaid claims law investigator shall furnish a copy of the transcript to the witness only; except that the attorney general, the deputy attorney general, or an assistant attorney general may, for good cause, limit the witness to inspection of the official transcript of the testimony of the witness.

(g) (I) A person compelled to appear for oral testimony under a civil investigative demand issued under subsection (1) of this section may be accompanied, represented, and advised by counsel. Counsel may advise the person, in confidence, with respect to any question asked of the person. The person or counsel may object on the record to any question, in whole or in part, and shall briefly state for the record the reason for the objection. An objection may be made, received, and entered upon the record when it is claimed that the person is entitled to refuse to answer the question on the grounds of any constitutional or other legal right or privilege, including the privilege against self-incrimination. The person may not otherwise object to or refuse to answer any question and may not directly or through counsel otherwise interrupt

the oral examination. If the person refuses to answer a question, the false medicaid claims law investigator may file a petition in a district court under paragraph (a) of subsection (10) of this section for an order compelling the person to answer the question.

(II) If the person refuses to answer a question on the grounds of the privilege against self-incrimination, the false medicaid claims law investigator may compel the testimony of the person in accordance with the provisions of section 13-90-118, C.R.S.

(III) A person appearing for oral testimony under a civil investigative demand issued under subsection (1) of this section shall be entitled to the same fees and allowances that are paid to witnesses in the district courts of this state.

(9) **Custodian of documents, answers, and transcripts.** (a) The attorney general shall designate a false medicaid claims law investigator to serve as custodian of documentary material, answers to interrogatories, and transcripts of oral testimony received under this section and shall designate such additional false medicaid claims law investigators as the attorney general determines from time to time to be necessary to serve as deputies to the custodian.

(b) (I) A false medicaid claims law investigator who receives any documentary material, answers to interrogatories, or transcripts of oral testimony under this section shall transmit them to the custodian. The custodian shall take physical possession of the material, answers, or transcripts and shall be responsible for the use made of them and for the return of documentary material under paragraph (d) of this subsection (9).

(II) The custodian may cause the preparation of copies of the documentary material, answers to interrogatories, or transcripts of oral testimony as may be required for official use by a false medicaid claims law investigator or other officer or employee of the department of law who is authorized for such use under regulations that the attorney general shall issue. The material, answers, and transcripts may be used by any such authorized false medicaid claims law investigator or other officer or employee in connection with the taking of oral testimony under this section.

(III) (A) Except as otherwise provided in this subsection (9), documentary material, answers to interrogatories, or transcripts of oral testimony, or copies thereof, while in the possession of the custodian, shall not be available for examination by an individual other than a false medicaid claims law investigator or other officer or employee of the department of law authorized under subparagraph (II) of this paragraph (b).

(B) Sub-subparagraph (A) of this subparagraph (III) shall not apply if consent is given by the person who produced the material, answers, or transcripts or, in the case of any product of discovery produced pursuant to an express demand for the material, if consent is given by the person from whom the discovery was obtained.

(C) Nothing in this subparagraph (III) is intended to prevent disclosure to the general assembly, including any committee of the general assembly, or to any other agency of the state for use by the agency in furtherance of its statutory responsibilities. Disclosure of information to any such other agency shall be allowed only upon application, made by the attorney general to a district court, showing substantial need for the use of the information by the agency in furtherance of its statutory responsibilities.

(IV) While in the possession of the custodian and under such reasonable terms and conditions as the attorney general shall prescribe:

(A) Documentary material and answers to interrogatories shall be available for examination by the person who produced the material or answers, or by a representative of that person authorized by that person to examine the material and answers; and

(B) Transcripts of oral testimony shall be available for examination by the person who produced the testimony or by a representative of that person authorized by that person to examine the transcripts.

(c) Whenever an attorney of the department of law has been designated to appear before a court, grand jury, or state agency in a case or proceeding, the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony received under this section may deliver to the attorney such material, answers, or transcripts for official use in connection with the case or proceeding as the attorney determines to be required. Upon the completion of the case or proceeding, the attorney shall return to the custodian the material, answers, or transcripts so delivered that are not in the control of the court, grand jury, or agency through introduction into the record of the case or proceeding.

(d) The custodian shall, upon written request of a person who produced any documentary material in the course of any false medicaid claims law investigation pursuant to a civil investigative demand under this section, return to the person any such material, other than copies furnished to the false medicaid claims law investigator under paragraph (b) of subsection (6) of this section or made for the department of law under subparagraph (II) of paragraph (b) of this subsection (9), that is not in the control of a court, grand jury, or agency through introduction into the record of the case or proceeding, if:

(I) A case or proceeding before a court or grand jury arising out of the investigation or any proceeding before a state agency involving the material has been completed; or

(II) A case or proceeding in which the material may be used has not been commenced within a reasonable time after completion of the examination and analysis of all documentary material and other information assembled in the course of the investigation.

(e) (I) In the event of the death, disability, or separation from service in the department of law of the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony produced pursuant to a civil investigative demand under this section, or in the event of the official relief of the custodian from responsibility for the custody and control of the material, answers, or transcripts, the attorney general shall promptly:

(A) Designate another false medicaid claims law investigator to serve as custodian of the material, answers, or transcripts; and

(B) Transmit in writing to the person who produced the material, answers, or testimony notice of the identity and address of the successor so designated.

(II) A person who is designated to be a successor under this paragraph (e) shall have, with regard to the material, answers, or transcripts, the same duties and responsibilities as were imposed by this section upon that person's predecessor in office; except that the successor shall not be held responsible for any default or dereliction that occurred before that designation.

(10) **Judicial proceedings.** (a) Whenever a person fails to comply with a civil investigative demand issued under subsection (1) of this section, or whenever satisfactory copying or reproduction of the material requested in a demand cannot be done and the person refuses to surrender the material, the attorney general may file, in a district court for the judicial district in which the person resides, is found, or transacts business, and serve upon the person a petition for an order of the court for the enforcement of the civil investigative demand.

(b) (I) A person who has received a civil investigative demand issued under subsection (1) of this section may file a petition for an order of the court to modify or set aside the demand. The person shall file the petition in a district court for the judicial district within which the person resides, is found, or transacts business and shall serve a copy of the petition upon the false medicaid claims law investigator identified in the demand. In the case of a petition addressed to an express demand for a product of discovery, the person may file a petition to modify or set aside the demand only in the district court for the judicial district in which the proceeding in which the discovery was obtained is or was last pending. The person shall file a petition under this subparagraph (I):

(A) Within twenty days after the date of service of the civil investigative demand or at any time before the return date specified in the demand, whichever date is earlier; or

(B) Within such longer period as may be prescribed in writing by a false medicaid claims law investigator identified in the demand.

(II) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (I) of this paragraph (b) and may be based upon any failure of the demand to comply with the provisions of this section or upon any constitutional or other legal right or privilege of the person. During the pendency of the petition in the court, the court may stay, as it deems proper, the running of the time allowed for compliance with the demand, in whole or in part; except that the person filing the petition shall comply with any portions of the demand not sought to be modified or set aside.

(c) (I) In the case of a civil investigative demand issued under subsection (1) of this section that is an express demand for a product of discovery, the person from whom the discovery was obtained may file a petition for an order of the court to modify or set aside those portions of the demand requiring production of any product of discovery. The person shall file the petition in the district court for the judicial district in which the proceeding in which the discovery was obtained is or was last pending and shall serve a copy of the petition upon the false medicaid claims law investigator identified in the demand and upon the recipient of the demand. The person shall file a petition under this subparagraph (I):

(A) Within twenty days after the date of service of the civil investigative demand or at any time before the return date specified in the demand, whichever date is earlier; or

(B) Within such longer period as may be prescribed in writing by the false medicaid claims law investigator identified in the demand.

(II) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (I) of this paragraph (c), and may be based upon any failure of the portions of the demand from which relief is sought to comply with the provisions of this section or upon any constitutional or other legal right or privilege of the petitioner. During the pendency of the petition, the court may stay, as it deems proper, compliance with the demand and the running of the time allowed for compliance with the demand.

(d) At any time during which a custodian is in custody or control of any documentary material or answers to interrogatories produced, or transcripts of oral testimony given, by a person in compliance with a civil investigative demand issued under subsection (1) of this section, the person, and in the case of an express demand for any product of discovery, the person from whom the discovery was obtained, may file a petition for an order of the court to require the performance by the custodian of any duty imposed upon the custodian by this

section. The person shall file the petition in the district court for the judicial district within which the office of the custodian is situated and shall serve a copy of the petition upon the custodian.

(e) Whenever a petition is filed in a district court under this subsection (10), the court shall have jurisdiction to hear and determine the matter so presented and to enter such order or orders as may be required to carry out the provisions of this section. A final order so entered shall be subject to appeal under section 13-4-102, C.R.S. Any disobedience of a final order entered by a court under this section shall be punished as a contempt of the court.

(f) The Colorado rules of civil procedure shall apply to a petition under this subsection (10) to the extent that the rules are consistent with the provisions of this section.

(11) **Disclosure exemption.** Any documentary material, answers to written interrogatories, or oral testimony provided under a civil investigative demand issued under subsection (1) of this section shall be exempt from disclosure under section 24-72-203, C.R.S.

(12) **Definitions.** As used in this section, unless the context otherwise requires:

(a) "Custodian" means the custodian, or any deputy custodian, designated by the attorney general under paragraph (a) of subsection (9) of this section.

(b) "Documentary material" means the original or a copy of a book, record, report, memorandum, paper, communication, tabulation, chart, or other document, or data compilations stored in or accessible through computer or other information retrieval systems, together with instructions and all other materials necessary to use or interpret the data compilations, and any product of discovery.

(c) "False medicaid claims law" means:

(I) This section and sections 25.5-4-303.5 to 25.5-4-308; and

(II) Any law enacted before, on, or after May 26, 2010, that prohibits or makes available to the state in a court of the state a civil remedy with respect to a false medicaid claim against, bribery of, or corruption of an officer or employee of the state.

(d) "False medicaid claims law investigation" means an inquiry conducted by a false medicaid claims law investigator for the purpose of ascertaining whether a person is or has been engaged in a violation of a false medicaid claims law.

(e) "False medicaid claims law investigator" means an attorney or investigator employed by the department of law who is charged with the duty of enforcing or carrying into effect a false medicaid claims law or an officer or employee of the state acting under the direction and supervision of the attorney or investigator in connection with a false medicaid claims law investigation.

(f) "Person" means a natural person, partnership, corporation, association, or other legal entity.

(g) "Product of discovery" means:

(I) The original or duplicate of a deposition, interrogatory, document, thing, result of the inspection of land or other property, examination, or admission, any one of which is obtained by a method of discovery in a judicial or administrative proceeding of an adversarial nature;

(II) A digest, analysis, selection, compilation, or derivation of an item listed in subparagraph (I) of this paragraph (g); and

(III) An index or other manner of access to an item listed in subparagraph (I) of this paragraph (g).

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1387, § 14, effective May 26.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-4-310. Medicaid false claims report. (1) Notwithstanding section 24-1-136 (11)(a)(I), on or before January 15, 2012, and on or before each January 15 thereafter, the attorney general shall submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, and to the joint budget committee of the general assembly concerning claims brought under the "Colorado Medicaid False Claims Act" during the previous fiscal year. The report shall include, but not be limited to:

(a) The number of actions filed by the attorney general;

(b) The number of actions filed by the attorney general that were completed;

(c) The amount that was recovered in actions filed by the attorney general through settlement or through a judgment and, if known, the amount recovered for damages, penalties, and litigation costs;

(d) The number of actions filed by a person other than the attorney general;

(e) The number of actions filed by a person other than the attorney general that were completed;

(f) The amount that was recovered in actions filed by a person other than the attorney general through settlement or through a judgment and, if known, the amount recovered for damages, penalties, and litigation costs, and the amount recovered by the state and the person; and

(g) The amount expended by the state for investigation, litigation, and all other costs for claims related to the "Colorado Medicaid False Claims Act".

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1399, § 14, effective May 26. **L. 2017:** IP(1) amended, (SB 17-233), ch. 175, p. 637, § 3, effective August 9.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

PART 4

PROVIDERS - REIMBURSEMENT

25.5-4-401. Providers - payments - rules. (1) (a) The state department shall establish rules for the payment of providers under this article and articles 5 and 6 of this title. Within the

limits of available funds, such rules shall provide reasonable compensation to such providers, but no provider shall, by this section or any other provision of this article or article 5 or 6 of this title, be deemed to have any vested right to act as a provider under this article and articles 5 and 6 of this title or to receive any payment in addition to or different from that which is currently payable on behalf of a recipient at the time the medical benefits are provided by said provider.

(b) (I) On and after July 1, 1992, the state department rules established for the payment of providers under this article and articles 5 and 6 of this title shall provide that services that are compensable under both Title XIX and Title XVIII of the social security act shall be paid at either the rate established under Title XIX or the rate established under Title XVIII, whichever is lower.

(II) If any provision of this paragraph (b) is found to be in conflict with any federal law or regulation, such conflicting portion of this paragraph (b) is declared to be inoperative to the extent of the conflict.

(c) The state department shall exercise its overexpenditure authority under section 24-75-109, C.R.S., and shall not intentionally interrupt the normal provider payment schedule unless notified jointly by the director of the office of state planning and budgeting and the state controller that there is the possibility that adequate cash will not be available to make payments to providers and for other state expenses. If it is determined that adequate cash is not available and the state department does interrupt the normal payment cycle, the state department shall notify the joint budget committee of the general assembly and any affected providers in writing of its decision to interrupt the normal payment schedule. Nothing in this paragraph (c) shall be interpreted to establish a right for any provider to be paid during any specific billing cycle.

(d) Repealed.

(2) As to all payments made pursuant to this article and articles 5 and 6 of this title, the state department rules for the payment of providers may include provisions that encourage the highest quality of medical benefits and the provision thereof at the least expense possible.

(3) (a) As used in this subsection (3), "capitated" means a method of payment by which a provider directly delivers or arranges for delivery of medical care benefits for a term established by contract with the state department based on a fixed rate of reimbursement per recipient.

(b) (I) In order to provide medical benefits under this article and articles 5 and 6 of this title on a capitated basis and subject to the condition imposed in subparagraph (II) of this paragraph (b), the state department is authorized to solicit negotiated contracts with providers based upon the requirements of this subsection (3). The state department may contract with one or more providers concerning the same medical services in a single geographic area.

(II) The state department may award a contract to one or more providers pursuant to subparagraph (I) of this paragraph (b) when the executive director determines that such contract will reduce the costs of providing medical benefits under this article and articles 5 and 6 of this title.

(III) The state department may define groups of recipients by geographic area or other categories and may require that all members of the defined group obtain medical services through one or more provider contracts entered into pursuant to this subsection (3).

(4) (a) The general assembly hereby finds, determines, and declares that access to health care services would be improved and costs of health care would be restrained if the recipients of the medicaid program would choose a primary care physician through a managed care provider.

For purposes of this subsection (4), "managed care provider" means either a primary care physician program, a health maintenance organization, or a prepaid health plan.

(b) Subject to the provisions of paragraph (c) of this subsection (4), the executive director of the state department has the authority to require a recipient of the medicaid program to select a managed care provider and to assign a recipient to a managed care provider if the recipient has failed to make a selection within a reasonable time. To the extent possible, this requirement shall be implemented on a statewide basis.

(c) The state department shall ensure the following:

(I) A managed care provider shall establish and implement consumer friendly procedures and instructions for disenrollment and shall have adequate staff to explain issues concerning service delivery and disenrollment procedures to recipients, including staff to address the communications needs and requirements of recipients with disabilities.

(II) All recipients shall be adequately informed about service delivery options available to them consistent with the provisions of this subparagraph (II). If a recipient does not respond to a state department request for selection of a delivery option within forty-five calendar days, the state department shall send a second notification to the recipient. If the recipient does not respond within twenty days of the date of the second notification, the state department shall ensure that the recipient remains with the recipient's primary care physician, regardless of whether said primary care physician is enrolled in a health maintenance organization.

(5) The state board may promulgate rules to provide for the implementation and administration of subsections (3) and (4) of this section.

(6) The state department shall make good faith efforts to obtain a waiver or waivers from any requirements of Title XIX of the social security act which would prohibit the implementation of subsections (3) and (4) of this section. Such waiver or waivers shall be obtained from the federal department of health and human services, or any successor agency. If such waivers are not granted, the state department shall not act to implement or administer subsections (3) and (4) of this section to the extent that Title XIX prohibits it.

Source: L. 2006: Entire article added with relocations, p. 1841, § 7, effective July 1. **L. 2009:** (1)(d) added, (SB 09-265), ch. 205, p. 935, § 2, effective May 1. **L. 2010:** (1)(d) repealed, (HB 10-1382), ch. 217, p. 939, § 1, effective May 6.

Editor's note: This section is similar to former § 26-4-404 as it existed prior to 2006.

25.5-4-401.2. Performance-based payments - reporting. (1) To improve health outcomes and lower health care costs, the state department may develop payments to providers that are based on quantifiable performance or measures of quality of care. These performance-based payments may include, but are not limited to, payments to:

(a) Primary care providers;

(b) Federally qualified health centers;

(c) Providers of long-term care services and supports; and

(d) Behavioral health providers, including, but not limited to:

(I) Community mental health centers, as defined in section 27-66-101; and

(II) Entities contracted with the department to administer the medicaid community mental health services program, established in section 25.5-5-411.

(2) (a) Prior to implementing performance-based payments in the medicaid program pursuant to this article 4 and articles 5 and 6 of this title 25.5, including performance-based payments set forth in this section, the state department shall submit to the joint budget committee:

(I) (A) Evidence that the performance-based payments are designed to achieve budget savings; or

(B) A budget request for costs associated with the performance-based payments;

(II) The estimated performance-based payments compared to total reimbursements for the affected service; and

(III) A description of the stakeholder engagement process for developing the performance-based payments, including the participants in the process and a summary of the stakeholder feedback, and the state department's response to stakeholder feedback.

(b) The information required pursuant to subsection (2)(a) of this section must be provided on or before November 1 for performance-based payments that will take effect in the following fiscal year unless the state department includes with its submission an explanation of the need for faster implementation of the payment. If faster implementation is requested, the state department shall provide the information at least three months prior to the implementation of the performance-based payments unless compliance with federal law necessitates shorter notice.

(3) On or before November 1, 2017, and on or before November 1 each year thereafter, the state department shall submit a report to the joint budget committee, the public health care and human services committee of the house of representatives, and the health and human services committee of the senate, or any successor committees, describing rules adopted by the state board and contract provisions approved by the centers for medicare and medicaid services in the preceding calendar year that authorize payments to providers based on performance. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), the report required pursuant to this subsection (3) continues indefinitely. The report must include, at a minimum:

(a) A description of performance-based payments included in state board rules, including which performance standards are targeted with each performance-based payment;

(b) A description of the goals and objectives of the performance-based payments, and how those goals and objectives align with other quality improvement initiatives;

(c) A summary of the research-based evidence for the performance-based payments, to the extent such evidence is available;

(d) A summary of the anticipated impact and clinical and nonclinical outcomes of implementing the performance-based payments;

(e) A description of how the impact or outcomes will be evaluated;

(f) An explanation of steps taken by the state department to limit the administrative burden on providers;

(g) A summary of the stakeholder engagement process with respect to each performance-based payment, including major concerns raised through the stakeholder process and how those concerns were remediated;

(h) When available, evaluation results for performance-based payments that were implemented in prior years; and

(i) A description of proposed modifications to current performance-based payments.

Source: L. 2017: Entire section added, (HB 17-1353), ch. 231, p. 898, § 3, effective May 23.

25.5-4-401.5. Review of provider rates - advisory committee - recommendations - repeal. (1) (a) On or before September 1, 2015, the state department shall establish a schedule for an annual review of provider rates paid under the "Colorado Medical Assistance Act" so that each provider rate is reviewed at least every five years and shall provide the schedule to the joint budget committee. If the state department receives any petitions or proposals for provider rates to be reviewed or adjusted, the state department must forward a copy of the petition or proposal to the advisory committee.

(b) The state department shall review each of the provider rates scheduled for review pursuant to the process described in this section. Additionally, the advisory committee established pursuant to subsection (3) of this section, by a majority vote, or the joint budget committee, by a majority vote, may direct that the state department conduct a review of a provider rate that is not scheduled for review during that year. The advisory committee or the joint budget committee shall notify the state department by December 1 of the year prior to the year in which the out-of-cycle review will take place of the request for an out-of-cycle review.

(c) (I) The state department may propose to exclude rates from the schedule established pursuant to paragraph (a) of this subsection (1) if those rates are adjusted on a periodic basis as a result of other state statute or federal law or regulation. The state department shall include the proposed list of exclusions with the schedule established pursuant to paragraph (a) of this subsection (1).

(II) The advisory committee or the joint budget committee may, by a majority vote, direct the state department to include any rate that the state department has proposed to exclude from the schedule.

(2) (a) In the first phase of the review process, the state department shall conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review. The state department shall compare the rates paid with available benchmarks, including medicare rates and usual and customary rates paid by private pay parties, and use qualitative tools to assess whether payments are sufficient to allow for provider retention and client access and to support appropriate reimbursement of high-value services. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), on or before May 1, 2016, and each May 1 thereafter, the state department shall provide a report on the analysis required by this paragraph (a) to the advisory committee, the joint budget committee, and any stakeholder groups identified by the state department whose rates are reviewed.

(b) Following the report required by paragraph (a) of this subsection (2), the state department shall work with the advisory committee and any stakeholders identified by the state department to review the report and develop strategies for responding to the findings, including any nonfiscal approaches or rebalancing of rates.

(c) Following the review required by paragraph (b) of this subsection (2), the state department shall work with the office of state planning and budgeting to determine achievable goals and executive branch priorities within the statewide budget.

(d) Notwithstanding the provisions of section 24-1-136 (11)(a)(I), on or before November 1, 2016, and each November 1 thereafter, the state department shall submit a written report to the joint budget committee and the advisory committee containing its recommendations

on all of the provider rates reviewed pursuant to this section and all of the data relied upon by the state department in making its recommendations. The joint budget committee shall consider the recommendations in formulating the budget for the state department.

(3) (a) There is created in the state department the medicaid provider rate review advisory committee, referred to in this section as the "advisory committee", to assist the state department in the review of the provider rate reimbursements under the "Colorado Medical Assistance Act". The advisory committee shall:

(I) Review the schedule for annual review of provider rates established by the state department pursuant to paragraph (a) of subsection (1) of this section and recommend any changes to the schedule;

(II) Review the reports prepared by the state department on its analysis of provider rates pursuant to paragraph (a) of subsection (2) of this section and provide comments and feedback to the state department on the reports;

(III) With the state department, conduct public meetings to allow providers, recipients, and other interested parties an opportunity to comment on the report required by paragraph (a) of subsection (2) of this section;

(IV) Review proposals or petitions for provider rates to be reviewed or adjusted received by the advisory committee;

(V) Determine whether any provider rates not scheduled for review during the next calendar year should be reviewed during that calendar year;

(VI) Recommend to the state department and to the joint budget committee any changes to the process of reviewing provider rates, including measures to increase access to the process such as by providing for electronic comments by providers and the public; and

(VII) Provide other assistance to the state department as requested by the state department or the joint budget committee.

(b) The advisory committee consists of the following twenty-four members:

(I) The following members appointed by the president of the senate:

(A) A recipient with a disability or a representative of recipients with a disability;

(B) A representative of hospitals providing services to recipients recommended by a statewide association of hospitals;

(C) A representative of providers of transportation;

(D) A representative of rural health centers;

(E) A representative of home health providers recommended by a statewide organization of home health providers; and

(F) A representative of providers of durable medical equipment recommended by a statewide association of durable medical equipment providers;

(II) The following members appointed by the minority leader of the senate:

(A) A representative of providers of behavioral health care services;

(B) A representative of primary care physicians who see recipients recommended by a statewide association of primary care physicians;

(C) A representative of dentists providing services to recipients recommended by a statewide association of dentists;

(D) A representative of federally qualified health centers;

(E) A representative of nonmedical home- and community-based service providers; and

(F) A representative of providers serving recipients with intellectual and developmental disabilities;

(III) The following members appointed by the speaker of the house of representatives:

(A) A representative of child recipients with a disability;

(B) A representative of specialty care physicians not employed by a hospital who see recipients recommended by a statewide association whose members include at least one-third of the doctors of medicine or osteopathy licensed by the state;

(C) A representative of providers of alternative care facilities recommended by a statewide association of alternative care facilities;

(D) A representative of single entry point agencies;

(E) A representative of ambulatory surgical centers;

(F) A representative of hospice providers recommended by a statewide association of hospice and palliative care providers; and

(IV) The following members appointed by the minority leader of the house of representatives:

(A) A representative of substance use disorder providers recommended by a statewide association of substance use disorder providers;

(B) A representative of facility-based physicians who see recipients. For purposes of this sub-subparagraph (B), "facility-based physicians" include anesthesiologists, emergency room physicians, neonatologists, pathologists, and radiologists.

(C) A representative of pharmacists providing services to recipients;

(D) A representative of managed care health plans;

(E) A representative of advanced practice nurses recommended by a statewide association of nurses; and

(F) A representative of physical therapists or occupational therapists recommended by a statewide association representing occupational or physical therapists.

(c) The appointing authorities shall make their initial appointments to the advisory committee no later than August 1, 2015. In making appointments to the advisory committee, the appointing authorities shall make a concerted effort to include members of diverse political, racial, cultural, income, and ability groups and members from urban and rural areas.

(d) Each member of the advisory committee serves at the pleasure of the official who appointed the member. Each member of the advisory committee serves a four-year term and may be reappointed.

(e) The members of the advisory committee serve without compensation and without reimbursement for expenses.

(f) At the first meeting of the advisory committee, to be held on or after September 1, 2015, the members shall elect a chair and vice-chair from among the members.

(g) The advisory committee shall meet at least once every quarter. The chair may call such additional meetings as may be necessary for the advisory committee to complete its duties.

(h) The advisory committee shall develop bylaws and procedures to govern its operations.

(i) (I) This subsection (3) is repealed, effective September 1, 2025.

(II) Prior to repeal, the department of regulatory agencies shall conduct a sunset review of the advisory committee pursuant to the provisions of section 2-3-1203, C.R.S.

Source: L. 2015: Entire section added, (SB 15-228), ch. 288, p. 1177, § 1, effective June 5. **L. 2017:** (2)(a) and (2)(d) amended, (HB 17-1060), ch. 6, p. 17, § 9, effective March 1.

25.5-4-402. Providers - hospital reimbursement - rules. (1) For all licensed or certified hospitals contracting for services under this article and articles 5 and 6 of this title, except those hospitals operated by the department of human services or those hospitals deemed exempt by the state board, the state department shall pay for inpatient hospital services pursuant to a system of prospective payment, generally based on the elements of a diagnosis-related group system. The state department shall develop and administer a system for ensuring appropriate utilization and quality of care provided by those providers who are reimbursed under this section. Subject to available appropriations, the state department may also make supplemental medicaid payments to certain hospitals. The state board shall promulgate rules to provide for the implementation of this section.

(2) (a) A hospital that receives payment under this article and articles 5 and 6 of this title for telemedicine services shall employ its existing quality-of-care protocols and patient confidentiality guidelines to ensure that such services meet the requirements of this article and articles 5 and 6 of this title.

(b) The executive director of the state department shall adopt rules in furtherance of this subsection (2), including, without limitation, rules to:

(I) Ensure the provision of appropriate care to patients;

(II) Prevent fraud and abuse; and

(III) Establish methods and procedures to avoid overuse of telemedicine services.

(3) (a) In addition to the reimbursement rate process described in subsection (1) of this section and subject to adequate funding being made available pursuant to section 25.5-4-402.4, the Colorado healthcare affordability and sustainability enterprise created in section 25.5-4-402.4 (3) shall pay an additional amount based upon performance to those hospitals that provide services that improve health care outcomes for their patients. The state department shall determine this amount based upon nationally recognized performance measures established in rules adopted by the state board. The state quality standards must be consistent with federal quality standards published by an organization with expertise in health care quality, including but not limited to, the centers for medicare and medicaid services, the agency for healthcare research and quality, or the national quality forum.

(b) The amount of the payments made pursuant to this subsection (3) shall be computed annually. For the first two fiscal years that payments are made pursuant to this subsection (3), the total amount of the payments shall be up to five percent of the total reimbursements made to hospitals in the previous year. For each fiscal year after the first two fiscal years, the total amount of the payments shall be up to seven percent of the total reimbursements made to hospitals in the previous year.

Source: L. 2006: Entire article added with relocations, p. 1844, § 7, effective July 1; entire section amended, p. 1546, § 3, effective July 1. **L. 2009:** (1) amended and (3) added, (HB 09-1293), ch. 152, p. 645, § 4, effective July 1. **L. 2017:** (3)(a) amended, (SB 17-267), ch. 267, p. 1448, § 15, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-405 as it existed prior to 2006.

(2) Amendments to section 26-4-405 by Senate Bill 06-165 were harmonized with this section as it appeared in Senate Bill 06-219.

(3) Section 34 of chapter 267 (SB 17-267), Session Laws of Colorado 2017, provides that the section of the act changing this section does not take effect if the centers for medicare and medicaid services determine that the amendments do not comply with federal law. For more information, see SB 17-267. (L. 2017, p. 1478.) The executive director of the department of health care policy and financing did not notify the revisor of statutes by June 1, 2017, of such determination; therefore, the changes to this section took effect July 1, 2017.

Cross references: (1) For the legislative declaration contained in the 2006 act amending this section, see section 1 of chapter 312, Session Laws of Colorado 2006.

(2) For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal. (Repealed)

Source: L. 2009: Entire section added, (HB 09-1293), ch. 152, p. 633, § 1, effective July 1. **L. 2010:** (4)(b)(VIII) added, (SB 10-169), ch. 307, p. 1445, § 1, effective May 27; (4)(b)(IV) amended, (HB 10-1422), ch. 419, p. 2110, § 141, effective August 11. **L. 2011:** (3)(a)(II) and (3)(a)(III) amended and (3)(a)(IV), (4)(b)(IX), and (5)(b.5) added, (SB 11-212), ch. 146, pp. 508, 509, §§ 1, 2, 3, effective May 5. **L. 2013:** (4)(b)(IV)(A) and (4)(b)(IV)(C) amended, (SB 13-200), ch. 216, p. 897, § 1, effective May 13. **L. 2017:** (5)(b.3) added, (SB 17-256), ch. 198, p. 720, § 1, effective May 8; entire section repealed, (SB 17-267), ch. 267, p. 1448, § 16, effective July 1.

Editor's note: (1) For amendments in SB 17-256 in effect from May 8, 2017, to July 1, 2017, see chapter 198, Session Laws of Colorado 2017. (L. 2017, p. 720.)

(2) Section 34 of chapter 267 (SB 17-267), Session Laws of Colorado 2017, provides that the section of the act repealing this section does not take effect if the centers for medicare and medicaid services determine that the amendments do not comply with federal law. For more information, see SB 17-267. (L. 2017, p. 1478.) The executive director of the department of health care policy and financing did not notify the revisor of statutes by June 1, 2017, of such determination; therefore, the repeal of this section took effect July 1, 2017.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-4-402.4. Hospitals - healthcare affordability and sustainability fee - legislative declaration - Colorado healthcare affordability and sustainability enterprise - federal waiver - fund created - rules. (1) **Short title.** The short title of this section is the "Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017".

(2) **Legislative declaration.** The general assembly hereby finds and declares that:

(a) The state and the providers of publicly funded medical services, and hospitals in particular, share a common commitment to comprehensive health care reform;

(b) Hospitals within the state incur significant costs by providing uncompensated emergency department care and other uncompensated medical services to low-income and uninsured populations;

(c) This section is enacted as part of a comprehensive health care reform and is intended to provide the following services and benefits to hospitals and individuals:

(I) Providing a payer source for some low-income and uninsured populations who may otherwise be cared for in emergency departments and other settings in which uncompensated care is provided;

(II) Reducing the underpayment to Colorado hospitals participating in publicly funded health insurance programs;

(III) Reducing the number of persons in Colorado who are without health care benefits;

(IV) Reducing the need of hospitals and other health care providers to shift the cost of providing uncompensated care to other payers;

(V) Expanding access to high-quality, affordable health care for low-income and uninsured populations; and

(VI) Providing the additional business services specified in subsection (4)(a)(IV) of this section to hospitals that pay the healthcare affordability and sustainability fee charged and collected as authorized by subsection (4) of this section by the Colorado healthcare affordability and sustainability enterprise created in subsection (3)(a) of this section;

(d) The Colorado healthcare affordability and sustainability enterprise provides business services to hospitals when, in exchange for payment of healthcare affordability and sustainability fees by hospitals, it:

(I) Obtains federal matching money and returns both the healthcare affordability and sustainability fee and the federal matching money to hospitals to increase reimbursement rates to hospitals for providing medical care under the state medical assistance program and the Colorado indigent care program and to increase the number of individuals covered by public medical assistance; and

(II) Provides additional business services to hospitals as specified in subsection (4)(a)(IV) of this section;

(e) It is necessary, appropriate, and in the best interest of the state to acknowledge that by providing the business services specified in subsections (2)(d)(I) and (2)(d)(II) of this section, the Colorado healthcare affordability and sustainability enterprise engages in an activity conducted in the pursuit of a benefit, gain, or livelihood and therefore operates as a business;

(f) Consistent with the determination of the Colorado supreme court in *Nicholl v. E-470 Public Highway Authority,* 896 P.2d 859 (Colo. 1995), that the power to impose taxes is inconsistent with enterprise status under section 20 of article X of the state constitution, it is the conclusion of the general assembly that the healthcare affordability and sustainability fee charged and collected by the Colorado healthcare affordability and sustainability enterprise is a fee, not a tax, because the fee is imposed for the specific purposes of allowing the enterprise to defray the costs of providing the business services specified in subsections (2)(d)(I) and (2)(d)(II) of this section to hospitals that pay the fee and is collected at rates that are reasonably calculated based on the benefits received by those hospitals; and

(g) So long as the Colorado healthcare affordability and sustainability enterprise qualifies as an enterprise for purposes of section 20 of article X of the state constitution, the revenues from the healthcare affordability and sustainability fee charged and collected by the enterprise are not state fiscal year spending, as defined in section 24-77-102 (17), or state revenues, as defined in section 24-77-103.6 (6)(c), and do not count against either the state fiscal year spending limit imposed by section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I).

(3) (a) **Colorado healthcare affordability and sustainability enterprise.** The Colorado healthcare affordability and sustainability enterprise, referred to in this section as the "enterprise", is created. The enterprise is and operates as a government-owned business within the state department for the purpose of charging and collecting the healthcare affordability and sustainability fee, leveraging healthcare affordability and sustainability fee revenue to obtain federal matching money, and utilizing and deploying the healthcare affordability and sustainability fee revenue and federal matching money to provide the business services specified in subsections (2)(d)(I) and (2)(d)(II) of this section to hospitals that pay the healthcare affordability and sustainability fee.

(b) The enterprise constitutes an enterprise for purposes of section 20 of article X of the state constitution so long as it retains the authority to issue revenue bonds and receives less than ten percent of its total revenues in grants from all Colorado state and local governments combined. So long as it constitutes an enterprise pursuant to this subsection (3)(b), the enterprise is not subject to any provisions of section 20 of article X of the state constitution.

(c) (I) The repeal of the hospital provider fee program, as it existed pursuant to section 25.5-4-402.3 before its repeal, effective July 1, 2017, by Senate Bill 17-267, enacted in 2017, and the creation of the Colorado healthcare affordability and sustainability enterprise as a new enterprise to charge and collect a new healthcare affordability and sustainability fee as authorized by subsection (4) of this section and provide healthcare affordability and sustainability fee-funded business services to hospitals that replace and supplement services previously funded by hospital provider fees is the creation of a new government-owned business that provides business services to hospitals as a new enterprise for purposes of section 20 of article X of the state constitution, does not constitute the qualification of an existing government-owned business as an enterprise for purposes of section 20 of article X of the state constitution or section 24-77-103.6 (6)(b)(II), and, therefore, does not require or authorize adjustment of the state fiscal year spending limit calculated pursuant to section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I).

(II) Notwithstanding subsection (3)(c)(I) of this section, because the repeal of the hospital provider fee program, as it existed pursuant to section 25.5-4-402.3 before its repeal by Senate Bill 17-267, enacted in 2017, will allow the state to spend more general fund money for general governmental purposes than it would otherwise be able to spend below the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I), it is appropriate to restrain the growth of government by lowering the base amount used to calculate the excess state revenues cap for the 2017-18 state fiscal year by two hundred million dollars.

(d) The enterprise's primary powers and duties are:

(I) To charge and collect the healthcare affordability and sustainability fee as specified in subsection (4) of this section;

(II) To leverage healthcare affordability and sustainability fee revenue collected to obtain federal matching money, working with or through the state department and the state board to the extent required by federal law or otherwise necessary;

(III) To expend healthcare affordability and sustainability fee revenue, matching federal money, and any other money from the healthcare affordability and sustainability fee cash fund as specified in subsections (4) and (5) of this section;

(IV) To issue revenue bonds payable from the revenues of the enterprise;

(V) To enter into agreements with the state department to the extent necessary to collect and expend healthcare affordability and sustainability fee revenue;

(VI) To engage the services of private persons or entities serving as contractors, consultants, and legal counsel for professional and technical assistance and advice and to supply other services related to the conduct of the affairs of the enterprise, including the provision of additional business services to hospitals as specified in subsection (4)(a)(IV) of this section; and

(VII) To adopt and amend or repeal policies for the regulation of its affairs and the conduct of its business consistent with the provisions of this section.

(e) The enterprise shall exercise its powers and perform its duties as if the same were transferred to the state department by a **type 2** transfer, as defined in section 24-1-105.

(4) **Healthcare affordability and sustainability fee.** (a) For the fiscal year commencing July 1, 2017, and for each fiscal year thereafter, the enterprise is authorized to charge and collect a healthcare affordability and sustainability fee, as described in 42 CFR 433.68 (b), on outpatient and inpatient services provided by all licensed or certified hospitals, referred to in this section as "hospitals", for the purpose of obtaining federal financial participation under the state medical assistance program as described in this article 4 and articles 5 and 6 of this title 25.5, referred to in this section as the "state medical assistance program", and the Colorado indigent care program described in part 1 of article 3 of this title 25.5, referred to in this section as the "Colorado indigent care program". The enterprise shall use the healthcare affordability and sustainability fee revenue to:

(I) Provide a business service to hospitals by increasing reimbursement to hospitals for providing medical care under:

(A) The state medical assistance program; and

(B) The Colorado indigent care program;

(II) Provide a business service to hospitals by increasing the number of individuals covered by public medical assistance and thereby reducing the amount of uncompensated care that the hospitals must provide;

(III) Pay the administrative costs to the enterprise in implementing and administering this section subject to the limitation that administrative costs of the enterprise are limited to three percent of the enterprise's expenditures based on a methodology approved by the office of state planning and budgeting and the staff of the joint budget committee of the general assembly; and

(IV) Provide or contract for or arrange the provision of additional business services to hospitals by:

(A) Consulting with hospitals to help them improve both cost efficiency and patient safety in providing medical services and the clinical effectiveness of those services;

(B) Advising hospitals regarding potential changes to federal and state laws and regulations that govern the provision of and reimbursement paid for medical services under the programs administered pursuant to this article 4 and articles 5 and 6 of this title 25.5;

(C) Providing coordinated services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the programs administered pursuant to this article 4 and articles 5 and 6 of this title 25.5, which may include data sharing, telehealth coordination and support, establishment of performance metrics, benchmarking to such metrics, and clinical and administrative process consulting and other appropriate services;

(D) Providing any other services to hospitals that aid them in efficiently and effectively participating in the programs administered pursuant to this article 4 and articles 5 and 6 of this title 25.5; and

(E) Providing funding for, and in cooperation with the state department and hospitals supporting the implementation of, a health care delivery system reform incentive payments program as described in subsection (8) of this section.

(b) The enterprise shall recommend for approval and establishment by the state board the amount of the healthcare affordability and sustainability fee that it intends to charge and collect. The state board must establish the final amount of the fee by rules promulgated in accordance with article 4 of title 24. The state board shall not establish any amount that exceeds the federal limit for such fees. The state board may deviate from the recommendations of the enterprise, but shall express in writing the reasons for any deviations. In establishing the amount of the fee and in promulgating the rules governing the fee, the state board shall:

(I) Consider recommendations of the enterprise;

(II) Establish the amount of the healthcare affordability and sustainability fee so that the amount collected from the fee and federal matching funds associated with the fee are sufficient to pay for the items described in subsection (4)(a) of this section, but nothing in this subsection (4)(b)(II) requires the state board to increase the fee above the amount recommended by the enterprise; and

(III) For the 2017-18 fiscal year, establish the amount of the healthcare affordability and sustainability fee so that the amount collected from the fee is approximately equal to the sum of the amounts of the appropriations specified for the fee in the general appropriation act, Senate Bill 17-254, enacted in 2017, and any other supplemental appropriation act.

(c) (I) In accordance with the redistributive method set forth in 42 CFR 433.68 (e)(1) and (e)(2), the enterprise, acting in concert with or through an agreement with the state department if required by federal law, may seek a waiver from the broad-based healthcare affordability and sustainability fee requirement or the uniform healthcare affordability and sustainability fee requirement, or both. In addition, the enterprise, acting in concert with or through an agreement with the state department if required by federal law, shall seek any federal waiver necessary to fund and, in cooperation with the state department and hospitals, support the implementation of a health care delivery system reform incentive payments program as described in subsection (8) of this section. Subject to federal approval and to minimize the financial impact on certain hospitals, the enterprise may exempt from payment of the healthcare affordability and sustainability fee certain types of hospitals, including but not limited to:

(A) Psychiatric hospitals, as licensed by the department of public health and environment;

(B) Hospitals that are licensed as general hospitals and certified as long-term care hospitals by the department of public health and environment;

(C) Critical access hospitals that are licensed as general hospitals and are certified by the department of public health and environment under 42 CFR part 485, subpart F;

(D) Inpatient rehabilitation facilities; or

(E) Hospitals specified for exemption under 42 CFR 433.68 (e).

(II) In determining whether a hospital may be excluded, the enterprise shall use one or more of the following criteria:

(A) A hospital that is located in a rural area;

(B) A hospital with which the state department does not contract to provide services under the state medical assistance program;

(C) A hospital whose inclusion or exclusion would not significantly affect the net benefit to hospitals paying the healthcare affordability and sustainability fee; or

(D) A hospital that must be included to receive federal approval.

(III) The enterprise may reduce the amount of the healthcare affordability and sustainability fee for certain hospitals to obtain federal approval and to minimize the financial impact on certain hospitals. In determining for which hospitals the enterprise may reduce the amount of the healthcare affordability and sustainability fee, the enterprise shall use one or more of the following criteria:

(A) The hospital is a type of hospital described in subsection (4)(c)(I) of this section;

(B) The hospital is located in a rural area;

(C) The hospital serves a higher percentage than the average hospital of persons covered by the state medical assistance program, medicare, or commercial insurance or persons enrolled in a managed care organization;

(D) The hospital does not contract with the state department to provide services under the state medical assistance program;

(E) If the hospital paid a reduced healthcare affordability and sustainability fee, the reduced fee would not significantly affect the net benefit to hospitals paying the healthcare affordability and sustainability fee; or

(F) The hospital is required not to pay a reduced healthcare affordability and sustainability fee as a condition of federal approval.

(IV) The enterprise may change how it pays hospital reimbursement or quality incentive payments, or both, in whole or in part, under the authority of a federal waiver if the total reimbursement to hospitals is equal to or above the federal upper payment limit calculation under the waiver.

(d) The enterprise may alter the process prescribed in this subsection (4) to the extent necessary to meet the federal requirements and to obtain federal approval.

(e) (I) The enterprise shall establish policies on the calculation, assessment, and timing of the healthcare affordability and sustainability fee. The enterprise shall assess the healthcare affordability and sustainability fee on a schedule to be set by the enterprise board as provided in subsection (7)(d) of this section. The periodic healthcare affordability and sustainability fee payments from a hospital and the enterprise's reimbursement to the hospital under subsections (5)(b)(I) and (5)(b)(II) of this section are due as nearly simultaneously as feasible; except that the enterprise's reimbursement to the hospital is due no more than two days after the periodic healthcare affordability and sustainability fee payment is received from the hospital. The healthcare affordability and sustainability fee must be imposed on each hospital even if more than one hospital is owned by the same entity. The fee must be prorated and adjusted for the expected volume of service for any year in which a hospital opens or closes.

(II) The enterprise is authorized to refund any unused portion of the healthcare affordability and sustainability fee. For any portion of the healthcare affordability and sustainability fee that has been collected by the enterprise but for which the enterprise has not received federal matching funds, the enterprise shall refund back to the hospital that paid the fee the amount of that portion of the fee within five business days after the fee is collected.

(III) The enterprise shall establish requirements for the reports that hospitals must submit to the enterprise to allow the enterprise to calculate the amount of the healthcare affordability and sustainability fee. Notwithstanding the provisions of part 2 of article 72 of title 24 or subsection (7)(f) of this section, information provided to the enterprise pursuant to this section is confidential and is not a public record. Nonetheless, the enterprise may prepare and release summaries of the reports to the public.

(f) A hospital shall not include any amount of the healthcare affordability and sustainability fee as a separate line item in its billing statements.

(g) The state board shall promulgate any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, necessary for the administration and implementation of this section. Prior to submitting any proposed rules concerning the administration or implementation of the healthcare affordability and sustainability fee to the state board, the enterprise shall consult with the state board on the proposed rules as specified in subsection (7)(d) of this section.

(5) **Healthcare affordability and sustainability fee cash fund.** (a) Any healthcare affordability and sustainability fee collected pursuant to this section by the enterprise must be transmitted to the state treasurer, who shall credit the fee to the healthcare affordability and sustainability fee cash fund, which fund is hereby created and referred to in this section as the "fund". The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the fund. The state treasurer shall invest any money in the fund not expended for the purposes specified in subsection (5)(b) of this section as provided by law. Money in the fund shall not be transferred to any other fund and shall not be used for any purpose other than the purposes specified in this subsection (5) and in subsection (4) of this section.

(b) All money in the fund is subject to federal matching as authorized under federal law and is continuously appropriated to the enterprise for the following purposes:

(I) To maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limits as defined in 42 CFR 447.272 and 42 CFR 447.321;

(II) To increase hospital reimbursements under the Colorado indigent care program to up to one hundred percent of the hospital's costs of providing medical care under the program;

(III) To pay the quality incentive payments provided in section 25.5-4-402 (3);

(IV) Subject to available revenue from the healthcare affordability and sustainability fee and federal matching funds, to expand eligibility for public medical assistance by:

(A) Increasing the eligibility level for parents and caretaker relatives of children who are eligible for medical assistance, pursuant to section 25.5-5-201 (1)(m), from sixty-one percent to one hundred thirty-three percent of the federal poverty line;

(B) Increasing the eligibility level for children and pregnant women under the children's basic health plan to up to two hundred fifty percent of the federal poverty line;

(C) Providing eligibility under the state medical assistance program for a childless adult or an adult without a dependent child in the home, pursuant to section 25.5-5-201 (1)(p), who earns up to one hundred thirty-three percent of the federal poverty line; and

(D) Providing a buy-in program in the state medical assistance program for disabled adults and children whose families have income of up to four hundred fifty percent of the federal poverty line;

(V) To provide continuous eligibility for twelve months for children enrolled in the state medical assistance program;

(VI) To pay the enterprise's actual administrative costs of implementing and administering this section, including but not limited to the following costs:

(A) Administrative expenses of the enterprise;

(B) The enterprise's actual costs related to implementing and maintaining the healthcare affordability and sustainability fee, including personal services, operating, and consulting expenses;

(C) The enterprise's actual costs for the changes and updates to the medicaid management information system for the implementation of subsections (5)(b)(I) to (5)(b)(III) of this section;

(D) The enterprise's personal services and operating costs related to personnel, consulting services, and for review of hospital costs necessary to implement and administer the increases in inpatient and outpatient hospital payments made pursuant to subsection (5)(b)(I) of this section, increases in the Colorado indigent care program payments made pursuant to subsection (5)(b)(II) of this section, and quality incentive payments made pursuant to subsection (5)(b)(III) of this section;

(E) The enterprise's actual costs for the changes and updates to the Colorado benefits management system and medicaid management information system to implement and maintain the expanded eligibility provided for in subsections (5)(b)(IV) and (5)(b)(V) of this section;

(F) The enterprise's personal services and operating costs related to personnel necessary to implement and administer the expanded eligibility for public medical assistance provided for in subsections (5)(b)(IV) and (5)(b)(V) of this section, including but not limited to administrative costs associated with the determination of eligibility for public medical assistance by county departments; and

(G) The enterprise's personal services, operating, and systems costs related to expanding the opportunity for individuals to apply for public medical assistance directly at hospitals or through another entity outside the county departments, in connection with section 25.5-4-205, that would increase access to public medical assistance and reduce the number of uninsured served by hospitals;

(VII) To offset the loss of any federal matching money due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums that were in effect as of July 1, 2008;

(VIII) Subject to any necessary federal waivers being obtained, to provide funding for a health care delivery system reform incentive payments program as described in subsection (8) of this section; and

(IX) To provide additional business services to hospitals as specified in subsection (4)(a)(IV) of this section.

(6) **Appropriations.** (a) (I) The healthcare affordability and sustainability fee is to supplement, not supplant, general fund appropriations to support hospital reimbursements. General fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008; except that general fund appropriations for hospital reimbursements may be reduced if an index of appropriations to other providers shows that general fund appropriations are reduced for other providers. If the index shows that general fund appropriations are reduced for other providers, the general fund appropriations for hospital reimbursements shall not be reduced by a greater percentage than the reductions of appropriations for the other providers as shown by the index.

(II) If general fund appropriations for hospital reimbursements are reduced below the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008, the general fund appropriations will be increased back to the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008, at the same percentage as the appropriations for other providers as shown by the index. The general assembly is not obligated to increase the general fund appropriations back to the level of appropriations in the medical services premium line item in a single fiscal year, and such increases may occur over nonconsecutive fiscal years.

(III) For purposes of this subsection (6)(a), the "index of appropriations to other providers" or "index" means the average percent change in reimbursement rates through appropriations or legislation enacted by the general assembly to home health providers, physician services, and outpatient pharmacies, excluding dispensing fees. The state board, after consultation with the enterprise board, is authorized to clarify this definition as necessary by rule.

(b) If the revenue from the healthcare affordability and sustainability fee is insufficient to fully fund all of the purposes described in subsection (5)(b) of this section:

(I) The general assembly is not obligated to appropriate general fund revenues to fund such purposes;

(II) The hospital provider reimbursement and quality incentive payment increases described in subsections (5)(b)(I) to (5)(b)(III) of this section and the costs described in subsection (5)(b)(VI) of this section shall be fully funded using revenue from the healthcare affordability and sustainability fee and federal matching funds before any eligibility expansion is funded; and

(III) (A) If the state board promulgates rules that expand eligibility for medical assistance to be paid for pursuant to subsection (5)(b)(IV) of this section, and the state department thereafter notifies the enterprise board that the revenue available from the healthcare affordability and sustainability fee and the federal matching funds will not be sufficient to pay for all or part of the expanded eligibility, the enterprise board shall recommend to the state board reductions in medical benefits or eligibility so that the revenue will be sufficient to pay for all of the reduced benefits or eligibility. After receiving the recommendations of the enterprise board, the state board shall adopt rules providing for reduced benefits or reduced eligibility for which the revenue will be sufficient and shall forward any adopted rules to the joint budget committee. Notwithstanding the provisions of section 24-4-103 (8) and (12), following the adoption of rules pursuant to this subsection (6)(b)(III)(A), the state board shall not submit the rules to the

attorney general and shall not file the rules with the secretary of state until the joint budget committee approves the rules pursuant to subsection (6)(b)(III)(B) of this section.

(B) The joint budget committee shall promptly consider any rules adopted by the state board pursuant to subsection (6)(b)(III)(A) of this section. The joint budget committee shall promptly notify the state department, the state board, and the enterprise board of any action on the rules. If the joint budget committee does not approve the rules, the joint budget committee shall recommend a reduction in benefits or eligibility so that the revenue from the healthcare affordability and sustainability fee and the matching federal funds will be sufficient to pay for the reduced benefits or eligibility. After approving the rules pursuant to this subsection (6)(b)(III)(B), the joint budget committee shall request that the committee on legal services, created pursuant to section 2-3-501, extend the rules as provided for in section 24-4-103 (8) unless the committee on legal services finds after review that the rules do not conform with section 24-4-103 (8)(a).

(C) After the state board has received notification of the approval of rules adopted pursuant to subsection (6)(b)(III)(A) of this section, the state board shall submit the rules to the attorney general pursuant to section 24-4-103 (8)(b) and shall file the rules and the opinion of the attorney general with the secretary of state pursuant to section 24-4-103 (12) and with the office of legislative legal services. Pursuant to section 24-4-103 (5), the rules are effective twenty days after publication of the rules and are only effective until the following May 15 unless the rules are extended pursuant to a bill enacted pursuant to section 24-4-103 (8).

(c) Notwithstanding any other provision of this section, if, after receipt of authorization to receive federal matching funds for money in the fund, the authorization is withdrawn or changed so that federal matching funds are no longer available, the enterprise shall cease collecting the healthcare affordability and sustainability fee and shall repay to the hospitals any money received by the fund that is not subject to federal matching funds.

(7) **Colorado healthcare affordability and sustainability enterprise board.** (a) (I) Except as otherwise provided in subsection (7)(a)(II) of this section, the enterprise board consists of thirteen members appointed by the governor, with the advice and consent of the senate, as follows:

(A) Five members who are employed by hospitals in Colorado, including at least one person who is employed by a hospital in a rural area, one person who is employed by a safety-net hospital for which the percent of medicaid-eligible inpatient days relative to its total inpatient days is equal to or greater than one standard deviation above the mean, and one person who is employed by a hospital in an urban area;

(B) One member who is a representative of a statewide organization of hospitals;

(C) One member who represents a statewide organization of health insurance carriers or a health insurance carrier licensed pursuant to title 10 and who is not a representative of a hospital;

(D) One member of the health care industry who does not represent a hospital or a health insurance carrier;

(E) One member who is a consumer of health care and who is not a representative or an employee of a hospital, health insurance carrier, or other health care industry entity;

(F) One member who is a representative of persons with disabilities, who is living with a disability, and who is not a representative or an employee of a hospital, health insurance carrier, or other health care industry entity;

(G) One member who is a representative of a business that purchases or otherwise provides health insurance for its employees; and

(H) Two employees of the state department.

(II) The initial members of the enterprise board are the members of the hospital provider fee oversight and advisory board that was created and existed pursuant to section 25.5-4-402.3 (6), prior to July 1, 2017, and such members shall serve on and after July 1, 2017, for the remainder of the terms for which they were appointed as members of the advisory board. The powers, duties, and functions of the hospital provider fee oversight and advisory board are transferred by a **type 3** transfer, as defined in section 24-1-105, to the enterprise, and the hospital provider fee oversight and advisory board is abolished.

(III) The governor shall consult with representatives of a statewide organization of hospitals in making the appointments pursuant to subsections (7)(a)(I)(A) and (7)(a)(I)(B) of this section. No more than six members of the enterprise board may be members of the same political party.

(IV) Members of the enterprise board serve at the pleasure of the governor. All terms are for four years. A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the former member.

(V) The governor shall designate a chair from among the members of the enterprise board appointed pursuant to subsections (7)(a)(I)(A) to (7)(a)(I)(G) of this section. The enterprise board shall elect a vice-chair from among its members.

(b) Members of the enterprise board serve without compensation but must be reimbursed from money in the fund for actual and necessary expenses incurred in the performance of their duties pursuant to this section.

(c) The enterprise board may contract for a group facilitator to assist the members of the enterprise board in performing their required duties.

(d) The enterprise board has, at a minimum, the following duties:

(I) To determine the timing and method by which the enterprise assesses the healthcare affordability and sustainability fee and the amount of the fee;

(II) If requested by the health and human services committee of the senate or the public health care and human services committee of the house of representatives, or any successor committees, to consult with the committees on any legislation that may impact the healthcare affordability and sustainability fee or hospital reimbursements established pursuant to this section;

(III) To determine changes in the healthcare affordability and sustainability fee that increase the number of hospitals benefitting from the uses of the healthcare affordability and sustainability fee described in subsections (5)(b)(I) to (5)(b)(IV) of this section or that minimize the number of hospitals that suffer losses as a result of paying the healthcare affordability and sustainability fee;

(IV) To recommend to the state department reforms or changes to the inpatient hospital and outpatient hospital reimbursements and quality incentive payments made under the state medical assistance program to increase provider accountability, performance, and reporting;

(V) To direct and oversee the enterprise in seeking, in concert with or through an agreement with the state department if required by federal law, any federal waiver necessary to fund and, in cooperation with the state department and hospitals, support the implementation of a

health care delivery system reform incentive payments program as described in subsection (8) of this section;

(VI) To recommend to the state department the schedule and approach to the implementation of subsections (5)(b)(IV) and (5)(b)(V) of this section;

(VII) If money in the fund is insufficient to fully fund all of the purposes specified in subsection (5)(b) of this section, to recommend to the state board changes to the expanded eligibility provisions described in subsection (5)(b)(IV) of this section;

(VIII) To prepare the reports specified in subsection (7)(e) of this section;

(IX) To monitor the impact of the healthcare affordability and sustainability fee on the broader health care marketplace;

(X) To establish requirements for the reports that hospitals must submit to the enterprise to allow the enterprise to calculate the amount of the healthcare affordability and sustainability fee; and

(XI) To perform any other duties required to fulfill the enterprise board's charge or those assigned to it by the state board or the executive director.

(e) On or before January 15, 2018, and on or before January 15 each year thereafter, the enterprise board shall submit a written report to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor, and the state board. The report shall include, but need not be limited to:

(I) The recommendations made to the state board pursuant to this section;

(II) A description of the formula for how the healthcare affordability and sustainability fee is calculated and the process by which the healthcare affordability and sustainability fee is assessed and collected;

(III) An itemization of the total amount of the healthcare affordability and sustainability fee paid by each hospital and any projected revenue that each hospital is expected to receive due to:

(A) The increased reimbursements made pursuant to subsections (5)(b)(I) and (5)(b)(II) of this section and the quality incentive payments made pursuant to subsection (5)(b)(III) of this section; and

(B) The increased eligibility described in subsections (5)(b)(IV) and (5)(b)(V) of this section;

(IV) An itemization of the costs incurred by the enterprise in implementing and administering the healthcare affordability and sustainability fee;

(V) Estimates of the differences between the cost of care provided and the payment received by hospitals on a per-patient basis, aggregated for all hospitals, for patients covered by each of the following:

(A) Medicaid;

(B) Medicare; and

(C) All other payers; and

(VI) A summary of:

(A) The efforts made by the enterprise, acting in concert with or through an agreement with the state department if required by federal law, to seek any federal waiver necessary to fund and, in cooperation with the state department and hospitals, support the implementation of a

health care delivery system reform incentive payments program as described in subsection (8) of this section; and

(B) The progress actually made by the enterprise, in cooperation with the state department and hospitals, towards the goal of implementing such a program.

(f) (I) The enterprise is subject to the open meetings provisions of the "Colorado Sunshine Act of 1972", contained in part 4 of article 6 of title 24, and the "Colorado Open Records Act", part 2 of article 72 of title 24.

(II) For purposes of the "Colorado Open Records Act", part 2 of article 72 of title 24, and except as may otherwise be provided by federal law or regulation or state law, the records of the enterprise are public records, as defined in section 24-72-202 (6), regardless of whether the enterprise receives less than ten percent of its total annual revenues in grants, as defined in section 24-77-102 (7), from all Colorado state and local governments combined.

(III) The enterprise is a public entity for purposes of part 2 of article 57 of title 11.

(8) **Health care delivery system reform incentive payments program - funding and implementation.** The enterprise, acting in concert with or through an agreement with the state department if required by federal law, shall seek any federal waiver necessary to fund and, in cooperation with the state department and hospitals, support the implementation, no earlier than October 1, 2019, of a health care delivery system reform incentive payments program that will improve health care access and outcomes for individuals served by the state department while efficiently utilizing available financial resources. Such a program must, at a minimum:

(a) Include an initial planning phase to:

(I) Assess needs; and

(II) Develop achievable outcome-based metrics to be used to measure progress towards program goals, including the goals of health care delivery system integration, improved patient outcomes, and more efficient provision of care; and

(b) Address the following focus areas:

(I) Care coordination and care transition management;

(II) Integration of physical and behavioral health care services;

(III) Chronic condition management;

(IV) Targeted population health; and

(V) Data-driven accountability and outcome measurement.

Source: L. 2017: Entire section added, (SB 17-267), ch. 267, p. 1448, § 17, effective July 1.

Editor's note: Section 34 of chapter 267 (SB 17-267), Session Laws of Colorado 2017, provides that the section of the act adding this section does not take effect if the centers for medicare and medicaid services determine that the amendments do not comply with federal law. For more information, see SB 17-267. (L. 2017, p. 1478.) The executive director of the department of health care policy and financing did not notify the revisor of statutes by June 1, 2017, of such determination; therefore, this section took effect July 1, 2017.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-4-402.5. Providers - state university teaching hospitals. Subject to appropriations by the general assembly, the state department shall make payments to state university teaching hospitals for providing care under the state's medical assistance program established pursuant to this article and articles 5 and 6 of this title.

Source: L. 2008: Entire section added, p. 1185, § 3, effective May 22.

25.5-4-402.7. Unexpended hospital provider fee cash fund - creation - transfer from hospital provider fee cash fund - use of fund - repeal. (1) The unexpended hospital provider fee cash fund, referred to in this section as the "fund", is hereby created in the state treasury. On June 30, 2017, the state treasurer shall transfer to the fund all money in the hospital provider fee cash fund created in section 25.5-4-402.3 (4)(a), as that section existed before its repeal by Senate Bill 17-267, enacted in 2017. The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the general fund. Money in the fund is continuously appropriated to the state department through October 30, 2018, for the purpose of paying claims incurred before July 1, 2017, that were payable pursuant to section 25.5-5-402.3 (4), as that section existed before its repeal by Senate Bill 17-267, enacted in 2017. The state department shall refund any money in the fund derived from hospital provider fees that is not expended for the purpose of paying claims to the hospitals that paid the fees.

(2) This section is repealed, effective November 1, 2018.

Source: L. 2017: Entire section added, (SB 17-267), ch. 267, p. 1464, § 18, effective July 1.

Editor's note: Section 34 of chapter 267 (SB 17-267), Session Laws of Colorado 2017, provides that the section of the act adding this section does not take effect if the centers for medicare and medicaid services determine that the amendments do not comply with federal law. For more information, see SB 17-267. (L. 2017, p. 1478.) The executive director of the department of health care policy and financing did not notify the revisor of statutes by June 1, 2017, of such determination; therefore, this section took effect July 1, 2017.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-4-403. Providers - community mental health center and clinics - reimbursement. For the purpose of reimbursing community mental health center and clinic providers, the state department shall establish a price schedule annually with the department of human services in order to reimburse each provider for its actual or reasonable cost of services.

Source: L. 2006: Entire article added with relocations, p. 1844, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-409 as it existed prior to 2006.

25.5-4-404. Payments for clinic services - restrictions on use. All payments received by county or district public health agencies or boards of health for clinic services, as defined in

section 25.5-5-301 (3), furnished to patients shall be used only to offset costs incurred for provision of services by such county or district public health agencies or boards of health or to cash fund health care services in the county where the services were provided.

Source: L. 2006: Entire article added with relocations, p. 1844, § 7, effective July 1. **L. 2010:** Entire section amended, (HB 10-1422), ch. 419, p. 2110, § 142, effective August 11.

Editor's note: This section is similar to former § 26-4-515 as it existed prior to 2006.

25.5-4-405. Mental health managed care service providers - requirements. (1) Each contract between the state department and a managed care organization providing mental health services to a recipient under the medical assistance program shall comply with all federal requirements, including but not limited to:

(a) Ensuring that a recipient with complex or multiple needs who requires mental health services shall have access to mental health professionals with appropriate training and credentials and shall provide the recipient with such services in collaboration with the recipient's other providers;

(b) Informing each recipient of his or her right to and the process for appeal upon notification of denial, termination, or reduction of a requested service; and

(c) Administering initial stabilization treatment for a recipient and transferring the recipient for appropriate continued services.

(1.5) Each contract between the state department and a managed care organization providing mental health services to a recipient under the medical assistance program shall allow for the use of telemedicine pursuant to the provisions of section 25.5-5-320.

(2) For mental health managed care recipients, the state department shall have a patient representative program for recipient grievances that complies with all federal requirements and that shall:

(a) Be posted in a conspicuous place at each location at which mental health services are provided;

(b) Allow for a patient representative to serve as a liaison between the recipient and the provider;

(c) Describe the qualifications for a patient representative;

(d) Outline the responsibilities of a patient representative;

(e) Describe the authority of a patient representative; and

(f) Establish a method by which each recipient is informed of the patient representative program and how a patient representative may be contacted.

Source: L. 2006: Entire article added with relocations, p. 1844, § 7, effective July 1. **L. 2008:** (1.5) added, p. 111, § 1, effective August 5.

Editor's note: This section is similar to former § 26-4-409.5 as it existed prior to 2006.

25.5-4-406. Rate setting - medicaid residential treatment service providers - monitoring and auditing - report. (1) The state department shall approve a rate-setting process consistent with medicaid requirements for providers of medicaid residential treatment services in

the state of Colorado as developed by the department of human services. The rate-setting process developed pursuant to this section may include, but shall not be limited to:

(a) A range for reimbursement that represents a base-treatment rate for serving a child who is subject to out-of-home placement due to dependency and neglect, a child placed in a residential child care facility pursuant to the "Child Mental Health Treatment Act", article 67 of title 27, C.R.S., or a child who has been adjudicated a delinquent, which includes a defined service package to meet the needs of the child;

(b) A request for proposal to contract for specialized service needs of a child, including but not limited to: Substance-abuse treatment services; sex offender services; and services for the developmentally disabled; and

(c) Negotiated incentives for achieving outcomes for the child as defined by the state department, counties, and providers.

(2) The medicaid rate-setting process approved by the state department shall include a two- or three-year implementation timeline with implementation beginning in state fiscal year 2008-09.

(3) The state department and the department of human services, in consultation with the representatives of the counties and the provider community, shall review the rate-setting process every two years and shall submit any changes to the joint budget committee of the general assembly.

Source: L. 2006: Entire article added with relocations, p. 1845, § 7, effective July 1. **L. 2007:** (1)(a), (2), and (3) amended, p. 618, § 2, effective August 3. **L. 2010:** (1)(a) amended, (SB 10-175), ch. 188, p. 800, § 66, effective April 29.

25.5-4-407. Services by licensed psychologists without a doctor's referral. The executive director of the state department may authorize the providing of services of licensed psychologists without the requirement that the services be referred by a doctor of medicine or a doctor of osteopathy, but such services shall be subject to the cost containment program specified under section 25.5-4-408. The executive director may except from the authorization those services the director determines to be necessary for the purpose of promoting the primary care physician program.

Source: L. 2006: Entire article added with relocations, p. 1846, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-412 as it existed prior to 2006.

25.5-4-408. Services provided by licensed psychologists - cost containment program. (1) Working in conjunction with licensed psychologists in the state, the state board shall promulgate rules to establish and implement mechanisms for containing the costs of services provided by licensed psychologists under the medical assistance programs established pursuant to this article and articles 5 and 6 of this title. The cost containment mechanism shall ensure that the costs to the medical assistance program will result in no increase in the total cost of the program solely as a result of the reimbursement for services of licensed psychologists pursuant to section 25.5-4-407. The cost containment mechanisms may include the following:

(a) Limiting the number of days a licensed psychologist may be reimbursed per patient for inpatient hospitalization, partial hospitalization, and outpatient visits without an order for continued treatment from a doctor of medicine or osteopathy;

(b) Limiting the number of hours a licensed psychologist may be reimbursed for diagnostic testing and evaluation per patient per year;

(c) Provision of group therapy when needed or appropriate;

(d) Provision of licensed psychologists' services from a pool of those licensed psychologists requesting to be included in such pool;

(e) Provision of a licensed psychologist's services through the use of telemedicine pursuant to the provisions of section 25.5-5-320.

Source: L. 2006: Entire article added with relocations, p. 1846, § 7, effective July 1. **L. 2008:** (1)(e) added, p. 111, § 2, effective August 5.

Editor's note: This section is similar to former § 26-4-516 as it existed prior to 2006.

25.5-4-409. Authorization of services - nurse anesthetists - advanced practice nurses. (1) When services by a certified registered nurse anesthetist are provided pursuant to an order by a physician in accordance with this article, articles 5 and 6 of this title, and section 12-38-103 (10), C.R.S., the executive director of the state department shall authorize reimbursement for said services. Payment for such services shall be made directly to the nurse anesthetist, if requested by the nurse anesthetist; except that this section shall not apply to nurse anesthetists when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

(2) When services by an advanced practice nurse registered pursuant to section 12-38-111.5, C.R.S., are provided in accordance with this article and articles 5 and 6 of this title, the executive director of the state department shall authorize reimbursement for said services. Payment for the services shall be made directly to the advanced practice nurse, if requested by the advanced practice nurse; except that this section shall not apply to advanced practice nurses when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

Source: L. 2006: Entire article added with relocations, p. 1846, § 7, effective July 1. **L. 2008:** (2) amended, p. 138, § 1, effective July 1.

Editor's note: This section is similar to former § 26-4-413 as it existed prior to 2006.

25.5-4-410. Services of audiologists and speech pathologists without supervision. (1) When medical or diagnostic services by an audiologist or speech pathologist are provided pursuant to an order by a physician in accordance with this article and articles 5 and 6 of this title, the executive director of the state department shall authorize reimbursement for said services. For the purposes of this section, "audiologist" or "speech pathologist" means an individual who meets the requirements set forth in the federal "Social Security Act", as amended, or any federal regulations adopted pursuant thereto, for participating providers of audiology or speech pathology services.

(2) Nothing in this section shall be construed as expanding the provision of services available as a part of the medical assistance program established pursuant to this article and articles 5 and 6 of this title. For the purposes of making payments to audiologists or speech pathologists pursuant to this section, the state board shall establish rules implementing this section. The rules promulgated pursuant to this subsection (2) shall ensure that the costs to the medical assistance program will result in no increase in the total cost of the program solely as a result of the reimbursement for services of an audiologist or speech pathologist pursuant to this section.

(3) Payments for services included in this section shall be made directly to the audiologist or speech pathologist, if requested by the audiologist or speech pathologist; except that this section shall not apply to audiologists or speech pathologists when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

Source: L. 2006: Entire article added with relocations, p. 1847, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-414 as it existed prior to 2006.

25.5-4-411. Authorization of services provided by dental hygienists. (1) When dental hygiene services are provided to children by a licensed dental hygienist who is providing dental hygiene services pursuant to section 12-35-124, C.R.S., without the supervision of a licensed dentist, the executive director of the state department shall authorize reimbursement for said services, subject to the requirements of this section. Payment for such services shall be made directly to the licensed dental hygienist, if requested by the licensed dental hygienist; except that this section shall not apply to licensed dental hygienists when acting within the scope of their employment as salaried employees of public or private institutions, physicians, or dentists.

(2) For each child provided dental hygiene services pursuant to this section, the dental hygienist shall attempt to identify a dentist participating in medicaid for the child.

Source: L. 2006: Entire article added with relocations, p. 1847, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-414.3 as it existed prior to 2006.

25.5-4-412. Medical services provided by certified family planning clinics - definition. (1) When medical or diagnostic services are provided in accordance with this article and articles 5 and 6 of this title by a certified family planning clinic, the executive director of the state department shall authorize reimbursement for the services. The reimbursement shall be made directly to the certified family planning clinic.

(2) For purposes of this section, "certified family planning clinic" means a family planning clinic certified by the Colorado department of public health and environment, accredited by a national family planning organization, and staffed by medical professionals licensed to practice in the state of Colorado, including, but not limited to, doctors of medicine, doctors of osteopathy, physician assistants, and advanced practice nurses.

(3) For purposes of this section, all medical care services or goods rendered by a certified family planning clinic that are benefits of the Colorado medical assistance program

shall be ordered by a physician who need not be physically present on the premises of the certified family planning clinic at the time services are rendered.

(4) Nothing in this section shall be construed as expanding the provision of services available as a part of the medical assistance program established pursuant to this article and articles 5 and 6 of this title. For purposes of making payments to certified family planning clinics pursuant to this section, the state board shall establish rules implementing this section. The rules promulgated pursuant to this subsection (4) shall ensure that the reimbursement for services rendered by a certified family planning clinic pursuant to this section shall not be the sole result of an increase in the costs to the state medical assistance program.

Source: L. 2006: Entire article added with relocations, p. 1848, § 7, effective July 1. **L. 2016:** (2) amended, (SB 16-158), ch. 204, p. 729, § 21, effective August 10.

Editor's note: This section is similar to former § 26-4-414.5 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 16-158, see section 1 of chapter 204, Session Laws of Colorado 2016.

25.5-4-413. Certain providers to inform patients of rights concerning advance medical directives. (1) On and after November 5, 1991, with regard to any service rendered on and after said date, each hospital, nursing care facility, home health agency, hospice program, and health maintenance organization participating in the state medical assistance program or providing medical assistance pursuant to parts 3 to 12 of article 6 of this title shall provide written information to all adult patients of such providers concerning patients' rights under state law to make medical treatment decisions, including the right to accept or refuse any medical or surgical treatment and the right to formulate advance directives regarding said decisions. As used in this section, "advance directives" includes any written or oral instructions recognized under state law concerning the making of medical treatment decisions on behalf of or the provision of medical care for the person who provided the instructions in the event such person becomes incapacitated. Advance directives include, but are not limited to, medical durable powers of attorney, durable powers of attorney, or living wills.

(2) Providers listed in subsection (1) of this section shall provide educational programs for staff and the community concerning advance directives and shall maintain written policies detailing methods for safeguarding patients' rights concerning medical treatment decisions, including documenting in the patient's medical or patient record whether the patient has executed, amended, or revoked an advance directive. No provider shall condition the provision of services or otherwise discriminate against a patient on the basis of whether the patient has executed an advance directive.

Source: L. 2006: Entire article added with relocations, p. 1848, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-403.5 as it existed prior to 2006.

25.5-4-414. Providers - physicians - prohibition of certain referrals - definitions. (1) As used in this section, unless the context otherwise requires:

(a) "Designated health services" means any of the following services:

(I) Clinical laboratory services;

(II) Physical therapy services;

(III) Occupational therapy services;

(IV) Radiology and other diagnostic services;

(V) Radiation therapy services;

(VI) Durable medical equipment;

(VII) Parenteral or enteral nutrients, equipment, and supplies;

(VIII) Prosthetics, orthotics, and prosthetic devices;

(IX) Home health services;

(X) Outpatient prescription drugs; and

(XI) Inpatient and outpatient hospital services.

(b) "Financial relationship" means an ownership or investment interest in an entity furnishing designated health services or a compensation arrangement between a provider or an immediate family member of the provider and the entity. An ownership or investment interest may be reflected in equity, debt, or other instruments.

(c) "Immediate family member of the provider" means any spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, stepbrother, stepsister, in-law, grandparent, or grandchild of the provider.

(d) "Provider" means:

(I) A doctor of medicine or osteopathy who is licensed to practice medicine pursuant to article 36 of title 12, C.R.S.;

(II) A doctor of dental surgery or of dental medicine who is licensed to practice dentistry pursuant to article 35 of title 12, C.R.S.;

(III) A doctor of podiatric medicine who is licensed to practice podiatry pursuant to article 32 of title 12, C.R.S.;

(IV) A doctor of optometry who is licensed to practice optometry pursuant to article 40 of title 12, C.R.S.; or

(V) A chiropractor who is licensed to practice chiropractic pursuant to article 33 of title 12, C.R.S.

(2) (a) Except as otherwise provided in this subsection (2), a provider participating in the medical assistance program under this article and articles 5 and 6 of this title is prohibited from making a referral to an entity for designated health services for which payment may be made under the state's medical assistance program if the provider or an immediate family member of the provider has a financial relationship with the entity.

(b) Paragraph (a) of this subsection (2) shall not apply to any financial relationship that meets the requirements of an exception to the prohibitions established by 42 U.S.C. sec. 1395nn, as amended, or any regulations promulgated thereunder, as amended.

(c) Paragraph (a) of this subsection (2) shall not apply to a financial relationship or referral for designated health services if the financial relationship or referral for designated health services would not violate 42 U.S.C. sec. 1395nn, as amended, and any regulations promulgated thereunder, as amended, if the designated health services were eligible for payment under medicare rather than the "Colorado Medical Assistance Act".

(3) An entity that provides designated health services as a result of a prohibited referral shall not present a claim or bill to any individual, any third-party payor, the state department, or any other entity for the designated health services.

(4) An entity that provides designated health services shall provide to the state department, upon its request and in the form specified by the state department, information concerning the entity's ownership arrangements including:

(a) The items and services provided by the entity;

(b) The names and provider identification numbers of all providers with a financial interest in the entity or whose immediate family members have a financial interest in the entity.

(5) If a provider refers a patient for designated health services in violation of paragraph (a) of subsection (2) of this section or the entity refuses to provide the information required in subsection (4) of this section, the state department may:

(a) Deny any claims for payment from the provider or entity;

(b) Require the provider or entity to refund payments for services;

(c) Refer the matter to the appropriate agency for medical assistance fraud investigation; or

(d) Terminate the provider's or entity's participation in the medical assistance program.

Source: L. 2006: Entire article added with relocations, p. 1849, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-410.5 as it existed prior to 2006.

25.5-4-415. No public funds for abortion - exception - repeal. (1) It is the purpose of this section to implement the provisions of section 50 of article V of the Colorado constitution, adopted by the registered electors of the state of Colorado at the general election November 6, 1984, which prohibits the use of public funds by the state of Colorado or its agencies or political subdivisions to pay or otherwise reimburse, directly or indirectly, any person, agency, or facility for any induced abortion.

(2) If every reasonable effort has been made to preserve the lives of a pregnant woman and her unborn child, then public funds may be used pursuant to this section to pay or reimburse for necessary medical services, not otherwise provided for by law.

(3) (a) Except as provided in paragraph (b) of this subsection (3), any necessary medical services performed pursuant to this section shall be performed only in a licensed health care facility by a provider who is a licensed physician.

(b) However, such services may be performed in other than a licensed health care facility if, in the medical judgment of the attending physician, the life of the pregnant woman or her unborn child is substantially threatened and a transfer to a licensed health care facility would further endanger the life of the pregnant woman or her unborn child. Such medical services may be performed in other than a licensed health care facility if the medical services are necessitated by a life-endangering circumstance described in subparagraph (II) of paragraph (b) of subsection (6) of this section and if there is no licensed health care facility within a thirty-mile radius of the place where such medical services are performed.

(4) (a) Any physician who renders necessary medical services pursuant to subsection (2) of this section shall report the following information to the state department:

(I) The age of the pregnant woman and the gestational age of the unborn child at the time the necessary medical services were performed;

(II) The necessary medical services which were performed;

(III) The medical condition which necessitated the performance of necessary medical services;

(IV) The date such necessary medical services were performed and the name of the facility in which such services were performed.

(b) The information required to be reported pursuant to paragraph (a) of this subsection (4) shall be compiled by the state department and such compilation shall be an ongoing public record; except that the privacy of the pregnant woman and the attending physician shall be preserved.

(5) For purposes of this section, pregnancy is a medically diagnosable condition.

(6) For the purposes of this section:

(a) (I) "Death" means:

(A) The irreversible cessation of circulatory and respiratory functions; or

(B) The irreversible cessation of all functions of the entire brain, including the brain stem.

(II) A determination of death under this section shall be in accordance with accepted medical standards.

(b) "Life-endangering circumstance" means:

(I) The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term;

(II) The presence of a lethal medical condition in the unborn child, as determined by the attending physician and one other physician, which would result in the impending death of the unborn child during the term of pregnancy or at birth; or

(III) The presence of a psychiatric condition which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such case, unless the pregnant woman has been receiving prolonged psychiatric care, the attending licensed physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition. The attending physician shall report the findings of such consultation to the state department.

(c) "Necessary medical services" means any medical procedures deemed necessary to prevent the death of a pregnant woman or her unborn child due to life-endangering circumstances.

(7) If any provision of this section or application thereof is held invalid, such invalidity shall not affect other provisions or applications of this section which can be given effect without the invalid provision or application, and to this end the provisions of this section are declared severable.

(8) Use of the term "unborn child" in this section is solely for the purposes of facilitating the implementation of section 50 of article V of the state constitution, and its use shall not affect any other law or statute nor shall it create any presumptions relating to the legal status of an unborn child or create or affect any distinction between the legal status of an unborn child and the legal status of a fetus.

(9) This section shall be repealed if section 50 of article V of the Colorado constitution is repealed.

Source: L. 2006: Entire article added with relocations, p. 1851, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-512 as it existed prior to 2006.

25.5-4-416. Providers - medical equipment and supplies - requirements. (1) As used in this section, unless the context otherwise requires, "provider" means a person or entity that delivers disposable medical supplies or durable medical equipment products or services directly to a recipient.

(2) On and after January 1, 2007, the state board rules for the payment for disposable medical supplies and durable medical equipment, including but not limited to prosthetic and orthotic devices, shall prohibit a provider from being reimbursed unless the provider:

(a) (I) Has one or more physical locations within the state of Colorado or within fifty miles of a border of Colorado with a street address, a local business telephone number, an inventory, and a sufficient staff to service or repair products; except that the requirements of this paragraph (a) shall not apply to durable medical equipment or disposable medical supplies that are medically necessary and cannot be purchased from a provider meeting the requirements of this paragraph (a);

(II) Complies with all state and local licensing, insurance, and regulatory requirements for operating the provider's business;

(III) Is responsible for the delivery of and instructing the recipient on the proper use of the equipment; and

(IV) Provides repairs, replacements, or adjustments to the provider's products pursuant to rules of the state board; or

(b) Contracts with a provider who meets the criteria established in paragraph (a) of this subsection (2).

(3) The provisions of this section shall apply to fee-for-service and primary care physician program recipients.

Source: L. 2006: Entire section added, p. 525, § 1, effective August 7.

Editor's note: This section was originally numbered as § 26-4-410.7 in House Bill 06-1299. Section 2 of the act provided for the renumbering and relocation of § 26-4-410.7 to this section. (See L. 2006, p. 526.)

25.5-4-417. Provider fee - medicaid providers - state plan amendment - rules - definitions. (1) For purposes of this section, unless the context otherwise requires:

(a) "Local government" means a county, home rule county, home rule or statutory city, town, territorial charter city, or city and county.

(b) "Provider fee" means a licensing fee, assessment, or other mandatory payment that is related to health care items or services as specified under 42 CFR 433.55.

(c) "Qualified provider" means a hospital licensed pursuant to section 25-3-101, C.R.S., or a certified home health care agency within the territorial boundaries of the local government.

(2) For the purpose of sustaining or increasing reimbursement for providing medical care under the state's medical assistance program and to low-income populations, the state department shall amend the state plan effective July 1, 2006. Implementation of the state plan amendment shall be subject to the approval of the federal government. The imposition and collection of a provider fee by a local government pursuant to article 28 of title 29, C.R.S., shall be prohibited without the federal government's approval of a state plan amendment authorizing federal financial participation for the provider fees.

(3) In accordance with the redistributive method set forth in 42 CFR 433.68 (e)(1) and (e)(2), the state department may seek a waiver from the broad-based provider fee requirement or the uniform provider fee requirement, or both, to exclude qualified providers from the provider fee.

(4) To the extent authorized by federal law, the state department may exclude a governmental qualified provider from payment of the provider fee, benefits from the provider fee, or any federal financial participation due to the fee.

(5) To the extent authorized by federal law, the state department shall distribute the provider fee and any associated federal financial participation either to a local government that has certified payment to qualified providers within the local government or directly to the qualified providers. The state department shall establish reimbursement methods to distribute the provider fee and associated federal financial participation to qualified providers. The state department may alter reimbursement methods to qualified providers participating under the state's medical assistance program and Colorado indigent care program to the extent necessary to meet the federal requirements and to obtain federal approval of the provider fee. The state department shall work with a statewide association of hospitals on changes to reimbursement methods or provider fees that impact hospital providers. The state department shall work with a statewide association of home health care agencies on changes to reimbursement methods or provider fees that impact home health care agencies.

(6) The state board shall adopt any rules necessary for the administration and implementation of this section.

Source: L. 2006: Entire section added, p. 887, § 2, effective May 5. **L. 2008:** Entire section amended, p. 927, § 1, effective May 20.

Editor's note: This section was enacted as § 26-4-427 in Senate Bill 06-145 but was relocated due to its harmonization with this article as it appeared in Senate Bill 06-219.

25.5-4-418. Integration of physical and behavioral health services - department review - report - repeal. (Repealed)

Source: L. 2011: Entire section added, (HB 11-1242), ch. 271, p. 1230, § 1, effective July 1.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2012. (See L. 2011, p. 1230.)

PART 5

STATE PLAN AMENDMENTS -
WAIVER AUTHORITY

25.5-4-501. State plan amendment - federal authorization - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1853, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 26-4-105.8 as it existed prior to 2006.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2007. (See L. 2006, p. 1853.)

25.5-4-502. Federal authorization - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1853, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 25.5-1-113 as it existed prior to 2006.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2007. (See L. 2006, p. 1853.)

25.5-4-503. Waiver applications - authorization. The state department is authorized to apply for health insurance flexibility and accountability waivers that will enable the state to add more flexibility to Colorado's medicaid program and that will result in a cost-effective method of providing health care services to Coloradans.

Source: L. 2006: Entire article added with relocations, p. 1853, § 7, effective July 1.

Editor's note: This section is similar to former § 25.5-1-111 as it existed prior to 2006.

ARTICLE 5

Colorado Medical Assistance Act -
Services and Programs

Editor's note: This article was added with relocations in 2006 containing provisions of some sections formerly located in article 4 of title 26. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

Cross references: For definitions applicable to this article, see § 25.5-4-103.

PART 1

MANDATORY PROVISIONS

25.5-5-101. Mandatory provisions - eligible groups. (1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law and except as provided in subsection (2) of this section, any person who is eligible for medical assistance under the mandated groups specified in this section shall receive both the mandatory services that are specified in sections 25.5-5-102 and 25.5-5-103 and the optional services that are specified in sections 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial participation, the following are the individuals or groups that are mandated under federal law to receive benefits under this article and articles 4 and 6 of this title:

(a) Repealed.

(b) Parents and caretaker relatives living with a dependent child who meet the eligibility criteria pursuant to section 1902 (a)(10)(A) of the federal "Social Security Act", including those who subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;

(c) Pregnant women whose family income does not exceed one hundred thirty-three percent of the federal poverty line, adjusted for family size, who meet the requirements pursuant to section 1902 (a)(10)(A) of the federal "Social Security Act". Once initial eligibility has been established, the pregnant woman is continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income.

(d) A newborn child born of a woman who is categorically needy. Such child is deemed medicaid-eligible on the date of birth and remains eligible for one year.

(e) Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the federal "Social Security Act", as amended, including foster care children, pursuant to section 1902 (a)(10)(A)(i)(IX) of the federal "Social Security Act", who are under twenty-six years of age, who were in foster care under the responsibility of the state or a tribe, and who were enrolled in medicaid under the state medicaid plan when they turned eighteen years of age;

(f) Individuals receiving supplemental security income;

(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;

(h) Institutionalized individuals who were eligible for medical assistance in December 1973;

(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under Pub.L. 92-336;

(j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April 1977;

(k) Disabled widows or widowers fifty through sixty years of age who have become ineligible for federal supplemental security income or state supplementation as a result of becoming eligible for federal social security survivor's benefits, in accordance with the social security act, 42 U.S.C. sec. 1383c;

(l) Individuals with income and resources at a level which qualifies them as medicare-eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act";

(m) Children under the age of nineteen who meet the eligibility criteria pursuant to section 1902 (a)(10)(A) of the federal "Social Security Act".

(2) (a) A qualified alien who entered the United States before August 22, 1996, who meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended, shall receive benefits under this article and articles 4 and 6 of this title.

(b) (I) A qualified alien who entered the United States on or after August 22, 1996, shall not be eligible for benefits under this article or article 4 or 6 of this title, except as provided in section 25.5-5-103 (3), for five years after the date of entry into the United States unless he or she meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended.

(II) Notwithstanding the five-year waiting period established in subparagraph (I) of this paragraph (b), but subject to the availability of sufficient appropriations and the receipt of federal financial participation, the state department may provide benefits under this article and articles 4 and 6 of this title to a pregnant woman who is a qualified alien and a child under nineteen years of age who is a qualified alien so long as such woman or child meets eligibility criteria other than citizenship.

(3) Notwithstanding any other provision of this article and articles 4 and 6 of this title, as a condition of eligibility for medical assistance under this article and articles 4 and 6 of this title, a legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service, or any successor agency, during the pendency of such legal immigrant's receipt of medical assistance. Nothing in this subsection (3) shall be construed to affect a legal immigrant's eligibility for medical assistance under this article and articles 4 and 6 of this title based upon such legal immigrant's responsibilities under an affidavit of support entered into before July 1, 1997.

(4) An asset test shall not be applied as a condition of eligibility for individuals or families described in paragraphs (b), (c), (d), and (e) of subsection (1) of this section.

Source: L. 2006: Entire article added with relocations, p. 1854, § 7, effective July 1. **L. 2009:** (2)(b) amended, (HB 09-1353), ch. 360, p. 1869, § 1, effective July 1, 2010. **L. 2010:** (4)(c) added, (HB 10-1043), ch. 92, p. 312, § 1, effective April 15; (1)(m) amended, (HB 10-1422), ch. 419, p. 2110, § 143, effective August 11. **L. 2011:** (3) amended, (HB 11-1303), ch. 264, p. 1168, § 67, effective August 10. **L. 2014:** (1)(a) repealed and (1)(b), (1)(c), (1)(d), (1)(e), (1)(m), and (4) amended, (SB 14-067), ch. 12, p. 111, § 3, effective February 27.

Editor's note: (1) This section is similar to former § 26-4-201 as it existed prior to 2006.

(2) Prior to the amendment to subsection (4) in 2014, subsection (4)(b)(II) provided for the repeal of subsection (4)(b), effective July 1, 2007. (See L. 2006, p. 1854.)

Cross references: For provisions of the federal "Medicare Catastrophic Coverage Act of 1988" referenced in this section, see section 301 of Pub.L. 100-360, codified at 42 U.S.C. sec. 1396a et seq.

25.5-5-102. Basic services for the categorically needy - mandated services. (1) Subject to the provisions of subsection (2) of this section and section 25.5-4-104, the program for the categorically needy shall include the following services as mandated and defined by federal law:

(a) Inpatient hospital services;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Physicians' services, wherever furnished;

(e) Nursing facility services;

(f) Home health services;

(g) Early and periodic screening, diagnosis, and treatment, as required by federal law;

(h) Family planning;

(i) Rural health services;

(j) Advanced practice nurse services;

(k) and (l) (Deleted by amendment, L. 2008, p. 138, § 2, effective July 1, 2008.)

(m) Federally qualified health centers.

(2) In order to keep expenditures within approved appropriations, the state board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (2), the state board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

Source: L. 2006: Entire article added with relocations, p. 1856, § 7, effective July 1. **L. 2008:** (1)(j), (1)(k), and (1)(l) amended, p. 138, § 2, effective July 1.

Editor's note: This section is similar to former § 26-4-202 as it existed prior to 2006.

Cross references: For the definition of "federally qualified health centers" in the federal "Social Security Act", see 42 U.S.C. sec. 1395x.

25.5-5-103. Mandated programs with special state provisions. (1) This section specifies programs developed by Colorado to meet federal mandates. These programs include but are not limited to:

(a) Repealed.

(b) Special provisions relating to nursing facilities, as specified in sections 25.5-6-201 to 25.5-6-203, 25.5-6-205, and 25.5-6-206;

(c) The program for qualified medicare beneficiaries, as specified in section 25.5-5-104;

(d) The program for qualified disabled and working individuals, as specified in section 25.5-5-105;

(e) Special provisions for the purchase of group health insurance for recipients, as specified in section 25.5-4-210;

(f) The program to provide health services to students by school districts as specified in section 25.5-5-318.

(2) The medical assistance program also is subject to special provisions relating to the use of public funds for abortion which are required by section 50 of article V of the Colorado constitution. Those special provisions are specified in section 25.5-4-415.

(3) (a) Emergency medical assistance shall be provided to any person who is not a citizen of the United States, including undocumented aliens, aliens who are not qualified aliens, and qualified aliens who entered the United States on or after August 22, 1996, who has an emergency medical condition and meets one of the categorical requirements set forth in section 25.5-5-101; except that such persons shall not be required to meet any residency requirement other than that required by federal law.

(b) The state board shall adopt rules necessary for the implementation of this subsection (3), including in such rules definitions of "emergency services", "emergency medical condition", "geographic area", and "prenatal care".

Source: L. 2006: Entire article added with relocations, p. 1856, § 7, effective July 1. **L. 2014:** (1)(a) repealed, (SB 14-067), ch. 12, p. 113, § 4, effective February 27.

Editor's note: This section is similar to former § 26-4-203 as it existed prior to 2006.

25.5-5-104. Qualified medicare beneficiaries. Qualified medicare beneficiaries are medicare-eligible individuals with income and resources at a level which qualifies them as eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act of 1988", as amended, or subsequent amending federal legislation. For purposes of this article and articles 4 and 6 of this title, such individuals shall be referred to as "qualified medicare beneficiaries". The state department is hereby designated as the single state agency to administer benefits available to qualified medicare beneficiaries in accordance with Title XIX and this article and articles 4 and 6 of this title. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified medicare beneficiaries the entire range of services set forth in section 25.5-5-102.

Source: L. 2006: Entire article added with relocations, p. 1857, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-510 as it existed prior to 2006.

Cross references: For provisions of the federal "Medicare Catastrophic Coverage Act of 1988" referenced in this section, see section 301 of Pub.L. 100-360, codified at 42 U.S.C. sec. 1396a et seq.

25.5-5-105. Qualified disabled and working individuals. Qualified disabled and working individuals are persons with income and resources and disability status, as determined by the social security administration, which qualify them as "qualified disabled and working individuals" under sections 6012 and 6408 of the federal "Omnibus Budget Reconciliation Act of 1989", or subsequent amending federal legislation. The state department is hereby designated

as the single state agency to administer benefits available to qualified disabled and working individuals. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified disabled and working individuals the entire range of services set forth in section 25.5-5-102.

Source: L. 2006: Entire article added with relocations, p. 1858, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-511 as it existed prior to 2006.

Cross references: For provisions of the federal "Omnibus Budget Reconciliation Act of 1989" referenced in this section, see sections 6012 and 6408 of Pub.L. 101-239, codified at 42 U.S.C. secs. 1395i and 1396a.

PART 2

OPTIONAL PROVISIONS

25.5-5-201. Optional provisions - optional groups. (1) The federal government allows the state to select optional groups to receive medical assistance. Pursuant to federal law, any person who is eligible for medical assistance under the optional groups specified in this section shall receive both the mandatory services specified in sections 25.5-5-102 and 25.5-5-103 and the optional services specified in sections 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial aid funds, the following are the individuals or groups that Colorado has selected as optional groups to receive medical assistance pursuant to this article and articles 4 and 6 of this title 25.5:

(a) Individuals who would be eligible for but are not receiving cash assistance;

(b) Individuals who would be eligible for cash assistance except for their institutionalized status;

(c) Individuals receiving home- and community-based services as specified in article 6 of this title;

(d) and (e) Repealed.

(f) Individuals receiving only optional state supplement;

(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision.

(h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706, C.R.S.;

(i) Persons who are eligible for the breast and cervical cancer prevention and treatment program pursuant to section 25.5-5-308;

(j) Individuals who are qualified aliens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

(k) Other qualified aliens who entered or were present in the United States before August 22, 1996;

(l) Children for whom subsidized adoption assistance payments are made by the state pursuant to article 7 of title 26, C.R.S., or foster care maintenance payments are made by the state pursuant to article 5 of title 26, C.R.S., but who do not meet the requirements of Title IV-E of the "Social Security Act", as amended;

(m) Parents and caretaker relatives of children who are eligible for the medical assistance program whose family income does not exceed one hundred thirty-three percent of the federal poverty line, adjusted for family size;

(m.5) Pregnant women, whose family income does not exceed one hundred eighty-five percent of the federal poverty line, adjusted for family size;

(n) Repealed.

(o) (I) Individuals with disabilities who are participating in the medicaid buy-in program established in part 14 of article 6 of this title.

(II) Notwithstanding the provisions of subsection (1)(o)(I) of this section, if the money in the healthcare affordability and sustainability fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for individuals with disabilities who are participating in the medicaid buy-in program established in part 14 of article 6 of this title 25.5, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the medical benefits offered or the percentage of the federal poverty line to below four hundred fifty percent or may eliminate this eligibility group.

(III) Repealed.

(p) Subject to federal approval, adults who are childless or without a dependent child in the home, as described in section 1902 (a)(10)(A)(i)(VIII) of the social security act, 42 U.S.C. sec. 1396a, who have attained nineteen years of age but have not attained sixty-five years of age, and whose family income does not exceed one hundred thirty-three percent of the federal poverty line, adjusted for family size;

(q) Children who are continuously eligible for twelve months pursuant to section 25.5-5-204.5;

(r) (I) Persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206 whose family income does not exceed a specified percentage of the federal poverty line, adjusted for family size and as set by the state board by rule, which percentage shall be not more than four hundred fifty percent.

(II) Notwithstanding the provisions of subsection (1)(r)(I) of this section, if the money in the healthcare affordability and sustainability fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the medical benefits offered, or the percentage of the federal poverty line, or may eliminate this eligibility group.

(III) Repealed.

(2) (a) A qualified alien, who entered the United States on or after August 22, 1996, shall not be eligible for benefits under this article and articles 4 and 6 of this title, except as provided in section 25.5-5-103 (3), for five years after the date of entry into the United States unless he or she meets the exceptions described in the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193, as amended. After five years, such qualified alien shall be eligible for benefits under this article and articles 4 and 6 of this title but shall have sponsor income and resources deemed to the individual or family under rules established by the state board of human services pursuant to section 26-2-137, C.R.S.

(b) Notwithstanding the five-year waiting period established in paragraph (a) of this subsection (2), but subject to the availability of sufficient appropriations and the receipt of federal financial participation, the state department may provide benefits under this article and articles 4 and 6 of this title to a pregnant woman who is a qualified alien and a child under nineteen years of age who is a qualified alien so long as such woman or child meets eligibility criteria other than citizenship.

(3) A legal immigrant who is receiving medicaid nursing facility care or home- and community-based services on July 1, 1997, shall continue to receive such services as long as he or she meets the eligibility requirements other than citizen status. State general funds may be used to reimburse such care in the event that federal financial participation is not available.

(4) A pregnant legal immigrant shall be eligible to receive prenatal and medical services for labor and delivery as long as she meets eligibility requirements other than citizen status. State general funds may be used to reimburse such care in the event that federal financial participation is not available.

(5) An asset test shall not be applied as a condition of eligibility for individuals or families described in paragraphs (a), (h), and (m.5) of subsection (1) of this section.

Source: L. 2006: Entire article added with relocations, p. 1858, § 7, effective July 1. **L. 2007:** (1)(n) added, p. 897, § 1, effective May 15. **L. 2008:** (1)(l) and (1)(n) amended and (1)(o) added, pp. 1532, 2200, §§ 1, 2, effective July 1. **L. 2009:** (1)(m)(I) and (1)(o) amended and (1)(p), (1)(q), and (1)(r) added, (HB 09-1293, ch. 152, p. 645, § 5, effective July 1; (2) amended, (HB 09-1353), ch. 390, p. 1869, § 2, effective July 1, 2010. **L. 2010:** (5)(c) added, (HB 10-1043), ch. 92, p. 312, § 2, effective April 15; (1)(m)(I), (1)(o)(II), (1)(p)(I), (1)(p)(II), (1)(r)(I), and (1)(r)(II) amended, (HB 10-1422), ch. 419, p. 2111, § 144, effective August 11. **L. 2013:** (1)(m) and (1)(p) amended, (SB 13-200), ch. 216, p. 898, § 2, effective May 13. **L. 2014:** (1)(d), (1)(e), and (1)(n) repealed, (1)(m.5) added, and (5) amended, (SB 14-067), ch. 12, p. 113, § 5, effective February 27. **L. 2017:** IP(1), (1)(o)(II), and (1)(r)(II) amended, (SB 17-267), ch. 267, p. 1465, § 19, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-301 as it existed prior to 2006.

(2) Prior to the amendment of subsection (1)(m) in 2013, subsection (1)(m)(II)(B) provided for the repeal of subsection (1)(m)(II), effective January 1, 2007. (See L. 2006, p. 1858.)

(3) Prior to the amendment of subsection (5) in 2014, subsection (5)(b)(II) provided for the repeal of subsection (5)(b), effective July 1, 2007. (See L. 2006, p. 1858.)

(4) Subsection (1)(o)(III)(C) provided for the repeal of subsection (1)(o)(III), effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (1)(o)(III)(B). (See L. 2009, p. 645.) The revisor of statutes received said notice dated March 23, 2012.

(5) Prior to the amendment of subsection (1)(p) in 2013, subsection (1)(p)(III)(C) provided for the repeal of subsection (1)(p)(III), effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (1)(p)(III)(B). (See L. 2009, p. 645.) The revisor of statutes received said notice dated April 2, 2012.

(6) Subsection (1)(r)(III)(C) provided for the repeal of subsection (1)(r)(III), effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (1)(r)(III)(B). (See L. 2009, p. 645.) The revisor of statutes received said notice dated February 17, 2017.

(7) Section 34 of chapter 267 (SB 17-267), Session Laws of Colorado 2017, provides that the section of the act changing this section does not take effect if the centers for medicare and medicaid services determine that the amendments do not comply with federal law. For more information, see SB 17-267. (L. 2017, p. 1478.) The executive director of the department of health care policy and financing did not notify the revisor of statutes by June 1, 2017 of such determination; therefore, the amendments to this section took effect July 1, 2017.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-5-202. Basic services for the categorically needy - optional services. (1) Subject to the provisions of subsection (2) of this section, the following are services for which federal financial participation is available and that Colorado has selected to provide as optional services under the medical assistance program:

(a) (I) Prescribed drugs.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (a), pursuant to the provisions of section 25.5-5-503, prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is enrolled in a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

(a.5) Over-the-counter medications, as specified in section 25.5-5-322;

(b) Clinic services, as defined in sections 25.5-5-301 and 25.5-5-302;

(c) Home- and community-based services, as specified in article 6 of this title, which include:

(I) Home- and community-based services for individuals who are elderly or blind and individuals with disabilities, as specified in part 3 of article 6 of this title;

(II) Home- and community-based services for persons with intellectual and developmental disabilities, as specified in part 4 of article 6 of this title;

(III) Home- and community-based services for persons living with AIDS, as specified in part 5 of article 6 of this title;

(IV) Home- and community-based services for persons with major mental illnesses, as specified in part 6 of article 6 of this title;

(V) Home- and community-based services for persons with brain injury, as specified in part 7 of article 6 of this title;

(d) Optometrist services;

(e) Eyeglasses when necessary after surgery;

(f) Prosthetic devices, including medically necessary augmentative communication devices; except that nonsurgically implanted prosthetic devices shall be included only after July 1, 1998, and only if the general assembly approves appropriations for these devices as a new benefit;

(g) Rehabilitation services as appropriate to community mental health centers;

(h) Intermediate care facilities for individuals with intellectual disabilities;

(i) Inpatient psychiatric services for persons under twenty-one years of age;

(j) Inpatient psychiatric services for persons over the age of sixty-five;

(k) Case management;

(l) Therapies under home health services, including:

(I) Speech and audiology;

(II) Physical;

(III) Occupational;

(m) Services of a licensed psychologist;

(n) Private duty nursing services;

(o) Podiatry services;

(p) Hospice care;

(q) The program of all-inclusive care for the elderly;

(r) For any pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1)(c), alcohol and substance use disorder counseling and treatment, including outpatient and residential care but not including room and board while receiving residential care;

(s) (I) Outpatient substance use disorder treatment.

(II) Repealed.

(t) Cervical cancer immunization for all females under twenty years of age;

(u) (I) Screening, brief intervention, and referral to treatment for individuals at risk of substance abuse, including referral to the appropriate level of intervention and treatment.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (u), services relating to screening, brief intervention, and referral to treatment shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of such services.

(v) (I) Counseling by primary care providers and other specialty providers caring for persons with serious, chronic, or terminal illness relating to medical orders for scope of treatment, which counseling may be reimbursed.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (v), counseling relating to medical orders for scope of treatment shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of such services.

(w) Dental services for adults.

(2) In addition to the services described in subsection (1) of this section and subject to continued federal financial participation, Colorado has selected to provide transportation services as an administrative cost.

(3) In order to keep expenditures within approved appropriations, the state board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (3), the state board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

Source: L. 2006: Entire article added with relocations, p. 1860, § 7, effective July 1. **L. 2007:** (1)(t) added, p. 1348, § 2, effective May 29. **L. 2010:** (1)(r) amended, (HB 10-1043), ch. 92, p. 313, § 3, effective April 15; (1)(a.5) added, (SB 10-117), ch. 227, p. 985, § 1, effective July 1; (1)(u) added, (HB 10-1033), ch. 346, p. 1601, § 1, effective August 11. **L. 2013:** (1)(h) amended, (SB 13-167), ch. 394, p. 2290, § 2, effective June 5; (1)(u)(II) amended and (1)(w) added, (SB 13-242), ch. 189, p. 761, § 1, effective August 7; (1)(v) added, (HB 13-1202), ch. 117, p. 401, § 1, effective August 7. **L. 2014:** (1)(r) amended, (SB 14-067), ch. 12, p. 114, § 6, effective February 27; (1)(c)(I) and (1)(c)(II) amended, (SB 14-118), ch. 250, p. 985, § 20, effective August 6. **L. 2017:** IP(1), (1)(r), and (1)(s)(I) amended, (SB 17-242), ch. 263, p. 1327, § 199, effective May 25; (1)(s)(II) repealed, (SB 17-294), ch. 264, p. 1409, § 92, effective May 25.

Editor's note: (1) This section is similar to former § 26-4-302 as it existed prior to 2006.

(2) The legislative audit committee did not adopt a resolution by March 31, 2011, as provided for in subsection (1)(s)(II).

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-5-203. Optional programs with special state provisions. (1) Subject to the provisions of subsection (2) of this section, this section specifies programs developed by Colorado to increase federal financial participation through selecting optional services or optional eligible groups. These programs include but are not limited to:

(a) Pharmaceutical services, as specified in section 25.5-5-504;

(b) The home- and community-based services program for the elderly, blind, and disabled, as specified in part 3 of article 6 of this title;

(c) The home- and community-based services program for the developmentally disabled, as specified in part 4 of article 6 of this title;

(d) The home- and community-based services program for persons living with AIDS, as specified in part 5 of article 6 of this title;

(e) The home- and community-based services program for persons with major mental illnesses, as specified in part 6 of article 6 of this title;

(f) The home- and community-based services program for persons with brain injury, as specified in part 7 of article 6 of this title;

(g) Clinic services, as defined in sections 25.5-5-301 and 25.5-5-302;

(h) The program for private duty nursing, as specified in section 25.5-5-303;

(i) The disabled children care program, as specified in section 25.5-6-901;

(j) The program of all-inclusive care for the elderly, as specified in section 25.5-5-412;

(k) Hospice care, as specified in section 25.5-5-304;

(l) The treatment program for high-risk pregnant women, as specified in section 27-80-112, C.R.S., and sections 25.5-5-309, 25.5-5-310, and 25.5-5-311;

(m) The program for residential child health care, as specified in section 25.5-5-306;

(n) The children's personal assistance services and family support waiver program, as specified in section 25.5-6-902;

(o) Home- and community-based services for children with autism, as specified in part 8 of article 6 of this title.

(2) In order to keep expenditures within approved appropriations, the state board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (2), the state board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

Source: L. 2006: Entire article added with relocations, p. 1862, § 7, effective July 1. **L. 2010:** (1)(l) amended, (SB 10-175), ch. 188, p. 801, § 67, effective April 29.

Editor's note: This section is similar to former § 26-4-303 as it existed prior to 2006.

25.5-5-204. Presumptive eligibility - pregnant women - children - long-term care - state plan. (1) For purposes of this section, "presumptive eligibility" means the self-declaration of income, assets, and status in order to promptly receive medical assistance services prior to the verification of income, assets, and status.

(2) (a) A pregnant woman shall be presumptively eligible for the medical assistance program and shall receive services specified by federal law only if the woman declares all pertinent information relating to the criteria of income, assets, and status.

(b) A woman shall declare her immigration status unless the general assembly provides funding for prenatal care services for undocumented residents.

(2.5) A child under the age of eighteen years shall be presumptively eligible for the medical assistance program and shall receive services specified by federal law only if a parent or legal guardian of the child declares all pertinent information relating to the criteria of income, assets, and status of the child's family.

(2.7) (a) The state department is authorized to seek federal authorization to allow a person who is in need of long-term care, as defined in section 25.5-6-104, to be presumptively eligible for the medical assistance program pursuant to this article and articles 4 and 6 of this title.

(b) If the state department receives federal authorization pursuant to paragraph (a) of this subsection (2.7) and sufficient spending authority, a person in need of long-term care shall be presumptively eligible for the medical assistance program if the person or the person's legal representative declares all pertinent information relating to the criteria of income, assets, and immigration status. Such person shall be assessed for the appropriate level of care pursuant to section 25.5-6-104. If required due to limitations of federal authorization or spending authority, the state department may implement this paragraph (b) as a pilot program rather than statewide.

(c) The state department shall make any necessary changes to the state plan and waivers for home- and community-based service programs authorized pursuant to this article and articles 4 and 6 of this title to comply with this subsection (2.7).

(d) If it is determined that a recipient was not eligible for medical benefits after the recipient had been determined to be eligible based upon presumptive eligibility, the state department shall not pursue recovery from a county department for the cost of medical services provided to the recipient, and the county department shall not be responsible for any federal error rate sanctions resulting from such determination.

(3) The state department shall make any necessary changes to the state plan to comply with this section.

Source: L. 2006: Entire article added with relocations, p. 1864, § 7, effective July 1. **L. 2007:** (2.5) added, p. 1493, § 4, effective January 1, 2008. **L. 2009:** (2.7) added, (HB 09-1103), ch. 160, p. 694, § 1, effective April 22.

Editor's note: This section is similar to former § 26-4-304 as it existed prior to 2006.

Cross references: For the legislative declaration contained in the 2007 act enacting subsection (2.5), see section 1 of chapter 347, Session Laws of Colorado 2007.

25.5-5-204.5. Continuous eligibility - children. (1) A child who is determined to be eligible for benefits under this article or under article 4 or 6 of this title shall remain eligible for twelve months subsequent to the last day of the month in which the child was enrolled; except that a child shall no longer be eligible and shall be disenrolled from the state medical assistance program if the state department becomes aware of or is notified that the child has moved out of the state or has reached nineteen years of age.

(2) Notwithstanding the provisions of subsection (1) of this section, if the money in the healthcare affordability and sustainability fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may eliminate the continuous enrollment requirement pursuant to this section.

(3) Repealed.

Source: L. 2009: Entire section added, (HB 09-1293), ch. 152, p. 648, § 6, effective July 1. **L. 2017:** (2) amended, (SB 17-267), ch. 267, p. 1466, § 20, effective July 1.

Editor's note: (1) Subsection (3)(c) provided for the repeal of subsection (3), effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (3)(b). (See L. 2009, p. 648.) The revisor of statutes received said notice dated February 17, 2017.

(2) Section 34 of chapter 267 (SB 17-267), Session Laws of Colorado 2017, provides that the section of the act amending this section does not take effect if the centers for medicare and medicaid services determine that the amendments do not comply with federal law. For more information, see SB 17-267. (L. 2017, p. 1478.) The executive director of the department of health care policy and financing did not notify the revisor of statutes by June 1, 2017 of such determination; therefore, the amendments to this section took effect July 1, 2017.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-5-205. Baby and kid care program - creation - eligibility. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1864, § 7, effective July 1. **L. 2007:** (3)(d) amended, p. 1493, § 5, effective January 1, 2008. **L. 2010:** (3)(a) and (3)(c)(I) amended, (HB 10-1043), ch. 92, p. 313, § 4, effective April 15. **L. 2011:** (3)(b) amended, (SB 11-250), ch. 219, p. 950, § 1, effective May 27; (3)(c) amended, (SB 11-008), ch. 100, p. 293, § 2, effective September 1. **L. 2014:** Entire section repealed, (SB 14-067), ch. 12, p. 114, § 7, effective February 27.

Editor's note: This section was similar to former § 26-4-508 as it existed prior to 2006.

25.5-5-206. Medicaid buy-in program - disabled children - disabled adults - federal authorization - rules. (1) (a) Subject to available appropriations, the state department is authorized to seek federal authorization to and to establish a medicaid buy-in program or programs for:

(I) Disabled children; or

(II) Disabled adults who do not qualify for the medicaid buy-in program established pursuant to part 14 of article 6 of this title.

(b) The medicaid buy-in program or programs established pursuant to paragraph (a) of this subsection (1) may provide for premium and cost-sharing charges on a sliding fee scale based upon a family's income.

(2) The state board shall promulgate rules consistent with any federal authorization to implement and administer the medicaid buy-in program or programs established pursuant to paragraph (a) of subsection (1) of this section.

Source: L. 2009: Entire section added, (HB 09-1293), ch. 152, p. 698, § 6, effective July 1.

25.5-5-207. Adult dental benefit - adult dental fund - creation - legislative declaration. (1) (a) The general assembly finds that:

(I) As of 2011, Colorado was one of only ten states that did not offer basic oral health services to adults under medicaid;

(II) Research has shown that untreated oral health conditions negatively affect a person's overall health and that gum disease has been linked to diabetes, heart disease, strokes, kidney disease, Alzheimer's disease, and even behavioral or mental health disorders;

(III) Regular dental care and prevention are the most cost-effective methods available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care;

(IV) Further, one in four adults has untreated tooth decay. Early detection and access to preventive and restorative treatments for oral health conditions can be up to ten times less expensive than treating those same conditions in an emergency setting.

(V) Research has also shown that good oral health improves medicaid beneficiaries' ability to obtain and keep employment. Employed adults lose more than one hundred and sixty-four million hours of work each year due to dental problems.

(VI) Children are more likely to receive regular dental services if their parents have access to dental services; and

(VII) Pregnant women are one of the most vulnerable adult populations that are without oral health benefits under medicaid. During pregnancy, the physical changes a woman's body undergoes can negatively affect oral health. Untreated decay and periodontal disease are associated with adverse pregnancy outcomes such as increased risk for preeclampsia, pre-term labor, and low birth weight babies.

(b) Therefore, the general assembly declares that in order to improve overall health, promote savings in medicaid programs, and prevent future health conditions caused by oral health problems, it is in the best interest of the state of Colorado to create a limited oral health benefit for adults in the medicaid program.

(2) (a) Pursuant to section 25.5-5-202 (1)(w), by April 1, 2014, the state department shall design and implement a limited dental benefit for adults using a collaborative stakeholder process to consider the components of the benefit, including but not limited to the cost, best practices, the effect on health outcomes, client experience, service delivery models, and maximum efficiencies in the administration of the benefit.

(b) The state department shall determine the most cost-effective method for providing the adult dental benefit, including but not limited to a comparison of a capitated or fee-for-service method of payment and the purchase of dental insurance.

(c) The state department shall seek any federal authorization necessary to provide the adult dental benefit.

(d) Subject to federal authorization and federal financial participation, on or after July 1, 2016, the diagnosis, development of a treatment plan, instruction to perform an interim therapeutic restoration procedure, or supervision of a dental hygienist performing an interim therapeutic restoration procedure may be provided through telehealth, including store-and-forward transfer, in accordance with section 25.5-5-321.5.

(3) If the state department chooses to use an administrative service organization to manage the adult dental benefit:

(a) The contract with the administrative service organization must provide that the contracting entity is prohibited from requiring dental providers to participate in any other public

or private program or to accept any other insurance products as a condition of participating as a dental provider; and

(b) The state department shall retain policy-making authority, including but not limited to policies concerning covered benefits and rate setting.

(4) (a) There is hereby created in the state treasury the adult dental fund, referred to in this section as the "fund", consisting of moneys transferred to the fund from the unclaimed property trust fund pursuant to section 38-13-116.5 (2.8), C.R.S., and any moneys that may be appropriated to the fund by the general assembly. The moneys in the fund are subject to annual appropriation by the general assembly to the state department for the direct and indirect costs associated with implementing the adult dental benefit pursuant to section 25.5-5-202 (1)(w).

(b) The state treasurer may invest any unexpended moneys in the fund as provided by law. The state treasurer shall credit all interest and income derived from the investment and deposit of moneys in the fund to the fund.

(c) Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year remain in the fund and shall not be credited or transferred to the general fund or another fund.

Source: L. 2013: Entire section added, (SB 13-242), ch. 189, p. 761, § 2, effective August 7. **L. 2015:** (2)(d) added, (HB 15-1309), ch. 326, p. 1334, § 7, effective August 5. **L. 2017:** IP(1)(a) and (1)(a)(II) amended, (SB 17-242), ch. 263, p. 1327, § 200, effective May 25.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-5-208. Additional services - training - grants - screening, brief intervention, and referral. On or before June 30, 2016, the state department shall grant, through a competitive grant program, up to five hundred thousand dollars to one or more organizations to provide evidence-based training and outreach to health professionals statewide related to screening, brief intervention, and referral to treatment for individuals at risk of substance abuse for whom Colorado provides optional services in accordance with section 25.5-5-202 (1)(u). For any fiscal year beginning on or after July 1, 2016, the state department shall award additional grants for this training and outreach, subject to available appropriations. Any moneys appropriated for grants pursuant to this section are not subject to federal financial participation.

Source: L. 2015: Entire section added, (HB 15-1367), ch. 271, p. 1078, § 17, effective January 1, 2016.

Editor's note: Section 23(2) of chapter 271 (HB 15-1367), Session Laws of Colorado 2015, provides that this section takes effect only if a majority of voters approve the ballot issue referred in accordance with section 39-28.8-603 (1) at the November 2015 statewide election. If the voters approve the ballot measure, this section is effective on the date of the official declaration of the vote by the governor, or January 1, 2016, whichever is later. The ballot issue was approved by voters on November 3, 2015. The governor's proclamation was issued on December 28, 2015, establishing an effective date of January 1, 2016, for this section. The vote count for the measure was as follows:

FOR: 847,380
AGAINST: 373,734

Cross references: For the legislative declaration in HB 15-1367, see section 1 of chapter 271, Session Laws of Colorado 2015.

PART 3

SERVICES WITH SPECIAL STATE PROVISIONS

25.5-5-301. Clinic services. (1) As used in this article and articles 4 and 6 of this title, unless the context otherwise requires, "clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients.

(2) Under the federal option for clinic services, Colorado has selected clinic services provided by the following:

(a) Community mental health centers or clinics;

(b) Community centered boards;

(c) Birthing centers;

(d) Ambulatory surgery facilities;

(e) Freestanding dialysis clinics.

(3) "Clinic services" also means preventive, therapeutic, or palliative items or services that are furnished to patients by county or district public health agencies or county or district boards of health established pursuant to part 5 of article 1 of title 25, C.R.S., that are recommended for certification by the department of public health and environment as qualified to receive payments pursuant to this article and articles 4 and 6 of this title.

(4) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to a pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1)(c) or 25.5-5-201 (1)(m.5) in a facility that is not a part of a hospital but is organized and operated as a freestanding substance use disorder treatment program approved and licensed by the office of behavioral health in the department of human services pursuant to section 27-80-108 (1)(c).

(5) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to children up to age twenty-one or to high-risk pregnant women in a facility which is not a part of a hospital but is organized and operated as a school-based clinic.

(6) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to students by a school district, board of cooperative services, or state educational institution within the scope of the "Colorado Medical Assistance Act" pursuant to the provisions of section 25.5-5-318.

Source: L. 2006: Entire article added with relocations, p. 1866, § 7, effective July 1. **L. 2010:** (4) amended, (HB 10-1043), ch. 92, p. 314, § 5, effective April 15; (4) amended, (SB 10-175), ch. 188, p. 801, § 68, effective April 29; (3) amended, (HB 10-1422), ch. 419, p. 2113, § 145, effective August 11. **L. 2014:** (4) amended, (SB 14-067), ch. 12, p. 116, § 12, effective February 27. **L. 2017:** (4) amended, (SB 17-242), ch. 263, p. 1328, § 201, effective May 25.

Editor's note: (1) This section is similar to former § 26-4-513 as it existed prior to 2006.

(2) Amendments to subsection (4) by House Bill 10-1043 and Senate Bill 10-175 were harmonized.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-5-302. Clinic services - children and pregnant women - utilization of certain providers. (1) The state department shall utilize, to the extent possible and appropriate, county or district public health agencies or boards of health established pursuant to part 5 of article 1 of title 25, C.R.S., that are certified by the department of public health and environment as qualified to receive payments pursuant to this article and articles 4 and 6 of this title and that meet the requirements and standards set forth in rules promulgated by the state board in the state department pursuant to section 25.5-4-104 to provide clinic services to patients who are children under age seven or patients who are pregnant women.

(2) In complying with the provisions of subsection (1) of this section, the state department shall utilize, to the extent possible and appropriate, the county or district public health agencies and boards of health specified in subsection (1) of this section to provide outreach to eligible pregnant women and children and to provide clinic services:

(a) Upon the referral of any physician; or

(b) When there exists no primary care physician who agrees to provide clinic services to such patients.

Source: L. 2006: Entire article added with relocations, p. 1867, § 7, effective July 1. **L. 2010:** (1) and IP(2) amended, (HB 10-1422), ch. 419, p. 2113, § 146, effective August 11.

Editor's note: This section is similar to former § 26-4-514 as it existed prior to 2006.

25.5-5-303. Private-duty nursing. (1) The medical assistance program in this state shall include private-duty nursing to persons who are technology dependent and otherwise eligible as provided under this section.

(2) A recipient is eligible for private-duty nursing services if he or she:

(a) Is dependent on technology at least part of each day;

(b) Requires private-duty nursing care as determined in accordance with state department rules;

(c) Is able to be served safely under the limitations of the private-duty nursing benefit and within the availability of services; and

(d) Is not residing in a nursing facility or hospital at the time of the delivery of the private-duty nursing services.

(3) (a) The state board shall establish rules in accordance with this section that identify medical criteria for determining the circumstances under which private-duty nursing services will be delivered to assure that only persons who need the services receive them and only to the extent medically necessary.

(b) Private-duty nursing services shall not be provided as twenty-four-hour care except in special circumstances and for limited time periods as established by the state department pursuant to this section.

(c) The home health agency, in conjunction with the family or in-home caregiver and the attending physician, shall include in a care plan that includes private-duty nursing services a process by which the eligible person may receive necessary care, which may include respite care, if the family or in-home caregiver is unavailable due to an emergency situation or to unforeseen circumstances. The family or in-home caregiver shall be duly informed by the home health agency of these alternative care provisions at the time the care plan is initiated.

(4) As used in this section, unless the context otherwise requires, "private-duty nursing" means nursing care that is more individualized and continuous than both the nursing care available under the home health benefit and the nursing care routinely provided in a hospital or nursing facility.

Source: L. 2006: Entire article added with relocations, p. 1867, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-517 as it existed prior to 2006.

25.5-5-304. Hospice care. (1) The medical assistance program in this state shall include hospice care. Except as otherwise provided in subsection (2) of this section, hospice care shall be provided for a period of up to two hundred ten days in accordance with rules adopted by the state board, which rules shall comply with 42 U.S.C. sec. 1396d, and shall include at least the following requirements:

(a) That a person shall obtain a certified medical prognosis indicating a life expectancy of nine months or less, which certification shall comply with rules adopted by the state board;

(b) That a person shall execute a waiver of other medical benefits available under this article and articles 4 and 6 of this title, which election shall be executed in accordance with rules adopted by the state board;

(c) That the service shall be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

(2) Hospice care may be provided to a person beyond two hundred ten days if such person is recertified by a physician or hospice medical director as terminally ill in accordance with subsection (1) of this section.

(3) (a) Subject to the receipt of any necessary federal authorization, for a person who has executed the waiver described in paragraph (b) of subsection (1) of this section and who is a resident in a class I facility, as defined in section 25.5-6-201 (13), the class I facility shall bill the state department and the state department shall pay the class I facility for the room and board costs of the person.

(b) Subject to the receipt of any necessary federal authorization, the hospice care provided pursuant to this section may include room and board in a hospice inpatient facility licensed pursuant to section 25-3-101, C.R.S. The state department is authorized to establish the reimbursement rate for the costs for room and board at a licensed hospice inpatient facility for patients eligible for the routine level of hospice care.

(c) (I) If required, the state department shall seek the appropriate federal authorization, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's

administrative costs of preparing and submitting the request, to make the payment described in paragraph (a) of this subsection (3) and to include room and board at a licensed hospice inpatient facility as described in paragraph (b) of this subsection (3). On or before January 15, 2011, the state department shall submit a brief report to the members of the health and human services committees of the senate and house of representatives, or any successor committees, on the status of any request for authorization pursuant to this subparagraph (I). If federal authorization to implement the changes described in paragraphs (a) and (b) of this subsection (3) is obtained, the state department shall request, through the state budget process, that the changes be implemented during the fiscal year following the year in which the approval is obtained.

(II) The state department is authorized to seek and accept gifts, grants, or donations from private or public sources for the purpose of providing for the administrative costs of preparing and submitting the request for federal approval for the payments described in paragraphs (a) and (b) of this subsection (3). All such private and public funds received through gifts, grants, or donations shall be transmitted to the state treasurer, who shall credit the same to the hospice care account in the department of health care policy and financing cash fund created pursuant to section 25.5-1-109, which account is hereby created. Moneys in the account shall be subject to appropriation and shall only be used for the purposes described in this subparagraph (II).

(4) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1868, § 7, effective July 1. **L. 2010:** IP(1) and (1)(a) amended and (4) added, (HB 10-1027), ch. 274, p. 1256, § 1, effective August 11; (3) added, (SB 10-061), ch. 247, p. 1104, § 1, effective August 11.

Editor's note: (1) This section is similar to former § 26-4-520 as it existed prior to 2006.

(2) Subsection (4)(b) provided for the repeal of subsection (4), effective the July 1 following the revisor of statutes' receipt of the required notice. (See L. 2010, p. 1256.) The revisor of statutes received the required notice on May 31, 2012.

25.5-5-305. Pediatric hospice care - legislative declaration - federal authorization - rules - fund. (1) **Legislative declaration.** (a) The general assembly finds and declares that:

(I) The death of a child has a devastating and enduring impact on the child's family;

(II) Too often, children with fatal conditions and their families fail to receive compassionate and consistent care that meets their physical, emotional, and spiritual needs;

(III) Better care is possible but current methods of organizing and financing palliative, end-of-life, and bereavement care impede the provision of services that are both more appropriate and more cost-efficient;

(IV) Current federal medicaid regulations contain inherent barriers to providing appropriate palliative and end-of-life care to pediatric patients. These barriers include requirements that preclude the pursuit of curative treatments, mandate a do-not-resuscitate order, and require physician certification that death is expected within six months.

(b) The general assembly declares that it is in the best interest of the state to investigate and implement hospice guidelines that provide appropriate, compassionate care to dying children and their families while proving to be cost-neutral or cost-saving to the state and federal medicaid programs.

(c) The general assembly further finds and declares that, while this direction immediately concerns federal approval for hospice care that recognizes the distinct circumstances of children facing life-threatening illnesses and their families, it is the intent of the general assembly that the information and data produced as a result of this act shall be used to improve the delivery of palliative and end-of-life services to persons of all ages when such improvements can be made in a manner that is cost-neutral or cost-saving to the state.

(2) **Definitions.** As used in this section, unless the context otherwise requires:

(a) "Eligible child" means a child who:

(I) Is less than nineteen years of age; and

(II) Is eligible for the state's medicaid program pursuant to section 25.5-5-101, 25.5-5-201, or 25.5-5-203;

(b) "Pediatric hospice care" means hospice care for eligible children as authorized in this section.

(3) **Pediatric hospice care.** (a) (I) The state department shall seek the appropriate federal authorization, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, for pediatric hospice care that shall include but may not be limited to:

(A) Respite care;

(B) Expressive therapies, as defined in rule by the state board;

(C) Palliative care from the time of diagnosis of a potentially life-threatening illness; and

(D) A continuum of care through the coordination of services, which may include skilled, intermittent, and around-the-clock nursing care.

(II) The state department is authorized to seek federal approval for modifications to the provision of hospice care for adults who are eligible for the state's medicaid program.

(b) For the provision of pediatric hospice care, the state department shall seek an exemption from the following federal medicaid requirements for the eligibility of and election for hospice care:

(I) The mandatory do-not-resuscitate order;

(II) A physician's certification that a patient is expected to live less than six months; and

(III) The nonallowance of curative care therapies concurrent with palliative and hospice care.

(c) In any application for federal authorization pursuant to this section, the state department shall retain bereavement services to the extent available under federal law.

(d) Pediatric hospice care, as authorized pursuant to this section, shall meet aggregate federal waiver budget neutrality requirements.

(e) The state department shall implement the provision of pediatric hospice care to the extent authorized by the federal government.

(4) **Review.** The state department shall notify the joint budget committee of the general assembly of the extent to which the state department received federal authorization for pediatric hospice care services pursuant to this section in order for the joint budget committee to review the approved budget neutrality analysis for such services prior to the state department's implementation.

(5) **Rules.** The state department shall develop the service provisions for pediatric hospice care in consultation with medical professionals who have expertise in providing end-of-life and palliative care to pediatric patients and family members who have experienced the death

of a child. The state board shall adopt rules necessary to implement and administer the provisions of this section.

(6) **Fund.** The state department is authorized to seek and accept gifts, grants, or donations from private or public sources for the purpose of providing for the administrative costs of preparing and submitting the request for federal approval for the provision of pediatric hospice care. All private and public funds received through gifts, grants, or donations shall be transmitted to the state treasurer, who shall credit the same to the pediatric hospice care cash fund, which fund is hereby created and referred to in this section as the "fund". The moneys in the fund shall be subject to annual appropriation by the general assembly for preparing and submitting the request for federal approval pursuant to this section. Any moneys in the fund not expended for the purpose of this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year shall remain in the fund and shall not be credited or transferred or revert to the general fund or another fund.

Source: L. 2006: Entire article added with relocations, p. 1868, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-533 as it existed prior to 2006.

25.5-5-306. Residential child health care - waiver - program - rules. (1) The state department, in cooperation with the department of human services, shall implement a program concerning residential child health care under this article and articles 4 and 6 of this title to provide services pursuant to article 67 of title 27, C.R.S., to medicaid-eligible children residing in residential child care facilities, as that term is defined in section 26-6-102 (33), C.R.S., to medicaid-eligible children residing in psychiatric residential treatment facilities, and children placed by the department of human services or through county departments of social services in licensed or certified out-of-home placement facilities. Children with intellectual and developmental disabilities, as defined in section 25.5-10-202, who are placed in such facilities shall meet the out-of-home placement criteria described in section 19-1-107, C.R.S., and shall be neglected or dependent as described in section 19-3-102, C.R.S. The state board shall establish the type of rehabilitative or medical assistance services to be provided under the program as described in subsection (3) of this section, to the extent such services are cost-efficient, and the recipient eligibility criteria that may include, but are not limited to, a medical necessity determination and a financial eligibility determination. The state board shall define in rule the staff permitted to order, monitor, and assess seclusion and restraint in psychiatric residential treatment facilities, and the corresponding restrictions on the use of seclusion and restraint.

(2) The state department, in cooperation with the department of human services, may limit the number of recipients or providers participating in the program in accordance with any federal waiver obtained by the state department to implement this section.

(3) The state board, in cooperation with the department of human services, shall promulgate rules as necessary for the implementation of the program, including, but not limited to, rules regarding program services that may include rehabilitative services as appropriate to residential child health care when referred by a physician licensed pursuant to article 36 of title 12, C.R.S. a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a registered

professional nurse as defined in section 12-38-103 (11), C.R.S., who, by reason of postgraduate education and additional nursing preparation, has gained knowledge, judgment, and skill in psychiatric or mental health nursing, a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., or a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S.; the number of recipients participating; eligibility criteria including financial eligibility criteria; reimbursement of providers; and such other rules as are necessary for the implementation and administration of the program. The county contribution established in section 26-1-122, C.R.S., for residential child care facilities may be used by the state to obtain federal financial participation under Title XIX of the social security act for any residential child health care program established pursuant to this section. The county contribution shall not be increased due to any federal financial participation received as a result of any programs established pursuant to this section. Nothing in this section shall be construed to prohibit an adjustment in the county contribution due to caseload or service cost increases. Nothing in this section shall be construed to create a county obligation to directly participate in the financing of any program established pursuant to the "Colorado Medical Assistance Act" as set forth in this article and articles 4 and 6 of this title.

(4) Services provided in a residential child care facility by a provisional licensee as defined in section 12-43-201 (7.8), C.R.S., to medicaid-eligible children shall receive medicaid reimbursement only if approved by the federal government.

Source: L. 2006: (1) and (3) amended and (4) added, p. 1202, § 2, effective May 26; entire article added with relocations, p. 1871, § 7, effective July 1. **L. 2008:** (3) amended, p. 1517, § 1, effective May 28. **L. 2010:** (1) amended, (SB 10-175), ch. 188, p. 801, § 69, effective April 29. **L. 2013:** (1) amended, (HB 13-1314), ch. 323, p. 1809, § 45, effective March 1, 2014. **L. 2016:** (1) amended, (SB 16-189), ch. 210, p. 773, § 68, effective June 6.

Editor's note: (1) This section is similar to former § 26-4-527 as it existed prior to 2006.

(2) (a) Amendments to section 26-4-527 (1) and (3) by House Bill 06-1395 were harmonized with subsections (1) and (3), respectively, as they appeared in Senate Bill 06-219.

(b) Subsection (4) was enacted as § 26-4-527 (6) in House Bill 06-1395 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

25.5-5-307. Child mental health treatment and family support program. (1) The general assembly finds that many parents in Colorado who have experienced challenging circumstances because their children have significant mental health needs and who have attempted to care for their children or seek services on their behalf often are burdened with the excessive financial and personal costs of providing such care. Private insurance companies may not cover mental health services and rarely cover residential mental health treatment services; those that do seldom cover a sufficient percentage of the expense to make such mental health treatment a viable option for many families in need. The result is that many families do not have the ability to obtain the mental health services that they feel their children desperately need. The general assembly finds that it is in the best interests of these families and the citizens of the state

to encourage the preservation of family units by making mental health treatment available to these children pursuant to article 67 of title 27, C.R.S.

(2) In order to make mental health treatment available, it is the intent of the general assembly that each medicaid-eligible child who is diagnosed as a person with a mental health disorder, as that term is defined in section 27-65-102 (11.5), must receive mental health treatment, which may include in-home family mental health treatment, other family preservation services, residential treatment, or any post-residential follow-up services, that must be paid for through federal medicaid funding.

Source: L. 2006: Entire article added with relocations, p. 1872, § 7, effective July 1; (2) amended, p. 1389, § 19, effective August 7. **L. 2010:** Entire section amended, (SB 10-175), ch. 188, p. 802, § 70, effective April 29. **L. 2017:** (2) amended, (SB 17-242), ch. 263, p. 1328, § 202, effective May 25.

Editor's note: (1) This section is similar to former § 26-4-509.5 as it existed prior to 2006.

(2) Amendments to section 26-4-509.5 (2) by House Bill 06-1277 were harmonized with subsection (2) as it appeared in Senate Bill 06-219.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-5-308. Breast and cervical cancer prevention and treatment program - creation - legislative declaration - definitions - funds - repeal. (1) The general assembly hereby finds and declares that breast and cervical cancer are significant health problems for women in this state. The general assembly further finds and declares that these cancers can and should be prevented and treated whenever possible. It is therefore the intent of the general assembly to enact this section to provide for the prevention and treatment of breast and cervical cancer to women where it is not otherwise available for reasons of cost.

(2) As used in this section, unless the context otherwise requires:

(a) "Eligible person" means a person who:

(I) (A) Has been screened for breast or cervical cancer under the centers for disease control and prevention's national breast and cervical cancer early detection program established under Title XV of the federal "Public Health Service Act", 42 U.S.C. sec. 300k et seq., in accordance with the requirements of section 1504 of such act, 42 U.S.C. sec. 300n, on or after July 1, 2002, unless the centers for medicare and medicaid services approves the state department's amendment to the medical assistance plan and the state department is able to implement the breast and cervical cancer prevention and treatment program before such date, then the person must be screened on or after the implementation date of such program; or

(B) Has been screened for breast or cervical cancer by any provider, within the provider's scope of practice, who does not receive funds through the centers for disease control and prevention's national breast and cervical cancer early detection program but whose screening activities are recognized by the department of public health and environment as part of screening activities under the centers for disease control and prevention's national breast and cervical cancer early detection program.

(II) Has been diagnosed with breast or cervical cancer and is in need of breast or cervical cancer treatment;

(III) Has not yet attained sixty-five years of age; and

(IV) Does not have any creditable coverage as defined under federal law pursuant to 42 U.S.C. sec. 300gg (c).

(b) "Qualified entity" shall be defined pursuant to 42 U.S.C. sec. 1396r-1b(b)(2).

(3) There is hereby created a breast and cervical cancer prevention and treatment program to provide medical benefits to eligible persons under this section.

(4) (a) Benefits for medical assistance to an eligible person shall be made available beginning on the day on which a determination is made that the person is eligible for medical assistance and throughout the period in which such person meets the definition of an eligible person.

(b) Benefits for medical assistance to an eligible person shall also be available for the following period of presumptive eligibility:

(I) Such period of presumptive eligibility shall begin when a qualified entity determines that the eligible person is in need of treatment for breast or cervical cancer.

(II) Such period of presumptive eligibility shall end with the earlier of:

(A) The day on which a determination is made that the person is eligible or not eligible for medical assistance; or

(B) If the eligible person does not file a simplified application for medical assistance developed by the state department and approved by the centers for medicare and medicaid services on or before the last day of the month following the month during which the eligible person was found to be qualified for services under this section, then benefits shall end on such last day.

(5) The state department shall have the following powers and duties:

(a) To establish, operate, and monitor the breast and cervical cancer prevention and treatment program to provide medical assistance to eligible persons in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000", enacted October 24, 2000, Pub.L. 106-354, as amended;

(b) To amend the state's medical assistance plan to incorporate the breast and cervical cancer prevention and treatment program. The state department shall submit such proposed amendment to the centers for medicare and medicaid services regional office for approval.

(c) To accept and expend any grant or award of moneys from the federal government, any moneys appropriated by the general assembly, any moneys received through gifts, grants, or donations from nonprofit or for-profit entities, and any interest and income earned on such moneys for the purposes set forth in this section;

(d) To inform the joint budget committee of the general assembly in writing as soon as practicable about any change in the rate of federal financial participation in the program.

(6) The state board shall adopt such rules as are necessary to carry out the provisions of this section.

(7) The breast and cervical cancer prevention and treatment program is subject to the annual financial and compliance audit of the "Colorado Medical Assistance Act" performed by the state auditor's office and shall not be considered a tobacco settlement program for purposes of section 2-3-113, C.R.S.

(8) (a) (I) There is hereby created in the state treasury the breast and cervical cancer prevention and treatment fund, referred to in this subsection (8) as the "fund". The fund shall consist of any moneys credited thereto pursuant to section 24-22-115 (1), C.R.S., any gifts, grants, and donations, any moneys appropriated thereto by the general assembly, and moneys credited thereto pursuant to section 42-3-217.5 (3)(c), C.R.S. Except as provided for in paragraph (b.5) of this subsection (8), all moneys credited to the fund and all interest and income earned on the moneys in the fund shall remain in the fund for the purposes set forth in this section. Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or another fund. The state department is encouraged to secure private gifts, grants, and donations to fund the state costs of the breast and cervical cancer prevention and treatment program.

(II) Moneys in the fund may be used to cover the administrative costs of the department of public health and environment to recognize providers in accordance with sub-subparagraph (B) of subparagraph (I) of paragraph (a) of subsection (2) of this section as providing screening activities under the centers for disease control and prevention's national breast and cervical cancer early detection program.

(b) Repealed.

(b.5) Until section 24-30-2204.5, C.R.S., is repealed, the state treasurer shall transfer any interest or income earned on moneys in the fund to the disability investigational and pilot support fund, created in section 24-30-2205.5, C.R.S.

(c) Repealed.

(9) (a) For the fiscal year 2005-06, the general assembly shall appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and fifty percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(b) For the fiscal year 2006-07, the general assembly shall appropriate seventy-five percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and twenty-five percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(c) For the fiscal year 2007-08, the general assembly shall appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(d) For the fiscal year 2008-09, the general assembly shall appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(e) For the fiscal years 2009-10 through 2011-12, the general assembly shall annually appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(f) For the fiscal years 2012-13 and 2013-14, the general assembly shall annually appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and fifty percent from the moneys credited to the breast

and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(g) For the fiscal years 2014-15 through 2018-19, the general assembly shall annually appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund to such program; except that, if the moneys in the breast and cervical cancer prevention and treatment fund are insufficient to fully fund the program, the general assembly shall appropriate sufficient moneys from the general fund.

(10) This section is repealed, effective July 1, 2019, unless, in any fiscal year before such date, moneys received as federal financial participation provided pursuant to the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000", enacted October 24, 2000, Pub.L. 106-354, as amended, are no longer available to the fund or the rate of federal financial participation has been decreased, in which case the general assembly may repeal this section at the regular session of the general assembly immediately following such decrease or discontinuation of federal moneys.

Source: L. 2006: (8) amended, p. 1117, § 2, effective May 25; entire article added with relocations, p. 1872, § 7, effective July 1. **L. 2008:** (8)(a), (9)(b), (9)(c), and (10) amended and (9)(d) and (9)(e) added, p. 1830, § 1, effective June 2. **L. 2009:** (9)(e) amended and (9)(f) added, (SB 09-262), ch. 202, p. 912, § 1, effective May 1; (2)(a)(I) and (8)(a) amended and (8)(c) added, (HB 09-1164), ch. 215, p. 973, § 4, effective May 2. **L. 2013:** (8)(a)(I) and (8)(c)(II) amended, (8)(b) repealed, and (8)(b.5) added, (SB 13-276), ch. 256, p. 1352, § 8, effective May 23. **L. 2014:** (2)(a)(I)(B), (8)(a)(I), and (10) amended, (8)(c) repealed, and (9)(g) added, (HB 14-1045), ch. 137, p. 468, § 1, effective July 1. **L. 2015:** (7) amended, (SB 15-189), ch. 104, p. 304, § 5, effective April 16.

Editor's note: (1) This section is similar to former § 26-4-532 as it existed prior to 2006.

(2) Subsection (8) was originally numbered as § 26-4-532 (7), and the amendments to it in Senate Bill 06-128 were harmonized with subsection (8) as it appeared in Senate Bill 06-219.

Cross references: (1) For the "Breast and Cervical Cancer Prevention and Treatment Act of 2000", Pub.L. 106-354, see 42 U.S.C. sec. 1396r-1b.

(2) For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201, scheduled in 2014, see sections 1 and 15 of chapter 215, Session Laws of Colorado 2009. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-5-309. Pregnant women - needs assessment - referral to treatment program. (1) The health care practitioner for each pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1)(c) or 25.5-5-201 (1)(m.5) shall be encouraged to identify as soon as possible after such woman is determined to be pregnant whether such woman is at risk of a poor birth outcome due to substance abuse during the prenatal period and in need of special assistance in order to reduce such risk. If the health care practitioner makes such a determination

regarding any pregnant woman, the health care practitioner shall be encouraged to refer such woman to any entity approved and licensed by the department of human services for the performance of a needs assessment. Any pregnant woman who is eligible for services pursuant to section 25.5-5-201 (1)(m.5) may refer herself for such needs assessment.

(2) For the purposes of this section, unless the context otherwise requires, a "needs assessment" means an assessment that is designed to make a determination of what services are needed by a pregnant woman to minimize the occurrence of a poor birth outcome due to substance abuse by such pregnant woman.

Source: L. 2006: Entire article added with relocations, p. 1875, § 7, effective July 1. **L. 2010:** (1) amended, (HB 10-1043), ch. 92, p. 314, § 6, effective April 15. **L. 2014:** (1) amended, (SB 14-067), ch. 12, p. 116, § 13, effective February 27.

Editor's note: This section is similar to former § 26-4-508.2 as it existed prior to 2006.

25.5-5-310. Treatment program for high-risk pregnant women - cooperation with private entities. The state department and the departments of human services and public health and environment shall cooperate with any private entities that desire to assist such departments in the provision of services connected with the treatment program for high-risk pregnant women. Private entities may provide services that are not provided to persons pursuant to this article or article 4 or 6 of this title or article 2 of title 26, C.R.S., which may include, but shall not be limited to, needs assessment services, preventive services, rehabilitative services, care coordination, nutrition assessment, psychosocial counseling, intensive health education, home visits, transportation, development of provider training, child care, and other necessary components of residential or outpatient treatment or care.

Source: L. 2006: Entire article added with relocations, p. 1875, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-508.4 as it existed prior to 2006.

25.5-5-311. Treatment program for high-risk pregnant women - data collection. The state department, in cooperation with the department of human services, shall create a data collection mechanism regarding persons receiving services pursuant to the treatment program for high-risk pregnant women which shall include the collection of such data as such departments deem appropriate.

Source: L. 2006: Entire article added with relocations, p. 1875, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-508.5 as it existed prior to 2006.

25.5-5-312. Treatment program for high-risk pregnant women - extended coverage - federal approval. The state department shall seek federal approval to continue providing substance abuse treatment services for twelve months following a pregnancy to women who are eligible to receive services under the medical assistance program, who are receiving services pursuant to the treatment program for high-risk pregnant women, and who continue to

participate in the treatment program. The state department shall implement the continued services to the extent allowed by the federal government.

Source: L. 2006: Entire article added with relocations, p. 1876, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-508.6 as it existed prior to 2006.

25.5-5-313. Outpatient substance abuse treatment - report of state auditor - amendment to state plan - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1876, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 26-4-536 as it existed prior to 2006.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2011. (See L. 2006, p. 1876.)

25.5-5-314. Substance use disorder treatment for Native Americans - federal approval. (1) The state department shall request federal approval, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, to include any substance use disorder treatment benefits available to Native Americans in which there is one hundred percent federal financial participation.

(2) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1876, § 7, effective July 1. **L. 2014:** (2) repealed, (HB 14-1363), ch. 302, p. 1269, § 30, effective May 31. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1328, § 203, effective May 25.

Editor's note: This section is similar to former § 26-4-422 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-5-315. Acceptance of gifts, grants, and donations - Native American substance abuse treatment cash fund. (1) The executive director may accept and expend money from gifts, grants, and donations for purposes of providing for the administrative costs of preparing and submitting the request for federal approval to provide substance use disorder treatment services to Native Americans as provided for in section 25.5-5-314. All such gifts, grants, and donations shall be transmitted to the state treasurer who shall credit the same to the Native American substance abuse treatment cash fund, which fund is created and referred to in this section as the "fund". The money in the fund is subject to annual appropriation by the general assembly. All investment earnings derived from the deposit and investment of money in the fund remains in the fund and shall not be transferred or revert to the general fund of the state at the end of any fiscal year.

(2) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1876, § 7, effective July 1. **L. 2014:** (2) repealed, (HB 14-1363), ch. 302, p. 1269, § 31, effective May 31. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1328, § 204, effective May 25.

Editor's note: This section is similar to former § 26-4-423 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-5-316. Legislative declaration - state department - disease management programs authorization - report. (1) The general assembly finds that, because Colorado is faced with rising health care costs and limited resources, it is necessary to seek new ways to ensure the availability of high-quality, cost-efficient care for medicaid recipients. The general assembly further finds that disease management is a patient-focused, integrated approach to providing all components of care with attention to both quality of care and total cost. In addition, the general assembly finds that this approach may include coordination of physician care with pharmaceutical and institutional care. The general assembly further finds that disease management also addresses the various aspects of a disease state, including meeting the needs of persons who have multiple chronic illnesses. The general assembly declares that the improved coordination in disease management helps to provide chronically ill patients with access to the latest advances in treatment and teaches them how to be active participants in their health care through health education, thus reducing total health care costs.

(2) The state department, in consultation with the department of public health and environment, is authorized to develop and implement disease management programs, for fee-for-service and primary care physician program recipients, that are designed to address over- or under-utilization or the inappropriate use of services or prescription drugs and that may affect the total cost of health care utilization by a particular medicaid recipient with a particular disease or combination of diseases. The disease management programs shall target medicaid recipients who are receiving prescription drugs or services in an amount that exceeds guidelines outlined by the state department. The state department shall not restrict a medicaid recipient's access to the most cost-effective and medically appropriate prescription drugs or services. The state department may contract on a contingency basis for the development or implementation of the disease management programs authorized in this subsection (2).

(3) If the state department implements any disease management programs authorized in subsection (2) of this section, the state department shall report to the joint budget committee of the general assembly an estimate of the fiscal implications generated by the implementation of the disease management programs. Such report shall be made on or before February 1 of the year following the implementation of a disease management program and on or before each February 1 thereafter in which such program is in place.

Source: L. 2006: Entire article added with relocations, p. 1877, § 7, effective July 1. **L. 2008:** (2) amended, p. 800, § 2, effective May 14.

Editor's note: This section is similar to former § 26-4-408.5 as it existed prior to 2006.

25.5-5-317. Obesity treatment pilot program - development and implementation - report - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1878, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 26-4-534 as it existed prior to 2006.

(2) Subsection (4) provided for the repeal of this section, effective July 1, 2010. (See L. 2006, p. 1878.)

25.5-5-318. Health services - provision by school districts - repeal. (1) As used in this section:

(a) "School district" means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado school for the deaf and the blind, created in article 80 of title 22, C.R.S., and any public school district organized under the laws of Colorado, except a local college district.

(b) "Underinsured" means a person who has some health insurance, but whose insurance does not adequately cover the types of health services for which a school district may receive federal matching funds under this section.

(2) (a) Any school district may contract with the state department under this section to receive federal matching funds for amounts spent in providing health services through the public schools to students who are receiving medicaid benefits pursuant to this article and articles 4 and 6 of this title.

(a.5) Repealed.

(b) Approval of contracts under this section does not constitute a commitment by the general assembly to continue providing health services to students through the public schools using state general funds if federal matching funds are not available in the future. Any moneys provided to a school district pursuant to a contract entered into under this section shall not supplant state or local moneys provided to school districts pursuant to the provisions of articles 20 to 28 or article 54 of title 22, C.R.S.

(c) Nothing in this section shall be construed as requiring any school district to enter into a contract as provided in this section. Participation in a contract by a school district is voluntary.

(d) The state department may make contracting and reimbursement of moneys under this section contingent upon either:

(I) The contracting school district certifying to the state department, through the department of education, that it has expended local and state moneys in an amount sufficient to meet the nonfederal share of expenditures being claimed for federal financial participation; or

(II) The contracting school district meeting the requirements of the intergovernmental transfer provisions of the federal medicaid law, 42 U.S.C. sec. 1396 et seq.

(3) Each year, by a date established by rule of the state board, the department of education shall notify the state department concerning any school district that chooses to enter into a contract as provided in this section and the anticipated level of funding for the school district. Nothing in this section shall be construed to require a school district to maintain the same level of funding or services from year to year.

(4) (a) (I) Each school district that chooses to enter into a contract as provided in this section shall develop a services plan with input from the local community that identifies the types of health services needed by students within the school district and the services it anticipates providing. Except for medical emergencies and services related to allegations of child abuse, a student's participation in any psychological, behavioral, social, or emotional services, including counseling or referrals, shall be optional and shall require the prior written and informed consent of a parent or legal guardian of the student.

(II) (A) Any health questionnaire or form related to services funded in part through this section shall only relate to the student's personal health, habits, or conduct and shall not include questions concerning the habits or conduct of any other member of the student's family.

(B) No medical or health data or information identifying the student or the student's family shall be disclosed to any person other than a person specifically authorized to receive the information or data without the prior written and informed consent of a parent or legal guardian of the student.

(b) Each school district that chooses to enter into a contract as provided in this section shall perform an assessment of the health care needs of its uninsured and underinsured students and may spend an appropriate portion, not to exceed thirty percent, of the federal moneys received on health care for low-income students. For purposes of this paragraph (b), "low-income students" means students whose families are below one hundred eighty-five percent of the federal poverty line.

(c) The school district shall submit the services plan to the department of education with a notice of participation for purposes of technical assistance evaluation and to the executive director for approval.

(5) Each year not less than ninety days prior to the notification date established pursuant to subsection (3) of this section, the state department shall provide information through the department of education to school districts regarding the amount of available moneys and the administrative activities required to enter into a contract for federal matching funds for that year. To the extent allowed by existing resources, the department of education shall provide technical assistance to school districts in determining levels of funding, meeting administrative requirements, and developing services plans.

(6) Following the notification date established pursuant to subsection (3) of this section, each contracting school district, through the department of education, shall enter into a contract with the state department specifying the health services to be provided by the school district, the amount to be expended in providing the services, and the amount of federal matching funds for which the school district is eligible under the contract.

(7) The state department is authorized to accept and expend donations, contributions, grants, including federal matching funds, and other moneys that it may receive to finance the costs associated with implementing this section.

(8) (a) Under the contract entered into pursuant to this section, a contracting school district shall receive from the state department all of the federal matching funds for which it is eligible under the contract, less the amount of state administrative costs allowed under paragraph (b) of this subsection (8). All moneys received by a school district pursuant to this section shall be used only to offset costs incurred for provision of student health services by the school district or to cash fund student health services in the school district.

(b) Total allowable state administrative costs for contracts entered into under this section for both the state department and the department of education shall not exceed ten percent of the total annual amount of federal funds reflected by the general assembly for such contracts in the annual general appropriations bill. State administrative costs include costs incurred in evaluating the implementation of this section.

(9) The state board shall specify by rule the types of health services for which a school district may receive federal matching funds under a contract created under this section, including but not limited to:

(a) Basic primary, physical, dental, and mental health services;

(b) Rehabilitation services;

(c) Early and periodic screening, diagnosis, and treatment services; and

(d) Service coordination, outreach, enrollment, and administrative support.

(10) (a) A school district that provides health services under contract pursuant to this section may provide the health services directly or through contractual relationships or agreements with public or private entities, as allowed by applicable federal regulations. However, no moneys shall be expended in any form for abortions, except as provided in section 25.5-4-415 or as required by federal law.

(b) Where possible, the school district shall coordinate the provision of health services to a student with the student's primary health care provider. Except for those services that are required by an individualized educational program developed pursuant to section 22-20-108 (4), C.R.S., or by a section 504 plan developed pursuant to the federal "Rehabilitation Act of 1973", 29 U.S.C. sec. 701 et seq., school districts shall not claim reimbursement under this section for direct services to students enrolled in health maintenance organizations that would normally be provided to students by their health maintenance organization.

(11) (a) The executive director shall apply for and secure any federal waivers and state plan amendments required to implement this section.

(b) This section shall remain in effect only for so long as federal financial participation is available for reimbursements to school districts. In the event, as specified in writing by the attorney general to the governor that federal law does not allow or is amended to disallow reimbursements to school districts or otherwise prevent the implementation of this section, this section is repealed, effective on the date of the attorney general's opinion.

(12) The state department and the department of education shall work with the office of state planning and budgeting and the joint budget committee in implementing this section.

(13) The state department and the department of education shall enter into an interagency agreement to provide for the implementation of this section. The state board and the state board of education are authorized to promulgate rules as may be necessary in accordance with the agreement.

(14) The state department shall annually, or more often as necessary, hold a public hearing to receive comments from school districts, state agencies, and interested persons regarding implementation of this section.

(15) On or before December 15, 2002, the state department shall submit a formal evaluation of the implementation of this section to the committees on education and the committees on health and human services of the house of representatives and the senate, or any successor committees.

Source: L. 2006: Entire article added with relocations, p. 1878, § 7, effective July 1. **L. 2009:** (2)(a.5) added, (SB 09-264), ch. 204, p. 928, § 6, effective May 1. **L. 2010:** (4)(b) amended, (HB 10-1422), ch. 419, p. 2113, § 147, effective August 11.

Editor's note: (1) This section is similar to former § 26-4-531 as it existed prior to 2006.

(2) Subsection (2)(a.5)(II) provided for the repeal of subsection (2)(a.5), effective July 1, 2011. (See L. 2009, p. 928.)

25.5-5-319. Family planning pilot program - rules - federal waiver - repeal. (1) There is hereby established a family planning pilot program for the provision of family planning services to categorically eligible individuals who are at or below a percentage of the federal poverty line established pursuant to the federal waiver sought pursuant to subsection (2) of this section. The state board shall promulgate rules setting forth the family planning services to be provided under the family planning pilot program.

(2) The executive director of the state department, in consultation with the department of public health and environment, shall seek a federal waiver that is cost-neutral to the state general fund for the implementation of the family planning pilot program established pursuant to this section such that ten percent of the family planning services provided to low-income families pursuant to the program as described in subsection (1) of this section would be funded with state general fund moneys and ninety percent would be funded with federal matching funds. In the federal waiver, the executive director shall not seek authority to waive or disregard the provisions of 42 U.S.C. sec. 1396a (a)(23)(B).

(3) (a) Upon issuance of the federal waiver sought pursuant to subsection (2) of this section, the departments of health care policy and financing and public health and environment shall seek the necessary appropriation of general funds through the normal budgetary process for the implementation of this act.

(b) The executive director of the state department is authorized to accept and expend on behalf of the state any funds, grants, gifts, and donations from any private or public source for the purpose of implementing the family planning pilot program established in this section; except that no gift, grant, donation, or funds shall be accepted if the conditions attached thereto require the expenditure thereof in a manner contrary to law.

(4) The executive director of the state department, or such executive director's designee, shall prepare a written report for the members of the general assembly concerning the findings of the department based upon the family planning pilot program. Such report shall be provided to the members of the general assembly not more than three years after commencement of the program. The report shall address the number of individuals served, the type of services provided, the cost of the program, and such other information as the executive director deems appropriate.

(5) The implementation of this section is conditioned upon the issuance of any necessary waiver by the federal government and available appropriations pursuant to paragraph (a) of subsection (3) of this section. The provisions of this section shall be implemented to the extent authorized by federal waiver. The pilot program established by this section shall continue for five years from the receipt of the federal waiver or for so long as specified in the federal waiver. The executive director of the state department shall provide written notice to the revisor of

statutes of the final termination date of the waiver, and this section shall be repealed, effective July 1 five years after the issuance of the federal waiver or July 1 in the year in which the waiver is terminated, whichever occurs first.

Source: L. 2006: Entire article added with relocations, p. 1882, § 7, effective July 1. **L. 2008:** (1) and (2) amended, p. 41, § 1, effective March 13. **L. 2010:** (1) amended, (HB 10-1422), ch. 419, p. 2113, § 148, effective August 11.

Editor's note: (1) This section is similar to former § 26-4-414.7 as it existed prior to 2006.

(2) As of publication date, the revisor of statutes has not received the notice referred to in subsection (5).

25.5-5-320. Telemedicine - reimbursement - disclosure statement. (1) On or after July 1, 2006, in-person contact between a health care or mental health care provider and a patient shall not be required under the state's medical assistance program for health care or mental health care services delivered through telemedicine that are otherwise eligible for reimbursement under the program. The services shall be subject to reimbursement policies developed pursuant to the medical assistance program. This section also applies to managed care organizations that contract with the state department pursuant to the statewide managed care system only to the extent that:

(a) Health care or mental health care services delivered through telemedicine are covered by and reimbursed under the medicaid per diem payment program; and

(b) Managed care contracts with managed care organizations are amended to add coverage of health care or mental health care services delivered through telemedicine and any appropriate per diem rate adjustments are incorporated.

(2) The reimbursement rate for a telemedicine service shall, as a minimum, be set at the same rate as the medical assistance program rate for a comparable in-person service. The state department may consider setting the reimbursement rate on a monthly basis as well as on a daily or per-visit basis.

(3) The state department shall establish rates for transmission cost reimbursement for telemedicine services, considering, to the extent applicable, reductions in travel costs by health care or mental health care providers and patients to deliver or to access such services and such other factors as the state department deems relevant.

(4) A health care or mental health care provider who delivers health care or mental health care services through telemedicine shall provide to each patient, before treating that patient through telemedicine for the first time, the following written statements:

(a) That the patient retains the option to refuse the delivery of the services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;

(b) That all applicable confidentiality protections shall apply to the services; and

(c) That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

(5) Subsection (4) of this section shall not apply in an emergency.

Source: L. 2006: Entire section added, p. 1548, § 5, effective July 1. **L. 2008:** (1), (3), IP(4), and (4)(a) amended, p. 112, § 3, effective August 5.

Editor's note: This section was enacted as § 26-4-421.5 in Senate Bill 06-165. Section 9 of the bill provided for the renumbering of that section. (See L. 2006, p. 1552.)

Cross references: For the legislative declaration contained in the 2006 act enacting this section, see section 1 of chapter 312, Session Laws of Colorado 2006.

25.5-5-321. Telemedicine - home health care - home health telemedicine cash fund - rules. (1) On or after August 11, 2010, at-home telemedicine shall be eligible for reimbursement under the state's medical assistance program. The services delivered through telemedicine shall be subject to reimbursement policies promulgated by rule of the state board after consultation with home health care and home- and community-based services providers. This section also applies to managed care organizations that contract with the state department pursuant to the statewide managed care system, but only to the extent that:

(a) Home health care or home- and community-based services delivered through telemedicine are covered by and reimbursed under the medicaid program; and

(b) Managed care contracts with managed care organizations are amended to add coverage of home health care or home- and community-based services delivered through telemedicine.

(2) (a) The reimbursement rate for home health care or home- and community-based services delivered through telemedicine that are otherwise eligible for reimbursement under the medical assistance program shall be set by rule of the state board and shall be:

(I) In the form of a flat fee in one or more levels, depending on acuity.

(II) (Deleted by amendment, L. 2010, (HB 10-1005), ch. 345, p. 1598, § 1, effective August 11, 2010.)

(b) Any cost savings identified pursuant to this section shall be considered for use in paying for home- and community-based services under part 6 of this article, community-based long-term care, and home health services.

(c) For the first two years after August 11, 2010, gifts, grants, and donations shall be used to implement this section. Gifts, grants, and donations made for this purpose shall be transferred to the home health telemedicine cash fund, which is hereby created in the state treasury. Moneys in the home health telemedicine cash fund shall be appropriated to the state board and used to implement this section. Moneys in the fund shall remain in the fund and not be transferred to the general fund at the end of any fiscal year. After two years or if the moneys in the cash fund are depleted, the department is authorized to go through the normal budget process to continue implementation of this section.

(3) Reimbursement shall not be provided for purchase or lease of telemedicine equipment.

(4) (a) A home health care or home- and community-based services provider who delivers services through telemedicine shall provide to each patient, before treating that patient through telemedicine for the first time, the following written statements:

(I) That the patient retains the option to refuse the delivery of home health care or home- and community-based services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;

(II) That all applicable confidentiality protections shall apply to the services; and

(III) That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

(b) The provisions of paragraph (a) of this subsection (4) shall not apply in an emergency.

(5) Nothing in this section shall be construed to:

(a) Alter the scope of practice of any home health care or home- and community-based services provider; or

(b) Authorize the delivery of home health care or home- and community-based services in a setting or manner not otherwise authorized by law.

Source: L. 2007: Entire section added, p. 1182, § 2, effective January 1, 2008. **L. 2010:** (1), (2), and (3) amended, (HB 10-1005), ch. 345, p. 1598, § 1, effective August 11.

25.5-5-321.5. Telehealth - interim therapeutic restorations - reimbursement - definitions. (1) Subject to federal authorization and federal financial participation, on or after July 1, 2016, in-person contact between a health care provider and a recipient is not required under the state's medical assistance program for the diagnosis, development of a treatment plan, instruction to perform an interim therapeutic restoration procedure, or supervision of a dental hygienist performing an interim therapeutic restoration procedure. A health care provider may provide these services through telehealth, including store-and-forward transfer, and is entitled to reimbursement for the delivery of those services via telehealth to the extent the services are otherwise eligible for reimbursement under the program when provided in person. The services are subject to the reimbursement policies developed pursuant to the state medical assistance program.

(2) As used in this section:

(a) "Interim therapeutic restoration" has the same meaning as set forth in section 12-35-103 (10.5), C.R.S.

(b) "Store-and-forward transfer" means a telehealth by store-and-forward transfer, as defined in section 12-35-103 (16), C.R.S.

Source: L. 2015: Entire section added, (HB 15-1309), ch. 326, p. 1334, § 8, effective August 5.

25.5-5-322. Over-the-counter medications - rules. (1) (a) Subject to approval through the state budget process in paragraph (b) of this subsection (1), the state board shall adopt by rule a system to allow pharmacies to be reimbursed for providing certain over-the-counter medications to recipients if prescribed by a licensed practitioner authorized to prescribe prescription drugs or, subject to the limitations contained in subsection (2) of this section, a licensed pharmacist. Over-the-counter medications subject to reimbursement pursuant to this

section shall be identified through the drug utilization review process established in section 25.5-5-506, and shall be limited to medications that, if reimbursed, shall result in overall cost savings to the state.

(b) After the list of over-the-counter medications is identified pursuant to paragraph (a) of this subsection (1), the state department shall request, through the state budget process, that the reimbursements be implemented. The state department shall report to the joint budget committee annually concerning the amount of any savings realized from the reimbursements.

(2) (a) The state board, in consultation with the state board of pharmacy created pursuant to section 12-42.5-103, C.R.S., shall establish by rule standards for when a licensed pharmacist may prescribe over-the-counter medications as provided under this section for purposes of receiving reimbursement under the medical assistance program.

(b) When prescribing over-the-counter medications under this section, a licensed pharmacist shall consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

Source: L. 2010: Entire section added, (SB 10-117), ch. 227, p. 985, § 2, effective July 1. **L. 2012:** (2)(a) amended, (HB 12-1311), ch. 281, p. 1628, § 75, effective July 1.

25.5-5-323. Complex rehabilitation technology - legislative declaration - definitions. (1) The general assembly finds and declares it is in the best interests of the people of the state of Colorado to:

(a) Continue to protect access to important technology and supporting services for eligible clients;

(b) Establish and improve current safeguards relating to the delivery, provision, and repair of medically necessary complex rehabilitation technology;

(c) Continue to provide supports for clients accessing complex rehabilitation technology to stay in the home or community setting; engage in basic activities of daily living and instrumental activities of daily living, including employment; prevent institutionalization; and prevent hospitalization and other costly secondary complications; and

(d) Continue adequate pricing for complex rehabilitation technology for the purpose of allowing continued access to appropriate products and related services including maintenance and repair.

(2) As used in this section, unless the context otherwise requires:

(a) "Complex rehabilitation technology" means individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designated options and accessories classified as durable medical equipment that:

(I) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living, including employment, identified as medically necessary to promote mobility in the home and community or prevent hospitalization or institutionalization of the client;

(II) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury; and

(III) Require certain services provided by a qualified complex rehabilitation technology provider to ensure appropriate design, configuration, and use of such items, including patient evaluation or assessment of the client by a health care professional, and that are consistent with the client's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

(b) "Individually configured" means that a device has features, adjustments, or modifications specific to a client that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, adapting, and maintaining the device so that the device is consistent with an assessment or evaluation of the client by a health care professional and consistent with the client's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

(c) "Qualified complex rehabilitation technology professional" means an individual who is certified by the rehabilitation engineering and assistive technology society of North America or other nationally recognized accrediting organizations as an assistive technology professional.

(d) "Qualified complex rehabilitation technology supplier" means a company or entity that:

(I) Is accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology;

(II) Meets the supplier and quality standards established for durable medical equipment suppliers under the medicare or medicaid program;

(III) Employs at least one qualified complex rehabilitation technology professional for each location to:

(A) Analyze the needs and capacities of clients for a complex rehabilitation technology item in consultation with the evaluating clinical professionals;

(B) Assist in selecting appropriate complex rehabilitation technology items for such needs and capacities; and

(C) Provide the client technology-related training in the proper use and maintenance of the selected complex rehabilitation technology items;

(IV) Has the qualified complex rehabilitation technology professional directly involved with the assessment, and determination of the appropriate individually configured complex rehabilitation technology for the client, with such involvement to include seeing the client visually either in person or by any other real-time means within a reasonable time frame during the determination process.

(V) Maintains a reasonable supply of parts, adequate physical facilities, and qualified service or repair technicians to provide clients with prompt service and repair of all complex rehabilitation technology it sells or supplies; and

(VI) Provides the client written information at the time of sale as to how to access service and repair.

(3) The state department shall provide a separate recognition within the state's medicaid program established under articles 4, 5, and 6 of this title for complex rehabilitation technology and shall make other required changes to protect client access to appropriate products and services. Such separate recognition must take into consideration the customized nature of complex rehabilitation technology and the broad range of related services necessary to meet the unique medical and functional needs of clients and include the following:

(a) The state department notifying the qualified rehabilitation technology suppliers concerning the parameters of the complex rehabilitation technology benefit, which benefit must include the use of qualified rehabilitation technology suppliers as well as billing procedures that specify the types of equipment identified and included in the complex rehabilitation technology benefit. The state department shall create complex rehabilitation technology benefit parameters that are easily understood by and accessible to clients and qualified rehabilitation technology suppliers. The state department shall provide public notice no later than thirty days prior to a collaborative process that includes discussion of any proposed changes to the types of equipment identified and included in the complex rehabilitation technology benefit.

(b) Adopting specific supplier standards, as described in paragraph (d) of subsection (2) of this section, for companies or entities that provide complex rehabilitation technology and restricting the provision of complex rehabilitation technology to those companies or entities that are qualified complex rehabilitation suppliers;

(c) Ensuring that clients receiving complex rehabilitation technology are evaluated or assessed, as needed, by:

(I) A qualified health care professional, including but not limited to a licensed physical therapist, a licensed occupational therapist, or other licensed health care professional who has no financial relationship with the qualified complex rehabilitation technology supplier and performs specialty evaluations within his or her scope of practice; and

(II) A qualified complex rehabilitation technology professional employed by the qualified complex rehabilitation technology supplier. The assessment and determination performed by the qualified complex rehabilitation technology professional employed by the qualified complex rehabilitation supplier shall continue to be included in the reimbursement for the purchased or rented complex rehabilitation technology;

(d) Continuing pricing policies for complex rehabilitation technology, unless specifically prohibited by the centers for medicare and medicaid services, including the following:

(I) Continuing to ensure that the reimbursement amounts for complex rehabilitation technology, repairs, and supporting clinical complex rehabilitation technology services are adequate to ensure that qualified clients have access to the items, taking into account the unique needs of the clients and the complexity and customization of complex rehabilitation technology. This includes developing pricing policies that ensure access to adequate and timely repairs.

(II) Exempting complex rehabilitation technology from inclusion in competitive bidding programs or similar processes; and

(III) Preserving the option for complex rehabilitation technology to be billed and paid for as a purchase allowing for lump sum payments for devices with a length of need of one year or greater, excluding approved crossover claims for clients enrolled in medicare and medicaid; and

(e) Making other changes as needed to protect access to complex rehabilitation technology for clients.

Source: L. 2014: Entire section added, (HB 14-1211), ch. 253, p. 1008, § 1, effective January 1, 2015.

PART 4

STATEWIDE MANAGED CARE SYSTEM

25.5-5-401. Short title. This part 4 shall be known and may be cited as the "Statewide Managed Care System".

Source: L. 2006: Entire article added with relocations, p. 1883, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-111 as it existed prior to 2006.

25.5-5-402. Statewide managed care system. (1) The state board shall adopt rules to implement a managed care system for Colorado medical assistance clients pursuant to the provisions of this article and articles 4 and 6 of this title. The statewide managed care system shall be implemented to the extent possible.

(2) The managed care system implemented pursuant to this article shall not include:

(a) The services delivered under the residential child health care program described in section 25.5-5-306, except in those counties in which there is a written agreement between the county department of social services, the designated and contracted behavioral health organization selected pursuant to section 25.5-5-411, and the state department;

(b) Long-term care services and the program of all-inclusive care for the elderly, as described in section 25.5-5-412. For purposes of this subsection (2), "long-term care services" means nursing facilities and home- and community-based services provided to eligible clients who have been determined to be in need of such services pursuant to the "Colorado Medical Assistance Act" and the state board's rules.

(3) **Bidding.** The state department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203, C.R.S., for managed care entities seeking to provide medical services for medicaid clients eligible to be enrolled in managed care. The state department is authorized to award contracts to more than one offeror. The state department procedures shall seek to use competitive bidding procedures to maximize the number of managed care choices available to medicaid clients over the long term that meet the requirements of sections 25.5-5-404 and 25.5-5-406.

(4) **Waivers.** The implementation of this part 4 is conditioned, to the extent applicable, on the issuance of necessary waivers by the federal government. The provisions of this part 4 shall be implemented to the extent authorized by federal waiver, if so required by federal law.

(5) **Graduate medical education.** The state department shall continue the graduate medical education, referred to in this subsection (5) as "GME", funding to teaching hospitals that have graduate medical education expenses in their medicare cost report and are participating as providers under one or more MCEs with a contract with the state department under this part 4. GME funding for recipients enrolled in an MCE shall be excluded from the premiums paid to the MCE and shall be paid directly to the teaching hospital. The state board shall adopt rules to implement this subsection (5) and establish the rate and method of reimbursement.

(6) (a) For requests for proposals occurring on and after January 1, 2015, the state department shall allow for payment proposals that include, but need not be limited to, global payment, risk adjustment, risk sharing, and aligned payment incentives, including, but not limited to, gainsharing, for health benefits and services provided to medical assistance clients

pursuant to sections 25.5-5-404 (1)(k) and (1)(l), 25.5-5-406 (2), and paragraph (b) of subsection (2) of this section.

(b) The state department shall have the discretion to determine which proposals satisfy the request for proposal, including:

(I) Whether the proposals are appropriate for the state's coordinated care system; and

(II) The state department's ability to ensure inpatient and outpatient hospital reimbursements are maximized up to the upper limits, as defined in 42 CFR 447.272 and 42 CFR 447.321 and calculated by the state department periodically.

(c) The state department may seek any federal waiver necessary to ensure that the effect of the request for proposals does not adversely impact upper payment limits and considerations shall include, but are not limited to, the establishment of an uncompensated care cost pool or a hospital incentive program.

Source: L. 2006: Entire article added with relocations, p. 1883, § 7, effective July 1. **L. 2008:** (3) and (5) amended, p. 390, § 1, effective August 5. **L. 2012:** (6) added, (HB 12-1281), ch. 246, p. 1187, § 3, effective June 4.

Editor's note: This section is similar to former § 26-4-113 as it existed prior to 2006.

25.5-5-403. Definitions. As used in this part 4, unless the context otherwise requires:

(1) "Behavioral health organization", referred to in this part 4 as a "BHO", means an entity contracting with the state department to provide only behavioral health services.

(2) "Essential community provider", referred to in this part 4 as an "ECP", means a health care provider that:

(a) Has historically served medically needy or medically indigent patients and that demonstrates a commitment to serve low-income and medically indigent populations who comprise a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and

(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

(2.5) "Global payment" means a population-based payment mechanism that is constructed on a per-member, per-month calculation. Global payments shall account for prospective local community or health system cost trends and value, as measured by quality and satisfaction metrics, and shall incorporate community cost experience and reported encounter data to the greatest extent possible to address regional variation and improve longitudinal performance. Risk adjustments, risk-sharing, and aligned payment incentives may be utilized to achieve performance improvement. The rate calculations for global payment are exempt from the provisions of section 25.5-5-408. An entity that uses global payment pursuant to section 25.5-5-404 shall meet the applicable financial solvency requirements of section 25.5-5-404 (1)(k) and (1)(l), and the essential community provider requirements of section 25.5-5-404 (2) and (3).

(3) (a) "Managed care" means:

(I) A predefined set of services to recipients delivered by a managed care entity as defined in subsection (4) of this section; or

(II) The delivery of services provided by the primary care physician program established in section 25.5-5-407, which is a primary care case manager as defined in subsection (8) of this section.

(III) (Deleted by amendment, L. 2008, p. 390, § 2, effective August 5, 2008.)

(b) Nothing in this section shall be deemed to affect the benefits authorized for recipients of the state medical assistance program.

(4) "Managed care entity", referred to in this part 4 as an "MCE", means an entity that enters into a contract to provide services in a managed care system, including managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans but excluding primary care case managers, as defined in subsection (8) of this section.

(5) "Managed care organization", referred to in this part 4 as an "MCO", means an entity contracting with the state department that meets the definition of managed care organization as defined in 42 CFR 438.2.

(6) "Prepaid ambulatory health plan", referred to in this part 4 as a "PAHP", means an entity contracting with the state department that meets the definition of prepaid ambulatory health plan as defined in 42 CFR 438.2.

(7) "Prepaid inpatient health plan", referred to in this part 4 as "PIHP", means an entity contracting with the state department that meets the definition of prepaid inpatient health plan as defined in 42 CFR 438.2.

(8) "Primary care case manager", referred to in this part 4 as a "PCCM", means an entity contracting with the state department that meets the definition of primary care case manager as defined in 42 CFR 438.2.

Source: L. 2006: Entire article added with relocations, p. 1884, § 7, effective July 1. **L. 2007:** (1)(a) amended, p. 1354, § 3, effective May 29. **L. 2008:** Entire section amended, p. 390, § 2, effective August 5. **L. 2012:** (2.5) added, (HB 12-1281), ch. 246, p. 1187, § 4, effective June 4.

Editor's note: This section is similar to former § 26-4-114 as it existed prior to 2006.

25.5-5-404. Selection of managed care entities. (1) In addition to any other criteria specified in rule by the state board, in order to participate in the managed care system, the MCE shall comply with specific criteria that include, but are not limited to, the following:

(a) The MCE shall not interfere with appropriate medical care decisions rendered by the provider nor penalize the provider for requesting medical services outside the standard treatment protocols developed by the MCE or its contractors.

(b) The MCE shall make or ensure payments to providers within the time allowed for the state to make payments on state liabilities under the rules adopted by the department of personnel pursuant to section 24-30-202 (13), C.R.S.

(c) The MCE shall have an educational component in its plan that takes into consideration recipient input and that informs recipients as to availability and use of the medical services system, appropriate preventive health care procedures, self-care, and appropriate health care utilization.

(d) The MCE shall provide the minimum benefit requirements as established by the state board.

(e) The MCE shall provide necessary and appropriate services to recipients that shall include but not be limited to the following:

(I) With respect to recipients who are unable to make decisions for themselves, the MCE and all relevant providers in the MCE's network serving the recipients shall collaborate with the designated advocate or family member in all decision-making, including enrollment and disenrollment.

(II) The MCE shall deliver services that are covered benefits in a manner that accommodates or is compatible with the recipient's ability to fulfill duties and responsibilities in work and community activities.

(f) The MCE shall provide appropriate use of ancillary health care providers by appropriate qualified health care professionals.

(g) The MCE shall comply with all data collection and reporting requirements established by the state department.

(h) The MCE shall, to the extent provided by law or waiver, provide recipient benefits that the state board shall develop and the state department shall implement in partnership with local government and the private sector, including but not limited to:

(I) Recipient options to rent, purchase, or own durable medical equipment; or

(II) (Deleted by amendment, L. 2008, p. 392, § 3, effective August 5, 2008.)

(III) Receipt of medical disposable supplies without charge.

(i) The MCE shall comply with utilization requirements established by the state department.

(j) The MCE shall develop and utilize a form or process for measuring group and individual recipient health outcomes, including but not limited to the use of tools or methods that identify increased health status or maintenance of the individual's highest level of functioning, determine the degree of medical access, and reveal recipient satisfaction and habits. Such tools shall include the use of client surveys, anecdotal information, complaint and grievance data, and disenrollment information. The MCE shall annually submit a care management report to the state department that describes techniques used by the MCE to provide more efficient use of health care services, better health status for populations served, and better health outcomes for individuals.

(k) Except as provided in paragraph (m) of this subsection (1), for capitation payments effective on and after July 1, 2003, an MCE that is contracting for a defined scope of services under a risk contract shall certify the financial stability of the MCE pursuant to criteria established by the division of insurance and shall certify, as a condition of entering into a contract with the state department, that the capitation payments set forth in the contract between the MCE and the state department are sufficient to ensure the financial stability of the MCE with respect to delivery of services to the medicaid recipients covered in the contract.

(l) Except as provided in paragraph (m) of this subsection (1), for capitation payments effective on and after July 1, 2003, an MCE that is contracting for a defined scope of services under a risk contract shall certify, through a qualified actuary retained by the MCE, that the capitation payments set forth in the contract between the MCE and the state department comply with all applicable federal and state requirements that govern said capitation payments. For purposes of this paragraph (l), a "qualified actuary" means a person deemed as such by rule promulgated by the commissioner of insurance.

(m) An MCO providing services under the PACE program as described in section 25.5-5-412 shall certify that the capitation payments are in compliance with applicable federal and state requirements that govern said capitation payments and that the capitation payments are sufficient to ensure the financial viability of the MCO with respect to the delivery of services to the PACE program participants covered in the contract.

(n) The MCE shall ensure, to the extent that voluntary enrollment into the MCE is possible, that the MCE has not provided to a recipient any premiums or other inducements in exchange for the recipient selecting the MCE for coverage.

(o) The MCE has established a grievance procedure pursuant to the provisions in section 25.5-5-406 (1)(b) that allows for the timely resolution of disputes regarding the quality of care, services to be provided, and other issues raised by the recipient. Matters shall be resolved in a manner consistent with the medical needs of the individual recipient. The MCE shall notify all recipients involved in a dispute with the MCE of their right to seek an administrative review of an adverse decision made by the MCE pursuant to section 25.5-1-107.

(p) With respect to pregnant women and infants, the MCE shall comply with the following:

(I) With the exception of BHOs, enrollment of pregnant women without restrictions and including an assurance that the health care provider shall provide timely access to initiation of prenatal care in accordance with practice standards;

(II) With the exception of BHOs, coverage without restrictions for newborns, including all services such as, but not limited to, preventive care, screening, and well-baby examinations during the first month of life;

(III) With the exception of BHOs, the imposition of performance standards and the use of quality indicators with respect to perinatal, prenatal, and postpartum care for women and birthing and neonatal care for infants. The standards and indicators shall be based on nationally approved guidelines.

(IV) With the exception of BHOs, follow-up basic health maintenance services for women and children, including immunizations and early periodic screening, diagnosis, and treatment services for children and appropriate preventive care services for women.

(q) The MCE shall accept all enrollees regardless of health status.

(r) The MCE shall comply with disclosure requirements as established by the state department and the state board.

(s) The MCE shall provide a mechanism whereby a prescribing physician can request to override restrictions to obtain medically necessary, off-formulary prescription drugs, supplies, equipment, or services for his or her patient.

(t) The MCE shall maintain a network of providers sufficient to ensure that all services to recipients will be accessible without unreasonable delay. The state department shall develop explicit contract standards, in consultation with stakeholders, to assess and monitor the MCE's criteria. Sufficiency shall be determined in accordance with the requirements of this paragraph (t) and may be established by reference to any reasonable criteria used by the MCE, including but not limited to the following:

(I) Geographic accessibility in regard to the special needs of recipients;

(II) Waiting times for appointments with participating providers;

(III) Hours of operation;

(IV) Volume of technological and specialty services available to serve the needs of recipients requiring technologically advanced or specialty care.

(u) (I) For the delivery of prescription drug benefits to recipients enrolled in an MCE who are residents of a nursing facility, MCEs that provide prescription drug benefit services shall use pharmacies with a demonstrated capability of providing prescription drugs in a manner consistent with the needs of clients in institutional settings such as nursing facilities. In cases where a nursing facility and a pharmacy have a contract for a single pharmacy delivery system for residents of the nursing facility:

(A) An MCE providing prescription drug benefits for residents of the nursing facility shall agree to contract with that pharmacy under reasonable contract terms; and

(B) The pharmacy shall agree to contract with each MCE that provides prescription drug benefits for residents of the nursing facility under reasonable contract terms.

(II) Any disputes concerning providing prescription drug benefits between nursing facilities, pharmacies, and MCEs that cannot be resolved through good faith negotiations may be resolved through a party requesting an informal review by the state department.

(III) The state board shall adopt rules requiring MCEs that provide prescription drug benefit services to contract with qualified pharmacy providers in a manner permitting a nursing facility to continue to comply with federal medicaid requirements of participation for nursing facilities. Such rules shall define "qualified pharmacy providers" and shall be based upon consultations with nursing facilities, MCEs, pharmacies, and medicaid clients. The state department shall provide MCEs with a list of pharmacies that have a contract with nursing facilities serving recipients in nursing facilities in each county in which the MCE is contracting with the state department.

(v) The MCE shall comply with provisions relating to complex rehabilitation technology established by the state department pursuant to section 25.5-5-323. This provision does not apply to article 8 of this title.

(2) The MCE shall seek proposals from each ECP in a county in which the MCE is enrolling recipients for those services that the MCE provides or intends to provide and that an ECP provides or is capable of providing. To assist MCEs in seeking proposals, the state department shall provide MCEs with a list of ECPs in each county. The MCE shall consider such proposals in good faith and shall, when deemed reasonable by the MCE based on the needs of its enrollees, contract with ECPs. Each ECP shall be willing to negotiate on reasonably equitable terms with each MCE. ECPs making proposals under this subsection (2) must be able to meet the contractual requirements of the MCE. The requirements of this subsection (2) shall not apply to an MCE in areas in which the MCE operates entirely as a group model health maintenance organization.

(3) In selecting MCEs, the state department shall not penalize an MCE for paying cost-based reimbursement to federally qualified health centers as defined in the "Social Security Act".

(4) (a) Notwithstanding any waivers authorized by the federal department of health and human services, or any successor agency, each contract between the state department and an MCE selected to participate in the statewide managed care system under this part 4 shall comply with the requirements of 42 U.S.C. sec. 1396a (a)(23)(B).

(b) Each MCE shall advise its enrollees of the services available pursuant to this subsection (4).

(5) Nothing in this part 4 shall be construed to create an exemption from the applicable provisions of title 10, C.R.S.

(6) Nothing in this part 4 shall be construed to create an entitlement to an MCE to contract with the state department.

Source: L. 2006: Entire article added with relocations, p. 1885, § 7, effective July 1. **L. 2008:** Entire section amended, p. 392, § 3, effective August 5. **L. 2014:** (1)(v) added, (HB 14-1211), ch. 253, p. 1011, § 2, effective January 1, 2015.

Editor's note: This section is similar to former § 26-4-115 as it existed prior to 2006.

Cross references: For the definition of "federally qualified health centers" in the federal Social Security Act, see 42 U.S.C. sec. 1395x.

25.5-5-405. Quality measurements. (1) The state department shall measure quality pursuant to the following criteria:

(a) Quality shall be measured and considered based upon individuals and groups with the satisfaction of the service received analyzed and compared to nonrecipient populations for the same or similar services when available.

(b) Quality shall focus on health status or maintenance of the individual's highest level of functioning, without strict adherence to statistical norms.

(2) The state board shall promulgate rules to clarify and administer quality measurements.

Source: L. 2006: Entire article added with relocations, p. 1889, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-116 as it existed prior to 2006.

25.5-5-406. Required features of managed care system. (1) **General features.** All medicaid managed care programs shall contain the following general features, in addition to others that the state department and the state board consider necessary for the effective and cost-efficient operation of those programs:

(a) **Recipient selection of MCEs.** (I) The state department shall, to the extent it determines feasible, provide medicaid-eligible recipients a choice among competing MCEs. MCEs shall provide enrollees a choice among providers within the MCE. Consistent with federal requirements and rules promulgated by the state board, the state department is authorized to assign a medicaid recipient to a particular MCE or PCCM if:

(A) The state department determines that no other MCE or PCCM has the capacity or expertise necessary to serve the recipient; or

(B) A recipient does not respond within thirty days after the date of a notification of a request for selection of an MCE or PCCM.

(II) The state department shall inform recipients of the choices available in their area by appropriate sources of information and counseling. This may include an independent, objective facilitator acting under the supervision of the state department. The state department may contract for the facilitator through a competitive bidding process. This function shall ensure that

consumers have informed choice among available options to assure the fullest possible voluntary participation in managed care. The state department, in conjunction with the state board, shall adopt rules setting forth minimum disclosure requirements for all MCEs and PCCMs. Once a recipient is enrolled in an MCE or PCCM, the recipient may not change to a different MCE or PCCM for a period of twelve months; except that the recipient may disenroll without good cause during the first ninety days of enrollment or any time thereafter for good cause as determined by the state department. Good cause shall include, but need not be limited to, administrative error and an MCE's or PCCM's inability to provide its covered services to a recipient after reasonable efforts on the part of the MCE or PCCM and the recipient, as defined by the state board. Based upon its assessment of any special needs of recipients with cognitive disabilities, the state board may adopt rules relating to any necessary good cause provisions for recipients with cognitive disabilities who are assigned to a particular MCE or PCCM pursuant to subparagraph (I) of this paragraph (a).

(III) When eligible consumers choose to change or disenroll from their selected MCE or PCCM, the state department shall monitor and gather data about the reasons for disenrolling, including denial of enrollment or disenrollment due to an act or omission of an MCE or PCCM. The state department shall analyze this data and provide feedback to the plans or providers and shall use the information in the state department's contracting and quality assurance efforts. Persons who have been denied enrollment or have disenrolled due to an act or omission of an MCE or PCCM may seek review by an independent hearing officer, as provided for and required under federal law and any state statute or rule.

(b) **Complaints and grievances.** Each MCE or PCCM shall utilize a complaint and grievance procedure and a process for expedited reviews that comply with rules established by the state board. The complaint and grievance procedure shall provide a means by which enrollees may complain about or grieve any action or failure to act that impacts an enrollee's access to, satisfaction with, or the quality of health care services, treatments, or providers. The state department shall establish the position of ombudsman for medicaid managed care. It is the intent of the general assembly that the ombudsman for medicaid managed care be independent from the state department and selected through a competitive bidding process. In the event the state department is unable to contract with an independent ombudsman, an employee of the state department may serve as the ombudsman for medicaid managed care. The ombudsman shall, if the enrollee requests, act as the enrollee's representative in resolving complaints and grievances with the MCE or PCCM. The process for expedited reviews shall provide a means by which an enrollee may complain and seek resolution concerning any action or failure to act in an emergency situation that immediately impacts the enrollee's access to quality health care services, treatments, or providers. An enrollee shall be entitled to designate a representative, including but not limited to an attorney, the ombudsman for medicaid managed care, a lay advocate, or the enrollee's physician, to file and pursue a grievance or expedited review on behalf of the enrollee. The procedure shall allow for the unencumbered participation of physicians. An enrollee whose complaint or grievance is not resolved to his or her satisfaction by a procedure described in this paragraph (b) or who chooses to forego a procedure described in this paragraph (b) shall be entitled to request a second-level review by an independent hearing officer, further judicial review, or both, as provided for by federal law and any state statute or rule. The state department may also provide by rule for arbitration as an optional alternative to

the complaint and grievance procedure set forth is this paragraph (b) to the extent that such rules do not violate any other state or federal statutory or constitutional requirements.

(c) **Billing medicaid recipients.** Notwithstanding any federal regulations or the general prohibition of section 25.5-4-301 against providers billing medicaid recipients, a provider may bill a medicaid recipient who is enrolled with a specific medicaid PCCM or MCE and, in circumstances defined by the rules of the state board, receives care from a medical provider outside that organization's network or without referral by the recipient's PCCM.

(d) **Marketing.** In marketing coverage to medicaid recipients, all MCEs shall comply with all applicable provisions of title 10, C.R.S., regarding health plan marketing. The state board is authorized to promulgate rules concerning the permissible marketing of medicaid managed care. The purposes of such rules shall include but not be limited to the avoidance of biased selection among the choices available to medicaid recipients.

(e) **Prescription drugs.** All MCEs that have prescription drugs as a covered benefit shall provide prescription drug coverage in accordance with the provisions of section 25.5-5-202 (1)(a) as part of a comprehensive health benefit and with respect to any formulary or other access restrictions:

(I) The MCE shall supply participating providers who may prescribe prescription drugs for MCE enrollees with a current copy of such formulary or other access restrictions, including information about coverage, payment, or any requirement for prior authorization; and

(II) The MCE shall provide to all medicaid recipients at periodic intervals, and prior to and during enrollment upon request, clear and concise information about the prescription drug program in language understandable to the medicaid recipients, including information about such formulary or other access restrictions and procedures for gaining access to prescription drugs, including off-formulary products.

(f) **Access to prescription drugs.** (I) The state department shall encourage an MCE to solicit competitive bids for the prescription drug benefit and discourage an MCE that has prescription drugs as a covered benefit from contracting for the prescription drug benefit with a sole source provider as much as possible.

(II) If an MCE solicits competitive bids for the prescription drug benefit, the MCE shall request bids from each pharmacy provider located in the geographic areas in which the MCE is soliciting bids. All MCEs shall follow a reasonable standard for recipient access to prescription drugs. At a minimum, the state department shall verify compliance with these requirements by reviewing evidence provided by the commissioner of insurance concerning compliance with any standards or guidance established by the commissioner of insurance for consumer access to prescription drugs.

(III) The standards and guidance from the insurance commissioner shall be based on the following:

(A) Procedures that an MCE shall follow to ensure that pharmacies in rural communities with fewer than twenty-five thousand persons have the opportunity to join retail prescription drug networks if they agree to reasonable contract terms;

(B) Procedures that an MCE shall follow to notify the pharmacy community of competitively bid prescription drug contracts;

(C) Procedures that an MCE shall follow to give all pharmacies and pharmacy networks a fair opportunity to participate in prescription drug contracts;

(D) Any related matters that are designed to expand consumer access to pharmacy services; and

(E) Any related matters that will enhance the functioning of the free market system with respect to pharmacies.

(IV) Nothing in this paragraph (f) shall apply to the delivery of prescription drug benefits to recipients enrolled in an MCE who are residents of a nursing facility or to the delivery of medicare part D prescription drugs to recipients who are eligible for such drugs.

(g) **Continuity of care.** (I) New enrollees, with special needs as defined by the state board and as certified by a non-plan physician, may continue to see a non-plan provider for sixty days from the date of enrollment in an MCE, if the enrollee is in an ongoing course of treatment with the previous provider and only if the previous provider agrees:

(A) To accept reimbursement from the MCE as payment in full at rates established by the MCE that shall be no more than the level of reimbursement applicable to similar providers within the MCE's group or network for such services;

(B) To adhere to the MCE's quality assurance requirements and to provide to the MCE necessary medical information related to such care; and

(C) To otherwise adhere to the MCE's policies and procedures including but not limited to procedures regarding referrals, obtaining pre-authorizations, and MCE-approved treatment plans.

(II) New enrollees who are in their second or third trimester of pregnancy may continue to see their practitioner until the completion of postpartum care directly related to the delivery only if the practitioner agrees:

(A) To accept reimbursement from the MCE as payment in full at rates established by the MCE that shall be no more than the level of reimbursement applicable to similar providers within the MCE's group or network for such services;

(B) To adhere to the MCE's quality assurance requirements and to provide to the MCE necessary medical information related to such care; and

(C) To otherwise adhere to the MCE's policies and procedures including but not limited to procedures regarding referrals, obtaining pre-authorizations, and MCE-approved treatment plans.

(III) New enrollees with special needs as defined by the state department may continue to see ancillary providers at the level of care received prior to enrollment for a period of up to seventy-five days. The terms and conditions, including reimbursement rates, shall remain the same as prior to enrollment if the provider and enrollee agree to work in good faith with the MCE toward a transition.

(IV) This paragraph (g) shall not be construed to require an MCE to provide coverage for benefits not otherwise covered.

(2) (a) After January 1, 2015, the state department shall open for competitive bid the state department's medicaid coordinated care system within regions of the state. Before issuing a request for proposal, the state department shall analyze the regions of the state to determine the appropriate number of care coordination regions that should be created. Further, before issuing a request for proposal, the state department shall also analyze the appropriate number of care coordination contracts in each region of the state.

(b) Nothing in this subsection (2) shall delay the implementation of the medicaid payment reform and innovation pilot program created in section 25.5-5-415.

Source: L. 2006: Entire article added with relocations, p. 1889, § 7, effective July 1. **L. 2008:** Entire section amended, p. 396, § 4, effective August 5. **L. 2012:** (2) amended, (HB 12-1281), ch. 246, p. 1187, § 5, effective June 4. **L. 2016:** (1)(f)(I) amended, (HB 16-1081), ch. 22, p. 53, § 9, effective August 10.

Editor's note: This section is similar to former § 26-4-117 as it existed prior to 2006.

25.5-5-407. State department recommendations - primary care physician program. (1) The primary care physician program requires medicaid recipients to select a primary care physician who is solely authorized to provide primary care and referral to all necessary specialty services. To encourage low-cost and accessible care, the state department is authorized to utilize the primary care physician program to deliver services to appropriate medicaid recipients.

(2) The state department shall establish procedures and criteria for the cost-effective operation of the primary care physician program, including but not limited to such matters as appropriate eligibility criteria and geographic areas served by the programs.

Source: L. 2006: Entire article added with relocations, p. 1893, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-118 as it existed prior to 2006.

25.5-5-407.5. Prepaid inpatient health plan agreements - rules. (1) Subject to the receipt of any required federal authorizations, pursuant to the requirements of this section, the state department may enter into prepaid inpatient health plan agreements, referred to in this section as a "PIHP agreement", with an entity that:

(a) Provides medical services to enrollees on the basis of prepaid capitation payments, or other payment arrangements that do not use payment rates contained in the state plan; and

(b) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees.

(1.5) Repealed.

(2) (a) A PIHP agreement may include a provision for a quality incentive payment that is distributed to the contractor within a reasonable period of time, as specified in the contract, following the end of each fiscal year if the contractor substantially exceeds predetermined quality indicators. The quality indicators shall be based upon broadly accepted measures of performance adopted by rule of the state board and agreed upon at the outset of the contract period, and shall include, but need not be limited to, the health plan employers data and information set measures. The quality incentive payment may be made proportional if the state board establishes multiple quality measurements. The quality incentive payments shall not exceed the total cost savings created under the PIHP agreement, as determined by comparison of the PIHP members with an actuarially equivalent fee-for-service population, and the quality incentive payment shall not exceed five percent of the total medicaid payments received by the contractor during the performance period of the PIHP agreement.

(b) (I) Except as provided for in subparagraph (II) of this paragraph (b), the contractor shall distribute at least seventy-five percent of the incentive payment to providers with which it has contracted to serve medicaid recipients.

(II) Subparagraph (I) of this paragraph (b) shall not apply to a contractor that has an exclusive contract with a single medical group in a specific geographic area to provide or arrange for health care services for its members, such as a multi-specialty group model. Such a contractor shall negotiate the distribution of the qualified incentive payment with the medical group.

(3) Subject to the approval of the state board, a PIHP agreement may also provide for an increase in the fee paid to the contractor in an amount reasonably calculated to cover the costs of collecting and maintaining the medical records of recipients through an electronic medical records system.

(4) Nothing in this section shall prevent, to the extent possible, a government-owned entity from using certified public expenditure or other federally recognized financing mechanisms to provide the state share for the federal match to enhance capitation payments up to or above the one hundred percent limit contained in section 25.5-5-408 (9). The state shall not be obligated to increase any general fund expenditures because of the use of certified public expenditure or other federally recognized financing mechanism pursuant to this subsection (4).

Source: L. 2007: Entire section added, p. 1351, § 1, effective May 29. **L. 2009:** (1.5) added, (SB 09-265), ch. 205, p. 936, § 3, effective May 1. **L. 2010:** (1.5) repealed, (HB 10-1382), ch. 217, p. 939, § 2, effective May 6. **L. 2013:** (2)(a) amended, (SB 13-044), ch. 54, p. 180, § 1, effective March 22.

25.5-5-407.7. Disability care coordination organization - rules. (Repealed)

Source: L. 2007: Entire section added, p. 1352, § 1, effective May 29. **L. 2008:** Entire section amended, p. 1909, § 109, effective August 5. **L. 2013:** Entire section repealed, (SB 13-276), ch. 256, p. 1353, § 9, effective May 23.

25.5-5-408. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid recipients. (1) (a) (I) The state department shall make capitation payments to MCEs based upon a defined scope of services under a risk contract.

(II) Repealed.

(b) A certification by a qualified actuary retained by the state department shall be conclusive evidence that the state department has correctly calculated the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407.

(c) Except as otherwise provided in paragraph (d) of this subsection (1) and where the state department has instituted a program of competitive bidding provided in section 25.5-5-402 (3), the state department may utilize a market rate set through the competitive bid process for a set of defined services. The state department shall only use market rate bids that do not discriminate and are adequate to assure quality and network sufficiency. A certification of a qualified actuary, retained by the state department, to the appropriate lower limit shall be conclusive evidence of the state department's compliance with the requirements of this paragraph

(c). For the purposes of this subsection (1), a "qualified actuary" shall be a person deemed as such under rules promulgated by the commissioner of insurance.

(d) A federally qualified health center, as defined in the federal "Social Security Act", shall be reimbursed by the state department for the total reasonable costs incurred by the center in providing health care services to all recipients of medical assistance.

(2) The state department shall develop capitation rates for MCEs contracting for a defined scope of services under a risk contract that include risk adjustments, reinsurance, or stop-loss funding methods. Payments to plans may vary when it is shown through diagnoses or other relevant data that certain populations are expected to cost more or less than the capitated population as a whole.

(3) The state board, in consultation with recognized medical authorities, shall develop a definition of special needs populations that includes evidence of diagnosed or medically confirmed health conditions. The state department shall develop a method for adjusting payments to plans for such special needs populations when diagnoses or other relevant data indicates these special needs populations would cost significantly more than similarly capitated populations.

(4) Under no circumstances shall the risk adjustments, reinsurance, or stop-loss methods developed by the state department pursuant to subsection (2) of this section cause the average per capita medicaid payment to a plan to be greater than the projected medicaid expenditures for treating medicaid enrollees of that plan under fee-for-service medicaid.

(5) The state department may develop quality incentive payments to recognize superior quality of care or service provided by a managed care plan.

(6) Within thirty days from the beginning of each fiscal year, the state department, in cooperation with the MCEs, shall set a timeline for the rate-setting process for the following fiscal year's rates and for the provision of base data to the MCEs that is used in the calculation of the rates, which shall include but not be limited to the information included in subsection (7) of this section.

(7) The state department shall identify and make available to the MCEs the base data used in the calculation of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407. The state department shall consult with the MCEs regarding any and all adjustments in the base data made to arrive at the capitation payments.

(8) For capitation payments effective on and after July 1, 2003, the state department shall recalculate the base calculation every three years. The three-year cycle for the recalculation of the base calculation shall begin with capitation payments effective for fiscal year 2003-04. In the years in which the base calculation is not recalculated, the state department shall annually trend the base calculation after consulting with the MCEs. The state department shall take into consideration when trending the base calculation any public policy changes that affect reimbursement under the "Colorado Medical Assistance Act".

(9) The rate-setting process referenced in subsection (6) of this section shall include a time period after the MCEs have received the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407, for each MCE to submit to the state department the MCE's capitation payment

proposal, which shall not exceed one hundred percent of the direct health care cost of providing these same services on an actuarially equivalent Colorado medicaid population group consisting of unassigned recipients and recipients in the primary care physician program provided in section 25.5-5-407. The state department shall provide to the MCEs the MCE's specific adjustments to be included in the calculation of the MCE's proposal. Each MCE's capitation payment proposal shall meet the requirements of section 25.5-5-404 (1)(k) and (1)(l).

(10) For capitation payments effective on and after July 1, 2003, unless otherwise required by federal law, the state department shall certify, through a qualified actuary retained by the state department, that the capitation payments set forth in the contract between the state department and the MCEs comply with all applicable federal and state requirements that govern said capitation payments.

(11) Effective on and after July 1, 2003, the capitation payments certified by the qualified actuary under subsection (10) of this section shall not be subject to any dispute resolution process, including any such process set forth in any settlement agreement entered into prior to July 1, 2002.

(12) Nothing in this section shall prevent, to the extent possible, an MCE that is also a government-owned entity from using certified public expenditure or other federally recognized financing mechanisms to provide the state share for the federal match to enhance capitation payments up to or above the one hundred percent limit contained in subsection (9) of this section. The state shall not be obligated to increase any general fund expenditures because of the use of certified public expenditure or other federally recognized financing mechanism pursuant to this subsection (12).

Source: L. 2006: Entire article added with relocations, p. 1893, § 7, effective July 1. **L. 2007:** (1)(b) and (9) amended and (12) added, p. 1354, § 4, effective May 29. **L. 2008:** (1)(a), (2), (6), (7), (8), (9), (10), and (12) amended, p. 400, § 5, effective August 5. **L. 2009:** (1)(a) amended, (SB 09-265), ch. 205, p. 936, § 4, effective May 1. **L. 2010:** (1)(a)(II) repealed, (HB 10-1382), ch. 217, p. 939, § 3, effective May 6.

Editor's note: This section is similar to former § 26-4-119 as it existed prior to 2006.

25.5-5-409. State department - privatization. (1) The general assembly finds that the statewide managed care system is a program under which the private sector has a great deal of experience in making various health care plans available to the private sector and serving as the liaison between large employers and health care providers, including but not limited to health maintenance organizations. The general assembly therefore determines that a statewide managed care system involves duties similar to duties currently or previously performed by state employees but is different in scope and policy objectives from the state medical assistance program.

(2) To that end, pursuant to section 24-50-504 (2)(a), C.R.S., the state department shall enter into personal services contracts that create an independent contractor relationship for the administration of not less than twenty percent of the statewide managed care system. The state department shall enter into personal service contracts for the administration of the managed care system according to the implementation of the statewide managed care system in accordance with section 25.5-5-402.

(3) The implementation of this section is contingent upon:

(a) Legislative review of the cost-effectiveness of privatization and the extent to which such privatization enhances the quality of care to recipients; and

(b) A finding by the state personnel director that any of the conditions of section 24-50-504 (2), C.R.S., have been met or that the conditions of section 24-50-503 (1), C.R.S., have been met.

Source: L. 2006: Entire article added with relocations, p. 1896, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-120 as it existed prior to 2006.

25.5-5-410. Data collection for managed care programs.

(1) Repealed.

(2) The state department of human services, in conjunction with the state department, shall continue its existing efforts, which include obtaining and considering consumer input, to develop managed care systems for the developmentally disabled population and to consider a pilot program for a certificate system to enable the developmentally disabled population to purchase managed care services or fee-for-service care, including long-term care community services. The department of human services shall not implement any managed care system for developmentally disabled services without the express approval of the joint budget committee. Any proposed implementation of fully capitated managed care in the developmental disabilities community service system shall require legislative review.

(3) In addition to any other data collection and reporting requirements, each managed care organization shall submit the following types of data to the state department or its agent:

(a) Medical access;

(b) Consumer outcomes based on statistics maintained on individual consumers as well as the total consumer populations served;

(c) Consumer satisfaction;

(d) Consumer utilization;

(e) Health status of consumers; and

(f) Uncompensated care delivered.

Source: L. 2006: Entire article added with relocations, p. 1896, § 7, effective July 1. **L. 2008:** (1) amended, p. 402, § 6, effective August 5. **L. 2016:** (1) repealed and (2) amended, (HB 16-1081), ch. 22, p. 51, § 3, effective August 10.

Editor's note: This section is similar to former § 26-4-121 as it existed prior to 2006.

25.5-5-411. Medicaid community mental health services - legislative declaration - administration - rules. (1) The general assembly hereby finds, determines, and declares that:

(a) There is an urgent need to address the economic, social, and personal costs to the state of Colorado and its citizens of untreated mental health and substance use disorders;

(b) Behavioral health disorders, including mental health and substance use disorders, are treatable conditions not unlike other chronic health issues that require a combination of behavioral change and medication or other treatment. When individuals receive appropriate

prevention, early intervention, treatment, and recovery services, they can live full, productive lives.

(c) Untreated behavioral health disorders place individuals at high risk for poor health outcomes and significantly affect virtually all aspects of local and state government by reducing family stability, student achievement, workforce productivity, and public safety;

(d) Currently, there is no single behavioral health care system in Colorado. Instead, consumers of all ages with behavioral health disorders receive services from a number of different systems, including the health care, behavioral health care, child welfare, juvenile and criminal justice, education, and higher education systems.

(e) Adult and youth consumers and their families need quality behavioral health care that is individualized and coordinated to meet their changing needs through a comprehensive and integrated system;

(f) Timely access through multiple points of entry to a full continuum of culturally responsive services, including prevention, early intervention, crisis response, treatment, and recovery, is necessary for an effective integrated system;

(g) Evidence-based and promising practices result in favorable outcomes for Colorado's adult and youth consumers, their families, and the communities in which they live;

(h) Lack of public awareness regarding behavioral health issues creates a need for public education that emphasizes the importance of behavioral health as part of overall health and wellness and creates the desire to invest in and support an integrated behavioral health system in Colorado;

(i) To reduce the economic and social costs of untreated behavioral health disorders, Colorado needs a systemic transformation of the behavioral health system through which transformation the state strives to achieve critical goals to address mental health and substance use disorders; and

(j) The overarching goal of this behavioral health system transformation shall be to make the behavioral health system's administrative processes, service delivery, and funding more effective and efficient to improve outcomes for Colorado citizens.

(2) The general assembly further finds and declares that, to improve the quality of life for the citizens of Colorado, strengthen the economy, and continue the responsible management of the state's resources, the leadership of the three branches of Colorado's state government and the stakeholders most affected by mental health and substance use disorders must collaborate to build on the progress of past efforts and to sustain a focus on the improvement of behavioral health services.

(3) Except as provided for in subsection (6) of this section, the state department shall administer all medicaid community mental health services for medical assistance recipients including but not limited to the prepaid capitated single entry point system for mental health services, the fee-for-service mental health services, and alternatives to institutionalization. The administration of medicaid community mental health services shall include but shall not be limited to program approval, program monitoring, and data collection.

(4) (a) The requirements of section 25.5-5-408 shall not apply to the capitated rate calculation process for medicaid community mental health services; except that each medicaid community mental health services MCO shall be subject to the requirements of section 25.5-5-404 (1)(k) and (1)(l).

(b) The state department shall establish cost-effective, capitated rates for community mental health services in a manner that includes cost containment mechanisms. These cost containment mechanisms may include, but are not limited to, restricting average per member per month utilization growth, restricting unit cost growth, limiting allowable administrative cost, establishing minimum medical loss ratios, or establishing other cost containment mechanisms that the state department determines appropriate.

(c) Repealed.

(5) The state department is authorized to seek federal approval for any necessary changes to the state's waiver that authorizes the statewide system of community mental health care to reflect the provisions of this section. The state department is authorized to limit a recipient's freedom of choice with respect to a provider of mental health services and to restrict reimbursements for mental health services to designated and contracted agencies in such waiver.

(6) The administration of the mental health institutes shall remain the responsibility of the department of human services.

(7) On and after April 6, 2004, all positions of employment in the department of human services concerning the powers, duties, and functions of administering all medicaid community mental health services for medical assistance recipients transferred to the state department pursuant to this section and determined to be necessary to carry out the purposes of this section by the executive director of the state department shall be transferred to the state department and shall become employment positions therein.

(8) On and after April 6, 2004, all items of property, real and personal, including office furniture and fixtures, computers and software, books, documents, and records of the department of human services pertaining to the duties and functions of administering all medicaid community mental health services for medical assistance recipients are transferred to the state department and shall become the property thereof.

(9) On and after April 6, 2004, for state fiscal year 2003-04, the state department may bill the department of human services medicaid-funded programs division appropriation within the state department's appropriation for the provision of medicaid community mental health services as authorized in this section.

(10) On or before July 1, 2004, the state department and the department of human services shall jointly produce a document to assist mental health consumers and advocates and providers that participate in Colorado's publicly funded mental health system to understand the respective roles of each department in the provision of mental health services and each department's ability to provide high quality and accessible mental health services. The state department and the department of human services shall make the document available to the public and shall send at least one copy to each community mental health center, statewide mental health advocacy organization, and mental health assessment and services agency. The information contained in the document shall be made available on each department's internet website. The state department and the department of human services are encouraged to consult with representatives of mental health consumer and provider organizations in the development of the document to ensure that it benefits consumers seeking mental health services and consumers who need to express concerns or complaints regarding the quality, availability, or accessibility of mental health services.

(11) When the state auditor conducts an audit of the statewide mental health system, the state auditor shall evaluate the coordination of services between the state department and the

department of human services and the impact of the administration of the mental health system on the quality of care within the statewide mental health system.

(12) The state board shall adopt any rules necessary for the implementation of this section. In adopting rules concerning medicaid community mental health services, the state board shall consider the effect the rules may have on the statewide mental health system.

Source: L. 2006: Entire article added with relocations, p. 1897, § 7, effective July 1. **L. 2007:** (3) amended, p. 331, § 1, effective August 3. **L. 2008:** (1.5) added, p. 289, § 1, effective April 3. **L. 2009:** (1.5)(c) added, (SB 09-265), ch. 205, p. 936, § 5, effective May 1. **L. 2010:** (4)(c) repealed, (HB 10-1382), ch. 217, p. 940, § 4, effective May 6; entire section amended, (SB 10-153), ch. 295, p. 1372, § 3, effective May 26.

Editor's note: (1) This section is similar to former § 26-4-123 as it existed prior to 2006.

(2) Subsection (4)(c) was numbered as subsection (1.5)(c) in House Bill 10-1382 (see L. 2010, p. 940). That provision was harmonized with subsection (4)(c) as it appears in Senate Bill 10-153.

25.5-5-412. Program of all-inclusive care for the elderly - legislative declaration - services - eligibility - rules - definitions - repeal. (1) (a) The general assembly hereby finds and declares that it is the intent of this section to replicate the ON LOK program in San Francisco, California, that has proven to be cost-effective at both the state and federal levels. The PACE program is part of a national replication project authorized in section 9412(b)(2) of the federal "Omnibus Budget Reconciliation Act of 1986", as amended. The general assembly finds that, by coordinating an extensive array of medical and nonmedical services, the needs of the participants will be met primarily in an outpatient environment in an adult day health center, in their homes, or in an institutional setting. The general assembly finds that such a service delivery system will enhance the quality of life for the participant and offers the potential to reduce and cap the costs to Colorado of the medical needs of the participants, including hospital and nursing home admissions.

(b) Repealed.

(2) The general assembly has determined on the recommendation of the state department that the PACE program is cost-effective. As a result of such determination and after consultation with the joint budget committee of the general assembly, application has been made to and waivers have been obtained from the federal health care financing administration to implement the PACE program as provided in this section. The general assembly, therefore, authorizes the state department to implement the PACE program in accordance with this section. In connection with the implementation of the program, the state department shall:

(a) Provide a system for reimbursement for services to the PACE program pursuant to this section;

(b) Develop and implement a contract with any public, private, nonprofit, or for-profit entity providing the PACE program, as permitted by federal law, that sets forth contractual obligations for the PACE program as required by the state department, including but not limited to reporting and monitoring of utilization of services and of the costs of the program, quality of care, and a comprehensive assessment of the provider's fiscal soundness;

(c) Acknowledge that it is participating in the national PACE project as initiated by congress;

(d) Be responsible for certifying the eligibility for services of all PACE program participants.

(3) The general assembly declares that the purpose of this section is to provide services that would foster the following goals:

(a) To maintain eligible persons at home as an alternative to long-term institutionalization;

(b) To provide optimum accessibility to various important social and health resources that are available to assist eligible persons in maintaining independent living;

(c) To provide that eligible persons who are frail elderly but who have the capacity to remain in an independent living situation have access to the appropriate social and health services without which independent living would not be possible;

(d) To coordinate, integrate, and link such social and health services by removing obstacles that impede or limit improvements in delivery of these services;

(e) To provide the most efficient and effective use of capitated funds in the delivery of such social and health services.

(f) Repealed.

(4) Within the context of the PACE program, the state department may include any or all of the services listed in sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203, as applicable.

(5) An eligible person may elect to receive services from the PACE program as described in subsection (4) of this section. If such an election is made, the eligible person shall not remain eligible for services or payment through the regular medicare or medicaid programs. All services provided by said programs shall be provided through the PACE program in accordance with this section. An eligible person may elect to disenroll from the PACE program at any time.

(6) The state department, in cooperation with the single entry point agencies established in section 25.5-6-106, shall develop and implement a coordinated plan to provide education about PACE program site operations under this section. The state board shall adopt rules:

(a) To ensure that case managers and any other appropriate state department staff discuss the option and potential benefits of participating in the PACE program with all eligible long-term care clients. These rules shall require additional and on-going training of the single entry point agency case managers in counties where a PACE program is operating. This training shall be provided by a federally approved PACE provider. In addition, each single entry point agency may designate case managers who have knowledge about the PACE program; and

(b) To allow PACE providers to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term clients.

(6.5) An eligible person who is enrolled in a managed care organization, an organization contracted with the state department pursuant to part 4 of article 5 of this title, or other risk-bearing entity may elect to withdraw from or terminate such enrollment and enroll in and receive services through a PACE program. The state board's rules shall define how such election is made. The effective date of an eligible person's election shall not be more than thirty days after the eligible person's date of election.

(7) For purposes of this section:

(a) "Dually eligible person" means a person who is eligible for assistance or benefits under both medicaid and medicare.

(b) "Eligible person" means a frail elderly individual who voluntarily enrolls in the PACE program and whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department of human services for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, C.R.S., or in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101, and for whom a physician licensed pursuant to article 36 of title 12, C.R.S., certifies that such a program provides an appropriate alternative to institutionalized care. "Eligible person" may also include a dually eligible person.

(c) "Frail elderly" means an individual who meets functional eligibility requirements, as established by the state department, for nursing home care and who is fifty-five years of age or older.

(d) "Upper payment limit" means a federal upper payment limit on the amount of the medicaid payment for which federal financial participation is available for a class of services and a class of health care providers, as specified in 42 CFR 447.

(8) Using a risk-based financing model, any public, private, nonprofit, or for-profit entity providing the PACE program, as permitted by federal law, shall assume responsibility for all costs generated by PACE program participants, and shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by the multidisciplinary team. Any public, private, nonprofit, or for-profit entity providing the PACE program, as permitted by federal law, is responsible for the full financial risk at the conclusion of the demonstration period and when permanent waivers from the federal health care financing administration are granted. Specific arrangements of the risk-based financing model shall be adopted and negotiated by the federal health care financing administration, any public, private, nonprofit, or for-profit entity providing the PACE program, as permitted by federal law, and the state department.

(9) Nothing in this section requires a PACE program site operator to hold a certificate of authority as a health maintenance organization under part 4 of article 16 of title 10, C.R.S., for purposes of the PACE program.

(10) (a) The state department shall perform a feasibility study, conditioned on the receipt of sufficient gifts, grants, and donations, in order to identify viable communities that may support a PACE program site. This study shall be completed on or before May 1, 2003.

(b) The state department, consistent with the results of the feasibility study, shall use its best efforts to have in operation:

(I) One additional PACE program site by July 1, 2004;

(II) A total of four additional PACE program sites by July 1, 2005; and

(III) A total of six additional PACE program sites by July 1, 2006.

(c) (I) No later than May 30, 2003, the executive director of the state department shall submit to the joint budget committee of the general assembly and to the health and human services committees of the house of representatives and the senate, or any successor committees, a written report of the results of the feasibility study conducted under paragraph (a) of this subsection (10).

(II) No later than January 1, 2007, the executive director of the state department shall submit to the joint budget committee of the general assembly and to the health and human services committees of the house of representatives and the senate, or any successor committees, a final written report detailing the expansion of PACE program sites across the state.

(11) The state board shall promulgate such rules, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this section.

(12) (a) The general assembly shall make appropriations to the state department to fund services under this section provided at a monthly capitated rate. The state department shall annually renegotiate a monthly capitated rate for the contracted services.

(b) Repealed.

(c) The monthly capitated rate negotiated with the state department shall be included in the contract with the PACE organization and must be based upon a prospective monthly capitation payment to a PACE organization for a medicaid participant enrolled in a PACE program that is less than what would otherwise have been paid under the state medicaid plan if the participant were not enrolled in the PACE program.

(d) (I) The state department, with the participation of Colorado PACE organizations, shall develop an actuarially sound upper payment limit methodology that complies with federal law relating to PACE organizations and addresses a PACE-comparable population and employs functional, diagnostic, and other information on the PACE population and its service use and cost characteristics. The state department shall contract with an actuary that has experience with the methods described in this paragraph (d).

(II) For purposes of computing the upper payment limit, the state department shall provide to the contracted actuary state long-term care options data describing the health characteristics, functional acuity, and long-term services and supports needs of the PACE-comparable population, as well as relevant medicare and medicaid claims, cost, utilization, and vital statistics data necessary for the computation. The upper payment limit methodology must apply grade of membership methods to characterize the health deficit structure of long-term services and supports populations, demonstrating an empirical upper payment limit.

(III) Notwithstanding the provisions of this paragraph (d) to the contrary, the state department shall not be required to develop an upper payment limit methodology pursuant to this paragraph (d) or comply with the requirements of subparagraph (I) of paragraph (e) of this subsection (12) if the state department does not receive sufficient gifts, grants, and donations to fund the contract for actuarial services pursuant to subparagraph (I) of this paragraph (d).

(e) (I) Contingent upon any necessary federal approval, until the upper payment limit methodology is developed pursuant to paragraph (d) of this subsection (12) and adopted in state board rules, the percentage of the upper payment limit used to calculate the monthly capitated rate shall not be less than the percentage negotiated by the state department with the PACE organizations for the 2016-17 state fiscal year.

(II) This paragraph (e) is repealed, effective July 1 of the year following the year in which the executive director notifies the revisor of statutes that the state board has adopted rules relating to the upper payment limit methodology developed pursuant to paragraph (d) of this subsection (12).

(13) The state department may accept grants and donations from private sources for the purpose of implementing this section.

(14) (a) No later than sixty days prior to the closing or effective date of a conversion of a nonprofit PACE provider to a for-profit PACE provider, the nonprofit PACE provider shall:

(I) Transmit a conversion plan and written notice of the conversion to the attorney general, which conversion plan must include, at a minimum:

(A) A copy of the results of an independent valuation of the fair market value of the business that proposes to convert;

(B) A detailed explanation of the plans for distribution of the proceeds of the conversion, including whether the proceeds will be distributed to a new nonprofit entity or to an existing organization and, if to an existing nonprofit organization, which organization and the reasons for selecting that organization, or, if to a new nonprofit organization, how the initial board of directors will be selected;

(C) Information about any compensation, bonus, or inducement to any officers or directors of the converting entity resulting from the conversion; and

(D) The PACE organization's audited financial statements for its three most recent fiscal years for Colorado, and separately, for those operations outside of Colorado, for any such operations that may be related to the conversion; and

(II) Bear all costs associated with public oversight and review by the attorney general of the conversion, including the retention of outside experts, if any.

(b) Within ten days after the receipt of the conversion plan, the attorney general shall post the complete conversion plan on its website and receive public comments about the plan, which shall also be posted as soon as practicable to the attorney general's website. Public comment shall be received for a minimum of thirty days and available on the website for at least the duration of the comment period.

(c) Nothing in this section shall be construed to affect the common law authority of the attorney general.

Source: L. 2006: Entire article added with relocations, p. 1898, § 7, effective July 1. **L. 2008:** (12) amended, p. 1749, § 1, effective June 2. **L. 2009:** (12) amended, (SB 09-265), ch. 205, p. 936, § 6, effective May 1. **L. 2010:** (12)(b) repealed, (HB 10-1382), ch. 217, p. 940, § 5, effective May 6. **L. 2012:** (6) and (7) amended and (6.5) added, (SB 12-023), ch. 94, p. 308, § 1, effective April 12. **L. 2013:** (3)(f) repealed, (HB 13-1300), ch. 316, p. 1690, § 81, effective August 7. **L. 2015:** (1)(a), (2)(b), and (8) amended, (1)(b) repealed, and (14) added, (SB 15-137), ch. 163, pp. 496, 498, §§ 1, 2, effective August 5. **L. 2016:** (7)(d) added and (12) amended, (SB 16-199), ch. 270, p. 1117, § 1, effective June 10.

Editor's note: (1) This section is similar to former § 26-4-124 as it existed prior to 2006.

(2) As of publication date, the revisor of statutes has not received the notice referred to in subsection (12)(e)(II).

Cross references: For the federal laws creating the Program of All-Inclusive Care for the Elderly (PACE), see section 9412 (b)(2) of the "Omnibus Budget Reconciliation Act of 1986", Pub.L. 99-509, and section 4802 of the federal "Balanced Budget Act of 1997", Pub.L. 105-33, codified at 42 U.S.C. secs. 1395 and 1396.

25.5-5-413. Direct contracting with providers - legislative declaration. (1) The general assembly hereby finds, determines, and declares that costs associated with providing medical assistance to recipients have increased substantially due in part to increased costs of health care services and higher utilization rates. These cost pressures have been most dramatically demonstrated in the southern area of the state. Therefore, the general assembly finds, determines, and declares that pilot programs should be created to evaluate whether a provider may contract directly with the state department for the provision of services to recipients.

(2) The state department is authorized to contract directly with any provider who is able to demonstrate compliance with state laws and rules pertaining to risk-bearing entities to provide a capitated-risk program on a per member per month basis. The provider shall not serve more than two thousand five hundred recipients. The provider shall accept full risk for each participant, except for transplants or out-of-area services.

(3) The state department is authorized to contract directly with any provider who is able to provide a cost-effective and quality health care system through a capitated partial risk program on a per member per month basis or through any other financial arrangement with the department where the provider manages the health care available to the recipients and shares with the state department the savings associated with management of such health care.

(4) **Selection of the provider.** The state department shall select any provider who:

(a) Is able to provide evidence of a successful history of risk management for recipients;

(b) Initiates direct contracting with the state department; and

(c) Is able to demonstrate compliance with state laws and rules pertaining to risk-bearing entities.

Source: L. 2006: Entire article added with relocations, p. 1902, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-127 as it existed prior to 2006.

25.5-5-414. Telemedicine - legislative intent. (1) It is the intent of the general assembly to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with a provider.

(2) For the purposes of this section, "telemedicine" shall have the same meaning as set forth in section 12-36-106 (1)(g), C.R.S.

(3) On or after January 1, 2002, face-to-face contact between a health care provider and a patient shall not be required under the managed care system created in this part 4 for services appropriately provided through telemedicine, subject to reimbursement policies developed by the state department to compensate providers who provide health care services covered by the program created in section 25.5-4-104. Telemedicine services may only be used in areas of the state where the technology necessary for the provision of telemedicine exists. The audio and visual telemedicine system used shall, at a minimum, have the capability to meet the procedural definition of the most recent edition of the current procedural terminology that represents the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the current procedural terminology fourth edition codes that are billed. If a peripheral diagnostic

scope is required to assess the patient, it shall provide adequate resolution or audio quality for decision-making.

(4) The state department shall report to the health and human services committees of the house of representatives and the senate, or any successor committees, no later than January 1, 2006, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including, but not limited to, neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential managed care system benefits. Such report shall take into account the availability of technology as of the time of the report to use telemedicine for home health care, emergency care, and critical and intensive care and the availability of broadband access within the state.

(5) The managed care system shall not be required to pay for consultation provided by a provider by telephone or facsimile machines.

(6) The state department may accept and expend gifts, grants, and donations from any source to conduct the valuation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the managed care system.

(7) Nothing in this section shall be construed to:

(a) Alter the scope of practice of any health care provider; or

(b) Authorize the delivery of health care services in a setting or manner not otherwise authorized by law.

Source: L. 2006: Entire article added with relocations, p. 1903, § 7, effective July 1; (3) amended and (7) added, p. 1547, § 4, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-421 as it existed prior to 2006.

(2) (a) Amendments to section 26-4-421 (3) by Senate Bill 06-165 were harmonized with subsection (3) as it appeared in Senate Bill 06-219.

(b) Subsection (7) was enacted as 26-4-421 (7) in Senate Bill 06-165 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

Cross references: For the legislative declaration contained in the 2006 act amending subsection (3) and enacting subsection (7), see section 1 of chapter 312, Session Laws of Colorado 2006.

25.5-5-415. Medicaid payment reform and innovation pilot program - legislative declaration - creation - selection of payment projects - report - rules. (1) (a) The general assembly finds that:

(I) Increasing health care costs in Colorado's medicaid program creates challenges for the state's budget. Further, the increasing health care costs do not necessarily reflect improvements in either health outcomes for patients or in patient satisfaction with the care received;

(II) Moreover, the fee-for-service payment model may not support or align financially with evolving care coordination and delivery systems;

(III) The reform of medicaid payment policies offers a significant opportunity for the state to contain costs and improve quality;

(IV) New payment methodologies, including global payments, have been developed to respond to rising costs and the complexities of health care delivery. Opportunities now exist to explore, test, and implement such payment reforms in the medicaid program.

(V) The state department should explore how these new payment methodologies may result in improved health outcomes and patient satisfaction and support the financial sustainability of the medicaid program; and

(VI) The state department shall evaluate how successful payment projects could be replicated and incorporated within the state department's current medicaid coordinated care system.

(b) Therefore, the general assembly declares that Colorado should build upon ongoing reforms of health care delivery in the medicaid program by implementing a pilot program within the structure of the state department's current medicaid coordinated care system that encourages the use of new and innovative payment methodologies, including global payments.

(2) (a) There is hereby created the medicaid payment reform and innovation pilot program for purposes of fostering the use of innovative payment methodologies in the medicaid program that are designed to provide greater value while ensuring good health outcomes and client satisfaction.

(b) (I) The state department shall create a process for interested contractors of the state department's current medicaid coordinated care system to submit payment projects for consideration under the pilot program. Payment projects submitted pursuant to the pilot program may include, but need not be limited to, global payments, risk adjustment, risk sharing, and aligned payment incentives, including, but not limited to, gainsharing, to achieve improved quality and to control costs.

(II) The design of the payment project or projects shall address the client population of the state department's current medicaid coordinated care system and be tailored to the region's health care needs and the resources of the state department's current medicaid coordinated care system.

(III) A contractor of the state department's current medicaid coordinated care system shall work in coordination with the providers and managed care entities contracted with the contractor of the state department's current medicaid coordinated care system in developing the payment project or projects.

(c) (I) The state department shall review and select payment projects to be included in the pilot program.

(II) For purposes of selecting payment projects for the pilot program, the state department shall consider, at a minimum:

(A) The likely effect of the payment project on quality measures, health outcomes, and client satisfaction;

(B) The potential of the payment project to reduce the state's medicaid expenditures;

(C) The state department's ability to ensure that inpatient and outpatient hospital reimbursements are maximized up to the upper payment limits, as defined in 42 CFR 447.272 and 42 CFR 447.321 and calculated by the state department periodically;

(D) The client population served by the state department's current medicaid coordinated care system and the particular health needs of the region;

(E) The business structure or structures likely to foster cooperation, coordination, and alignment and the ability of the contractor of the state department's current medicaid coordinated care system to implement the payment project, including the resources available to the contractor of the state department's current medicaid coordinated care system and the technological infrastructure required; and

(F) The ability of the contractor of the state department's current medicaid coordinated care system to coordinate among providers of physical health care, behavioral health care, oral health care, and the system of long-term care services and supports.

(III) For payment projects not selected by the state department, the state department shall respond to the contractor of the state department's current medicaid coordinated care system, in writing, stating the reason or reasons why the payment project was not selected. The state department shall send a copy of the response to the joint budget committee of the general assembly, the health and human services committee of the senate, or any successor committee, and the health and environment committee of the house of representatives, or any successor committee.

(d) (I) The payment projects selected for the program shall be for a period of at least one year and shall not extend beyond the length of the contract with the contractor of the state department's current medicaid coordinated care system. The provider contract shall specify the payment methodology utilized in the payment project.

(II) The requirements of section 25.5-5-408 do not apply to the rate-calculation process for payments made to MCEs pursuant to this section.

(III) MCEs participating in the pilot program are subject to the requirements of section 25.5-5-404 (1)(k) and (1)(l), as applicable.

(IV) Payments made to MCEs under the pilot program shall account for prospective, local community or health system cost trends and values, as measured by quality and satisfaction measures, and shall incorporate community cost experience and reported encounter data to the extent possible to address regional variation and improve longitudinal performance.

(V) Notwithstanding any provisions of this section or state board rules to the contrary, it is the intent of the general assembly that total payments, adjustments, and incentives will be budget-neutral with respect to state expenditures. The state department shall not enter into a contract with a provider pursuant to this section if the state department estimates that total payments to the provider will be greater than without the contract.

(3) Pilot program participants shall provide data and information to the state department and any designated evaluator concerning health outcomes, cost, provider participation and satisfaction, client satisfaction, and any other data and information necessary to evaluate the efficacy of the payment methodology.

(4) (a) The state department shall submit a report to the joint budget committee of the general assembly, the health and human services committee of the senate, or any successor committee, and the health and environment committee of the house of representatives, or any successor committee, as follows:

(I) On or before February 1, 2013, concerning the design and implementation of the pilot program, including a description of any payment projects received by the state department and the time frame for implementation;

(II) On or before September 15, 2014, concerning the pilot program as implemented, including but not limited to an analysis of the initial data and information concerning the

utilization of the payment methodology, quality measures, and the impact of the payment methodology on health outcomes, cost, provider participation and satisfaction, and patient satisfaction;

(III) On or before September 15, 2015, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across patients utilizing existing state department data;

(IV) On or before April 15, 2017, and each April 15 that the program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across patients utilizing existing state department data. Specifically, the report must include:

(A) An evaluation of all current payment projects and whether the state department intends to extend any current payment project into the next fiscal year;

(B) The state department's plans to incorporate any payment project into the larger medicaid payment framework;

(C) A description of any payment project proposals received by the state department since the prior year's report, and whether the state department intends to implement any new payment projects in the upcoming fiscal year; and

(D) The results of the state department's evaluation of payment projects pursuant to paragraph (a.5) of this subsection (4).

(a.5) The state department shall evaluate each payment project to determine:

(I) Whether the payment project offers the potential for better patient outcomes or improved care and the impact of better outcomes and improved care on medicaid costs;

(II) Whether the payment project creates the opportunity for administrative efficiency in the medicaid program;

(III) Whether the payment project is budget neutral or generates savings for the medicaid program; and

(IV) Whether the payment project resulted in changes in provider participation in the medicaid program, and the nature of those changes.

(b) For purposes of evaluating the pilot program and payment methodologies, the state department may collaborate with a nonprofit entity or an institution of higher education to analyze and verify data and information received from pilot participants and to evaluate quality measures and the cost-effectiveness of the payment reforms.

(5) The state department shall seek any federal authorization necessary to implement the pilot program.

(6) The state department may promulgate any rules necessary to implement the pilot program.

Source: L. 2012: Entire section added, (HB 12-1281), ch. 246, p. 1182, § 2, effective June 4. **L. 2016:** (1)(a)(V), (2)(c)(I), (2)(c)(III), (2)(d)(I), (4)(a)(II), and (4)(a)(III) amended and (1)(a)(VI), (4)(a)(IV), and (4)(a.5) added, (HB 16-1407), ch. 152, p. 453, § 1, effective May 4.

25.5-5-416. Report concerning efficient contracting in managed care - legislative declaration - repeal. (Repealed)

Source: L. 2012: Entire section added, (HB 12-1281), ch. 246, p. 1186, § 2, effective June 4.

Editor's note: Subsection (3) provided for the repeal of this section, effective July 1, 2013. (See L. 2012, p. 1186.)

25.5-5-417. Reducing unnecessary duplicative services in the accountable care collaborative program - repeal. (1) (a) The general assembly finds and declares that:

(I) The state department has created a medicaid coordinated care system known and referred to in this section as the "accountable care collaborative" to improve client health and reduce costs in the medicaid program;

(II) One of the primary goals of the accountable care collaborative is to reduce costs to the medicaid program through coordination between the primary care medical providers, the regional care collaborative organizations, and the statewide data and analytics contractor;

(III) Additionally, the accountable care collaborative is also evaluating the payment system used for the medicaid program to improve client health outcomes through more effective payment systems;

(IV) The state department has entered into contracts with regional organizations for the accountable care collaborative;

(V) These regional care collaborative organizations, referred to in this section as "RCCOs", receive a per-member, per-month payment to perform a number of functions that include but are not limited to supporting community-based care coordination, being accountable for health and cost outcomes, and ensuring care coordination for all clients; and

(VI) Despite care coordination and accountability efforts, there remains within the medicaid system waste and duplication of services that are increasing state medicaid costs and preventing maximum efficiency in the medicaid system.

(b) Therefore, the general assembly declares that, in an effort to bring greater transparency to cost-containment efforts by the accountable care collaborative, the state department shall report annually to the general assembly concerning efforts to reduce waste and duplication within the accountable care collaborative.

(2) As part of the annual report required pursuant to part 2 of article 7 of title 2, C.R.S., the state department shall provide information concerning the following:

(a) The specific efforts within the accountable care collaborative, including a summary of technology-based efforts, to identify and implement best practices relating to cost containment, and reducing avoidable, duplicative, variable, and inappropriate use of health care resources, and the outcome of those efforts, including cost savings if known;

(b) Any statutes or policies or procedures that prevent the RCCOs from realizing efficiencies and reducing waste within the medicaid system; and

(c) Any other efforts by the RCCOs or the state department to ensure that those who provide care for medicaid clients are aware of and actively participate in reducing waste within the medicaid system.

(3) The state department shall indicate on its report the counties being served by each RCCO.

(4) This section is repealed, effective July 15, 2018.

Source: L. 2013: Entire section added, (HB 13-1196), ch. 201, p. 817, § 1, effective August 7.

25.5-5-418. Primary care provider sustainability fund - creation - use of fund. The primary care provider sustainability fund is hereby created in the state treasury. The fund consists of money transferred to the fund from the children's basic health plan trust created in section 25.5-8-105 (1) pursuant to section 25.5-8-105 (8)(b) and any other money that the general assembly may appropriate or transfer to the fund. The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the fund. Any unexpended and unencumbered money in the fund at the end of any fiscal year remains in the fund and shall not be credited or transferred to the general fund or any other fund. Subject to annual appropriation by the general assembly, the state department may expend money from the fund for the purpose of increasing access to primary care through rate enhancements for primary care office visits, preventive medicine visits, counseling and health-risk assessments, immunization administration, health screening services, and newborn care, including neonatal critical care. Money expended from the fund for the purposes of increasing access to primary care through rate enhancements supplements and does not supplant general fund appropriations for that purpose.

Source: L. 2016: Entire section added, (HB 16-1408), ch. 153, p. 468, § 18, effective July 1.

25.5-5-419. Accountable care collaborative - reporting - rules. (1) In 2011, the state department created the accountable care collaborative, also referred to in this title 25.5 as the medicaid coordinated care system. The state department shall continue to provide care delivery through the accountable care collaborative. The goals of the accountable care collaborative are to improve member health and reduce costs in the medicaid program. To achieve these goals, the state department's implementation of the accountable care collaborative must include, but need not be limited to:

(a) Establishing primary care medical homes for medicaid clients within the accountable care collaborative;

(b) Providing regional care coordination and provider network support;

(c) Providing data to regional entities and providers to help manage client care;

(d) Integrating the delivery of behavioral health, including mental health and substance use disorders, and physical health services for clients;

(e) Connecting primary care with specialty care and nonhealth community supports;

(f) Promoting member choice and engagement;

(g) Promoting telehealth and telemedicine;

(h) Utilizing innovative care models and provider payment models as part of the care delivery system, including capitated managed care models within the broader accountable care collaborative;

(i) Receiving feedback from affected stakeholder groups;

(j) Establishing a flexible structure that would allow for the efficient operation of the accountable care collaborative to further include medicaid populations and services, including long-term care services and supports; and

(k) Establishing a care delivery system and provider payment platform that can adapt to changing federal financial participation models or funding levels.

(2) The state department shall facilitate transparency and collaboration in the development, performance management, and evaluation of the accountable care collaborative through the creation of stakeholder advisory committees.

(3) On or before December 1, 2017, and on or before December 1 each year thereafter, the state department shall prepare and submit a report to the joint budget committee, the public health care and human services committee of the house of representatives, and the health and human services committee of the senate, or any successor committees, concerning the implementation of the accountable care collaborative. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), the report required pursuant to this subsection (3) continues indefinitely. At a minimum, the state department's report must include the following information concerning the accountable care collaborative:

(a) The number of medicaid clients enrolled in the program;

(b) Performance results with an emphasis on member health impacts;

(c) Current administrative fees and costs for the program;

(d) Fiscal performance;

(e) A description of activities that promote access to services for medicaid members in rural and frontier counties;

(f) A description of the state department's coordination with entities that authorize long-term care services for medicaid clients;

(g) Information on any advisory committees created, including the participants, focus, stakeholder feedback, and outcomes of the work of the advisory committees;

(h) Future areas of program focus and development, including, among others, a plan to study the costs and benefits of further coverage of substance use disorder treatment; and

(i) Information concerning efforts to reduce medicaid waste and inefficiencies through the accountable care collaborative, including:

(I) The specific efforts within the accountable care collaborative, including a summary of technology-based efforts, to identify and implement best practices relating to cost containment; reducing avoidable, duplicative, variable, and inappropriate uses of health care resources; and the outcome of those efforts, including cost savings, if known;

(II) Any statutes, policies, or procedures that prevent regional entities from realizing efficiencies and reducing waste within the medicaid system; and

(III) Any other efforts by regional entities or the state department to ensure that those who provide care for medicaid clients are aware of and actively participate in reducing waste within the medicaid system.

(4) On or before December 1, 2017, the state department shall submit a report to the joint budget committee, the public health care and human services committee of the house of

representatives, and the health and human services committee of the senate, or any successor committees, outlining the statutory changes needed to part 4 of this article 5 relating to the statewide managed care system, as well as any other sections of the Colorado Revised Statutes, in order to align Colorado law with the federal "Medicaid and CHIP Managed Care Final Rule", CMS-2390-F.

(5) The state board shall promulgate rules implementing the accountable care collaborative.

(6) The state department shall consider new technologies and business practices for medical management reform that would reduce medical costs due to misuse, overuse, waste, fraud, and abuse. Better drug management, especially of avoidable prescriptions and inefficient use of specialty drugs, would allow the entire prescription drug cost continuum to be managed more effectively to contain costs and achieve better patient outcomes. New technologies and business practices for medical management reform may also benefit Colorado by providing a more powerful medicaid enrollment platform that properly enrolls only those individuals who are truly eligible for medicaid benefits.

Source: L. 2017: Entire section added, (HB 17-1353), ch. 231, p. 895, § 2, effective May 23.

25.5-5-420. Advancing care for exceptional kids. Within one hundred twenty days of the enactment of the federal "Advancing Care for Exceptional Kids Act", subject to available appropriations, the state department shall seek any federal approval necessary to fund, in cooperation with hospitals that meet the specified requirements, the implementation of an enhanced pediatric health home for children with complex medical conditions. Requirements for participation by the state department, along with the requirement of an enhanced pediatric health home, are stipulated by the "Advancing Care for Exceptional Kids Act" and shall be complied with accordingly.

Source: L. 2017: Entire section added, (SB 17-267), ch. 267, p. 1466, § 21, effective May 30.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

PART 5

PRESCRIPTION DRUGS

25.5-5-500.3. Authorization to bill third party. As a condition of doing business in the state, each provider is deemed to authorize the state department, or an independent contractor retained by the state department, to bill a third party, as defined in section 25.5-4-209 (2)(g)(II), on behalf of the provider if the third party is determined to be liable to pay for care pursuant to sections 25.5-4-209 and 25.5-4-300.4.

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1379, § 9, effective May 26.

Cross references: For the legislative declaration stating the purpose of and the provision directing legislative staff agencies to conduct a post-enactment review pursuant to § 2-2-1201 scheduled in 2015, see sections 1 and 17 of chapter 296, Session Laws of Colorado 2010. To obtain a copy of the review, once completed, go to "Legislative Reports and Requirements" on the Colorado General Assembly's website.

25.5-5-501. Providers - drug reimbursement. (1) (a) As to drugs for which payment is made, the state board's rules for payment must include the requirement that the generic equivalent of a brand-name drug be prescribed if the generic equivalent is a therapeutic equivalent to the brand-name drug, except when reimbursement to the state for a brand-name drug makes the brand-name drug less expensive than the cost of the generic equivalent. The state department shall grant an exception to this requirement if the patient has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand-name drug would be unacceptably disruptive. The requirements of this subsection (1) do not apply to medications for the treatment of behavioral or mental health disorders, cancer, epilepsy, or human immunodeficiency virus and acquired immune deficiency syndrome.

(b) The provisions of this subsection (1) shall apply to fee-for-service and primary care physician program recipients.

(2) It is the general assembly's intent that requiring the use of a generic equivalent of a brand-name drug will produce savings within the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the administrative review process required by subsection (1) of this section.

Source: L. 2006: Entire article added with relocations, p. 1904, § 7, effective July 1. **L. 2013:** (1)(a) amended, (HB 13-1266), ch. 217, p. 992, § 63, effective May 13. **L. 2017:** (1)(a) amended, (SB 17-242), ch. 263, p. 1329, § 205, effective May 25.

Editor's note: This section is similar to former § 26-4-406 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-5-502. Unused medications - reuse - rules. (1) As used in this section, unless the context otherwise requires, "medication" means prescription medication that is not a controlled substance.

(2) A pharmacist participating in the medical assistance program may accept unused medication from a licensed facility, as defined in section 12-42.5-133 (1)(a), C.R.S., or a licensed health care provider for the purpose of dispensing the medication to another person. A pharmacist shall reimburse the state department for the cost of medications that the state department has paid to the pharmacist if medications are returned to a pharmacist and the

medications are available to be dispensed to another person. Medications shall only be available to be dispensed to another person under this section if the medications are:

(a) Liquid and the vial is still sealed and properly stored;

(b) Individually packaged and the packaging has not been damaged; or

(c) In the original, unopened, sealed, and tamper-evident unit dose packaging.

(3) Medication dispensed pursuant to this section shall bear an expiration date that is later than six months after the date the drug was donated.

(4) Any savings realized through reimbursements received pursuant to subsection (1) of this section shall fund the administration of this section.

(5) The state board, in consultation with the state board of pharmacy, shall adopt rules for the implementation of this section.

Source: L. 2006: Entire article added with relocations, p. 1904, § 7, effective July 1. **L. 2012:** IP(2) amended, (HB 12-1311), ch. 281, p. 1621, § 76, effective July 1.

Editor's note: This section is similar to former § 26-4-406.3 as it existed prior to 2006.

25.5-5-503. Prescription drug benefits - authorization - dual-eligible participation. (1) The state department is authorized to ensure the participation of Colorado medical assistance recipients, who are also eligible for medicare, in any federal prescription drug benefit enacted for medicare recipients.

(2) Prescribed drugs shall not be a covered benefit under the medical assistance program for a recipient who is eligible for a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

Source: L. 2006: Entire article added with relocations, p. 1905, § 7, effective July 1. **L. 2007:** (2) amended, p. 1631, § 1, effective July 1.

Editor's note: This section is similar to former § 26-4-406.5 as it existed prior to 2006.

Cross references: For additional information on the federal "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", see Pub.L. 108-173.

25.5-5-504. Providers of pharmaceutical services. (1) Consistent with the provisions of section 25.5-4-401 (1), and consistent with subsections (2) and (3) of this section, and subject to available appropriations, no provider of pharmaceutical services who meets the conditions imposed by this article and articles 4 and 6 of this title and who complies with the terms and conditions established by the state department and contracting health maintenance organizations and prepaid health plans shall be excluded from contracting for the provision of pharmaceutical services to recipients authorized in this article and articles 4 and 6 of this title.

(2) This provision shall not apply to a health maintenance organization or prepaid health plan that enrolls less than forty percent of all the resident medicaid recipients in any county with over one thousand medicaid recipients.

(3) The state board shall establish specifications in rules in order to provide criteria to health maintenance organizations and prepaid health plans which ensure the accessibility and quality of service to clients and the terms and conditions for pharmaceutical contracts.

Source: L. 2006: Entire article added with relocations, p. 1905, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-407 as it existed prior to 2006.

25.5-5-505. Prescribed drugs - mail order - rules. (1) (a) (I) The state board shall adopt by rule a system to allow medical assistance recipients the option to receive through the mail prescribed maintenance medications used to treat chronic medical conditions.

(II) The state board rules must include the definition of maintenance medications. The rules may allow a medical assistance recipient to receive through the mail up to a three-month supply, or the maximum allowed under federal law, of maintenance medications used to treat chronic medical conditions.

(b) To the extent allowed by federal law, the state department shall require that a medical assistance recipient receiving prescription medication through the mail pay the same copayment amount as a medical assistance recipient receiving prescription medication through any other method. The state department shall encourage medical assistance recipients who choose to receive maintenance medications through the mail to use local retail pharmacies for mail delivery.

(c) A pharmacy may provide maintenance medications through the mail to medical assistance recipients in accordance with all applicable state and federal laws if the pharmacy is enrolled as a provider with the state department and is registered with the state board of pharmacy, created and existing pursuant to section 12-42.5-103, C.R.S.

(d) A nonresident prescription drug outlet doing business in this state shall provide a means for recipients of state medical assistance who have third-party insurance with whom the nonresident prescription drug outlet has a contractual relationship to receive their required pharmacy benefits at a cost to the recipients of no more than the legally allowed state medical assistance copayment. If a third-party insurance carrier's copayment or deductible for pharmacy benefits is larger than the legally allowed state medical assistance copayment, the prescription drug outlet may bill the state medical assistance program for the difference pursuant to state medical assistance reimbursement rules.

(1.5) The state department shall publish on its website and include in the recipient handbook the following information for recipients enrolled in fee-for-service medical assistance programs:

(a) That a medical assistance recipient may use the pharmacy of his or her choice;

(b) That a medical assistance recipient may use a local retail pharmacy for mail delivery of maintenance medications, if offered; and

(c) That the copayment amount for prescription medications is the same at any pharmacy enrolled in the medical assistance program.

(2) The state department shall seek any federal authorization necessary to implement this section.

Source: L. 2006: Entire article added with relocations, p. 1905, § 7, effective July 1. **L. 2008:** (1) amended, p. 890, § 1, effective May 20. **L. 2009:** (1)(a)(I)(B) amended, (SB 09-252), ch. 271, p. 1228, § 1, effective May 18. **L. 2016:** (1) amended and (1.5) added, (SB 16-027), ch. 208, p. 745, § 1, effective August 10.

Editor's note: This section is similar to former § 26-4-407.5 as it existed prior to 2006.

25.5-5-506. Prescribed drugs - utilization review. (1) The state department shall develop and implement a drug utilization review process to assure the appropriate utilization of drugs by patients receiving medical assistance in the fee-for-service and primary care physician programs. The review process shall include the monitoring of prescription information and shall address at a minimum underutilization and overutilization of benefit drugs. Periodic reports of findings and recommendations shall be forwarded to the state department.

(2) It is the general assembly's intent that the implementation of a drug utilization review process for the fee-for-service and primary care physician programs will produce savings within the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the development and implementation of a drug utilization review process for these programs, as required by subsection (1) of this section. The state department may contract on a contingency basis for the development or implementation of the review process required by subsection (1) of this section.

(3) (a) The state department shall implement drug utilization mechanisms, including, but not limited to, prior authorization, to control costs in the medical assistance program associated with prescribed drugs. The state board shall promulgate a rule that outlines a process in which any interested party may be notified of and comment on the implementation of any prior authorization for a class of prescribed drugs before the class is prior authorized.

(b) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1906, § 7, effective July 1. **L. 2016:** (3)(b) repealed, (HB 16-1081), ch. 22, p. 51, § 4, effective August 10.

Editor's note: This section is similar to former § 26-4-408 as it existed prior to 2006.

25.5-5-507. Prescription drug information and technical assistance program - rules. There is hereby created the prescription drug information and technical assistance program. The program shall provide advice on the prudent use of prescription drugs to persons who receive prescription drug benefits pursuant to this part 5. The state department shall contract with licensed pharmacists for statewide medicaid pharmacy services and pharmacy consultations for persons receiving prescription drug benefits pursuant to this part 5 regarding how each person may, with the approval of the appropriate prescribing health care provider, avoid dangerous drug interactions, improve patient outcomes, and save the state money for the drugs prescribed. The state department shall promulgate rules to establish and administer the program and to provide

incentive payments to pharmacists and physicians who participate in the program. The state department shall design a calculation for savings under the program.

Source: L. 2007: Entire section added, p. 1631, § 2, effective July 1.

25.5-5-508. Electronic prescriptions - study - report - repeal. (Repealed)

Source: L. 2009: Entire section added, (HB 09-1073), ch. 282, p. 1286, § 1, effective August 5.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2010. (See L. 2009, p. 1286.)

PART 6

PROGRAM FOR TEEN PREGNANCY
AND DROPOUT PREVENTION

Editor's note: Section 25.5-5-605 provides for the termination of the teen pregnancy and dropout prevention program and repeal of this part 6, effective September 1, 2016. However, the provisions are printed in the statutes for an additional year to accommodate the one-year period for winding up the affairs of the program in accordance with § 24-34-104 (2), (8), and (9).

25.5-5-601 to 25.5-5-605. (Repealed)

Editor's note: (1) This part 6 was added in 1995. For amendments to this part 6 prior to its repeal in 2016, consult the 2015 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(2) Section 25.5-5-605 provided for the repeal of this part 6, effective September 1, 2016. (See L. 2011, p. 1458.)

PART 7

TELEMEDICINE PILOT PROGRAMS FOR
CHRONIC MEDICAL CONDITIONS

Editor's note: This part 7 was added in 2006 and was not amended prior to its repeal in 2010. For the text of this part 7 prior to 2010, consult the 2009 Colorado Revised Statutes.

25.5-5-701 to 25.5-5-703. (Repealed)

Source: L. 2010: Entire part repealed, (HB 10-1322), ch. 29, p. 105, § 1, effective March 18.

ARTICLE 6

Editor's note: This article was added with relocations in 2006 containing provisions of some sections formerly located in article 4 of title 26. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

Cross references: For definitions applicable to this article, see § 25.5-4-103.

Law reviews: For article, "Colorado Medicaid Home and Community-Based Services and Least-Restrictive Environment", see 39 Colo. Law. 35 (May 2010).

PART 1

LONG-TERM CARE ADMINISTRATION

25.5-6-101. Spousal protection - protection of income and resources for community spouse - definitions - amounts retained - responsibility of state department - right to appeal. (1) As used in this section, unless the context otherwise requires:

(a) "Community spouse" means the spouse of a person who is in an institution or nursing facility, the spouse of a person who is enrolled in the PACE program authorized pursuant to section 25.5-5-412, or the spouse of a person who is receiving home- and community-based services pursuant to this article.

(b) "Community spouse monthly income allowance" means the amount by which the minimum monthly maintenance needs allowance exceeds the amount of monthly income that is available to the community spouse.

(c) "Community spouse resource allowance" means the amount of assets, excluding the value of the home and other exempt resources under federal law, that the community spouse shall be allowed to retain and that shall not be available to cover an institutionalized spouse's cost of care.

(d) (I) "Institutionalized spouse" means an individual who is in an institution or nursing facility who is married to a spouse who is not in an institution or nursing facility.

(II) For purposes of this section, "institutionalized spouse" includes an individual who is enrolled in the PACE program authorized pursuant to section 25.5-5-412 or is receiving home- and community-based services pursuant to this article, and who is married to a spouse who is not enrolled in the PACE program or receiving home- and community-based services.

(e) (I) (A) "Minimum monthly maintenance needs allowance" means an amount which is equal to an applicable percent of the nonfarm income official poverty line (increased annually by the consumer price index for all urban consumers), as defined by the federal office of management and budget, for a family unit of two members.

(B) For the purposes of sub-subparagraph (A) of this subparagraph (I), the applicable percent shall be: As of September 30, 1989, one hundred twenty-two percent; as of July 1, 1991, one hundred thirty-three percent; as of July 1, 1992, one hundred fifty percent.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (e), the minimum monthly maintenance needs allowance may be increased on an individual basis if:

(A) The community spouse has shelter and utilities expenses that exceed thirty percent of the minimum monthly maintenance needs allowance; except that the total allowance shall not exceed fifteen hundred dollars (increased annually by the consumer price index for all urban consumers);

(B) Either spouse is responsible for a dependent family member, including children, parents, or siblings who reside with the community spouse; or

(C) The community spouse has exceptional circumstances which would result in significant financial duress.

(2) (a) In order to implement the medical assistance program in compliance with the federal "Medicare Catastrophic Coverage Act of 1988", as amended, the state department shall ensure, when an institutionalized spouse is eligible for medical assistance under this article and articles 4 and 5 of this title, that the community spouse retain a community spouse monthly income allowance but only to the extent that income of the institutionalized spouse is made available to the community spouse.

(b) (I) The resources available to the married couple shall be calculated at the beginning of a continuous period of institutionalization of the institutionalized spouse. The community spouse shall retain the remainder of the couple's countable resources up to the federal maximum resource allowance as a community spouse resources allowance. The institutionalized spouse may keep an amount up to the amount of resources allowed under the federal medicaid program.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (b), if either spouse establishes that the community spouse resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, an amount adequate to provide the minimum monthly maintenance needs allowance shall be substituted.

(3) The state board shall have the authority to promulgate any rules that are necessary to implement the provisions of this section in accordance with the federal "Medicare Catastrophic Coverage Act of 1988", as amended. The rules adopted by the state board shall include, as a minimum, provisions regarding the following matters:

(a) The treatment of a married couple's income and resources before and after eligibility for medical assistance is established, including the basis for dividing such income and resources between the two parties;

(b) The process for appealing any determinations regarding income and resources that are made pursuant to these rules.

Source: L. 2006: Entire article added with relocations, p. 1907, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-506 as it existed prior to 2006.

Cross references: For provisions of the federal "Medicare Catastrophic Coverage Act of 1988" referenced in this section, see section 303 of Pub.L. 100-360, codified at 42 U.S.C. sec. 1396r-5.

25.5-6-102. Court-approved trusts - transfer of property for persons seeking medical assistance for nursing home care - undue hardship - legislative declaration. (1) The general assembly hereby finds, determines, and declares that:

(a) The state makes significant expenditures for nursing home care under the "Colorado Medical Assistance Act";

(b) A large number of persons do not have enough income to afford nursing home care, but have too much income to qualify for state medical assistance, a situation popularly referred to as the "Utah gap";

(c) Some persons in the Utah gap, through innovative court-approved trust arrangements, have become qualified for state medical assistance, thereby increasing state medical assistance expenditures;

(d) It is therefore appropriate to enact state laws which limit such court-approved trusts in a manner that is consistent with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396 et seq., as amended, and which provide that persons who qualify for assistance as a result of the creation of such trusts shall be treated the same as any other recipient of medical assistance for nursing home care;

(e) In enacting this section, the general assembly intends only to limit certain court-approved trusts and court-approved transfers of property. It is not the general assembly's intent to approve or disapprove of privately created trusts or private transfers of property made under the same or similar circumstances.

(2) The county department shall verify that an applicant for medical assistance for nursing home care, pursuant to the provisions of this title, meets applicable eligibility criteria for assistance other than those set forth in subsection (3) of this section. Upon verification, for eligibility purposes and in accordance with subsection (3) of this section, the county department shall make a determination of the status of any court-approved trust established for or court-approved transfer of property made by or for the applicant.

(3) (a) If a person who applies for medical assistance for nursing home care would be deemed ineligible for assistance as a result of deeming a court-approved trust established for the applicant as a medicaid qualifying trust or as a result of deeming property in the court-approved trust as an improper transfer of assets, the person's application shall, nonetheless, be treated as a case of undue hardship and the person shall be eligible for medical assistance for said care if the establishment of the court-approved trust meets the following criteria:

(I) The applicant's monthly gross income from all sources, without reference to the court-approved trust, exceeds the income eligibility standard for medical assistance then in effect but is less than the average private pay rate for nursing home care for the geographic region in which the applicant lives;

(II) The property used to fund the trust shall be limited to monthly unearned income owned by the applicant, including any pension payment;

(III) The applicant and the state medical assistance program shall be the sole beneficiaries of the trust. The entire corpus of the trust, or as much of the corpus as may be distributed each month without violating federal requirements for federal financial participation, shall be distributed each month for expenses related to the beneficiary's nursing home care that are approved under the medical assistance program; except that an amount reasonably necessary to maintain the existence of the trust and to comply with federal requirements may be retained in the trust. Deductions may be distributed from the trust to the same extent deductions from the

income of a nursing home resident who is not a trust beneficiary are allowed under the medical assistance program, which shall include the following:

(A) A monthly personal needs allowance;

(B) Payments to the beneficiary's community spouse or dependent family members as provided and in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396r-5, as amended, and section 25.5-6-101;

(C) Specified health insurance costs and special medical services provided under Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396a(r), as amended; and

(D) Any other deduction provided in the rules of the state department.

(IV) Upon the death of the beneficiary, a remainder interest in the corpus of the trust shall pass to the state agency responsible for administering the state medical assistance program;

(V) The trust shall not be subject to modification by the beneficiary or the trustee unless otherwise provided by this section or section 15-14-412.5, C.R.S.

(b) For the purposes of this subsection (3), "medicaid qualifying trust" shall have the same meaning as set forth in Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396a(k).

(4) The state board shall adopt rules as are necessary for the implementation of this section and as are necessary to comply with federal law. In addition, the state department shall amend the state medical assistance plan in a manner that is consistent with the provisions of this section.

(5) This section shall take effect January 1, 1992, and shall apply to any court-approved trust established for or court-approved transfer of property made by or for a protected person applying for or receiving medical assistance for nursing home care pursuant to the provisions of this title, on or after said date; except that a court-approved trust created before said date that does not comply with this section shall be modified to comply with this section no later than July 1, 1992, before which time the court-approved trust or court-approved transfer of property to a trust shall not render the protected person ineligible for medical assistance.

(6) The provisions of this section shall not apply if federal funds are not available for persons who would qualify for medical assistance as a result of a court-approved trust that meets the criteria set forth in this section.

(7) This section shall apply to trusts established or transfers of property made prior to July 1, 1994. The provisions set forth in sections 15-14-412.6 to 15-14-412.9, C.R.S., and any rules adopted by the state board pursuant to section 25.5-6-103 shall apply to trusts established or property transferred on or after that date.

Source: L. 2006: Entire article added with relocations, p. 1908, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-506.5 as it existed prior to 2006.

25.5-6-103. Court-approved trusts - transfer of property for persons seeking medical assistance - rule-making authority for trusts created on or after July 1, 1994 - undue hardship. (1) The state board shall adopt such rules as are necessary with respect to trusts established pursuant to sections 15-14-412.6 to 15-14-412.9, C.R.S. The state board shall adopt rules that address, but need not be limited to, the following:

(a) The definition, including any limitations, of permissible distributions from trusts, taking federal guidelines into consideration;

(b) Reasonable financial reimbursement or incentives to the state department, county departments of social services, and any other designated agencies for the efforts and expenses in monitoring trusts, and where necessary, for the recovery of trust property that has been improperly distributed or otherwise expended.

(2) The state board shall comply with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p (d)(5), as amended, which requires the state medicaid agency to establish procedures, in accordance with standards specified by the secretary of the United States department of health and human services, under which the state medicaid agency may waive the application of the general rules for considering trust property in determining eligibility for medical assistance if the applicant for medical assistance establishes that the application of the general rules would work an undue hardship on the individual.

(3) The state department shall determine the feasibility of providing ongoing support of dependents by using the trust corpus during the life of the person for whom a trust is created or using the remainder of the trust after the death of the person for whom the trust was created. If the state department determines that it is feasible to provide that support, the state department shall seek a waiver from the federal government to permit the use of trust property for that purpose.

Source: L. 2006: Entire article added with relocations, p. 1911, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-506.6 as it existed prior to 2006.

25.5-6-104. Long-term care placements - comprehensive and uniform client assessment instrument - report - legislative declaration - definitions - repeal. (1) (a) The general assembly hereby finds, determines, and declares that there is an increasing strain on long-term care services in the state; that the number of persons in need of long-term care continues to grow; that community-based resources are not integrated into a centralized system for referrals, assessment of needs, development of care plans, and case management; and that persons in need of long-term care services have difficulty accessing and using the current system, which is fragmented and which results in inappropriate placements.

(b) The general assembly further finds, determines, and declares that the state is in need of a long-term care system that organizes each long-term care client's entry, assessment of need, and service delivery into a single unified system; and that such system must include, at a minimum, a locally established single entry point administered by a designated entity, a single client assessment instrument and administrative process, targeted case management in order to maximize existing federal, state, and local funding, case management, and an accountability mechanism designed to assure that budget allocations are being effectively managed.

(c) The general assembly therefore concludes that it is appropriate to develop and implement a comprehensive and uniform long-term care client assessment process and to study the establishment of a single entry point system that provides for the coordination of access and service delivery to long-term care clients at the local level, that is available to all persons in need of long-term care, and that is well managed and cost-efficient.

(2) As used in this section and in sections 25.5-6-105 to 25.5-6-107, unless the context otherwise requires:

(a) "Activities of daily living" means the basic self-care activities, including eating, bathing, dressing, transferring from bed to chair, bowel and bladder control, and independent ambulation.

(b) "Case management services" means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the direct delivery of services as provided by this article or by rules adopted by the state board pursuant to this article, the evaluation of service effectiveness, and the reassessment of such client's needs, all of which shall be performed by a single entry point as defined in paragraph (k) of this subsection (2).

(c) "Community-based" means services provided in an individual's home or in a homelike setting. "Community-based" does not include a hospital, hospital unit, nursing facility, or nursing home.

(d) "Comprehensive and uniform client assessment process" means a standard procedure, which includes the use of a uniform assessment instrument, to measure a client's functional capacity, to determine the social and medical needs of a current or potential client of any long-term care program, and to target resources to the functionally impaired.

(e) "Continuum of care" means an organized system of long-term care, benefits, and services to which a client has access and which enables a client to move from one level or type of care to another without encountering gaps in or barriers to service.

(f) "Information and referral" means the provision of specific, accurate, and timely public information about services available to aging and disabled adults in need of long-term care and referral to alternative agencies, programs, and services based on client inquiries.

(g) "Instrumental activities of daily living" means home management and independent living activities such as cooking, cleaning, using a telephone, shopping, doing laundry, providing transportation, and managing money.

(h) "Long-term care" means those services designed to provide diagnostic, preventive, therapeutic, rehabilitative, supportive, and maintenance services for individuals who have chronic physical or mental impairments, or both, in a variety of institutional and noninstitutional settings, including the home, with the goal of promoting the optimum level of physical, social, and psychological functioning of the individuals.

(i) "Resource development" means the study, establishment, and implementation of additional resources or services which will extend the capabilities of community long-term care systems to better serve long-term care clients.

(j) "Screening" means a preliminary determination of need for long-term care services and, on the basis of such determination, the making of an appropriate referral for a client assessment in accordance with subsection (3) of this section or referral to another community resource to assist clients who are not in need of long-term care services.

(k) "Single entry point" means the availability of a single access or entry point within a local area where a current or potential long-term care client can obtain long-term care information, screening, assessment of need, and referral to appropriate long-term care program and case management services.

(3) (a) On or before July 1, 1991, the state department shall establish, by rule in accordance with article 4 of title 24, C.R.S., a comprehensive and uniform client assessment

process for all individuals in need of long-term care, the purpose of which is to determine the appropriate services and levels of care necessary to meet clients' needs, to analyze alternative forms of care and the payment sources for such care, and to assist in the selection of long-term care programs and services that meet clients' needs most cost-efficiently.

(b) Participation in the process shall be mandatory for clients of publicly funded long-term care programs, including, but not limited to, the following:

(I) Nursing facilities;

(II) Home- and community-based services for the elderly, the blind, and the disabled;

(III) Alternative care facilities;

(IV) to (VI) (Deleted by amendment, L. 2008, p. 437, § 1, effective August 5, 2008.)

(VII) Home health services for long-term care clients; and

(VIII) Home- and community-based services for persons living with acquired immune deficiency syndrome (AIDS).

(c) Private paying clients of long-term care programs may participate in the process for a fee to be established by the state department and adopted through rules.

(d) The state department, through rules, shall develop and implement no later than July 1, 1991, a uniform long-term care client needs assessment instrument for all individuals needing long-term care. The instrument shall be used as part of the comprehensive and uniform client assessment process to be established in accordance with paragraph (a) of this subsection (3) and shall serve the following functions:

(I) To obtain information on each client's status in the following areas:

(A) Activities of daily living and instrumental activities of daily living;

(B) Physical health;

(C) Cognitive and emotional well-being;

(D) Social interaction and current support resources;

(II) To assess each client's physical environment in terms of meeting the client's needs;

(III) To obtain information on each client's payment sources, including obtaining financial eligibility information for publicly funded long-term care programs;

(IV) To disclose the need for more intensive needs assessments in areas such as nutrition, adult protection, dementia, and mental health;

(V) To prioritize a client's need for care using criteria established by the state department for specific publicly funded long-term care programs;

(VI) To serve as the functional assessment for the determinations of medical necessity.

(e) On and after July 1, 1991, no publicly funded client shall be placed in a long-term care program unless such placement is in accordance with rules adopted by the state board in implementing this section.

(4) Repealed.

(5) (a) On or before July 1, 2018, pursuant to the state department's ongoing stakeholder process relating to eligibility determination for long-term services and supports pursuant to this article, the state department shall select a needs assessment tool for persons receiving long-term services and supports, including persons with intellectual and developmental disabilities who are eligible for services pursuant to section 25.5-6-409. Once selected, the state department shall begin assessing client needs using the needs assessment tool as soon as practicable.

(b) Pursuant to the state department's ongoing stakeholder process relating to eligibility determination for long-term services and supports pursuant to this article, the state department

shall develop or select the needs assessment tool in collaboration with persons with intellectual and developmental disabilities who receive services, legal guardians, case managers, and any other stakeholders as determined by the state department.

(c) The needs assessment tool developed or selected by the state department must include a reasonable reassessment process, set forth in state board rules, that allows a reassessment to be completed within thirty days after receipt of a request for reassessment made by a person with intellectual and developmental disabilities or his or her legal guardian.

(d) (I) Once the state department has selected a needs assessment tool, the state department shall report to the public health care and human services committee of the house of representatives, or its successor committee; the health and human services committee of the senate, or its successor committee; and the joint budget committee concerning the needs assessment tool selected and the level of stakeholder involvement in the process of selecting the tool.

(II) This paragraph (d) is repealed, effective July 1, 2019.

Source: L. 2006: Entire article added with relocations, p. 1911, § 7, effective July 1. **L. 2007:** (4) added, p. 1393, § 2, effective May 30. **L. 2008:** (3)(b) amended, p. 437, § 1, effective August 5. **L. 2016:** (5) added, (SB 16-192), ch. 256, p. 1051, § 1, effective June 8.

Editor's note: (1) This section is similar to former § 26-4-507 as it existed prior to 2006.

(2) Subsection (4)(c) provided for the repeal of subsection (4), effective July 1, 2008. (See L. 2007, p. 1393.)

Cross references: For the legislative declaration contained in the 2007 act enacting subsection (4), see section 1 of chapter 328, Session Laws of Colorado 2007.

25.5-6-105. Legislative declaration relating to implementation of single entry point system. (1) The general assembly hereby finds, determines, and declares that:

(a) A study of a single entry point system in accordance with former section 26-4.5-404, C.R.S., has been completed;

(b) The establishment of a single entry point system for the coordination of access to existing services and service delivery for all long-term care clients at the local level can be implemented in a cost-efficient manner;

(c) The implementation of a well-managed single entry point system will result in the utilization of more appropriate services by long-term care clients over time and will provide better information on the unmet service needs of clients; and

(d) The implementation of a statewide single entry point system is a comprehensive undertaking and would be more conducive to a phased-in approach.

(2) The general assembly further finds, determines, and declares that it is appropriate to develop and implement, through four phases, a single entry point system for the state and, therefore, enacts sections 26-4-522 to 26-4-525, which were relocated to sections 25.5-6-106 and 25.5-6-107, respectively, in the 2006 recodification of this title, to provide for such development and implementation.

Source: L. 2006: Entire article added with relocations, p. 1914, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-521 as it existed prior to 2006.

25.5-6-106. Single entry point system - authorization - phases for implementation - services provided. (1) **Authorization.** The state board is hereby authorized to adopt rules providing for the establishment of a single entry point system that consists of single entry point agencies throughout the state for the purpose of enabling persons eighteen years of age or older in need of long-term care to access appropriate long-term care services.

(2) **Single entry point agencies - service programs - functions.** (a) A single entry point agency must be an agency in a local community through which any person eighteen years of age or older who is in need of long-term care can access needed long-term care services. A single entry point agency may be a private, nonprofit organization; a county agency, including a county department of human or social services; a county nursing service; an area agency on aging; or a multicounty agency. Persons in need of specialized assistance such as services for persons with intellectual and developmental disabilities or behavioral or mental health disorders may be referred by a single entry point agency to programs under the department of human services.

(b) The agency may serve private paying clients on a fee-for-service basis and shall serve clients of publicly funded long-term care programs, including, but not limited to, the following:

(I) Nursing facility care;

(II) Home- and community-based services for the elderly, blind, and disabled;

(III) Home- and community-based services for persons living with acquired immune deficiency syndrome;

(IV) Long-term home health care, including services provided by a PACE organization providing a program of all-inclusive care for the elderly pursuant to section 25.5-5-412;

(V) Home care allowance;

(VI) Alternative care facilities;

(VII) Adult foster care;

(VIII) Certain in-home services available pursuant to the federal "Older Americans Act of 1965", as amended; and

(IX) Home- and community-based services for persons with brain injury.

(c) The major functions of a single entry point shall include, but need not be limited to, the following:

(I) Providing information;

(II) Screening and referral services;

(III) Assessing clients' needs in accordance with section 25.5-6-104;

(IV) Developing plans of care for clients;

(V) Determining payment sources available to clients for long-term care services;

(VI) Authorizing the provision of certain long-term care services, as designated by the state department;

(VII) Determining eligibility for certain long-term care programs, as designated by the state department;

(VIII) Delivering case management services as an administrative function;

(IX) Targeting outreach efforts to those most at risk of institutionalization;

(IX.5) Informing eligible persons about the benefits of participating in the program of all-inclusive care for the elderly provided by a PACE organization pursuant to section 25.5-5-412 as an alternative to enrollment in a managed care organization, an organization contracted with the state department pursuant to part 4 of article 5 of this title, or other risk-bearing entity.

(X) Identifying resource gaps and coordinating resource development;

(XI) Recovering overpayment of benefits in accordance with rules adopted by the state board;

(XII) Maintaining fiscal accountability; and

(XIII) Rendering state certified services, as provided by state board rules, as a qualified and state certified agency.

(3) **State certification of a single entry point agency - quality assurance standards.** (a) Upon selection of a single entry point agency, the state department shall contract with an agency for five years but shall recertify the agency annually based on an evaluation procedure provided for in paragraph (b) of this subsection (3).

(b) The state board shall adopt rules for the establishment of a quality assurance program for the purpose of monitoring the quality of services provided to clients and for recertifying single entry point agencies. The rules shall provide for: Procedures to evaluate the quality of services provided by the agency; an assessment of the agency's compliance with program requirements, including compliance with case management standards, which standards shall be adopted by the state department; an assessment of an agency's performance of administrative functions, including reasonable costs per client, timely responses, managing programs in one consolidated unit, on-site visits to clients, community coordination and outreach, and client monitoring; a determination as to whether targeted populations are being identified and served; and an evaluation concerning financial accountability.

(c) The state department shall monitor each single entry point agency in the state for compliance with quality assurance standards adopted by the state and may provide for the implementation of sanctions at any time for noncompliance. In addition, each county department may enter into cooperative agreements or contracts with the single entry point agencies to assure quality performance by the single entry point agency serving such county.

(d) Ongoing reimbursement to single entry points shall be contingent upon compliance with quality assurance standards.

(e) State board rules adopted pursuant to this section must include the requirement that, on and after January 1, 2019, prior to employment, a single entry point agency shall submit the name of a person who will be providing direct care, as defined in section 26-3.1-101 (3.5), to an at-risk adult, as defined in section 26-3.1-101 (1.5), as well as any other required identifying information, to the department of human services for a check of the Colorado adult protective services data system pursuant to section 26-3.1-111, to determine if the person is substantiated in a case of mistreatment of an at-risk adult.

Source: L. 2006: Entire article added with relocations, p. 1915, § 7, effective July 1. **L. 2012:** (2)(b)(IV) amended and (2)(c)(IX.5) added, (SB 12-023), ch. 94, p. 309, § 2, effective April 12. **L. 2017:** (2)(a) amended, (SB 17-242), ch. 263, p. 1329, § 206, effective May 25; (3)(e) added, (HB 17-1284), ch. 272, p. 1505, § 11, effective May 31.

Editor's note: This section is similar to former § 26-4-522 as it existed prior to 2006.

Cross references: (1) For the "Older Americans Act of 1965", see Pub.L. 89-73, codified at 42 U.S.C. sec. 3001 et seq.

(2) For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-6-107. Financing of single entry point system. (1) The single entry point system shall be financed with the following moneys:

(a) Federal financial participation moneys available for case management for home- and community-based services pursuant to this article, and for administration of medical assistance programs, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) The state's share or contribution for specific long-term care programs in accordance with or pursuant to sections 26-1-122 and 26-2-114, C.R.S.;

(c) County contributions, as follows:

(I) The total for the fiscal year beginning July 1, 1990, and for each fiscal year thereafter, which totals shall serve as the base for determining the contribution required in subparagraph (II) of this paragraph (c), of the following: The counties' five percent contribution for home care allowance and adult foster care services as required by section 26-1-122, C.R.S.

(II) The amount contributed from each county in accordance with subparagraph (I) of this paragraph (c) after making an adjustment based on the percentage of an increase or decrease per fiscal year in the service costs for clients of such county. However, in no case shall a county be required under this subparagraph (II) to contribute more than a five percent increase in said service costs.

(2) County contributions for client services made in accordance with subparagraph (I) of paragraph (c) of subsection (1) of this section shall be expended only for clients of the county providing said contribution.

Source: L. 2006: Entire article added with relocations, p. 1917, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-525 as it existed prior to 2006.

25.5-6-108. Legislative declaration - advisory committee - long-term care - report - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1917, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 26-4-425 as it existed prior to 2006.

(2) Subsection (9) provided for the repeal of this section, effective July 1, 2007. (See L. 2006, p. 1917.)

25.5-6-108.5. Community long-term care studies - authority to implement - alternative care facility report. (1) (a) Subject to the receipt of sufficient moneys pursuant to paragraph (c) of this subsection (1), the state department shall contract for one or more studies of

the population of recipients receiving services under the home- and community-based waivers authorized pursuant to this article. The state department shall make necessary data available to the contractor, including but not limited to data on activities of daily living. In selecting a contractor to perform any study conducted pursuant to this subsection (1), the state department is not required to follow the competitive bidding requirements of the "Procurement Code", articles 101 to 112 of title 24, C.R.S. The state department shall provide copies of all studies conducted pursuant to this subsection (1) to members of the health and human services committees of the general assembly, or any successor committees, and to the members of the joint budget committee.

(b) If a study conducted pursuant to this subsection (1) concludes that a program of home- and community-based services would result in cost savings, the state department shall seek any necessary federal authorization to implement the program. If federal authorization to implement the program is obtained, the state department shall request, through the state budget process, that the program be implemented. The state department shall report to the joint budget committee annually concerning the amount of any savings realized from the program.

(c) The state department is authorized to seek and accept gifts, grants, or donations from private and public sources for the purposes of this subsection (1); except that the state department may not accept a gift, grant, or donation that is subject to conditions that are inconsistent with this subsection (1) or any other law of the state. The state department shall transmit all private and public moneys received through gifts, grants, or donations to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund created in section 25.5-1-109.

(2) (a) Subject to the receipt of sufficient moneys, one of the studies contracted for pursuant to subsection (1) of this section shall include research and analysis of:

(I) The number of recipients with incontinence, Alzheimer's disease, dementia, or other diagnoses of a chronic incapacitating condition that severely limit their activities of daily living who would benefit from receiving additional services through an alternative care facility thereby avoiding nursing home placement;

(II) The actuarially sound rate for providing services for the recipients at an alternative care facility;

(III) The amount of savings associated with providing services at an alternative care facility;

(IV) Recommendations for utilization controls or program controls for a program to provide services at an alternative care facility;

(V) The experiences of the program of all-inclusive care for the elderly, created pursuant to section 25.5-5-412, with tiered rates for alternative care facilities, including cost savings or cost avoidance;

(VI) Other states' experiences with tiered rates for alternative care facilities, including cost savings or cost avoidance; and

(VII) Recommendations for maintaining or improving quality of care.

(b) The study conducted pursuant to this subsection (2) shall be completed by January 1, 2012, and, if federal approval is obtained prior to final figure-setting for the fiscal year commencing July 1, 2012, the state department shall submit a request through the budget process for implementation of the approved changes for that fiscal year.

Source: L. 2010: Entire section added, (HB 10-1053), ch. 276, p. 1264, § 2, effective May 26. **L. 2011:** (2)(b) amended, (HB 11-1242), ch. 271, p. 1231, § 2, effective July 1.

Cross references: For the legislative declaration in the 2010 act adding this section, see section 1 of chapter 276, Session Laws of Colorado 2010.

25.5-6-109. Community long-term care - coordinated care pilot program - federal authorization - rules - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1921, § 7, effective July 1. **L. 2007:** (1) and (7) amended, p. 2016, § 1, effective June 1. **L. 2010:** (2)(b) amended, (HB 10-1422), ch. 419, p. 2114, § 149, effective August 11.

Editor's note: (1) This section was similar to former § 26-4-426 as it existed prior to 2006.

(2) Subsection (7) provided for the repeal of this section, effective July 1, 2012. (See L. 2007, p. 2016.)

25.5-6-110. Private-public partnership education and information program concerning long-term care insurance authorized. (1) The general assembly hereby declares that:

(a) A large number of Coloradans are in need of long-term health care;

(b) The cost of long-term care, especially nursing home care, is significant;

(c) Many persons in need of long-term care are ineligible for state medical assistance due to countable resources. When faced with the need for long-term care, such persons expend such resources to pay for nursing home care.

(d) A person's resources may cover only a relatively short period of care, often resulting in rendering such person impoverished, and after which time the person must rely on state medical assistance;

(e) Expenditures for long-term care represent a significant portion of the state's medical assistance budget;

(f) Unless Colorado implements new methods for financing long-term care, which methods include participation by the private sector, the cost to the state for long-term care will increase astronomically; and

(g) It is therefore appropriate to enact legislation that allows the state department, upon a determination by the executive director of the state department that it is feasible, to design and implement a private-public partnership for financing long-term care in this state.

(2) The state department shall cooperate with the division of insurance in the department of regulatory agencies in a private-public partnership for financing long-term care in this state through the availability of long-term care insurance policies that result in a reduction of total dependency on the medical assistance program to finance such care. It is the general assembly's intent that such partnership shall be designed to encourage individuals to purchase long-term care insurance, which, with respect to middle to higher income individuals, will have the result of eliminating or delaying the individual's need for medical assistance.

(3) Under the partnership described in subsection (2) of this section, the division of insurance shall implement statutory changes to article 19 of title 10, C.R.S., concerning long-term care policies that the general assembly hereby declares are necessary to accomplish the purpose of the partnership described in this section. In addition, the state department is encouraged to implement a public education-awareness program based on recommendations from an advisory committee that the executive director of the state department is hereby authorized to establish.

(4) The state department is authorized to seek and accept funds, grants, or donations from any private entity for implementing the public education-awareness program. In addition, if necessary, the state department may assess a fee in connection with conducting any public education-awareness training program or seminar. Any such fee collected shall be transmitted to the state treasurer, who shall credit the same to the long-term care insurance fund, which fund is hereby created. The moneys in the fund shall be subject to annual appropriation by the general assembly for the sole purpose of public education-awareness training programs and seminars.

(5) In addition to administering the public education-awareness program under the partnership, the state department shall seek a federal waiver from the requirement of section 13612 of the federal "Omnibus Budget Reconciliation Act of 1993" (OBRA), Public Law 103-66, that prevents the state department from granting medical assistance applicants a full or partial resource exemption in determining eligibility for medical assistance and an exemption from estate recovery requirements.

(6) The state department, if funds are available, shall contract with a public or private entity to conduct an evaluation of the public education-awareness program on or before December 1, 2000.

(7) With respect to a policyholder who has allowed his or her private long-term care insurance policy to lapse, if the person is found to be eligible for the medical assistance program, the state department is authorized to pay the premium for a reinstated policy pursuant to section 10-19-107 (2), C.R.S., if the state department finds that to do so is feasible and cost-efficient.

Source: L. 2006: Entire article added with relocations, p. 1922, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-506.7 as it existed prior to 2006.

25.5-6-111. Pilot program for coordinated care for people with a disability - fund - repeal. (Repealed)

Source: L. 2006: Entire section added, p. 1115, § 1, effective May 25. **L. 2013:** (1), (2), (3), (5), (6), and (7) repealed and (4) amended, (SB 13-276), ch. 256, p. 1350, §§ 1, 2, effective May 23.

Editor's note: (1) This section was enacted as 26-4-537 in Senate Bill 06-128 but was relocated due to its harmonization with this article as it appeared in Senate Bill 06-219.

(2) Subsection (4)(b) provided for the repeal of subsection (4), effective July 1, 2014. (See L. 2013, p. 1350.)

25.5-6-112. Plan of financial operation - purpose - approval - financial audits - rules - repeal. (Repealed)

Source: L. 2007: Entire section added, p. 1352, § 2, effective May 29. **L. 2013:** Entire section repealed, (SB 13-276), ch. 256, p. 1353, § 10, effective May 23.

25.5-6-113. Health home - integrated services - legislative declaration - contracting - definitions. (1) (a) The general assembly hereby finds and declares that:

(I) The state demographer office in the department of local affairs estimates that between 2005 and 2015, the portion of Colorado's population that is over sixty-five years of age will increase by more than twenty-three percent;

(II) This drastic increase in the population that is over sixty-five years of age is driven by the aging "baby boomer" generation and will result in a parallel increase in a demand for community long-term care services;

(III) Older adults, persons with disabilities, and their families need quality health care coverage and choice and flexibility in accessing community long-term care services that support their independence and ability to live in the least restrictive environment;

(IV) Research has shown that older adults suffer from higher rates of depression, have a higher risk of suicide, and have an increased misuse of prescription and illicit drugs, making the need for behavioral health care services essential to long-term care services;

(V) Coloradans deserve to have access to the proper level of health care;

(VI) The state needs a long-term care delivery system that addresses the needs of older adults, persons with disabilities, and their families, and health care coverage and coordination should not be fragmented or difficult to access; instead, it should be integrated to meet the needs of older adults, persons with disabilities, and their families;

(VII) A community long-term care system should be integrated, person-centered, and provide maximum service delivery and make efficient use of available public funds; and

(VIII) The system must ensure a comprehensive approach to long-term care that addresses the different demographic and geographic challenges in the state and the various long-term care services and supports that clients need.

(b) Therefore, the general assembly declares that a comprehensive approach to long-term care requires that programs and policies integrating and coordinating care under the medicaid program be flexible and allow for full participation by providers of long-term care services to ensure quality of care for clients and efficient use of limited resources.

(2) As used in this section, unless the context otherwise requires:

(a) "Dually eligible person" means a person who is eligible for assistance or benefits under both medicaid and medicare.

(b) "Health home" means a provider or group of providers that operate in coordination with a team of health care professionals that shall include primary care providers selected by an eligible individual with chronic conditions to provide health home services, as the term is defined in section 2703 of the federal "Patient Protection and Affordable Care Act", 42 U.S.C. sec. 1396w-4.

(3) (a) In determining the structure of health homes for chronic conditions for purposes of the federal "Patient Protection and Affordable Care Act", 42 U.S.C. sec. 1396w-4, and state plan amendments to the medicaid program, the state department shall include, to the extent

permitted under federal law, provisions allowing providers of long-term care services and supports to participate as health homes or as part of a health home that provides:

(I) Comprehensive care management;

(II) Care coordination and health promotion;

(III) Comprehensive transitional care;

(IV) Patient and family support;

(V) Referral to community and social support services; and

(VI) The use of health information technology to link services, as is feasible and appropriate.

(b) The health home may consist of a multi-disciplinary team, including primary care management providers, behavioral health care providers, case managers, and providers of long-term care services and supports, including but not limited to single entry point agencies, nursing homes, alternative care facilities, day programs for the elderly, home care agencies, community mental health centers, hospice and palliative care centers, and community centered boards.

(4) To the extent provided under federal law, in integrating dually eligible persons, persons with chronic conditions, or persons needing long-term care services and supports in an organization with which the state department contracts pursuant to part 4 of article 5 of this title, the state department shall permit providers of long-term services and supports to contract as health homes or to provide some or all of the services provided by the organization contracted with the state department, which services may include, but need not be limited to, navigation of primary, specialty, or long-term care supports.

(5) Dually eligible clients may voluntarily elect to participate in a recognized medicare coordinated care system and may voluntarily elect to participate in the state department's medicaid coordinated care system.

Source: L. 2012: Entire section added, (SB 12-127), ch. 132, p. 453, § 1, effective April 23.

25.5-6-114. Alternative care facilities - reimbursement programs - legislative declaration - report - repeal. (Repealed)

Source: L. 2012: Entire section added, (SB 12-128), ch. 275, p. 1452, § 1, effective August 8.

Editor's note: Subsection (5) provided for the repeal of this section, effective July 1, 2015. (See L. 2012, p. 1452.)

PART 2

NURSING FACILITIES

25.5-6-201. Special definitions relating to nursing facility reimbursement. As used in this part 2, unless the context otherwise requires:

(1) "Acquisition cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

(2) "Actual cost" or "cost" means the audited cost of providing services.

(3) "Administration and general services costs" means costs in the following categories:

(a) Advertising, recruitment, and public relations, to the extent that such costs are necessary, reasonable, and patient-related;

(b) Travel and training of facility staff, unless the travel includes residents of the facility or the training is for the facility staff described in paragraph (a) of subsection (15) of this section; and

(c) All other costs that are not direct or indirect health care services, raw food costs, or capital-related assets.

(4) "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the "Boeckh Commercial Underwriter's Valuation System for Nursing Homes". The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by the state board.

(5) "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all medicaid-participating nursing facility providers in the state.

(6) (a) "Base value" means:

(I) For the fiscal year 1986-87 and every fourth year thereafter, the appraised value of a capital-related asset;

(II) For each year in which an appraisal is not done pursuant to subparagraph (I) of this paragraph (a), the most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index.

(b) For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

(c) An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

(7) "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

(8) "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

(9) "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to registered nurses, licensed practical nurses, and nurses' aides.

(10) "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.

(11) "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.

(12) "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's medicaid residents as further specified in this section.

(13) "Class I facility" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of a severe behavioral or mental health disorder.

(14) "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.

(15) "Direct or indirect health care services costs" means the costs incurred for patient support services, including the following:

(a) Salaries, payroll taxes, workers' compensation payments, training, and other employee benefits for registered nurses, licensed practical nurses, aides, medical records librarians, social workers, and activity personnel;

(b) Nonprescription drugs ordered by a physician;

(c) Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians, and therapies;

(d) Purchases, rentals, and costs incurred to operate, maintain, or repair health care equipment;

(e) Supplies for nurses, medical records personnel, social workers, activity personnel, and therapy personnel;

(f) Medical director fees;

(g) Therapies and other medically related services, including the following:

(I) Utilization review;

(II) Dental care, when required by federal law;

(III) Audiology;

(IV) Psychology;

(V) Physical therapy;

(VI) Recreational therapy;

(VII) Occupational therapy; and

(VIII) Speech therapy;

(h) Other patient support services determined and defined by the state board pursuant to rule;

(i) Raw food costs that do not include the costs of equipment, staff, or other costs associated with meal preparation;

(j) Malpractice insurance;

(k) Depreciation and interest for major health care equipment, such as equipment purchased for the sole purpose of providing care to facility residents; and

(l) Photocopying related to health care purposes such as medical records of patients.

(16) "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each resource utilization group as of a specific point in time.

(17) "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

(18) "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.

(19) "Index" means the RSMeans construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.

(20) "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.

(21) "Median per diem cost" means the average daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.

(22) "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the federal medicare and medicaid programs.

(23) "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.

(24) "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.

(25) "Nursing facility provider" means a facility provider that meets the state nursing home licensing standards established pursuant to section 25-1.5-103 (1)(a), C.R.S., and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

(26) "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurses' aides.

(27) "Nursing weights" means numeric scores assigned to each category of the resource utilization groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.

(28) "Occupancy-imputed days" means the use of a predetermined number for patient days rather than actual patients days in computing per diem cost.

(29) "Per diem cost" means the daily cost of care and services per patient for a nursing facility provider.

(30) "Per diem rate" means the daily dollar amount of reimbursement that the state department shall pay a nursing facility provider per patient.

(31) "Provider fee" means a licensing fee, assessment, or other mandatory payment that is related to health care items or services as specified under 42 CFR 433.55.

(32) "Raw food" means the products and substances, including but not limited to nutritional supplements, that are consumed by residents.

(33) "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

(34) "Resource utilization groups" means the system for grouping a nursing facility's residents according to their clinical and functional statuses as identified from data supplied by the facility's minimum data set as published by the United States department of health and human services.

(35) "Statewide average per diem rate" means the average daily dollar amount of the per patient payments to all medicaid-participating facility providers in the state.

(36) "Supplemental medicaid payment" means a lump sum payment that is made in addition to a provider's per diem rate. A supplemental medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

Source: L. 2006: Entire article added with relocations, p. 1924, § 7, effective July 1. **L. 2008:** Entire section R&RE, p. 1773, § 2, effective July 1. **L. 2009:** (36) added, (SB 09-263), ch. 203, p. 914, § 1, effective May 1. **L. 2017:** (13) amended, (SB 17-242), ch. 263, p. 1329, § 207, effective May 25.

Editor's note: This section is similar to former § 26-4-502 as it existed prior to 2006.

Cross references: For the legislative declaration contained in the 2008 act repealing and reenacting this section, see section 1 of chapter 383, Session Laws of Colorado 2008. For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-6-202. Providers - nursing facility provider reimbursement - rules. (1) (a) (I) Subject to available appropriations, for the purpose of reimbursing a medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the state department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. The payment shall not exceed one hundred twenty-five percent of the median cost of direct and indirect health care services and raw food as determined by an array of all facility providers; except that, for state veteran nursing homes, the payment shall not exceed one hundred thirty percent of the median cost.

(II) For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight-percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

(b) In computing per diem cost, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. In addition, in determining the median cost, the cost of direct health care shall be case-mix neutral.

The cost reports used by the state department to establish the per diem cost shall be those filed with the state department during the period ending December 31 of the prior year following implementation of this subsection (1) and for each succeeding year. The state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

(2) The state department shall further adjust and, subject to available appropriations, pay the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider residents in order to provide for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal medicare and medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's medicaid residents on a quarterly basis.

(3) (a) Subject to available appropriations, for the purpose of reimbursing a medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the state department shall establish an annually readjusted schedule to pay each nursing facility provider a reasonable price for the costs, which reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one licensed beds and more, the reasonable price shall be one hundred five percent of the median per diem cost for all class I facilities.

(b) In computing per diem cost, each nursing facility provider shall annually submit cost reports to the state department, and actual days of care shall be counted, not occupancy-imputed days of care. The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation of this subsection (3), and, for each succeeding fourth year, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

(c) Repealed.

(4) In addition to the reimbursement components paid pursuant to subsections (1) to (3) of this section, a per diem rate constituting a fair rental allowance for capital-related assets shall be paid to each nursing facility provider as a rental rate based upon the nursing facility's appraised value.

(5) Subject to available moneys and the priority of the uses of the provider fees as established in section 25.5-6-203 (2)(b), in addition to the reimbursement rate components paid pursuant to subsections (1) to (4) of this section, the state department shall make a supplemental medicaid payment based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents. This amount shall be determined by the state department based upon performance measures established in rules adopted by the state board in the domains of quality of life, quality of care, and facility management. The payment shall be computed annually as of July 1, 2009, and each July 1

thereafter, and shall not be less than twenty-five hundredths of one percent of the statewide average per diem rate for the combined rate components determined pursuant to subsections (1) to (4) of this section. During each state fiscal year, the state department may discontinue the supplemental medicaid payment established pursuant to this subsection (5) to any nursing facility provider that fails to comply with the established performance measures during the state fiscal year, and the state department may initiate the supplemental medicaid payment established pursuant to this subsection (5) to any provider who comes into compliance with the established performance measures during the state fiscal year.

(6) Subject to available moneys and the priority of the uses of the provider fees as established in section 25.5-6-203 (2)(b), in addition to the reimbursement rate components pursuant to subsections (1) to (5) of this section, the state department shall make a supplemental medicaid payment to nursing facility providers who have residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury as follows:

(a) A supplemental medicaid payment shall be made to nursing facility providers that serve residents who have severe mental health conditions that are classified at a level II by the medicaid program's preadmission screening and resident review assessment tool. The state department shall compute this payment annually as of July 1, 2009, and each July 1 thereafter, and it shall be not less than two percent of the statewide average per diem rate for the combined rate components determined pursuant to subsections (1) to (4) of this section.

(b) A supplemental medicaid payment shall be made to nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury. The state department shall calculate the payment based upon the resident's cognitive assessment established in rules adopted by the state board. The state department shall compute this payment annually as of July 1, 2009, and each July 1 thereafter, and it shall be not less than one percent of the statewide average per diem rate for the combined rate components determined under subsections (1) to (4) of this section.

(7) Subject to available moneys and the priority of the uses of the provider fees as established in section 25.5-6-203 (2)(b), in addition to the reimbursement rate components paid pursuant to subsections (1) to (6) of this section, the state department shall pay a nursing facility provider a supplemental medicaid payment for care and services rendered to medicaid residents to offset payment of the provider fee assessed under the provisions of section 25.5-6-203. The state department shall compute this payment annually, as of July 1, 2009, and each July 1 thereafter.

(8) (Deleted by amendment, L. 2009, (SB 09-263), ch. 203, p. 912, § 2, effective May 1, 2009.)

(9) (a) The per diem amount paid for direct and indirect health care services and administrative and general services costs shall include an allowance for inflation in the costs for each category using a nationally recognized service that includes the federal government's forecasts for the prospective medicare reimbursement rates recommended to the United States congress. Amounts contained in cost reports used to determine the per diem amount paid for each category shall be adjusted by the percentage change in this allowance measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

(b) (I) Except for changes in the number of patient days, the general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to subsections

(1) to (4) of this section shall be limited to an annual increase of three percent. The state's share of the reimbursement rate components pursuant to subsections (1) to (4) of this section may be funded through the provider fee assessed pursuant to the provisions of section 25.5-6-203 and any associated federal funds. Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation on the annual increase. For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, the general fund share of the aggregate statewide average per diem rate net of patient payment pursuant to subsections (1) to (4) of this section shall be calculated using the rates that were effective on July 1 of that fiscal year.

(II) If the aggregate statewide average per diem rate net of patient payment pursuant to subsections (1) to (4) of this section exceeds the general fund share, the amount of the average statewide per diem rate that exceeds the general fund share shall be paid as a supplemental medicaid payment using the provider fee established under section 25.5-6-203. Subject to the priority of the uses of the provider fee established under section 25.5-6-203 (2)(b), if the provider fee is insufficient to fully fund the supplemental medicaid payment, the supplemental medicaid payment shall be reduced to all providers proportionately.

(III) to (V) Repealed.

(VI) Notwithstanding any other provision of law, for the fiscal year commencing July 1, 2013, and each fiscal year thereafter, the general fund portion of the per diem rate pursuant to subsections (1) to (4) of this section shall be reduced by one and one-half percent. The state department may, but is not required to, increase the supplemental medicaid payment pursuant to subparagraph (II) of this paragraph (b) due to this reduction; except that the provider fee shall not exceed the amount specified in section 25.5-6-203 (1)(a)(II).

(b.3) (I) For the fiscal year commencing July 1, 2009, and for each fiscal year thereafter, if the provider fee established under section 25.5-6-203 is insufficient to fully fund the supplemental medicaid payments established under subsections (5) to (7) of this section, subject to the priority of the uses of the provider fee established pursuant to section 25.5-6-203 (2)(b), the state department may suspend or reduce the supplemental medicaid payment subject to the uses of the provider fee established under section 25.5-6-203.

(II) If it is determined by the state department that the case-mix reimbursement includes a factor for nursing facility providers who serve residents with severe cognitive dementia or acquired brain injury, the state department may eliminate the supplemental medicaid payment to those providers who serve residents with severe cognitive dementia or acquired brain injury.

(b.5) Notwithstanding any other provision of law or any federal law that temporarily increases the federal matching participation rate for any fiscal year, payments to nursing facility providers from the general fund share of the aggregate statewide average of the per diem rate shall be calculated based on a fifty-percent federal match.

(b.7) Repealed.

(c) (I) The general assembly finds that the historical growth in nursing facility provider rates has significantly exceeded the rate of inflation. These increases have been caused in part by the inclusion of medicare costs in medicaid cost reports. The state of Colorado has an interest in limiting these exceptional increases in medicaid nursing facility provider rates by removing medicare part B direct costs from the medicaid nursing facility provider rates and by imposing a ceiling on the medicare part A ancillary costs that are included in calculating medicaid nursing facility rates.

(II) For all rates effective on or after July 1, 1997, for each class I nursing facility provider, only such costs as are reasonable, necessary, and patient-related may be reported for reimbursement purposes. Nursing facility providers may include the level of medicare part A ancillary costs that was included and allowed in the facility's last medicaid cost report filed prior to July 1, 1997. Any subsequent increase in this amount shall be limited to either the increase in the facility's allowable medicare part A ancillary costs or the percentage increase in the cost of medical care reported in the United States department of labor bureau of labor statistics consumer price index for the same time period, whichever is lower. Part B direct costs for medicare shall be excluded from the allowable reimbursement for facilities.

(III) The specific methodology for calculating the limitations and cost-reporting requirements described in this paragraph (c) shall be established by rules promulgated by the state board.

(d) The reimbursement rate components pursuant to subsections (5) to (7) of this section shall be funded entirely through the provider fee assessed pursuant to the provisions of section 25.5-6-203 and any associated federal funds. No general fund moneys shall be used to pay for the reimbursement rate components established pursuant to subsections (5) to (7) of this section.

(10) The state board shall promulgate rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S.,to implement this section, including establishing uniform accounting, reporting, and payment procedures consistent with this section, to determine a nursing facility provider's costs and payments to the provider.

(11) (Deleted by amendment, L. 2009, (SB 09-263), ch. 203, p. 912, § 2, effective May 1, 2009.)

Source: L. 2006: Entire article added with relocations, p. 1925, § 7, effective July 1. **L. 2008:** Entire section R&RE, p. 1777, § 3, effective July 1. **L. 2009:** (1)(a), (3), (5), (6), (7), (8), (9)(b), and (11) amended and (9)(b.3), (9)(b.5), and (9)(b.7) added, (SB 09-263), ch. 203, p. 912, § 2, effective May 1. **L. 2010:** (9)(b)(III) added, (HB 10-1324), ch. 14, p. 69, § 1, effective March 1; (9)(b)(III) and (9)(b.7)(II) amended, (HB 10-1379), ch. 214, p. 930, §§ 1, 2, effective May 6. **L. 2011:** (9)(b)(IV) added, (SB 11-215), ch. 148, p. 514, § 1, effective May 5. **L. 2012:** (9)(b)(V) added, (HB 12-1340), ch. 154, p. 552, § 1, effective May 3. **L. 2013:** (9)(b)(III) and (9)(b)(IV) repealed, (9)(b)(V) amended, and (9)(b)(VI) added, (HB 13-1152), ch. 162, p. 520, § 1, effective May 3.

Editor's note: (1) This section is similar to former § 26-4-502.5 as it existed prior to 2006.

(2) Subsection (9)(b.7)(III) provided for the repeal of subsection (9)(b.7), effective July 1, 2011. (See L. 2009, p. 912.)

(3) Subsection (9)(b)(V)(B) provided for the repeal of subsection (9)(b)(V), effective July 1, 2014. (See L. 2012, p. 552.)

(4) Subsection (3)(c)(III) provided for the repeal of subsection (3)(c), effective July 1, 2015. (See L. 2009, p. 912.)

Cross references: For the legislative declaration contained in the 2008 act repealing and reenacting this section, see section 1 of chapter 383, Session Laws of Colorado 2008.

25.5-6-203. Nursing facilities - provider fees - federal waiver - fund created - rules. (1) (a) (I) Beginning with the fiscal year commencing July 1, 2008, and each fiscal year thereafter, the state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program as described in articles 4 to 6 of this title. As specified by the priority of the uses of the provider fee in paragraph (b) of subsection (2) of this section, the provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

(II) For the fiscal years commencing July 1, 2009, and July 1, 2010, the provider fee shall not exceed seven dollars and fifty cents per nonmedicare-resident day. For the fiscal year commencing July 1, 2011, and each fiscal year thereafter, the provider fee shall not exceed twelve dollars per nonmedicare-resident day plus inflation based on the national skilled nursing facility market basket index as determined by the secretary of the department of health and human services pursuant to 42 U.S.C. sec. 1395yy (e)(5) or any successor index.

(III) In calculating the amount of the provider fee portion of the supplemental medicaid payments established under section 25.5-6-202 (5), the state department may include an additional amount of up to five percent of the provider fee portion of said supplemental medicaid payments to initiate the payment to any provider who complies with the established performance measures during the state fiscal year.

(b) The provider fees shall be charged on a nonmedicare-resident day basis and shall be based upon the aggregate gross or net revenue, as prescribed by the state department, of all nursing facility providers subject to the provider fee. The state department may exempt revenue categories from the gross or net revenue calculation and the collection of the provider fee from nursing facility providers, as authorized by federal law.

(c) In accordance with the redistributive method set forth in 42 CFR 433.68 (e)(1) and (e)(2), the state department shall seek a waiver from the broad-based provider fees requirement or the uniform provider fees requirement, or both, to exclude nursing facility providers from the provider fee. The state department shall exempt the following nursing facility providers to obtain federal approval and minimize the financial impact on nursing facility providers:

(I) A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services, and skilled nursing care on a single, contiguous campus. Assisted living services include an assisted living residence as defined in section 25-27-102, C.R.S., or that provides assisted living services on-site, twenty-four hours per day, seven days per week.

(II) A skilled nursing facility owned and operated by the state;

(III) A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and

(IV) A facility that has forty-five or fewer licensed beds.

(d) The state department may lower the amount of the provider fee charged to certain nursing facility providers to meet the requirements of 42 CFR 433.68 (e) and to obtain federal approval.

(e) The imposition and collection of a provider fee shall be prohibited without the federal government's approval of a state medicaid plan amendment authorizing federal financial participation for the provider fees. The state department may alter the method prescribed in this section to the extent necessary to meet the federal requirements and to obtain federal approval.

(f) If the provider fee required by this subsection (1) is not approved by the federal government, notwithstanding any other provision of this section, the state department shall not implement the assessment or collection of the provider fee from nursing facility providers.

(g) The state department shall establish a schedule to assess and collect the provider fee on a monthly basis. The state board shall establish rules so that provider fee payments from a nursing facility provider and the state department's supplemental medicaid payments to the nursing facility are due as nearly simultaneously as feasible; except that the state department's supplemental medicaid payments to the nursing facility shall be due no more than fifteen days after the provider fee payment is received from the nursing facility. The state department shall require each nursing facility provider to report annually its total number of days of care provided to nonmedicare residents.

(h) The state department shall not assess or collect the provider fee until state medicaid plan amendments adopting the medicaid reimbursement system for the state's class I nursing facility providers, pursuant to section 25.5-6-202, including the waiver with respect to the provider fees pursuant to this section, have been approved by the federal government.

(i) The state board shall promulgate any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S., necessary for the administration and implementation of this section.

(j) A nursing facility provider shall not include any amount of the provider fee as a separate line item in its billing statements.

(2) (a) All provider fees collected pursuant to this section by the state department shall be transmitted to the state treasurer, who shall credit the same to the medicaid nursing facility cash fund, which fund is hereby created and referred to in this section as the "fund".

(b) (I) All moneys in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the administrative costs of implementing section 25.5-6-202 and this section, to satisfy settlements or judgments resulting from nursing facility provider reimbursement appeals, and to pay the supplemental medicaid payments to offset payment of the provider fee established under section 25.5-6-202 (7).

(II) Following the payment of the amounts described in subparagraph (I) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the supplemental medicaid payments for acuity or case-mix of residents established under section 25.5-6-202 (2).

(III) (A) Except as provided in sub-subparagraph (B) of this subparagraph (III), after the payment of the amounts described in subparagraphs (I) and (II) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the supplemental medicaid payments for higher quality performance established under section 25.5-6-202 (5).

(B) Notwithstanding any other provision of this paragraph (b), the supplemental medicaid payments established pursuant to section 25.5-6-202 (5) shall not be less than ten percent of the supplemental medicaid payments established under section 25.5-6-202 (7) in the prior state fiscal year.

(IV) Following the payment of the amounts described in subparagraphs (I) to (III) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the supplemental medicaid payments for residents who have moderately to very severe mental health conditions, cognitive dementia, or acquired brain injury established under section 25.5-6-202 (6).

(V) Following the payment of the amounts described in subparagraphs (I) to (IV) of this paragraph (b), the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the supplemental medicaid payments for the amount by which the average statewide per diem rate exceeds the general fund share established under section 25.5-6-202 (9)(b)(II).

(VI) Any moneys in the fund not expended for the purposes specified in this section may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or any other fund but may be appropriated by the general assembly to pay nursing facility providers in future fiscal years.

Source: L. 2006: Entire article added with relocations, p. 1926, § 7, effective July 1. **L. 2008:** Entire section R&RE, p. 1781, § 4, effective July 1. **L. 2009:** (1)(a), (1)(g), and (2)(b) amended and (1)(j) added, (SB 09-263), ch. 203, p. 918, § 3, effective May 1; (1)(c)(I) amended, (SB 09-292), ch. 369, p. 1975, § 98, effective August 5. **L. 2010:** (2)(b)(II.7) added, (HB 10-1324), ch. 14, p. 69, § 2, effective March 1. **L. 2011:** (1)(a)(II) and (2) amended, (SB 11-125), ch. 208, p. 900, § 1, effective August 10. **L. 2013:** (1)(c)(I) and (1)(g) amended, (HB 13-1199), ch. 63, p. 209, § 2, effective March 22. **L. 2014:** (2)(b)(I) amended, (SB 14-143), ch. 191, p. 712, § 1, effective May 15.

Editor's note: This section is similar to former § 26-4-503 as it existed prior to 2006.

Cross references: For the legislative declaration contained in the 2008 act amending this section, see section 1 of chapter 383, Session Laws of Colorado 2008. For the legislative declaration in the 2013 act amending subsections (1)(c)(I) and (1)(g), see section 1 of chapter 63, Session Laws of Colorado 2013.

25.5-6-204. Providers - reimbursement - intermediate care facility for individuals with intellectual disabilities - reimbursement - maximum allowable. (1) (a) For the purpose of making payments to intermediate care facilities for individuals with intellectual disabilities, the state department shall establish a price schedule to be readjusted every twelve months, that shall reimburse, subject to available appropriations, each provider, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health care services costs as defined in section 25.5-6-201 (9), and a fair rental allowance for capital-related assets as defined in section 25.5-6-201 (7). The state board shall adopt rules, including uniform accounting or reporting procedures, in order to determine the actual or reasonable cost of services and case-mix adjusted direct health care services costs and the

reimbursement therefor. The provisions of this paragraph (a) shall not apply to state-operated intermediate care facilities for individuals with intellectual disabilities.

(b) State-operated intermediate care facilities for individuals with intellectual disabilities shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services, and such costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period. Reimbursement to state-operated intermediate care facilities for individuals with intellectual disabilities shall be adjusted retrospectively at the close of each twelve-month period. The state board shall adopt rules to be effective by June 30, 1988, implementing the provisions of this paragraph (b). In the implementation of such rules, the state department shall ensure, by the establishment of classes of facilities, that the reimbursement to private, nonprofit, or proprietary state-operated intermediate care facilities for individuals with intellectual disabilities, as defined in section 25.5-10-202, is not adversely impacted.

(c) (I) Beginning in fiscal year 2013-14, and for each fiscal year thereafter, the state department is authorized to charge both privately owned intermediate care facilities for individuals with intellectual disabilities and state-operated intermediate care facilities for individuals with intellectual disabilities a service fee for the purposes of maintaining the quality and continuity of services provided by intermediate care facilities for individuals with intellectual disabilities. The service fee charged by the state department pursuant to this paragraph (c) will be assessed pursuant to rules adopted by the state board but must not exceed five percent of the total costs incurred by all intermediate care facilities for the fiscal year in which the service fee is charged. The state board shall adopt rules consistent with federal law in order to implement the provisions of this paragraph (c).

(II) The moneys collected in each fiscal year pursuant to subparagraph (I) of this paragraph (c) shall be transmitted by the state department to the state treasurer, who shall credit the same to the service fee fund, which fund is hereby created and referred to in this paragraph (c) as the "fund". The moneys in the fund shall be subject to annual appropriation by the general assembly to the state department to be used toward the state match for the federal financial participation to reimburse intermediate care facilities for individuals with intellectual disabilities pursuant to this section. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and not be credited or transferred to the general fund or any other fund.

(2) (a) In addition to the actual or reasonable costs and the reimbursement therefor, the state department shall, subject to available appropriations, include an allowance equal to the change in the national bureau of labor statistics consumer price index from the preceding year to compensate for fluctuating costs. This amount shall be determined every twelve months when the statewide average cost is determined by adjusting for inflation. The provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period. This allowance is applied to all costs, including case-mix adjusted direct health care services costs as defined in section 25.5-6-201 (9), less interest, up to the reasonable cost established and will be allowed to proprietary, nonprofit, and tax-supported homes; except that the allowance shall not be applied to the costs of state-operated intermediate facilities for individuals with intellectual disabilities.

(b) (I) The state board shall adopt rules to:

(A) Determine and pay to privately owned intermediate care facilities for individuals with intellectual disabilities a reasonable share of the amount by which the reasonable costs of the categories of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only. The reasonable share shall be defined as twenty-five percent of the amount in the categories for each facility, not to exceed twelve percent of the reasonable cost.

(B) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(II) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(c) to (e) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(3) to (5) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(6) and (7) Repealed.

Source: L. 2006: (5)(b) amended and (6) added, p. 1615, §§ 4, 3, effective June 2; entire article added with relocations, p. 1927, § 7, effective July 1. **L. 2007:** (7) added, p. 1802, § 2, effective July 1. **L. 2008:** (1)(a) and (2) to (5) amended, p. 1783, § 5, effective July 1. **L. 2013:** Entire section amended, (SB 13-167), ch. 394, p. 2290, § 3, effective June 5; (1)(b), (1)(c)(I), and (1)(c)(II) amended, (HB 13-1314), ch. 323, p. 1809, § 46, effective March 1, 2014.

Editor's note: (1) This section is similar to former § 26-4-410 as it existed prior to 2006.

(2) (a) Amendments to section 26-4-410 (5)(b) by Senate Bill 06-131 were harmonized with subsection (5)(b) as it appeared in Senate Bill 06-219.

(b) Subsection (6) was enacted as § 26-4-410 (6) in Senate Bill 06-131 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

(3) Subsection (6)(c) provided for the repeal of subsection (6), effective July 1, 2007. (See L. 2006, p. 1615.)

(4) Subsection (7)(c) provided for the repeal of subsection (7), effective July 1, 2008. (See L. 2007, p. 1802.)

(5) Amendments to this subsections (1)(b), (1)(c)(I), and (1)(c)(II) by House Bill 13-1314 and Senate Bill 13-167 were harmonized.

Cross references: For the legislative declaration contained in the 2006 act amending subsection (5)(b) and enacting subsection (6), see section 1 of chapter 324, Session Laws of Colorado 2006. For the legislative declaration contained in the 2008 act amending subsections (1)(a) and (2) to (5), see section 1 of chapter 383, Session Laws of Colorado 2008.

25.5-6-205. Collection of penalties assessed against nursing facilities - creation of cash fund. (1) (a) The state department shall assess, enforce, and collect any civil penalties that are recommended by the department of public health and environment pursuant to the authority granted under section 25-1-107.5, C.R.S.

(b) Prior to the denial of medicaid payments or the assessment of a civil money penalty against a nursing facility, the nursing facility shall be offered by the state department an opportunity for a hearing in accordance with the provisions of section 24-4-105, C.R.S. Enforcement and collection of the denial of medicaid payments or civil money penalty shall occur following the decision reached at such hearing.

(2) In conjunction with the authority granted under subsection (1) of this section, the state board shall promulgate rules that:

(a) Provide any nursing facility assessed a civil penalty the opportunity to appeal such assessment;

(b) Govern the procedures for such appeals, including the right of a nursing facility to thirty days' notice prior to the collection of any civil money penalty; and

(c) Are otherwise necessary to implement this section.

(3) (a) Any civil penalties collected by the state department pursuant to this section shall be transmitted to the state treasurer, who shall credit the same to the nursing home penalty cash fund, which fund is hereby created.

(b) (I) The moneys in the fund are subject to annual appropriation by the general assembly to the state department for the purposes set forth in section 25-1-107.5, C.R.S.

(II) Such moneys shall be used in the manner prescribed in section 25-1-107.5, C.R.S., and the rules promulgated thereunder.

(c) All interest derived from the deposit and investment of moneys in the fund shall be credited to the fund.

(d) At the end of any fiscal year, all unexpended and unencumbered moneys remaining in the fund shall remain therein and shall not be credited or transferred to the general fund or any other fund.

Source: L. 2006: Entire article added with relocations, p. 1933, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-505 as it existed prior to 2006.

25.5-6-206. Personal needs benefits - amount - patient personal needs trust fund required - funeral and burial expenses - penalty for illegal retention and use. (1) The state department, pursuant to its rules, has the authority to include in medical care benefits provided under this article and articles 4 and 5 of this title reasonable amounts for the personal needs of any recipient receiving nursing facility services or intermediate care facilities for individuals with intellectual disabilities, if the recipient is not otherwise eligible for such amounts from other categories of public assistance, but such amounts for personal needs shall not be less than the minimum amount provided for in subsection (2) of this section. Payments for funeral and burial expenses upon the death of a recipient may be provided under rules of the state department in the same manner as provided to recipients of public assistance as defined by section 26-2-103 (8), C.R.S.

(2) (a) The basic minimum amount payable pursuant to subsection (1) of this section for personal needs to any recipient admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities is seventy-five dollars monthly; except that, commencing January 1, 2015, and each January 1 thereafter, the basic minimum amount shall increase annually by the same percentage applied to the general fund share of the aggregate statewide average of the per diem net of patient payment pursuant to section 25.5-6-202 (9)(b)(I). Commencing with the fiscal year beginning July 1, 2014, and each fiscal year thereafter, the reduction to patient payments received by nursing facilities resulting from an increase in the basic minimum amount shall be funded in full by general fund and applicable federal funds.

(b) On and after October 1, 1992, the basic minimum amount payable pursuant to subsection (1) of this section for personal needs shall be ninety dollars for the following persons:

(I) A medical assistance recipient who receives a non-service connected disability pension from the United States veterans administration, has no spouse or dependent child, and is admitted to or is residing in a nursing facility; and

(II) A medical assistance recipient who is a surviving spouse of a person who received a non-service connected disability pension from the United States veterans administration, has no dependent child, and is admitted to or is residing in a nursing facility.

(3) (a) All personal needs funds shall be held in trust by the nursing facility or intermediate care facility for individuals with intellectual disabilities, or its designated trustee, separate and apart from any other funds of the facility. The facility shall deposit any personal needs funds of a resident in an amount of fifty or more dollars in an interest-bearing checking account or accounts or savings account or any combination thereof established to protect and separate the personal needs funds of the patients. Any interest earned on a resident's personal needs funds shall be credited to such account or accounts. In the event residents' personal needs funds are maintained in a pooled account, separate accountings shall be made for each resident's share of the pooled account. Any personal needs funds of a resident in an amount less than fifty dollars shall be maintained in a non-interest-bearing account, an interest-bearing account, or a petty cash fund.

(b) At all times, the principal and all income derived from said principal in the patient personal needs trust fund shall remain the property of the participating patients, and the facility or its designated trustee is bound by all of the duties imposed by law upon fiduciaries in the handling of such fund. Those duties include but are not limited to providing notice to a resident when the resident's personal needs account accumulates two hundred dollars less than the federal supplemental security income resource limit for one person.

(c) The facility or its designated trustee shall post a surety bond in an amount to assure the security of all personal needs funds deposited in the patient personal needs trust fund or shall otherwise demonstrate to the satisfaction of the state department that the security of residents' personal needs funds is assured.

(d) Within sixty days after a resident's death, the facility shall transfer the resident's personal needs funds and a final accounting of the funds to the person responsible for settling the resident's estate or, if there is none, to the resident's heirs in accordance with the provisions of title 15, C.R.S. Within fifteen days after receiving the funds, the executor, administrator, or other appropriate representative of the resident's estate shall provide written notice to the state department regarding the receipt of the funds. Upon receipt of the notice, the state department may bring an action to recover the funds pursuant to the provisions of this article and articles 4 and 5 of this title.

(4) The state department shall establish rules concerning the establishment of a patient personal needs trust fund and procedures for the maintenance of a system of accounting for expenditures of each patient's personal needs funds. The facility shall use an accounting system that assures a complete and separate accounting of residents' personal needs funds based on generally accepted accounting principles and that precludes the commingling of a resident's personal needs funds with the facility's funds or the funds of any other person other than the personal needs funds of another resident. These rules shall provide that the nursing facility or intermediate care facility for individuals with intellectual disabilities shall maintain complete

records of all receipts and expenditures involving the patient personal needs trust fund, that all expenditures shall be approved by the patient, legal custodian, guardian, or conservator prior to an expenditure, and that each patient or such patient's legal custodian, guardian, or conservator shall be given at least a quarterly accounting of the receipts and expenditures of such funds. In addition, the rules shall require that the person who maintains the patient personal needs trust fund for the facility and who is responsible for the deposit of moneys into such trust fund shall deposit any personal needs funds received from a patient or from the state department no later than sixty days after the receipt of such moneys.

(5) All patient personal needs trust funds shall be subject to audit by the state department. A record of a patient's personal needs trust fund shall be kept by the facility for a period of three years from the date of the patient's discharge from the facility or until such records have been audited by the state department, whichever occurs later.

(6) Any overpayment of personal needs funds to a nursing facility or an intermediate care facility for individuals with intellectual disabilities by the state department due to the omission, error, fraud, or defalcation of the nursing facility or intermediate care facility for individuals with intellectual disabilities or any shortage in an audited patient personal needs trust fund shall be recoverable by the state on behalf of the recipient in the same manner and following the same procedures as specified in section 25.5-4-301 (2) for an overpayment to a provider.

(7) Nothing in this section shall prevent a nursing facility or intermediate care facility for individuals with intellectual disabilities patient from excluding himself or herself from participation in the patient personal needs trust fund.

(8) (a) It is unlawful for any person to knowingly fail to deposit personal needs funds received from a patient or from the state department for a patient's personal needs into the patients' personal needs trust fund within sixty days after the receipt of such moneys or to knowingly apply, spend, commit, pledge, or otherwise use a patient personal needs trust fund, or any other moneys paid by a patient or the state department for patient personal needs, for any purpose other than the personal needs of the patient to purchase necessary clothing, incidentals, or other items of personal needs that are not reimbursed by any federal or state program. Deposit or use of personal needs funds, including the use of a petty cash fund for personal needs purposes, is not a violation of this section if such deposit or use is in substantial compliance with applicable rules of the state department. Sums later ordered repaid to the patients' personal needs trust fund as a result of an audit adjustment related to simple accounting errors such as data entry errors, mathematical errors, or posting errors or a dispute related to a proration of patient payment is not a violation of this section.

(b) Any person who knowingly violates any of the provisions of this subsection (8) by failing to deposit personal needs funds within sixty days after the receipt of such moneys commits the crime of unlawful retention of patient personal needs funds. Any person who violates any of the provisions of this subsection (8) by applying, spending, committing, pledging, or otherwise using a patient personal needs trust fund for any purpose other than the purposes permitted by this subsection (8) commits the crime of unlawful use of a patient personal needs trust fund.

(c) Unlawful retention of patient personal needs funds is a class 3 misdemeanor. When a person commits unlawful retention of patient personal needs funds twice or more within a period

of six months without having been placed in jeopardy for the prior offense or offenses, unlawful retention of patient personal needs funds is a class 1 misdemeanor.

(d) Unlawful use of a patient personal needs trust fund is:

(I) A class 2 misdemeanor, if the amount involved is less than five hundred dollars;

(II) A class 1 misdemeanor, if the amount involved is five hundred dollars or more but less than one thousand dollars;

(III) A class 4 felony, if the amount involved is one thousand dollars or more but less than twenty thousand dollars;

(IV) A class 3 felony, if the amount involved is twenty thousand dollars or more.

(e) Any person who is convicted of violating this subsection (8) may not own or operate a nursing facility that receives medical assistance pursuant to this article or article 4 or 5 of this title. For the purposes of this paragraph (e), "convicted" means the entry of a plea of guilty, including a plea of guilty entered pursuant to a deferred sentence under section 18-1.3-102, C.R.S., the entry of a plea of no contest accepted by the court, or the entry of a verdict of guilty by a judge or jury.

Source: L. 2006: Entire article added with relocations, p. 1934, § 7, effective July 1. **L. 2012:** (8)(a) and (8)(d) amended, (HB 12-1310), ch. 20, p. 1400, § 20, effective June 7. **L. 2013:** (1), (2)(a), (3)(a), (4), (6), and (7) amended, (SB 13-167), ch. 394, p. 2292, § 4, effective June 5. **L. 2014:** (2)(a) amended, (SB 14-130), ch. 338, p. 1504, § 1, effective July 1.

Editor's note: This section is similar to former § 26-4-504 as it existed prior to 2006.

25.5-6-207. Class I nursing facility reimbursement rates - study - report - repeal. (Repealed)

Source: L. 2006: Entire section added, p. 1614, § 2, effective June 2. **L. 2007:** (1) and (3) amended, p. 1802, § 1, effective June 1. **L. 2008:** Entire section repealed, p. 1788, § 6, effective July 1.

Editor's note: This section was enacted as § 26-4-410.1 in Senate Bill 06-131. Section 6 of the bill provided for the renumbering of that section. (See L. 2006, p. 1616.)

Cross references: For the legislative declaration contained in the 2008 act repealing this section, see section 1 of chapter 383, Session Laws of Colorado 2008.

PART 3

HOME- AND COMMUNITY-BASED SERVICES
FOR THE ELDERLY, BLIND, AND DISABLED

25.5-6-301. Short title. This part 3 shall be known and may be cited as the "Home- and Community-based Services for the Elderly, Blind, and Disabled Act".

Source: L. 2006: Entire article added with relocations, p. 1937, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-601 as it existed prior to 2006.

25.5-6-302. Legislative declaration. The general assembly hereby finds and declares that it is the purpose of this part 3 to provide, under a federal waiver of statutory requirements, for an array of home- and community-based services to eligible elderly, blind, and disabled individuals as an alternative to nursing facility placement.

Source: L. 2006: Entire article added with relocations, p. 1937, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-602 as it existed prior to 2006.

25.5-6-303. Definitions. As used in this part 3 and part 5 of this article, unless the context otherwise requires:

(1) "Adult day care facility" means a facility which meets all applicable state and federal requirements and is certified by the state to provide adult day care services to eligible persons.

(2) "Adult day care services" means health and social services provided on a less than twenty-four-hour basis to eligible persons in state-certified adult day care facilities.

(3) "Alternative care facility" means a residential facility which provides alternative care services and protective oversight to eligible persons, which meets applicable state and federal requirements, and which is state-certified.

(4) "Alternative care services" means a package of personal care and homemaker services provided in a state-certified alternative care facility.

(5) (a) "Case management agency" means agencies providing services on and before July 1, 1995, for home- and community-based programs for the elderly, blind, and disabled and for persons living with AIDS shall be terminated July 1, 1995, and case management functions shall thereafter be performed in accordance with this article.

(b) "Case management agency", for counties participating in the single entry point system pursuant to this article before July 1, 1995, and for all counties on and after said date, means a public or private, nonprofit or for profit agency that meets all applicable state and federal requirements and is certified by the state department to provide case management functions reimbursable under this article and articles 4 and 5 of this title, within a geographic area of the state consisting of one or more counties. Such functions shall be provided by the agency under a contract executed with the state department or other state designated agency. The state department shall establish procedures for the designation, certification, and decertification of case management agencies and requirements for performance and staffing of the agencies. Such procedures and requirements shall be set forth in rules promulgated by the state board or shall be included in the contracts executed by the state department.

(6) "Case management services" means functions performed by a case management agency, including: The assessment of a client's needs, the development and implementation of a case plan for the client, the coordination and monitoring of service delivery, the direct delivery of services as provided by parts 3 to 12 of this article or by rules adopted by the state board, the evaluation of service effectiveness, and the reassessment of the client's needs. Case management services shall be reimbursed as an administrative expense.

(7) "Case plan" means a coordinated plan for the provision of long-term-care services in a setting other than a nursing home, developed and managed by a case management agency, in coordination with the client, his family or guardian and physician, and other providers of care.

(8) "Electronic monitoring provider" means an entity that meets applicable state, federal, and local requirements and is certified to provide electronic monitoring services.

(9) "Electronic monitoring services" means electronic equipment or adaptations that are related to an eligible person's physical impairment and enable the person to remain at home.

(10) "Homemaker agency" means any agency that meets applicable state and federal requirements and is state-certified to provide homemaker services.

(11) "Homemaker services" means general household activities that are provided by state-certified agencies to maintain a healthy and safe home environment for eligible persons.

(12) "Home modification provider" means an entity that meets applicable state, federal, and local requirements and is certified to provide home modification services.

(13) "Home modification services" means home installations or adaptations that are related to the eligible person's physical impairment and enable the person to remain at home.

(14) "Medications administration" means the administration or monitoring of medications provided in a manner consistent with part 3 of article 1.5 of title 25, C.R.S., under the authority and direction of the state department, as part of the "alternative care services", as defined in subsection (4) of this section, as provided in an "alternative care facility", as defined in subsection (3) of this section.

(15) "Nonmedical transportation provider" means an entity that meets applicable state and federal requirements and is certified to provide nonmedical transportation services.

(16) "Nonmedical transportation services" means transportation of eligible persons to services such as, but not limited to, adult day care services, which enable the person to remain at home.

(17) "Personal care agency" means any agency that meets state and federal requirements and is state-certified to provide personal care services.

(18) "Personal care services" means services to meet an eligible person's physical requirements and functional needs, when such services do not require the supervision of a nurse.

(19) "Respite care provider" means a facility or agency that meets all applicable state and federal requirements and is state-certified to provide respite care services.

(20) "Respite care services" means services of a short-term nature provided to a client, in the home or in a facility approved by the state department, in order to temporarily relieve the family or other home providers from the care and maintenance of such client, including room and board, maintenance, personal care, and other related services.

(21) "Transition coordination service agency" means an agency that is certified by the state department, as specified in rule by the state board, and provides independent living core services as defined in section 8-85-102 (6), C.R.S., and community transition services.

Source: L. 2006: Entire article added with relocations, p. 1938, § 7, effective July 1. **L. 2015:** (21) amended, (SB 15-240), ch. 139, p. 423, § 4, effective July 1. **L. 2016:** (21) amended, (SB 16-093), ch. 54, p. 132, § 4, effective July 1.

Editor's note: This section is similar to former § 26-4-603 as it existed prior to 2006.

25.5-6-304. Administration. The provisions of this part 3 shall be administered by the state department.

Source: L. 2006: Entire article added with relocations, p. 1940, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-604 as it existed prior to 2006.

25.5-6-305. Provision of services for elderly and blind individuals and individuals with disabilities. The provision of the services set forth in this part 3 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and costs for the provision of such services.

Source: L. 2006: Entire article added with relocations, p. 1940, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-605 as it existed prior to 2006.

25.5-6-306. Eligible groups. (1) Home- and community-based services under this part 3 shall be offered only to persons:

(a) Who are elderly, blind, or physically disabled; and

(b) Who are in need of the level of care available in a nursing home; and

(c) Who are categorically eligible for medical assistance, or whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101.

(2) A long-term-care eligible person receiving home- and community-based services shall remain eligible for the services specified in sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203, as applicable.

Source: L. 2006: Entire article added with relocations, p. 1940, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-606 as it existed prior to 2006.

25.5-6-307. Services for the elderly, blind, and disabled. (1) Subject to the provisions of this part 3, home- and community-based services for the elderly, blind, and disabled include only the following services:

(a) Adult day care;

(b) Alternative care services;

(c) Electronic monitoring services;

(d) Home modification services;

(e) Homemaker services;

(f) Nonmedical transportation services;

(g) Personal care services;

(h) Respite care services;

(i) Community transition services not to exceed two thousand dollars per eligible person, unless otherwise authorized by the state department, which shall be administered by a transition coordination service agency;

(j) Services provided under the consumer-directed care service model, part 11 of this article;

(k) In-home support services provided pursuant to part 12 of this article.

(2) All providers of home- and community-based services for the elderly, blind, and disabled may be separately certified to provide other services, if otherwise qualified.

(3) A case management agency may be certified to provide the services described in subsection (1) of this section, if otherwise qualified as a provider under the state medical assistance program.

(4) (a) The case management agency, in coordination with the eligible person, the person's family or guardian, and the person's physician, shall include in each case plan a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(b) The requirements of this subsection (4) shall not apply if the eligible person is residing in an alternative care facility.

Source: L. 2006: Entire article added with relocations, p. 1940, § 7, effective July 1. **L. 2014:** IP(1) amended and (1)(k) added, (HB 14-1357), ch. 254, p. 1015, § 4, effective March 1, 2015.

Editor's note: This section is similar to former § 26-4-607 as it existed prior to 2006.

25.5-6-308. Cost of services. Home- and community-based services for the elderly, blind, and disabled shall meet aggregate federal waiver budget neutrality requirements.

Source: L. 2006: Entire article added with relocations, p. 1941, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-607.5 as it existed prior to 2006.

25.5-6-309. Special provisions - post-eligibility treatment of income. Persons who receive services under this part 3 shall pay to the state department, or designated agent or provider, all income remaining after application of federally allowed maintenance and medical deductions or shall pay the cost of home- and community-based services rendered, whichever is less.

Source: L. 2006: Entire article added with relocations, p. 1941, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-608 as it existed prior to 2006.

25.5-6-310. Special provisions - personal care services provided by a family. (1) A member of an eligible person's family, other than the person's spouse, may be employed to provide personal care services to such person.

(2) The maximum reimbursement for the services provided by a member of the person's family per year for each client shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-609 as it existed prior to 2006.

25.5-6-311. Duties of state department. (1) The state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this part 3, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) Provide a system for reimbursement for services provided pursuant to this part 3, which system shall encourage cost containment.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-610 as it existed prior to 2006.

25.5-6-312. Gifts - grants. The state department, acting for and on behalf of the state, may receive and accept title to any grant or gift from any source, including the federal government, and all grants, grants-in-aid, and gifts shall be deposited with the state treasurer, who shall credit the same to the general fund, and such moneys shall be appropriated to the state department to carry out the purposes of this article and articles 4 and 5 of this title.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-611 as it existed prior to 2006.

25.5-6-313. Rules - federal authorization. (1) Pursuant to article 4 of title 24, C.R.S., the state board shall adopt rules for the administration of this part 3.

(1.5) The rules adopted by the state board pursuant to subsection (1) of this section shall include the following provisions concerning adult day care facilities:

(a) A definition of a restricted environment and a restrictive egress alert device;

(b) Parameters governing how the restrictive egress alert device shall be used and tested and the staff roles regarding the use and oversight of the device; and

(c) Parameters governing a restricted environment, including but not limited to staffing and training requirements; appropriateness of placement; assessment; participant's rights; records and reporting requirements; building requirements including grounds and fire safety; restrictive egress alert systems and devices; fencing or other enclosures; and the application process to offer a restricted environment.

(2) The state department is authorized to seek any necessary federal authorization to implement the provisions of this part 3.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1. **L. 2010:** (1.5) added, (HB 10-1053), ch. 276, p. 1267, § 4, effective May 26.

Editor's note: This section is similar to former § 26-4-612 as it existed prior to 2006.

Cross references: For the legislative declaration in the 2010 act adding subsection (1.5), see section 1 of chapter 1267, Session Laws of Colorado 2010.

PART 4

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

25.5-6-401. Short title. This part 4 shall be known and may be cited as the "Home- and Community-based Services for Persons with Developmental Disabilities Act".

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-621 as it existed prior to 2006.

25.5-6-402. Legislative declaration. (1) The general assembly hereby finds and declares that it is the purpose of this part 4 to provide services for persons with developmental disabilities which would foster the following goals:

(a) To maintain eligible persons in the most appropriate settings possible and to minimize admissions to institutions;

(b) To recognize the unique services requirements of persons with developmental disabilities;

(c) To provide optimum accessibility to various important social, habilitative, remedial, residential, and health services that are available to assist in maintaining eligible persons in the least restrictive settings;

(d) To provide eligible persons who have the capacity to remain outside an institutional setting access to appropriate social, habilitative, remedial, residential, and health services, without which institutionalization would be necessary;

(e) To provide the most efficient and effective use of funds in the delivery of these social, habilitative, remedial, residential, and health services to eligible persons;

(f) To coordinate, integrate, and link these social, habilitative, remedial, residential, and health services into existing community-based service delivery systems for persons with developmental disabilities, to avoid unnecessary and expensive duplication of services;

(g) To allow the state substantial flexibility in organizing and administering the delivery of social, habilitative, remedial, residential, and health services to eligible citizens.

(2) The general assembly intends that the state department and the department of human services shall cooperate to the maximum extent possible in designing, implementing, and administering the programs authorized under this part 4.

(3) Nothing in this part 4 shall be construed to disqualify persons from receiving any benefits to which they would otherwise be eligible under parts 1 and 2 of article 5 of this title, or under Title XIX of the federal "Social Security Act", as amended, by reason of being designated as a person with developmental disabilities.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-622 as it existed prior to 2006.

25.5-6-403. Definitions. As used in this part 4, unless the context otherwise requires:

(1) "Developmentally disabled person" means a person with an intellectual and developmental disability as defined in section 25.5-10-202.

(2) (a) "Eligible person" means a person with developmental disabilities:

(I) Who meets the definition of categorically needy as defined in section 25.5-4-103 (4);

(II) Who is in need of the level of care available in an intermediate care facility for individuals with intellectual disabilities;

(III) Whose gross income does not exceed three hundred percent of the current federal supplemental security income benefits level or other applicable standard provided in federal regulations construing the federal "Social Security Act", as amended, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101; and

(IV) For whom it is determined that provision of such services is necessary to avoid placement in an intermediate care facility for individuals with intellectual disabilities.

(b) The amount of parental income and resources that shall be attributable to a child's gross income for purposes of eligibility under paragraph (a) of this subsection (2) shall be set forth in rules promulgated by the state board of human services created in section 26-1-107, C.R.S.

(3) "In-home services" means those services described in section 25.5-10-205 provided to support persons living with their family.

(3.3) (a) "Intellectual and developmental disability" means a disability that manifests before the person reaches twenty-two years of age, that constitutes a substantial disability to the affected person, and that is attributable to mental retardation or related conditions, which include cerebral palsy, epilepsy, autism, or other neurological conditions when those conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15001 et seq. shall not apply.

(b) "Person with an intellectual and developmental disability" or "youth with an intellectual and developmental disability" means a person or youth determined by a community-centered board to have an intellectual and developmental disability and shall include a child with a developmental delay.

(c) "Child with a developmental delay" means:

(I) A person less than five years of age with delayed development as defined by rule of the state board; or

(II) A person less than five years of age who is at risk of having a developmental disability as defined by rule of the state board.

(4) "Plan of care" means a coordinated plan of care for provision of services in other than a nursing facility or institutional setting, developed and managed, subject to review and approval pursuant to section 25.5-6-404, by a community centered board for persons with developmental disabilities. This plan of care shall fully identify the services to be provided to eligible persons. Prior to the provision of those services, a physician may be required to review an assessment document to insure that it adequately describes the medical needs of the eligible person.

(5) (a) "Services for persons with intellectual and developmental disabilities" means those services:

(I) Approved for reimbursement by the federal government; and

(II) Necessary to prevent a person, eligible for services under subsection (2) of this section, from being subjected to placement in an intermediate care facility for individuals with intellectual disabilities.

(b) "Services for persons with intellectual and developmental disabilities" includes, but is not limited to, social, habilitative, remedial, residential, health services, and services provided under the consumer-directed care service model, part 11 of this article, which shall include the selection, from a list of qualified entities, of an organization of the eligible person's choice to provide financial management services for the eligible person.

Source: L. 2006: Entire article added with relocations, p. 1943, § 7, effective July 1. **L. 2013:** (2)(a)(II), (2)(a)(IV), and (5)(a)(II) amended, (SB 13-167), ch. 394, p. 2294, § 5, effective June 5; (1), (3), IP(5)(a), (5)(a)(II), and (5)(b) amended, (HB 13-1314), ch. 323, p. 1810, § 47, effective March 1, 2014. **L. 2014:** (3.3) added, (HB 14-1368), ch. 304, p. 1288, § 1, effective May 31.

Editor's note: This section is similar to former § 26-4-623 as it existed prior to 2006.

25.5-6-404. Duties of the department of health care policy and financing and the department of human services. (1) The state department and the department of human services shall provide a system of reimbursement for services provided pursuant to this part 4 that encourages the most cost-effective provision of services.

(2) The state department and the department of human services shall, subject to appropriation, utilize any available federal, state, local, or private funds, including but not limited to, medicaid funds available under Title XIX of the federal "Social Security Act", as amended, such as medicaid home- and community-based waivers, to carry out the purposes of this part 4.

(3) The state department may contract with the department of human services to certify agencies providing services under this part 4 as eligible medicaid providers, to adopt fiscal and administrative procedures, to review plans of care, to set rates, and to make and implement recommendations regarding the scope, duration, and content of programs and the eligibility of persons for specific services provided pursuant to this part 4, and to fulfill any other

responsibilities necessary to implement this part 4 that are consistent with the single state agency designation set out in section 25.5-4-104.

(4) The executive director and the state board shall promulgate such rules regarding this part 4 as are necessary to fulfill the obligations of the state department as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended. Such rules may include, but shall not be limited to, determination of the level of care requirements for long-term care, patient payment requirements, clients' rights, medicaid eligibility, and appeal rights associated with these requirements.

(5) The state board of human services, created in section 26-1-107, C.R.S., shall promulgate such rules as are necessary to implement the provisions of this part 4 and to fulfill the responsibilities and duties set out in article 10.5 of title 27, C.R.S. Such rules shall be promulgated pursuant to section 24-4-103, C.R.S.

(6) In the event that a direct conflict arises between the rules of the state department promulgated pursuant to subsection (4) of this section and the rules of the department of human services promulgated pursuant to subsection (5) of this section, regarding implementation of this part 4, the rules of the state department shall control.

Source: L. 2006: Entire article added with relocations, p. 1944, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-624 as it existed prior to 2006.

25.5-6-405. Relationship to other programs. The provisions of part 3 of this article are separate and distinct from the provisions of this part 4. Therefore, the definitions and restrictions embodied in part 3 of this article shall not apply to services and programs provided pursuant to this part 4.

Source: L. 2006: Entire article added with relocations, p. 1945, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-625 as it existed prior to 2006.

25.5-6-406. Appropriations. To carry out duties and obligations pursuant to this part 4 and for the administration and provision of services to eligible persons, all medicaid funds appropriated pursuant to Title XIX of the federal "Social Security Act", as amended, for the provision of care for persons with developmental disabilities and all other funds otherwise appropriated by the general assembly as additional sources of program funding shall be available for the placement of eligible individuals either in intermediate care facilities for individuals with intellectual disabilities or alternatives to such placements.

Source: L. 2006: Entire article added with relocations, p. 1945, § 7, effective July 1. **L. 2013:** Entire section amended, (SB 13-167), ch. 394, p. 2294, § 6, effective June 5.

Editor's note: This section is similar to former § 26-4-626 as it existed prior to 2006.

25.5-6-407. Gifts - grants. The state department and the department of human services, acting on behalf of the state, may receive and accept title to gifts or grants from any source,

including the federal government. Both departments shall deposit all grants, grants-in-aid, and gifts with the state treasurer, who shall credit them to the general fund. These moneys shall remain available for appropriation to either department to carry out the purposes of this part 4.

Source: L. 2006: Entire article added with relocations, p. 1946, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-627 as it existed prior to 2006.

25.5-6-408. Eligibility - fees. (1) Subject to the availability of federal financial participation, services shall be provided to eligible persons pursuant to this part 4.

(2) Any eligible person who accepts and receives services pursuant to this part 4 shall pay to the state department, or to an agent designated by the state department, an amount determined pursuant to federal regulations construing the federal "Social Security Act", as amended, concerning the application of patient income to the cost of services.

Source: L. 2006: Entire article added with relocations, p. 1946, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-628 as it existed prior to 2006.

25.5-6-409. Services for persons with intellectual and developmental disabilities. (1) A program to provide home- and community-based services to persons with intellectual and developmental disabilities who are in need of the level of care available in an intermediate care facility for individuals with intellectual disabilities is hereby established pursuant to the federal "Social Security Act", as amended. This program shall provide for the social, habilitative, remedial, residential, health, and other needs of persons with intellectual and developmental disabilities to avoid placement in an intermediate care facility for individuals with intellectual disabilities.

(2) Services for persons with developmental disabilities provided through this program shall be delivered under the provisions of a statewide services plan, in the form of home- and community-based services waivers or model waivers, developed by the state department and the department of human services and approved by the federal centers for medicare and medicaid services, or any successor agency. This plan shall include the specific services to be offered, a plan for the delivery of such services through community centered boards or other service agencies approved pursuant to article 10.5 of title 27, C.R.S., utilizing where appropriate the provision of in-home services, the expected costs of such services, the expected benefits of providing those services, and the administrative provisions which shall govern the implementation of the plan. The plan shall provide for all necessary safeguards to ensure the health and welfare of any eligible persons. The average per capita expenditure for services under this plan shall not exceed the average per capita expenditure the department of human services or the state department would have made for services otherwise available without this plan.

(3) The plan shall utilize existing community-based services programs to the maximum extent possible and shall coordinate all available forms of assistance for the eligible person.

(4) Any services for persons with intellectual and developmental disabilities provided through this program shall be set forth in a plan of care developed and managed by a

community-centered board and subject to review and approval pursuant to section 25.5-6-404. The plan of care shall:

(a) Be based on the particular services needs of the eligible person;

(b) Describe the services necessary to avoid institutionalization; and

(c) (I) Include a process by which the person who is receiving services may receive necessary care for medical purposes, which may include respite care, if the person's service provider is unavailable due to an emergency situation or to unforeseen circumstances. The person who is receiving services and the person's family or guardian shall be duly informed by the community centered board of these alternative care provisions at the time the plan of care is initiated.

(II) Nothing in this paragraph (c) requires a community centered board to provide services set forth in a plan of care that the community centered board is not otherwise required to provide to the person receiving services, only that the plan of care include a contingency for such services.

Source: L. 2006: Entire article added with relocations, p. 1946, § 7, effective July 1. **L. 2013:** (1) amended, (SB 13-167), ch. 394, p. 2294, § 7, effective June 5; (1) and IP(4) amended, (HB 13-1314), ch. 323, p. 1811, § 48, effective March 1, 2014.

Editor's note: (1) This section is similar to former § 26-4-629 as it existed prior to 2006.

(2) Amendments to subsection (1) by Senate Bill 13-167 and House Bill 13-1314 were harmonized.

25.5-6-409.3. Consolidated waiver - intellectual and developmental disabilities - conflict-free case management - legislative declaration. (1) (a) The general assembly declares that it is the intent of the general assembly that moneys appropriated for services for individuals with intellectual and developmental disabilities be spent in the most effective manner, thereby enabling the greatest number of eligible individuals to receive the services that they need in the amounts needed so that they may live successfully in the community. Therefore, the general assembly finds that the best mechanism for providing adequate services for individuals with intellectual and developmental disabilities is to have a single consolidated medicaid waiver for home- and community-based individuals with intellectual and developmental disabilities.

(b) Further, the general assembly acknowledges the rights of individuals to make choices regarding their case managers and service providers. Therefore, the general assembly believes there exists the need to ensure conflict-free case management services within the medicaid waivers for persons with intellectual and developmental disabilities.

(2) The state department shall establish a redesigned medicaid waiver for home- and community-based services for adults with intellectual and developmental disabilities, effective July 1, 2016, or as soon as the centers for medicare and medicaid services approves the redesigned waiver.

(3) The redesigned waiver must include flexible service definitions, provide access to services and supports when and where they are needed, offer services and supports based on the individual's needs and preferences, and incorporate the following principles:

(a) Freedom of choice over living arrangements and social, community, and recreational opportunities;

(b) Individual authority over supports and services;

(c) Support to organize resources in ways that are meaningful to the individual receiving services;

(d) Health and safety assurances;

(e) Opportunity for community contribution; and

(f) Responsible use of public dollars.

(3.3) (a) The state department's administration of the redesigned waiver shall include:

(I) A functional eligibility and needs assessment tool used for the redesigned waiver that aligns with the recommendations of the community living advisory group and that is fully integrated with the assessment process for all clients receiving long-term services and supports;

(II) An assessment process that is person-centered, demonstrates inter-rater reliability, is norm referenced for people with intellectual and developmental disabilities, and includes the following principles and goals:

(A) Maximum personal control;

(B) System transparency; and

(C) Support needed to achieve key service outcomes, including health and welfare, improving quality of life, increasing independence, and supporting employment and community integration; and

(III) A service payment system that ensures fair distribution of available resources and that is efficient, transparent, and equitable for both providers and consumers.

(b) As part of the state department's fiscal year 2016-17 budget request to the joint budget committee, the state department shall include a justification for the continued use of the supports intensity scale assessment. If the joint budget committee concludes that the justification is insufficient to continue the use of the supports intensity scale assessment, the state department shall present a plan to the joint budget committee for the transition to a different assessment tool that meets the principles and goals set forth in subparagraph (II) of paragraph (a) of this subsection (3.3), as well as a timeline for transition to the new assessment tool that comports with the time frame set forth in subsection (2) of this section for the administration of the single consolidated medicaid waiver.

(3.5) The redesigned waiver must ensure continuity of support, including residential services, for eligible individuals enrolled in the home- and community-based services waivers serving adults with intellectual and developmental disabilities who were receiving services as of January 1, 2016, and who have maintained waiver eligibility.

(4) The state department shall notify the joint budget committee no later than June 1, 2016, if the centers for medicare and medicaid services has not approved a single consolidated medicaid waiver for home- and community-based services for adults with intellectual and developmental disabilities. If the state department has not received approval from the centers for medicare and medicaid services by July 1, 2016, the joint budget committee shall establish a notification and review process relating to the status of the pending waiver consolidation process.

(5) No later than July 1, 2016, the state department, with input from community-centered boards, single entry point agencies, and other stakeholders, shall develop a plan for the delivery of conflict-free case management services that complies with the federal regulations relating to

person-centered planning. The plan must include a reasonable timeline for implementation of the plan. The state department may hire a consultant to assist with plan development. During the budget process for the 2016-17 legislative session, the state department shall report to the joint budget committee on the development of the plan and any statutory changes required to implement the plan.

Source: L. 2015: Entire section added, (HB 15-1318), ch. 304, p. 1248, § 1, effective August 5.

25.5-6-409.5. Transition plan for youth with intellectual and developmental disabilities to adult services - legislative declaration - report - rules - cash fund. (1) The general assembly finds and declares that:

(a) Youth with intellectual and developmental disabilities who are eighteen to twenty years of age are currently served through the county child welfare system; and

(b) The home- and community-based services program for persons with intellectual and developmental disabilities is better designed to meet the complex needs of these youth.

(2) Therefore, the general assembly declares that, in order to have a person-centered system, youth with intellectual and developmental disabilities who are eighteen years of age and older who are currently being served through child welfare services must be transitioned to the home- and community-based services program for persons with intellectual and developmental disabilities and a plan developed for the ongoing transition of such youth when they turn eighteen years of age, except in extenuating circumstances when the court or interdisciplinary team determines that it is not in the best interest of the youth to transition.

(3) (a) On or before June 30, 2014, each county department of human or social services shall identify youth with intellectual and developmental disabilities who are receiving services through the child welfare system in that county and who:

(I) Are twenty years of age or older as of June 30, 2014;

(II) Are nineteen years of age or older but younger than twenty-one years of age as of June 30, 2014;

(III) Are eighteen years of age or older but younger than twenty years of age as of June 30, 2014; and

(IV) Will become eighteen years of age on or after June 30, 2014, and before January 1, 2015.

(b) On or before October 1, 2014, and as necessary thereafter, each county department of human or social services shall identify youth with intellectual and developmental disabilities who are receiving services through the child welfare system in that county and who will become eighteen years of age within the following six months.

(c) Each county department of human or social services shall develop a plan to transition youth identified pursuant to paragraphs (a) and (b) of this subsection (3) to adult services for persons with intellectual and developmental disabilities. The transition plan must meet the criteria set forth in subsection (4) of this section and any rules promulgated by the state board to implement this section. Each county's plan must provide for:

(I) Youth described in paragraph (a) of this subsection (3) to be transitioned as soon as possible but in no case later than January 1, 2016; and

(II) Youth described in subparagraph (IV) of paragraph (a) of this subsection (3) or paragraph (b) of this subsection (3) to be transitioned as soon as possible based on individual needs but in no case earlier than their eighteenth birthday.

(d) The requirement to transition youth as set forth in subsection (3)(c) of this section does not apply to youth currently serving a sentence in the division of youth services or to youth under a court order in a juvenile delinquency case, unless the court approves the transition by written court order.

(4) For each youth with intellectual and developmental disabilities who is going to be transitioned to adult services for persons with intellectual and developmental disabilities pursuant to subsection (3) of this section, the county department of human or social services that is currently providing services to the youth through its child welfare system shall develop a transition plan for that youth. The transition plan must, at a minimum:

(a) Include the department-prescribed assessment provided by the community-centered board that is performed as soon as possible for those youth who are being transitioned pursuant to subsection (3) of this section and at seventeen and a half years of age for those youth who are being transitioned pursuant to subparagraph (IV) of paragraph (a) of subsection (3) of this section or paragraph (b) of subsection (3) of this section. In all instances, the assessment must be completed within six months of a youth's transition to adult services.

(b) Provide for the social, habilitative, remedial, residential, educational, health, and other needs of the youth who is being transitioned; and

(c) Address any legal needs concerning guardianship of the youth who is being transitioned.

(5) In all instances, the involved parties and the county department of human or social services shall consider and place precedence on the best interest of the youth prior to the transition process, as set forth in sections 19-3-205 and 19-3-213, C.R.S.

(6) It is the intent of the general assembly that county child welfare systems and community-centered boards collaborate to ensure minimal disruption for youth during the transition process.

(7) The medical services board and the state board of human services may promulgate rules as necessary and appropriate for the implementation of this section.

(8) The department shall submit a report to the joint budget committee on or before January 1, 2015, and on or before January 1, 2016, on the status of the youth being transitioned. The report must include, at a minimum:

(a) The number of youth transitioned to date by county;

(b) The needs assessment of the youth who have been transitioned; and

(c) The type of adult residential locations of the youth who have been transitioned.

(9) Repealed.

Source: L. 2014: Entire section added, (HB 14-1368), ch. 304, p. 1289, § 2, effective May 31. **L. 2017:** (3)(d) amended, (HB 17-1329), ch. 381, p. 1983, § 60, effective June 6.

Editor's note: Subsection (9)(b) provided for the repeal of subsection (9), effective July 1, 2016. (See L. 2014, p. 1289.)

25.5-6-410. Qualification for federal funding. Nothing in this part 4 shall prevent the state department or the department of human services from complying with federal requirements in order for the state of Colorado to qualify for federal funds under Title XIX of the federal "Social Security Act", as amended.

Source: L. 2006: Entire article added with relocations, p. 1947, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-630 as it existed prior to 2006.

25.5-6-411. Personal needs trust fund required. All personal needs funds shall be held in trust by a residential facility authorized to provide services pursuant to this part 4, or its designated trustee, separate and apart from any other funds of the facility, in a checking account or savings account or any combination thereof established to protect and separate the personal needs funds of the clients. At all times, the principal and all income derived from said principal in the personal needs trust fund shall remain the property of the participating clients, and the facility or its designated trustee is bound by all of the duties imposed by law upon fiduciaries in the handling of such fund including accounting for all expenditures from the fund.

Source: L. 2006: Entire article added with relocations, p. 1947, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-631 as it existed prior to 2006.

25.5-6-412. Cross-system response for behavioral health crises pilot program - legislative declaration - creation - criteria - recommendations - fund - repeal. (1) The general assembly declares that:

(a) There is limited access to appropriate treatment in the behavioral health system, including crisis intervention, stabilization, and prevention, for individuals with intellectual and developmental disabilities;

(b) There is inadequate reimbursement and inappropriate service limits and definitions in the behavioral health capitated system as well as medical mental health benefits in the Colorado fee-for-service medicaid state plan for individuals with intellectual and developmental disabilities;

(c) There are conflicting requirements and confusion about diagnoses-based requirements that limit access to assessments as well as treatment;

(d) There is a lack of professional expertise and workforce capacity; and

(e) A systematic and strategic approach is needed to increase capacity among licensed medical professionals, credentialed service providers, and direct service personnel to help provide medical and behavioral health services for individuals with intellectual and developmental disabilities.

(2) The general assembly therefore supports funding for a pilot program with locations at multiple sites that represent different geographic regions of the state that will utilize collaborative approaches to provide a cross-system response to behavioral health crises for individuals with intellectual and developmental disabilities. The cross-system response will include written cooperative agreements among providers for medicaid state plan services, medicaid school-based health services, home- and community-based waiver services, and the

capitated mental health care system. The cross-system response would include timely crisis intervention, stabilization, evaluation, treatment, in-home therapeutic respite, site-based therapeutic respite, and follow-up services to integrate with the Colorado mental health crisis program and also require services specifically appropriate for the needs of individuals with intellectual and developmental disabilities. A cost analysis with accompanying actuarial study will complement the pilot program to ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system and are supported in the Colorado behavioral health crisis response system.

(3) There is created in the state department a cross-system response for behavioral health crises pilot program, referred to in this section as the "pilot program". The pilot program will have locations at multiple sites that represent different geographic regions of the state. The goal of the pilot program is to provide crisis intervention, stabilization, and follow-up services to individuals who have both an intellectual and developmental disability and a behavioral or mental health disorder and who also require services not available through an existing home- or community-based services waiver or covered under the Colorado behavioral health care system. To achieve this goal, the pilot program must complement and expand on the Colorado behavioral health crisis response system, provided through the department of human services pursuant to section 27-60-103, to:

(a) Provide access to intensive coordinated psychiatric, behavioral, and mental health services for crisis intervention as an alternative to emergency department care or in-patient hospitalization;

(b) Offer community-based, mobile supports to individuals with dual diagnoses and their families;

(c) Offer follow-up supports to individuals with dual diagnoses, families, and caregivers to reduce the likelihood of future crises;

(d) Provide education and training for families and service agencies;

(e) Provide data about the cost in Colorado of providing such services throughout the state to complement the cost-analysis study described in subsection (6) of this section related to the cost to eliminate service gaps for individuals who have an intellectual and developmental disability and who also have a behavioral or mental health disorder; and

(f) Provide data about systemic structural changes needed to remove existing regulatory or procedural barriers to the authorized use of public funds across systems, including the medicaid state plan, home- and community-based service medicaid waivers, the capitated mental health care system, and the Colorado behavioral health crisis response system.

(4) The department of health care policy and financing shall enter into an interagency agreement with the department of human services to jointly manage the integration of the pilot program with the Colorado behavioral health crisis response system.

(5) (a) The pilot program shall begin on or before March 1, 2016, and operate until March 1, 2019. The pilot program will provide support to eligible individuals to obtain the additional necessary services, regardless of the appropriate payer. Once an individual who is participating in the pilot program is stabilized, the pilot program shall determine where services should have been provided and who the appropriate payer is. If no service payer is available, moneys for the additional necessary behavioral health services will come from the cross-system response for behavioral health crises pilot program fund created in subsection (7) of this section.

(b) The pilot program must collect data concerning the support provided and services delivered for each individual participating in the pilot program. The data must include information on when the individual's situation stabilized and behavioral health services necessary for the individual to maintain stability. The pilot program shall analyze the data collected and provide a summary report to the state department regarding where service gaps exist, as well as recommended solutions to eliminate those gaps.

(6) On or before July 1, 2017, and each July 1 thereafter until this section is repealed, the state department shall conduct a cost analysis of the services that would need to be added to eliminate service gaps and ensure that individuals with intellectual and developmental disabilities are fully included in the Colorado behavioral health system and are supported in the Colorado behavioral health crisis response system. The state department shall provide the results of the cost analyses in an annual written report on the pilot program, as well as recommendations related to closing service gaps, to the health and human services committee of the senate and the public health care and human services committee of the house of representatives, or any successor committees.

(7) There is created in the state treasury the cross-system response for behavioral health crises pilot program fund, referred to in this section as the "fund". The fund consists of any moneys appropriated to the fund by the general assembly. The moneys in the fund are subject to annual appropriation by the general assembly to the state department for the direct and indirect costs associated with implementing the pilot program created pursuant to this section. The state treasurer may invest any moneys in the fund not expended for the purpose of this section as provided by law. The state treasurer shall credit all interest and income derived from the investment and deposit of moneys in the fund to the fund. Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year remain in the fund and shall not be credited or transferred to the general fund or another fund. The state treasurer shall transfer all unexpended and unencumbered moneys remaining in the fund as of July 1, 2019, to the general fund.

(8) The department of health care policy and financing and the department of human services are authorized to pursue the option of allowing a community-centered board to use a vacant state-owned group home for the purposes of the pilot program. In such an instance, the community-centered board may use up to one hundred thousand dollars from the fund created in subsection (7) of this section for any regulatory improvements for licensing and operations required by the department of public health and environment. General maintenance and upkeep of the facility is the responsibility of the community-centered board, with payment from the fund created in subsection (7) of this section; except that payment for and completion of any preexisting controlled maintenance projects required in order for the group home to become fully licensed is the responsibility of the department of human services and must be complete prior to occupancy of the group home.

(9) This section is repealed, effective July 1, 2019.

Source: L. 2015: Entire section added, (HB 15-1368), ch. 308, p. 1258, § 1, effective June 5. **L. 2017:** IP(3) and (3)(e) amended, (SB 17-242), ch. 263, p. 1329, § 208, effective May 25.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

PART 5

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH HEALTH COMPLEXES RELATED TO ACQUIRED IMMUNE DEFICIENCY SYNDROME

25.5-6-501. Short title. This part 5 shall be known and may be cited as the "Home- and Community-based Services for Persons with Health Complexes Related to Acquired Immune Deficiency Syndrome Act".

Source: L. 2006: Entire article added with relocations, p. 1947, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-641 as it existed prior to 2006.

25.5-6-502. Definitions. In addition to the definitions in section 25.5-6-303, as used in this part 5, unless the context otherwise requires:

(1) "AIDS" means acquired immune deficiency syndrome.

(2) "Continuum of long-term care" shall include all the services listed in section 25.5-6-505 and may include brief inpatient stays in a hospital or a nursing facility.

(3) "HIV" means the human immunodeficiency virus.

(4) "HIV/AIDS" means:

(a) A symptomatic HIV infection, as defined by the centers for disease control of the United States public health service; or

(b) AIDS.

(5) "Long-term-care eligible person" means a person who is determined to be:

(a) Eligible to receive services under sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203; and

(b) In need of the level of care available in a nursing facility or in need of the level of care available in a hospital.

Source: L. 2006: Entire article added with relocations, p. 1948, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-642 as it existed prior to 2006.

25.5-6-503. Administration. The provisions of this part 5 shall be administered by the state department.

Source: L. 2006: Entire article added with relocations, p. 1948, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-643 as it existed prior to 2006.

25.5-6-504. Program established - financial eligibility. (1) In recognition of the social and economic benefits accruing from the maintenance of persons with HIV/AIDS in their own homes, the general assembly hereby finds and declares that a program shall be implemented by the state department to provide the services set forth in section 25.5-6-505 to those persons with HIV/AIDS whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, C.R.S., or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101, and for whom a licensed physician or advanced practice nurse certifies that such program provides an appropriate alternative to institutionalized care.

(2) Any person who accepts and receives services authorized under this part 5 shall pay to the state department, or to an agent or provider designated by the state department, an amount that shall be the lesser of the person's gross income, minus federally allowed maintenance and medical deductions, or the projected cost of services to be rendered to the person under the case plan. Such amount shall be reviewed and revised as necessary each time the case plan is reviewed.

Source: L. 2006: Entire article added with relocations, p. 1948, § 7, effective July 1. **L. 2008:** (1) amended, p. 133, § 21, effective January 1, 2009.

Editor's note: This section is similar to former § 26-4-644 as it existed prior to 2006.

25.5-6-505. Services for long-term-care eligible persons. (1) Subject to the provisions of this part 5, the home- and community-based services program for persons with HIV/AIDS shall include the following continuum of long-term care services:

(a) Personal care and homemaker services;

(b) Adult day care services;

(c) Private duty nursing services;

(d) Electronic monitoring services as such term is defined in section 25.5-6-303 (9);

(e) Nonmedical transportation services as such term is defined in section 25.5-6-303 (16);

(f) Services provided under the consumer-directed care model, part 11 of this article.

(2) A long-term-care eligible person receiving home- and community-based services shall remain eligible for the services specified in sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203, as applicable.

(3) The provision of the services set forth in subsection (1) of this section shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and costs for the provision of such services. Case management services shall be reimbursed as an administrative cost.

(4) If the state department or the case management agency makes a determination that the cost for the provision of home- and community-based services necessary to allow an HIV/AIDS client to avoid institutionalization exceeds or would exceed either the average individual medicaid payment for like services for hospital care for clients needing a hospital

level of care or the average individual medicaid payment for like services for nursing facility care for clients needing a nursing facility level of care, such client shall not be considered eligible for home- and community-based services.

(5) The location for the provision of home- and community-based services shall be agreed upon by the HIV/AIDS client and the case management agency.

(6) The state department shall implement the provisions of subsection (1) of this section on a case-by-case basis as each service becomes available through approved providers.

(7) No service listed in subsection (1) of this section may be provided to an eligible person unless authorized pursuant to a case plan.

(8) (a) The case management agency, in coordination with the eligible person and the person's family or guardian, shall include in each case plan a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(b) The requirements of this subsection (8) shall not apply if the eligible person is residing in a nursing facility or an alternative care facility.

Source: L. 2006: Entire article added with relocations, p. 1949, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-645 as it existed prior to 2006.

25.5-6-506. Special provisions - personal care services provided by a family. (1) A member of an eligible person's family, other than the person's spouse, may be employed to provide personal care services to such person.

(2) The maximum reimbursement for the services provided by a member of the person's family per year for each client shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family.

Source: L. 2006: Entire article added with relocations, p. 1950, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-645.5 as it existed prior to 2006.

25.5-6-507. Duties of state department. (1) In addition to the duties set forth in section 25.5-6-311, the state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this part 5, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) Provide a system for reimbursement for services provided pursuant to this part 5 that encourages cost containment;

(c) Conduct feasibility studies and pilot programs as the general assembly may from time to time direct to lessen medical costs, including medicaid moneys, associated with persons with HIV/AIDS.

(2) Prior to the submittal of the home- and community-based services medicaid waiver application for this part 5, the state department shall consult with the joint budget committee of the general assembly concerning the proposed number of clients to be served, the savings anticipated, and the costs associated with the implementation of this program.

Source: L. 2006: Entire article added with relocations, p. 1950, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-646 as it existed prior to 2006.

25.5-6-508. Rules. The executive director and the state board shall promulgate such rules, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this part 5.

Source: L. 2006: Entire article added with relocations, p. 1951, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-648 as it existed prior to 2006.

PART 6

HOME- AND COMMUNITY-BASED SERVICES FOR
PERSONS WITH MAJOR MENTAL ILLNESSES

25.5-6-601. Short title. This part 6 shall be known and may be cited as the "Home- and Community-based Services for Persons with Major Mental Illnesses Act".

Source: L. 2006: Entire article added with relocations, p. 1951, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-671 as it existed prior to 2006.

25.5-6-602. Legislative declaration - no entitlement created. (1) The general assembly hereby finds and declares that the purpose of this part 6 is to provide, under federal authorization and subject to available appropriations, home- and community-based services for persons with major mental illnesses.

(2) Nothing in this part 6 shall be construed to establish that eligible persons as defined in section 25.5-6-603 (1) are entitled to receive services from the state department or the department of human services. The provision of any services pursuant to this part 6 shall be subject to federal waiver authorization and available appropriations.

Source: L. 2006: Entire article added with relocations, p. 1951, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-672 as it existed prior to 2006.

25.5-6-603. Definitions. As used in this part 6, unless the context otherwise requires:

(1) "Eligible person" means a person:

(a) Who has a primary diagnosis of a major mental health disorder, as such term is defined in the diagnostic and statistical manual of mental disorders used by the mental health

profession, and includes schizophrenic, paranoid, major affective, and schizoaffective disorders, and atypical psychosis, but does not include dementia, including Alzheimer's disease or related disorders;

(b) Who is in need of the level of care available in a nursing facility;

(c) Who is categorically eligible for medical assistance, or whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101.

Source: L. 2006: Entire article added with relocations, p. 1951, § 7, effective July 1. **L. 2017:** (1)(a) amended, (SB 17-242), ch. 263, p. 1330, § 209, effective May 25.

Editor's note: This section is similar to former § 26-4-673 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-6-604. Cost of services. Home- and community-based services for persons with major mental illnesses shall meet aggregate federal waiver budget neutrality requirements.

Source: L. 2006: Entire article added with relocations, p. 1952, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-673.5 as it existed prior to 2006.

25.5-6-605. Relationship to single entry point for long-term care. The home- and community-based services program for persons with major mental illnesses shall not be considered a publicly funded long-term care program for the purposes of sections 25.5-6-105 to 25.5-6-107, concerning the single entry point system, unless and until the departments of health care policy and financing and human services provide in the memorandum of understanding between the departments for the inclusion of the program in the single entry point system.

Source: L. 2006: Entire article added with relocations, p. 1952, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-674 as it existed prior to 2006.

25.5-6-606. Implementation of program for mentally ill authorized - federal waiver - duties of the department of health care policy and financing and the department of human services. (1) The state department is hereby authorized to seek any necessary waiver from the federal government to develop and implement a home- and community-based services program for persons with major mental illnesses. The program shall be designed to provide home- and community-based services to eligible persons. Eligibility may be limited to persons who meet the level of services provided in a nursing facility, and services for eligible persons may be established in state board rules to the extent such eligibility criteria and services are

authorized or required by federal waiver. The program shall include services provided under the consumer-directed care service model, part 11 of this article.

(2) The state department and the department of human services shall provide a system of reimbursement for services provided pursuant to this part 6 that encourages the most cost-effective provision of services.

(3) The state department and the department of human services shall, subject to appropriation, use available federal, state, local, or private funds, including but not limited to medicaid funds available under Title XIX of the federal "Social Security Act", as amended, to carry out the purposes of this part 6.

(4) The state department may include in the memorandum of understanding with the department of human services provisions that allow the department of human services to certify agencies as medicaid providers for the purposes of this part 6, to adopt fiscal and administrative procedures, to review plans of care, to recommend reimbursement rates, to make recommendations regarding the scope, duration, and content of programs and the eligibility of persons for specific services provided pursuant to this part 6, and to fulfill any other responsibilities necessary to implement this part 6. However, the provisions shall be consistent with the designation of the state department as the single state agency in section 25.5-4-104.

(5) The executive director and the state board shall promulgate such rules regarding this part 6 as are necessary to fulfill the obligations of the state department as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended.

(6) The department of human services shall promulgate such rules as are necessary to perform its function pursuant to this part 6. Such rules shall be promulgated in accordance with section 24-4-103, C.R.S., and shall be consistent with the rules of the executive director and the state board.

(7) In the event a direct conflict arises between the rules of the state department promulgated pursuant to subsection (5) of this section and the rules of the department of human services promulgated pursuant to subsection (6) of this section, regarding implementation of this part 6, the rules of the state department shall control.

Source: L. 2006: Entire article added with relocations, p. 1952, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-675 as it existed prior to 2006.

25.5-6-607. Implementation of part contingent upon receipt of federal waiver - repeal of part. (1) The implementation of this part 6 is conditioned upon the issuance of necessary waivers by the federal government and available appropriations. The provisions of this part 6 shall be implemented to the extent authorized by federal waiver. The state department shall propose legislation that conforms with the waiver provisions no later than the next regular legislative session following the issuance of the waiver.

(2) Provisions of this part 6 that are approved by the federal government and are authorized by federal waiver shall remain in effect only for so long as specified in the federal waiver, unless otherwise extended by the federal government. The state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this part 6 shall be repealed, effective July 1 of the year in which the waiver is terminated.

Source: L. 2006: Entire article added with relocations, p. 1953, § 7, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-676 as it existed prior to 2006.

(2) As of publication date, the revisor of statutes has not received the notice referred to in subsection (2).

PART 7

HOME- AND COMMUNITY-BASED SERVICES
FOR PERSONS WITH BRAIN INJURY

25.5-6-701. Short title. This part 7 shall be known and may be cited as the "Home- and Community-based Services for Persons with Brain Injury Act".

Source: L. 2006: Entire article added with relocations, p. 1953, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-681 as it existed prior to 2006.

25.5-6-702. Legislative declaration - no entitlement created. (1) The general assembly hereby finds and declares that the purpose of this part 7 is to provide, under federal authorization and subject to available appropriations, home- and community-based services for persons with brain injury.

(2) Nothing in this part 7 shall be construed to establish that eligible persons as defined in section 25.5-6-703 (4) are entitled to receive services from the state department. The provision of any services pursuant to this part 7 shall be subject to federal waiver authorization and available appropriations.

Source: L. 2006: Entire article added with relocations, p. 1953, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-682 as it existed prior to 2006.

25.5-6-703. Definitions. As used in this part 7, unless the context otherwise requires:

(1) "Adult day care" means health and social services furnished two or more hours per day on a regularly scheduled basis for one or more days per week in an outpatient setting and for the purpose of ensuring the optimal functioning of the recipient.

(2) "Behavioral programming" means an individualized plan that sets forth strategies to decrease a recipient's maladaptive behaviors that interfere with the recipient's ability to remain in the community. Behavioral programming includes a complete assessment of maladaptive behaviors of the recipient, the development and implementation of a structured behavioral intervention plan, continuous training and supervision of caregivers and behavioral aides, and periodic reassessment of the individualized plan.

(3) "Brain injury" means an injury to the brain arising from external forces including, but not limited to, toxic chemical reactions, anoxia, near drownings, closed or open head injuries, and focal brain injuries.

(4) "Eligible person" means a person:

(a) Who has a diagnosis of brain injury, as such term is defined in subsection (3) of this section;

(b) Who is in need of the level of care available in a hospital, rehabilitation hospital, hospital in lieu of a nursing facility, or is in need of specialized care provided in a nursing facility in lieu of a hospital;

(c) Who is categorically eligible for medical assistance, or has a gross income that does not exceed three hundred percent of the current federal supplemental security income benefit level and resources that do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101; and

(d) For whom the cost of services would not exceed the average cost of hospital care.

(5) "Independent living skills training" means skills and therapies that are directed at the development and maintenance of community living skills and community integration. Independent living skills include supervision or training with respect to or assistance with self-care, communication skills, socialization, sensory and motor development, reducing maladaptive behavior, community living and mobility, and therapeutic recreation.

(6) "Personal care services" means assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. Personal care services include assistance with the preparation of meals, but not the cost of the meals, and homemaker services that are necessary for the health and safety of the recipient.

(7) "Structured day treatment" means structured, nonresidential therapeutic treatment services that are directed at the development and maintenance of community living skills and are provided two or more hours per day on a regularly scheduled basis for one or more days per week. Day treatment services include supervision and specific training that allows a recipient to function at the recipient's maximum potential. The services include, but are not limited to, social skills training that allows for reintegration into the community, sensory and motor development services, and services aimed at reducing maladaptive behavior.

(8) "Supported living" means assistance or support designed to maximize or maintain independence and self-direction on a supportive care campus. Supported living services consist of structured interventions designed to provide:

(a) Protective oversight and supervision;

(b) Behavioral management and cognitive supports;

(c) Interpersonal and social skills development;

(d) Improved household management skills to support independence and community integration; and

(e) Medical management.

(9) "Supportive care campus" means a residential campus that provides supported living services.

(10) "Transitional living" means a nonmedical residential program that provides training and twenty-four-hour supervision to a recipient that will enhance the recipient's ability to live more independently.

Source: L. 2006: Entire article added with relocations, p. 1954, § 7, effective July 1. **L. 2014:** (10) amended, (SB 14-160), ch. 153, p. 531, § 1, effective May 9.

Editor's note: This section is similar to former § 26-4-683 as it existed prior to 2006.

25.5-6-704. Implementation of home- and community-based services program for persons with brain injury authorized - federal waiver - duties of the department. (1) (a) The state department is hereby authorized to seek any necessary waiver from the federal government to develop and implement a home- and community-based services program for persons with brain injury. The state department shall design the program to provide home- and community-based services to eligible persons. Eligibility shall be limited to persons who meet the level of services provided in a hospital, rehabilitation hospital, hospital in lieu of nursing facility care, or who are in need of specialized care provided in a nursing facility in lieu of a hospital.

(b) The state department shall seek any necessary amendments to the current federal waiver for the home- and community-based services program for persons with brain injury to allow supported living, as defined in section 25.5-6-703 (8), to be provided to eligible persons on a supportive care campus.

(2) Services for eligible persons may be established in department rules to the extent authorized or required by federal waiver, but must include at least the following:

(a) Independent living skills training, as indicated in the eligible person's plan of care, and provided by local agencies determined by the department to be qualified to provide the services;

(b) Residential care including, but not limited to:

(I) Transitional living;

(II) Respite care;

(III) Supported living;

(c) Personal care services;

(d) Assisted transportation;

(e) Counseling and training including treatment for substance use disorders and family counseling;

(f) Environmental modification services;

(g) Day care, which may include physical, occupational, and speech therapies as indicated in the eligible person's plan of care;

(h) Structured day treatment, which may include physical, occupational, speech, and cognitive therapies if deemed necessary by the eligible person's case manager and as indicated in the person's plan of care. Structured day treatment services are for individuals who may benefit from continued rehabilitation and reintegration into the community.

(i) Behavioral programming that may be provided in or outside an eligible person's residence;

(j) Assistive technology;

(k) Services provided under the consumer-directed care service model, part 11 of this article.

(3) The case manager, in coordination with the eligible person and the person's family or guardian, shall include in each plan of care a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person

and the person's family or guardian shall be duly informed by the case manager of these alternative care provisions at the time the plan of care is initiated.

(4) (a) The department shall provide a system of reimbursement for services provided pursuant to this part 7 that encourages the most cost-effective provision of services.

(b) A member of an eligible person's family, other than the person's spouse or a parent of a minor, may be employed to provide personal care services to such person. The maximum reimbursement for the services provided by a member of the person's family per year for an eligible person shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family. Standards that apply to other providers who provide personal care services apply to a family member who provides these services. In addition, a registered nurse shall supervise a family member in providing services to the extent indicated in the eligible person's plan of care.

(5) The state department shall, subject to appropriation, use available federal, state, local, or private funds including, but not limited to, medicaid funds available under Title XIX of the federal "Social Security Act", as amended, to carry out the purposes of this part 7.

(6) The state board shall adopt rules concerning the certification of agencies as medicaid providers for the purposes of this part 7, fiscal and administrative procedures, procedures for reviewing plans of care, reimbursement rates, and the scope, duration, and content of programs and the eligibility for specific services provided pursuant to this part 7. The state board shall adopt such rules as are necessary to fulfill the obligations of the state department as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended.

Source: L. 2006: Entire article added with relocations, p. 1955, § 7, effective July 1. **L. 2017:** IP(2) and (2)(e) amended, (SB 17-242), ch. 263, p. 1330, § 210, effective May 25.

Editor's note: This section is similar to former § 26-4-684 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-6-705. Implementation of part contingent upon receipt of federal waiver - repeal of part. (1) (a) The implementation of this part 7 is conditioned upon the issuance of necessary waivers by the federal government and available appropriations. The provisions of this part 7 shall be implemented to the extent authorized by federal waiver. The state department shall propose legislation that conforms with the waiver provisions no later than the next regular legislative session following the issuance of the waiver.

(b) The implementation of the provisions of this part 7 relating to services provided on a supportive care campus are conditioned upon the approval of necessary waiver amendments by the federal government. The provisions of this part 7 relating to supported living shall be implemented to the extent authorized by federal waiver and in accordance with applicable federal requirements.

(2) Provisions of this part 7 that are approved by the federal government and are authorized by federal waiver shall remain in effect only for so long as specified in the federal waiver, unless otherwise extended by the federal government. The state department shall provide

written notice to the revisor of statutes of the final termination date of the waiver, and this part 7 shall be repealed, effective July 1 of the year in which the waiver is terminated.

Source: L. 2006: Entire article added with relocations, p. 1957, § 7, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-685 as it existed prior to 2006.

(2) As of publication date, the revisor of statutes has not received the notice referred to in subsection (2).

25.5-6-706. Rate structure - rules - quality assurance. (1) (a) The state board, by rule, shall set tiered per diem rates for services provided on a supportive care campus under this part 7. When structuring the tiered per diem rates, the state board shall consider the medical and cognitive needs of eligible persons being served on the supportive care campus.

(b) The maximum per diem rate for the services provided on a supportive care campus shall not exceed the total per diem cost of comparable populations either in institutions or in other community-based settings.

(2) The state board shall adopt rules necessary for quality assurance, which shall include certification of supportive care campuses.

Source: L. 2006: Entire article added with relocations, p. 1958, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-686 as it existed prior to 2006.

PART 8

HOME- AND COMMUNITY-BASED SERVICES
FOR CHILDREN WITH AUTISM

25.5-6-801. Short title. This part 8 shall be known and may be cited as the "Home- and Community-based Services for Children with Autism Act".

Source: L. 2006: Entire article added with relocations, p. 1958, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-691 as it existed prior to 2006.

25.5-6-802. Definitions. As used in this part 8, unless the context otherwise requires:

(1) "Eligible child" means a child who:

(a) Is eligible for the state's medicaid program pursuant to section 25.5-5-101, 25.5-5-201, or 25.5-5-203;

(b) Is age birth to eight years; except that, so long as a child begins receiving services prior to his or her eighth birthday, the child is entitled to continue receiving services for a total of three full years;

(c) Has a diagnosis of autism;

(d) Is at risk of institutionalization in either an intermediate care facility for individuals with intellectual disabilities, a hospital, or a nursing facility; and

(e) Is not receiving services from any of the alternatives to long-term care waiver programs established in this title.

(2) "Lead provider" means the credentialed, certified, or licensed professional who is the eligible child's primary provider and who is responsible for supervision of the eligible child's care plan.

(3) "Services" means the home- and community-based services provided pursuant to this part 8.

Source: L. 2006: Entire article added with relocations, p. 1958, § 7, effective July 1. **L. 2013:** (1)(d) amended, (SB 13-167), ch. 394, p. 2295, § 8, effective June 5. **L. 2015:** (1)(b) amended, (HB 15-1186), ch. 234, p. 867, § 1, effective July 1.

Editor's note: This section is similar to former § 26-4-692 as it existed prior to 2006.

25.5-6-803. Federal authorization - budget neutrality. (1) The state department shall seek the federal authorization necessary to implement the provisions of this part 8.

(2) Home- and community-based services for children with autism shall meet aggregate federal waiver budget neutrality requirements.

(3) (a) Repealed.

(b) The provision of home- and community-based services pursuant to this part 8 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and the costs for the provision of such services.

(4) The state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this part 8, including but not limited to medicaid funds pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) Provide a system of reimbursement for services that encourages the most cost-effective provision of services.

Source: L. 2006: Entire article added with relocations, p. 1958, § 7, effective July 1. **L. 2015:** (3)(a) repealed, (HB 15-1186), ch. 234, p. 867, § 2, effective July 1.

Editor's note: This section is similar to former § 26-4-693 as it existed prior to 2006.

25.5-6-804. Services - duties of the state department - rules. (1) Subject to the provisions of this part 8, home- and community-based services for children with autism shall include only the following services, as specified in the eligible child's care plan:

(a) Occupational therapy;

(b) Speech therapy;

(c) Psychological and psychiatric services;

(d) Physical therapy;

(e) Behavioral therapy; and

(f) Services provided under the consumer-directed care service model, part 11 of this article.

(2) Within the limits of the general assembly's annual appropriations, the medical services board shall set an annual dollar limit on the amount of services that an eligible child may receive pursuant to this part 8.

(3) The state department shall utilize the services of existing service provider agencies to provide services pursuant to this part 8. A service provider agency shall retain no more than fifteen percent of the established service reimbursement rate for administrative costs.

(4) A care planning agency may be certified to provide the services described in subsection (1) of this section if otherwise qualified as a provider under the state medical assistance program.

(5) The state department shall contract with a community centered board for persons with developmental disabilities to serve as the single entry point agency for services and as the care planning agency for eligible children. If a community centered board is unwilling or unable to enter into the contract with the state department, the state department may contract with a single entry point agency identified pursuant to section 25.5-6-106 or a state-department-approved case management agency to serve as the entry point agency and as the care planning agency. The care planning process shall include the eligible child's family or guardian, the eligible child's lead provider, and the eligible child's case manager. For the purpose of implementing this part 8 the care planning process shall be coordinated with any other care plan or case manager the eligible child may have.

(6) A member of an eligible child's family may be employed to provide services to the child. The reimbursement limitation in section 25.5-6-310 shall not apply to services provided pursuant to this part 8 by a family member.

(7) The state department shall develop the service provisions, which shall include provisions for the supervision of direct care providers, and the care planning process under this part 8 in consultation with parents of children with autism and medical professionals who have expertise in treating children with autism.

(8) (a) The state board shall adopt rules necessary to implement and administer the provisions of this part 8, including but not limited to requiring an ongoing evaluation process for each eligible child and the use of an external evaluation contractor for this purpose.

(b) An eligible child participating in services pursuant to this part 8 shall be evaluated at entry into the program, at least every six months during the course of services, and at the termination of services pursuant to this part 8. The evaluations shall include, but need not be limited to:

(I) An assessment of the eligible child's expressive and receptive communication through the use of a standardized and norm-referenced assessment as determined by the state department through rule;

(II) An assessment of the eligible child's adaptive skills including self-help skills through the use of a norm-referenced and standardized assessment as determined by the state department through rule; and

(III) An assessment of the severity of the eligible child's maladaptive behavior, including self-injurious or aggressive behaviors or tantrums, through the use of a norm-referenced and standardized assessment as determined by the state department through rule.

(c) The evaluations shall be conducted pursuant to the provisions of paragraph (b) of this subsection (8) by the child's lead therapist or other trained professionals as designated by the department.

(d) The evaluator shall provide a copy of the evaluation, including any supporting data, to the eligible child's parent or legal guardian and to the agency responsible for the eligible child's care planning. The agency responsible for the eligible child's care planning shall retain a copy of the eligible child's evaluation and supporting data.

(e) Any costs associated with the evaluations required pursuant to this subsection (8) shall be included within the annual cost limitation on services set forth in subsection (2) of this section. Evaluations of an eligible child may be conducted through the eligible child's school or with other resources that are not part of the services provided pursuant to this part 8, so long as the evaluations are consistent with the provisions of paragraph (b) of this subsection (8).

(f) The ongoing evaluation of children receiving services under the program pursuant to this subsection (8) shall not be used to alter a child's eligibility to participate in the program.

(9) Repealed.

(10) Subject to available appropriations, it is the intent of the general assembly to provide services to every eligible child who applies for the waiver program and that no eligible child is placed on a waiting list for services.

Source: L. 2006: Entire article added with relocations, p. 1959, § 7, effective July 1. **L. 2010:** (5) amended, (SB 10-129), ch. 105, p. 354, § 1, effective April 15. **L. 2012:** (8) amended and (9) and (10) added, (SB 12-159), ch. 203, p. 808, § 2, effective July 1. **L. 2015:** (2) and (10) amended and (9) repealed, (HB 15-1186), ch. 234, p. 867, § 3, effective July 1.

Editor's note: This section is similar to former § 26-4-694 as it existed prior to 2006.

Cross references: For the legislative declaration in the 2012 act amending subsection (8) and adding subsections (9) and (10), see section 1 of chapter 203, Session Laws of Colorado 2012.

25.5-6-805. Colorado autism treatment fund. (1) The Colorado autism treatment fund is hereby created and established in the state treasury for the purpose of paying for services provided to eligible children, early and periodic screening diagnosis and treatment services required by section 25.5-5-102 (1)(g), and participant and program evaluations pursuant to this part 8. The fund is comprised of tobacco settlement moneys allocated to the fund. Moneys in the fund are subject to annual appropriation by the general assembly for the purposes of this part 8. At the end of any fiscal year, all unexpended and unencumbered moneys in the fund shall remain therein and shall not be credited or transferred to the general fund or any other fund. Any moneys in the fund not expended for the purpose of this part 8 may be invested by the state treasurer as provided by law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.

(2) Pursuant to section 24-75-1104.5 (1.7)(k), C.R.S., for the 2016-17 fiscal year and for each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement, the state treasurer shall annually transfer to the fund two percent of the moneys received by the state pursuant to the master settlement agreement for the preceding fiscal year.

The state treasurer shall transfer the amount specified in this subsection (2) from moneys credited to the tobacco litigation settlement cash fund created in section 24-22-115, C.R.S.

Source: L. 2006: Entire article added with relocations, p. 1960, § 7, effective July 1. **L. 2009:** Entire section amended, (SB 09-210), ch. 124, p. 531, § 4, effective April 16. **L. 2012:** (1) amended, (SB 12-159), ch. 203, p. 809, § 3, effective July 1. **L. 2016:** Entire section amended, (HB 16-1408), ch. 153, p. 468, § 19, effective July 1.

Editor's note: This section is similar to former § 26-4-695 as it existed prior to 2006.

Cross references: For the legislative declaration in the 2012 act amending subsection (1), see section 1 of chapter 203, Session Laws of Colorado 2012.

25.5-6-806. Autism waiver - program evaluation. (1) As provided in subsection (2) of this section, the state department shall submit written program evaluations to the health and environment committee of the house of representatives, or any successor committee, and to the health and human services committee of the senate, or any successor committee, concerning home- and community-based services provided to children with autism pursuant to this part 8. The state department shall determine the appropriate process and procedures for conducting the evaluation, including procedures to protect a program participant's individually identifying information.

(2) (a) On or before June 1, 2013, the state department's evaluation shall include, at a minimum, information concerning:

(I) The number of eligible children receiving services or who have received services under the waiver program;

(II) The average and median age of eligible children when they begin receiving services and the average length of time that children receive services; and

(III) The average cost of services provided to an eligible child.

(b) On or before June 1, 2014, the state department's evaluation shall include, at a minimum, information concerning the design and implementation of the ongoing evaluation process pursuant to section 25.5-6-804 (8).

(c) (I) On or before June 1, 2015, and every June 1 thereafter, the state department's evaluation shall include an evaluation of eligible children's care plans and evaluations conducted at the beginning and ending of services, as well as ongoing evaluations during the course of services, to determine whether home- and community-based services provided pursuant to this part 8 are effective in meeting the goals of the waiver program, which goals include, but are not limited to:

(A) Serving the children most vulnerable to institutionalization without the services provided pursuant to this part 8;

(B) Keeping children out of institutions; and

(C) Demonstrating improvement in the child's expressive and receptive communication, adaptive skills, such as dressing and toileting, and a reduction in the severity of the child's maladaptive behavior, including self-injurious or aggressive behavior and tantrums, through the use of standardized and norm-referenced assessments.

(II) The state department may contract with an independent program evaluator with expertise in reviewing treatment progress reports, individual evaluations, and medical records for purposes of conducting the evaluation pursuant to this paragraph (c) concerning the effectiveness of the home- and community-based services provided pursuant to this part 8.

Source: L. 2012: Entire section added, (SB 12-159), ch. 203, p. 809, § 4, effective July 1. **L. 2015:** IP(2)(c)(I) amended, (HB 15-1186), ch. 234, p. 868, § 5, effective July 1.

Cross references: For the legislative declaration in the 2012 act adding this section, see section 1 of chapter 203, Session Laws of Colorado 2012.

PART 9

HOME- AND COMMUNITY-BASED SERVICE
PROGRAMS FOR CHILDREN

25.5-6-901. Disabled children care program - eligibility criteria - documentation requirements - report to the general assembly. (1) The general assembly hereby finds and declares that a program shall be established by the state department to provide services not otherwise available to eligible disabled children outside the confines of an acute care hospital or nursing facility. Such program shall be known as the "disabled children care program" and shall be designed to safely provide services to eligible disabled children in a home- or community-based setting at a cost to the medicaid program equal to or less than the medicaid cost of inpatient hospital or nursing facility care.

(2) (a) The state department is authorized to seek a waiver from the federal department of health and human services to qualify for federal financial participation in the disabled children care program. Application for such waiver is contingent upon a finding that continuation of the disabled children care program results in less expenditures from the general fund than if such program were terminated.

(b) If federal financial participation is secured, eligibility for participation in the program and the number of children to be served under the program shall be in accordance with federal regulations.

(3) (a) "Eligible disabled children" means any children eighteen years of age and under who:

(I) Have medical needs which would qualify them, pursuant to state department criteria, for institutionalization or place them at risk for institutionalization in any one of the following: An acute care hospital or a nursing facility; and

(II) Have gross incomes which do not exceed three hundred percent of the current federal supplemental security income benefit level. The amount of parental or spousal income and resources which shall be attributable to a child's gross income for purposes of eligibility shall be set forth in rules promulgated by the state board and shall be in relation to the parent's or spouse's financial responsibility for such child; and

(III) Are not receiving services from any of the alternatives to long-term care waiver programs established under this title.

(b) "Home care services" means all services available under sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203 that may be received in a noninstitutional setting.

(4) (a) The state department shall require the following documentation on each applicant for the program:

(I) An assessment by the disabled child's attending physician of the child's medical, functional, and social status and a determination by such physician that the quality of care which can be provided in the noninstitutional setting is equal to or exceeds the quality of care the child could receive in an acute care hospital or nursing facility;

(II) An analysis of the cost of services for the disabled child in an institutional setting as compared to the cost of such services in a noninstitutional setting;

(III) An assessment of the caregiver's ability to provide the needed services to the disabled child in a noninstitutional setting and an assessment of such caregiver's social history.

(b) The information required under paragraph (a) of this subsection (4) shall be collected and reviewed by the state department at least every six months for disabled children who enter the disabled children care program in order to ensure that the quality of noninstitutional care continues to equal or exceed such care in an institutional setting and that the costs for care under the program are less than the costs for such care in an institution. When the disabled child is found to no longer qualify for institutionalization or be at risk for institutionalization pursuant to state department criteria, the child shall no longer be eligible for the disabled children care program.

Source: L. 2006: Entire article added with relocations, p. 1960, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-509 as it existed prior to 2006.

25.5-6-902. Children's personal assistance services and family support program. (1) The general assembly finds that many families who attempt to care for severely disabled or terminally ill children at home often are burdened with the excessive financial and personal costs of providing continuous care. Private insurance companies rarely support essential, long-term custodial services and often establish monetary limits that are well below the levels required by these disabled children. When coverage is available, care is frequently provided in a medical model that is marginally appropriate to the needs of the children and the family and usually more expensive to the payor. The resulting pressures often contribute to family disintegration and increased dependency on public programs. The general assembly finds that it is in the best interests of the citizens of the state to encourage the preservation of families with children with disabilities.

(2) As used in this section, unless the context otherwise requires, "eligible disabled children" means children eighteen years of age or younger:

(a) Who have medical needs that, pursuant to state department rules, would qualify them for institutionalization or place them at risk of institutionalization in an acute care hospital or nursing facility;

(b) Who have gross incomes, including the amount of parental income and resources to be attributed to the child's gross income according to rules to be promulgated by the state board, that do not exceed three hundred percent of the current federal supplemental security income benefit level;

(c) Who are not receiving long-term services from any alternative waiver program established under this title;

(d) For whom a licensed physician or an advanced practice nurse has certified that in-home care is an appropriate way to meet the child's needs; and

(e) For whom the cost of care outside of the institution is no higher than the estimated medicaid cost of appropriate institutional care.

(3) There is hereby established in the state department the children's personal assistance services and family support waiver program, referred to in this section as the "program", to provide services to eligible disabled children in their homes rather than in the confines of an acute care hospital or nursing facility. The number of children enrolled in this program or any other model 200 program shall not exceed the state department's ability to cover the costs of the programs within the annual appropriations for this program and any other model 200 program.

(4) Priority for participation in the program shall be given first to children who are on the waiting list for other model 200 programs and secondly to children whose parents will return to work if appropriate care for their disabled child is provided under the program. Spaces in the program shall also be available to children who were already covered by medicaid but who were rendered temporarily ineligible for a period of not more than three months due to a periodic or cyclical peak in their parents' income.

(5) The state board shall adopt rules to govern the program consistent with any federal waivers including, but not limited to, rules concerning:

(a) Services that are reimbursable under this section including, but not limited to:

(I) Respite care, to the degree its additional cost is offset by collection of a parental copayment;

(II) Case management; and

(III) Medically necessary professional or community services beyond those specified in section 25.5-5-102 or 25.5-5-202, to the degree that they provide a cost-effective and medically appropriate alternative to covered services;

(b) Provider selection and certification;

(c) Documentation for assessment and recertification;

(d) Case management agency selection and responsibility; and

(e) Reimbursement.

(6) The case management agency, in coordination with the eligible disabled child's family and the child's physician, shall include in each case plan a process by which the eligible disabled child may receive necessary care, which may include respite care, if the eligible disabled child's family or care provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible disabled child's family shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(7) If the state department finds it cost-effective and all necessary federal waivers are obtained, parents of eligible disabled children may be authorized to hire and manage care providers from certified medicaid agencies. Case management agencies shall work with parents to develop the skills necessary for ongoing care management.

(8) The state department is authorized to seek waivers from the federal government to qualify for federal financial participation in the program.

(9) The state department is authorized to charge and collect copayments from parents for services rendered.

(10) The state department is directed to study the advisability of setting an upper limit on parental income for participation in this program and other children's medicaid waiver programs.

Source: L. 2006: Entire article added with relocations, p. 1962, § 7, effective July 1. **L. 2008:** (2)(d) amended, p. 134, § 22, effective January 1, 2009.

Editor's note: This section is similar to former § 26-4-509.2 as it existed prior to 2006.

PART 10

CONSUMER-DIRECTED ATTENDANT SUPPORT
FOR PERSONS WITH DISABILITIES

25.5-6-1001 to 25.5-6-1004. (Repealed)

Editor's note: (1) This article was added with relocations in 2006, and this part 10 was subsequently repealed in 2009. For amendments to this part 10 prior to its repeal in 2009, consult the Colorado statutory research explanatory note beginning on page vii in the front of this volume and the editor's note following the article heading.

(2) Section 25.5-6-1004 provided for the repeal of this part 10, effective July 1, 2009. (See L. 2006, p. 1967.)

(3) Section 25.5-6-1002 (4) was amended in Senate Bill 09-292, effective August 5, 2009. However, those amendments did not take effect due to the repeal of this part 10, effective July 1, 2009.

PART 11

CONSUMER-DIRECTED CARE

25.5-6-1101. Definitions. As used in this part 11, unless the context otherwise requires:

(1) "Attendant support" means any action to assist an eligible person in accomplishing activities of daily living, instrumental activities of daily living, and habilitative and health-related tasks. Such activities include, but are not limited to, personal care services, household services, cognitive services, mobility services, and health-related tasks.

(2) "Authorized representative" means an individual designated by the eligible person, by the parent of a minor, or by the legal guardian of the eligible person if the eligible person cannot demonstrate sound judgment to his or her primary care physician, who has the judgment and ability to assist the eligible person in acquiring and utilizing services under this part 11. The extent of the authorized representative's involvement shall be determined upon designation.

(3) "Consumer-directed" means that an eligible person receives a direct payment through a voucher and employs, trains, and in other ways manages the person who provides his or her attendant support. The direct payment through a voucher that is received by an eligible person to pay for attendant support shall not be counted as income for purposes of determining eligibility for medicaid and other state programs that use income to determine eligibility.

(4) "Eligible person" means a person who is eligible to receive services under parts 3 to 12 of this article or any other home- and community-based service waiver for which the state department has federal waiver authority.

(5) "Primary care physician" means a physician who is the primary provider of physician services to the eligible person or who is familiar with the eligible person's needs and capabilities.

(6) "Qualified services" means services provided under the eligible person's applicable waiver program and attendant support.

Source: L. 2006: Entire article added with relocations, p. 1967, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-1301 as it existed prior to 2006.

25.5-6-1102. Service model - consumer-directed care. (1) The state department shall implement a consumer-directed care service model that allows eligible persons to receive a direct payment through a voucher to purchase qualified services. The state department is authorized to seek any federal waivers or waiver amendments that may be necessary to implement this part 11. The state department shall design and implement the consumer-directed care service model with input from consumers of home- and community-based services or their authorized representatives. An eligible person shall not be required to disenroll from the person's waiver program in order to receive qualified services through the consumer-directed care service model.

(2) In order to qualify and to remain eligible for the consumer-directed care service model authorized by this section, a person shall:

(a) Be eligible for home- and community-based services under parts 3 to 12 of this article or any other home- and community-based service waiver for which the state department has federal waiver authority;

(b) Be willing to participate;

(c) Obtain a statement from his or her primary care physician or advanced practice nurse indicating that the person has sound judgment and the ability to direct his or her care or has an authorized representative;

(d) Demonstrate the ability to handle the financial aspects of self-directed care or has an authorized representative who is able to handle the financial aspects of the eligible person's care; and

(e) Meet any other qualifications established by the state board by rule.

(3) The voucher issued to the eligible person under this part 11 shall be based on the eligible person's historical utilization of home- and community-based services under parts 3 to 12 of this article, the single entry point agency's care plan, or any approved resource allocation process as determined by the state department and the department of human services for the eligible person.

(4) While an eligible person is participating in the consumer-directed care service model established in this part 11, that person shall be ineligible to receive a home care allowance as provided in section 26-2-122.3 (1)(b), C.R.S.

(5) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars, to promote effective and efficient delivery of services, and to monitor the safety and welfare of eligible persons under this part 11.

(6) The state board shall adopt rules as necessary for the implementation and administration of the consumer-directed care service model authorized by this part 11. Such rules shall include a provision allowing an eligible person to designate a family member or authorized representative to be responsible for managing the financial matters associated with the consumer-directed care or to direct the eligible person's care. The designee shall not receive reimbursement for managing the financial matters associated with the eligible person's care or for directing the eligible person's care.

(7) Sections 12-38-103 (8), 12-38-103 (11), 12-38-123 (1)(a), 12-38.1-102 (5), and 12-38.1-117 (1)(b), C.R.S., shall not apply to a person who is directly employed by an individual participating in the consumer-directed care service model pursuant to this section and who is acting within the scope and course of such employment. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(8) Section 25.5-6-310 does not apply to a family member of an eligible person who provides consumer-directed care services to the eligible person pursuant to this part 11.

(9) A person who has been designated as an authorized representative under this part 11 shall submit an affidavit, which shall become part of the eligible person's file, stating that:

(a) He or she is at least eighteen years of age;

(b) He or she has known the eligible person for at least two years;

(c) He or she has not been convicted of any crime involving exploitation, abuse, or assault on another person; and

(d) He or she does not have a mental, emotional, or physical condition that could result in harm to the eligible person.

Source: L. 2006: Entire article added with relocations, p. 1968, § 7, effective July 1. **L. 2008:** (2)(c) amended, p. 134, § 24, effective January 1, 2009.

Editor's note: This section is similar to former § 26-4-1302 as it existed prior to 2006.

25.5-6-1103. Reporting. (1) The state department shall provide a report to the joint budget committee of the general assembly and the health and human services committees of the house of representatives and the senate, or any successor committees, by October 1, 2006, that includes, but is not limited to, the following:

(a) The number of elderly persons participating in the consumer-directed care program;

(b) The cost-effectiveness of the consumer-directed care program;

(c) Feedback from consumers and the state department concerning the progress and success of the consumer-directed care program; and

(d) Any changes to the health status or health outcomes of the program participants.

Source: L. 2006: Entire article added with relocations, p. 1969, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-1303 as it existed prior to 2006.

PART 12

IN-HOME SUPPORT SERVICES

25.5-6-1201. Legislative declaration. (1) The general assembly finds that there may be a more effective way to deliver home- and community-based services to the elderly, blind, and disabled; to disabled children; and to persons with spinal cord injuries, that allows for more self-direction in their care and a cost savings to the state. The general assembly also finds that every person that is currently receiving home- and community-based services does not need the same level of supervision and care from a licensed health care professional in order to meet his or her care needs and remain living in the community. The general assembly, therefore, declares that it is beneficial to the elderly, blind, and disabled clients of home- and community-based services, to clients of the disabled children care program, and to clients enrolled in the spinal cord injury waiver pilot program, for the state department to develop a service that would allow these people to receive in-home support.

(2) The general assembly further finds that allowing clients more self-direction in their care is a more effective way to deliver home- and community-based services to clients with major mental illnesses and brain injuries, as well as to clients receiving home- and community-based supportive living services and children's extensive support services. Therefore, the general assembly declares that it is appropriate for the state department to develop a plan for expanding the availability of in-home support services to include these clients.

Source: L. 2006: Entire article added with relocations, p. 1970, § 7, effective July 1. **L. 2014:** Entire section amended, (HB 14-1358), ch. 255, p. 1017, § 2, effective August 6; entire section amended, (HB 14-1357), ch. 254, p. 1013, § 1, effective March 1, 2015.

Editor's note: (1) This section is similar to former § 26-4-1401 as it existed prior to 2006.

(2) Amendments to this section by HB 14-1357 and HB 14-1358 were harmonized.

25.5-6-1202. Definitions. As used in this part 12, unless the context otherwise requires:

(1) "Attendant" means a person who is directly employed by an in-home support service agency to provide, or a family member, including a spouse, providing, in-home support services to eligible persons.

(2) "Authorized representative" means an individual designated by the eligible person receiving services, or by the parent or guardian of the eligible person receiving services, if appropriate, who has the judgment and ability to assist the eligible person receiving services in acquiring and utilizing services under this part 12. The extent of the authorized representative's involvement shall be determined upon designation. The authorized representative shall not be the eligible person's service provider.

(3) "Eligible person" means any person who:

(a) Is enrolled in home- and community-based services pursuant to part 3 of this article, is enrolled in the spinal cord injury waiver pilot program pursuant to part 13 of this article, or is enrolled in the disabled children care program pursuant to section 25.5-6-901;

(b) Is willing to participate;

(c) Obtains a statement from his or her primary care physician indicating that the person has sound judgment and the ability to direct his or her care, the eligible child's parent or guardian has sound judgment and the ability to direct the eligible child's care, or the person has an authorized representative; and

(d) Meets any other qualifications established by the state board by rule.

(4) "Health maintenance activities" means health-related tasks as defined in rule by the state board and include, but are not limited to, catheter irrigation; administration of medication, enemas, and suppositories; and wound care.

(5) "In-home support service agency" means an agency that is certified by the state department and provides independent living core services as defined in section 8-85-102 (6), C.R.S., and in-home support services.

(6) "In-home support services" means services that are provided in the home and in the community by an attendant under the direction of the eligible person or the eligible person's authorized representative including health maintenance activities and support for activities of daily living or instrumental activities of daily living, and personal care services and homemaker services as defined in rules promulgated by the medical services board pursuant to section 24-4-103, C.R.S.

Source: L. 2006: Entire article added with relocations, p. 1970, § 7, effective July 1. **L. 2014:** (3)(a) amended, (HB 14-1358), ch. 255, p. 1018, § 3, effective August 6; (1), (3)(a), and (6) amended, (HB 14-1357), ch. 254, p. 1014, § 2, effective March 1, 2015. **L. 2015:** (5) amended, (SB 15-240), ch. 139, p. 423, § 5, effective July 1. **L. 2016:** (5) amended, (SB 16-093), ch. 54, p. 132, § 5, effective July 1.

Editor's note: This section is similar to former § 26-4-1402 as it existed prior to 2006.

25.5-6-1203. In-home support services - eligibility - licensure exclusion - in-home support service agency responsibilities - rules. (1) The state department shall offer in-home support services as an option for eligible persons who receive home- and community-based services. In-home support services shall be provided to eligible persons. The state department shall seek any federal authorization that may be necessary to implement this part 12. The state department shall design and implement in-home support services with input from consumers of home- and community-based services and independent living centers and home- and community-based service providers.

(1.5) The state department shall develop a plan to expand the provision of in-home support services to include clients eligible for home- and community-based services pursuant to parts 6 and 7 of this article and home- and community-based adult supportive living services and children's extensive support services pursuant to part 4 of this article. On or before March 1, 2015, the state department shall report to the public health and human services committee of the house of representatives and to the health and human services committee of the senate, or any successor committees, concerning the state department's plan for providing in-home support services to these clients, including the timeline for implementation of the service.

(2) An eligible person receiving in-home support services or the eligible person's authorized representative or parent or guardian shall be allowed to:

(a) Choose the eligible person's in-home support service agency or the eligible person's attendant; and

(b) Direct the eligible person's care, including directly scheduling, managing, and supervising the attendant, and determine the level of in-home support services agency support.

(3) Sections 12-38-103 (8), 12-38-103 (11), 12-38-123 (1)(a), 12-38.1-102 (5), and 12-38.1-117 (1)(b), C.R.S., shall not apply to a person who is directly employed by an in-home support service agency to provide in-home support services and who is acting within the scope and course of such employment or is a family member providing in-home support services pursuant to this part 12. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(4) (a) In-home support service agencies providing in-home support services shall provide twenty-four-hour back-up services to their clients. In-home support service agencies shall either contract with or have on staff a state licensed health care professional, as defined by the state board by rule, acting within the scope of the person's profession. The state board shall promulgate rules setting forth the training requirements for attendants providing in-home support services and the oversight and monitoring responsibilities of the state licensed health care professional that is either contracting with or is on staff with the in-home support service agency. The state board rules must allow the eligible person or the eligible person's authorized representative, parent of a minor, or guardian to determine, in conjunction with the in-home support services agency, the amount of oversight needed in connection with the eligible person's in-home support services.

(b) The state board shall promulgate rules that establish how an in-home support service agency can discontinue a client under this part 12. The rules shall establish that a client can only be involuntarily discontinued when equivalent care in the community has been secured or that a client can be discontinued after exhibiting documented prohibited behavior involving attendants, including abuse of attendants, and that dispute resolution has failed. The determination of whether an in-home support service agency has made adequate attempts at resolution shall be made by the state department.

(5) The single entry point agencies established in section 25.5-6-106 shall be responsible for determining a person's eligibility for in-home support services; except that for eligible disabled children the state department shall designate the entity that will determine the child's eligibility. The state board shall promulgate rules specifying the single entry point agencies' responsibilities under this part 12. At a minimum, these rules shall require that case managers discuss the option and potential benefits of in-home support services with all eligible long-term care clients.

(6) Section 25.5-6-310 does not apply to a family member of an eligible person who provides in-home support services to the eligible person pursuant to this part 12. The state board shall promulgate rules, as necessary, to establish limits on reimbursement to family members.

(7) In administering the provision of in-home support services pursuant to this part 12, the state department shall:

(a) Implement a system for the routine and accurate monitoring of the number of persons receiving in-home support services; and

(b) Provide comprehensive, periodic training for all single entry point agencies in the state, which training shall include, at a minimum:

(I) The current eligibility requirements for the receipt of in-home support services; and

(II) The location of, and contact information for, the in-home support service agencies providing in-home support services in the state.

Source: L. 2006: Entire article added with relocations, p. 1971, § 7, effective July 1. **L. 2011:** (7) added, (SB 11-105), ch. 277, p. 1244, § 1, effective June 2. **L. 2014:** (1.5) added and (2), (4)(a), and (6) amended, (HB 14-1357), ch. 254, p. 1014, § 3, effective March 1, 2015.

Editor's note: This section is similar to former § 26-4-1403 as it existed prior to 2006.

25.5-6-1204. Provision of services - duties of state department - gifts - grants. (1) The provision of the in-home support services set forth in this part 12 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and the costs for the provision of such services.

(2) The state department shall seek and utilize any available federal, state, or private funds that are available for carrying out the purposes of this part 12, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended.

(3) The executive director of the state department is authorized to accept and expend on behalf of the state any grants or gifts from any public or private source for the purpose of implementing this part 12.

Source: L. 2006: Entire article added with relocations, p. 1972, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-1404 as it existed prior to 2006.

25.5-6-1205. Accountability - rate structure - rules. (1) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars and to promote effective and efficient service delivery under this part 12.

(2) The state board, by rule, shall set a separate rate structure for in-home support services provided under this part 12.

(3) The state board shall adopt rules as necessary for the implementation and administration of the in-home support services authorized by this part 12. At a minimum, the rules shall include certification of in-home support service agencies and standards of care for the provision of services under this part 12.

Source: L. 2006: Entire article added with relocations, p. 1972, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-1405 as it existed prior to 2006.

25.5-6-1206. Report. The state department shall report annually to the joint budget committee of the general assembly and the health and human services committee of the senate, or any successor committee, and the health and environment committee of the house of

representatives, or any successor committee, on the implementation of in-home support services. At a minimum the report shall include the cost-effectiveness of providing in-home support services to the elderly, blind, and disabled and to eligible disabled children, the number of persons receiving such services, and any strategies and resources that are available or that are necessary to assist more persons in staying in their homes through the use of in-home support services.

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1. **L. 2011:** Entire section amended, (SB 11-105), ch. 277, p. 1244, § 2, effective June 2.

Editor's note: This section is similar to former § 26-4-1406 as it existed prior to 2006.

25.5-6-1207. Repeal of part. This part 12 is repealed, effective September 1, 2019. Prior to such repeal, in-home support services established under this part 12 shall be reviewed as provided for in section 24-34-104, C.R.S.

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1. **L. 2008:** Entire section amended, p. 323, § 3, effective April 7. **L. 2011:** Entire section amended, (SB 11-105), ch. 277, p. 1245, § 3, effective June 2. **L. 2014:** Entire section amended, (HB 14-1358), ch. 255, p. 1018, § 4, effective August 6.

Editor's note: This section is similar to former § 26-4-1407 as it existed prior to 2006.

25.5-6-1208. Conditional repeal of part. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1. **L. 2011:** Entire section repealed, (SB 11-105), ch. 277, p. 1245, § 4, effective June 2; entire section repealed, (HB 11-1303), ch. 264, p. 1169, § 69, effective August 10.

Editor's note: This section is similar to former § 26-4-1408 as it existed prior to 2006.

PART 13

COMPLEMENTARY AND ALTERNATIVE MEDICINE FOR A PERSON WITH A SPINAL CORD INJURY

25.5-6-1301. Legislative declaration. (1) The general assembly finds that:

(a) A person with a spinal cord injury could benefit from complementary and alternative medicine such as chiropractic care, massage therapy, or acupuncture; and

(b) Complementary and alternative medicine could improve the quality of life and help reduce the need for continuous or more expensive procedures, medications, and hospitalizations for a person with a spinal cord injury and could allow a person with a spinal cord injury to be employed.

Source: L. 2009: Entire part added, (HB 09-1047), ch. 395, p. 2128 § 1, effective August 5. **L. 2015:** Entire section amended, (SB 15-011), ch. 333, p. 1354, § 1, effective June 5.

25.5-6-1302. Definitions. As used in this part 13, unless the context otherwise requires:

(1) "Complementary or alternative medicine" means a form of diverse health care services not provided for under this article or article 4 or 5 of this title prior to August 5, 2009, but authorized by the rules of the state board adopted pursuant to section 25.5-6-1303 (4). The medicine is limited to chiropractic care, massage therapy, and acupuncture performed by licensed or certified providers.

(2) "Eligible person with a disability" means a person with a disability who meets the eligibility criteria specified in section 25.5-6-1303 (2)(b).

(3) "Pilot program" means the pilot program authorized pursuant to section 25.5-6-1303 to allow an eligible person with a disability to receive complementary and alternative medicine.

Source: L. 2009: Entire part added, (HB 09-1047), ch. 395, p. 2128, § 1, effective August 5. **L. 2015:** (1) and (3) amended, (SB 15-011), ch. 333, p. 1354, § 2, effective June 5.

25.5-6-1303. Pilot program - complementary or alternative medicine - rules. (1) (a) The general assembly authorizes the state department to implement a pilot program that would allow an eligible person with a disability to receive complementary or alternative medicine to the extent authorized by federal waiver. The pilot program may begin no later than January 1, 2012. The state department shall design and implement the pilot program with input from an advisory committee that must include, but need not be limited to, persons with spinal cord injuries who are receiving complementary or alternative medicine. The state department shall continue to utilize a volunteer outreach coordinator throughout the duration of the pilot program whose duties include, but are not limited to, facilitating participant and provider enrollment and acting as an informal liaison between the state department, pilot program participants, and other stakeholders. The state department may seek any federal waivers that may be necessary to implement this part 13.

(b) Subject to available funds, it is the intent of the general assembly that the state department enroll every eligible person that applies for the waiver and that an eligible person is not placed on a waiting list for services.

(2) (a) The purpose of the pilot program is to expand the choice of therapies available to eligible persons with disabilities, to study the success of complementary and alternative medicine, and to produce an overall cost savings for the state compared to the estimated expenditures that would have otherwise been spent for the same persons with spinal cord injuries absent the pilot program.

(b) In order to qualify and to remain eligible for the pilot program authorized by this section, a person shall:

(I) Be diagnosed with a spinal cord injury;

(II) Be willing to participate in the pilot program;

(III) Demonstrate a current need, as further defined in rule by the state board, for complementary or alternative medicine; and

(IV) Be eligible for medicaid, including but not limited to persons whose gross income does not exceed three hundred percent of the current federal supplemental security income

benefit level and who are eligible for a home- and community-based program authorized pursuant to this title or the consumer-directed attendant support pilot program authorized pursuant to part 10 of article 6 of this title.

(3) The state department shall develop the accountability requirements for the pilot program necessary to safeguard the use of public moneys and to promote effective and efficient service delivery.

(4) The state board shall adopt rules as necessary for the implementation and administration of the pilot program.

(5) The state department shall cause to be conducted an independent evaluation of the pilot program to be completed no later than January 1, 2020. The state department shall provide a report of the evaluation to the health and human services committees of the senate and the house of representatives, or any successor committees. The report on the evaluation must include the following:

(a) The number of eligible persons with disabilities participating in the pilot program;

(b) The cost-effectiveness of the pilot program;

(c) Feedback from consumers and the state department concerning the progress and success of the pilot program;

(d) Any changes to the health status or health outcomes of the persons participating in the pilot program;

(e) Other information relevant to the success and problems of the pilot program; and

(f) Recommendations concerning the feasibility of continuing the pilot program beyond the pilot stage and changes, if any, that are needed.

(6) Repealed.

(7) Unless the state department receives sufficient appropriations, the state department is not required to seek federal approval or implement the pilot program.

Source: L. 2009: Entire part added, (HB 09-1047), ch. 395, p. 2129, § 1, effective August 5. **L. 2015:** (1), (2)(a), (2)(b)(III), (5), and (7) amended and (6) repealed, (SB 15-011), ch. 333, p. 1355, § 3, effective June 5.

25.5-6-1304. Repeal of part. This part 13 is repealed, effective September 1, 2020.

Source: L. 2009: Entire part added, (HB 09-1047), ch. 395, p. 2130, § 1, effective August 5. **L. 2015:** Entire section amended, (SB 15-011), ch. 333, p. 1356, § 4, effective June 5.

PART 14

MEDICAID BUY-IN

Cross references: For the "Ticket to Work and Work Incentives Improvement Act of 1999", see Pub.L. 106-170, codified at 42 U.S.C. sec. 1320b-19.

25.5-6-1401. Legislative declaration. The general assembly hereby declares its support for the full employment of people with disabilities. It is the general assembly's intent to enact this part 14 for the purpose of allowing an individual with disabilities to purchase medicaid

coverage that will enable the individual to maintain employment without losing his or her medicaid benefits.

Source: L. 2008: Entire part added, p. 2197, § 1, effective July 1.

25.5-6-1402. Definitions. As used in this part 14, unless the context otherwise requires:

(1) "Basic coverage group" means the category of eligibility under the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170, that provides an opportunity to buy into medicaid consistent with the federal "Social Security Act", 42 U.S.C. sec. 1396a (a)(10)(A)(ii)(XV), as amended, for each worker with disabilities who is at least sixteen years of age but less than sixty-five years of age and who, except for earnings, would be eligible for the supplemental security income program. A person who is eligible under the basic coverage group may also be a home- and community-based services waiver recipient.

(2) "Family" means an individual, the individual's spouse, and any dependent child of the individual.

(3) "Health insurance" means surgical, medical, hospital, major medical, or other health service coverage, including a self-insured health plan, but does not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time, or accident benefits.

(4) "Medicaid buy-in program" means a program that gives each person with disabilities the opportunity to buy into medicaid if the person meets the eligibility criteria specified in section 25.5-6-1404.

(5) "Medical improvement group" means the category of eligibility under the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170, that provides an opportunity to buy into medicaid consistent with the federal "Social Security Act", 42 U.S.C. sec. 1496a (a)(10)(A)(ii)(XV), as amended, for each worker with a medically improved disability who is at least sixteen years of age but less than sixty-five years of age and who was previously in the basic coverage group and is no longer eligible for the basic coverage group due to medical improvement. A person who is eligible under the medical improvement group may also be a home- and community-based services waiver recipient.

Source: L. 2008: Entire part added, p. 2197, § 1, effective July 1.

25.5-6-1403. Waivers and amendments.

(1) Repealed.

(2) If approved by the joint budget committee and subject to available appropriations, the state department shall submit to the federal centers for medicare and medicaid services an amendment to the state medical assistance plan, and shall request any necessary waivers from the secretary of the federal department of health and human services, to permit the state department to expand medical assistance eligibility as provided in this part 14 for the purpose of implementing a medicaid buy-in program for people with disabilities who are in the basic coverage group or the medical improvement group. In addition, the state department shall apply to the secretary of the federal department of health and human services for a medicaid infrastructure grant, if available, to develop and implement the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170.

(3) If the state medical assistance plan amendment and all necessary waivers are approved, the state department shall implement the medicaid buy-in program provided in this part 14 not later than three months after receiving full federal approval, whichever is later.

(4) The state department shall seek federal authorization to implement a medicaid buy-in program for adults who are eligible to receive home- and community-based services pursuant to the supported living services waiver; the persons with brain injury waiver, part 7 of this article; and the spinal cord injury waiver pilot program, part 13 of this article. The state department shall prepare and submit any requests necessary for federal approval not later than January 1, 2017, and shall implement the medicaid buy-in program pursuant to this subsection (4) not later than three months after receiving federal approval.

Source: L. 2008: Entire part added, p. 2198, § 1, effective July 1. **L. 2009:** (2) amended, (HB 09-1293), ch. 152, p. 649, § 7, effective July 1. **L. 2016:** (4) added, (HB 16-1321), ch. 344, p. 1398, § 1, effective June 10; (1) repealed and (2) amended, (HB 16-1081), ch. 22, p. 52, § 7, effective August 10.

25.5-6-1404. Medicaid buy-in program - eligibility - premiums - medicaid buy-in cash fund - report. (1) **Eligibility.** An individual is eligible for and shall receive medicaid provided in this part 14 through a medicaid buy-in program without losing eligibility for medicaid if all of the following conditions are met:

(a) The individual meets the requirements for the basic coverage group or the individual was previously in the basic coverage group and now meets the requirements for the medical improvement group;

(b) The individual maintains premium payments calculated by the state department in accordance with subsection (3) of this section, unless the individual is exempted from premium payments under rules promulgated by the state board; and

(c) The individual meets all other requirements established by rule of the state board.

(2) There is no income or asset limitation for a participant in the medicaid buy-in program. In addition, there is no income or asset limitation for an individual who participates in the medicaid buy-in program and also receives home- and community-based services.

(3) **Premiums.** (a) An individual who is eligible for and receives medicaid under subsection (1) of this section shall pay a premium pursuant to a payment schedule established by the state department. The amount of the premium shall be determined from a sliding-fee scale adopted by rule of the state board that is based on a percentage of the individual's income adjusted for family size and on any impairment-related work expenses; except that, consistent with federal law, if the amount of the individual's adjusted gross income exceeds seventy-five thousand dollars, the individual shall be responsible for paying one hundred percent of the premium. The actuarial study shall also consider contributions from employers pursuant to paragraph (b) of subsection (4) of this section. The rules shall specify the amount of unearned income the state department shall disregard in calculating the individual's income.

(b) The rules setting the premiums and the sliding-fee scale shall be based on an actuarial study of the disabled population in this state. The state department may solicit and accept federal grants to cover the costs of the actuarial study. Moneys received through any grants and any premiums shall be credited to the medicaid buy-in cash fund, which fund is hereby created in the state treasury. Moneys in the fund shall be appropriated by the general

assembly and expended by the state department for the purpose of conducting implementation activities as determined by the state department, including conducting the actuarial study. Premiums shall be credited to the fund for the purpose of offsetting program costs.

(c) Within three years after implementation of the medicaid buy-in program pursuant to this part 14, the state department shall submit a report on the effectiveness of the program to the health and human services committees of the general assembly, or any successor committees, and the joint budget committee of the general assembly.

(4) **Private health insurance.** (a) The state department shall, on behalf of an individual who is eligible for medicaid under subsection (1) of this section, pay premiums for or purchase individual coverage offered by the individual's employer if the state department determines that paying the premiums or purchasing the coverage will be less than providing medicaid coverage. Any employer-sponsored health insurance plan shall be the primary payer, and any payments made under medicaid shall be secondary. In the event that the employer-sponsored health insurance plan provides benefits that are not equivalent to the benefits provided under medicaid, medicaid shall provide all additional benefits that are not provided by the employer-sponsored health insurance plan.

(b) If an individual is eligible for medicaid under subsection (1) of this section and the individual's employer would pay for all or a portion of the individual's private insurance, the state department may accept contributions from the individual's employer to offset part of the cost of providing services pursuant to this section.

(5) **Medicare.** If federal financial participation is available, subject to available appropriations, the state department may pay medicare part A and part B premiums for individuals who are eligible for medicare and for medicaid under subsection (1) of this section.

Source: L. 2008: Entire part added, p. 2199, § 1, effective July 1.

25.5-6-1405. Rule-making authority. (1) The state board shall promulgate rules necessary to implement and administer the medicaid buy-in program created in this part 14, including the establishment of appropriate premium and cost-sharing charges on a sliding-fee scale based on income. The premiums and cost-sharing charges shall be based upon an actuarial study of the disabled population in this state.

(2) Any rules adopted by the state board shall be consistent with the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170.

Source: L. 2008: Entire part added, p. 2200, § 1, effective July 1.

25.5-6-1406. Availability of federal financial assistance under medical assistance. Notwithstanding any other provision of law, this part 14 shall be implemented only if, and to the extent that, the state department determines that federal financial participation is available under the medicaid program.

Source: L. 2008: Entire part added, p. 2200, § 1, effective July 1.

CHILDREN'S BASIC HEALTH PLAN

ARTICLE 8

Children's Basic Health Plan

Editor's note: This article was added with relocations in 2006 containing provisions of some sections formerly located in article 19 of title 26. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

25.5-8-101. Short title. This article shall be known and may be cited as the "Children's Basic Health Plan Act".

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1.

Editor's note: This section is similar to former § 26-19-101 as it existed prior to 2006.

25.5-8-102. Legislative declaration. (1) The general assembly hereby finds and declares that a significant percentage of children are uninsured. This lack of health insurance coverage decreases children's access to preventive health care services, compromises the productivity of the state's future workforce, and results in avoidable expenditures for emergency and remedial health care. Health care providers, health care facilities, and all purchasers of health care, including the state, bear the costs of this uncompensated care.

(2) The general assembly further finds and declares that the coordination and consolidation of funding sources currently available to provide services to uninsured children such as the Colorado indigent care program pursuant to part 1 of article 3 of this title, the children's basic health plan, and other children's health programs would efficiently and effectively meet the health care needs of uninsured children and would help to reduce the volume of uncompensated care in the state.

(3) (a) It is the intent of the general assembly to make health insurance coverage available and affordable and to support employers in their efforts to provide their employees and their dependents with health insurance coverage and to support increased availability of affordable health insurance in the individual market.

(b) It is the intent of the general assembly that the savings and efficiencies realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and achieved in consolidating other health care programs should be identified.

(4) It is not the intent of the general assembly to create an entitlement for health insurance coverage.

(5) The general assembly hereby declares that the following principles shall be used in implementing the children's basic health plan set forth in this article:

(a) The department shall establish and maintain a goal of inter-program communication in order to maximize existing state appropriations for the population served in the program;

(b) There shall be efficient program utilization through inter-program coordination and program consolidation and, where appropriate, through contracting with the private sector and with essential community providers;

(c) The policies enacted in House Bill 97-1304 regarding a strong managed care direction shall be emphasized;

(d) The private sector shall be involved to the greatest possible degree with respect to contracting for managed care;

(e) There shall be maximum emphasis on coordination with local and state public health programs and initiatives for children.

(6) The general assembly hereby finds and declares:

(a) That the goal of the "Children's Basic Health Plan Act" is to support low-income, working parents and families in overcoming barriers in obtaining good quality, affordable health care services for their children;

(b) That the health services that low-income children receive through the children's basic health plan should be cost-effective, of high quality, and promote positive health outcomes for enrolled children;

(c) That the children's basic health plan was designed as, and should continue to be, a private-public partnership that encourages enrollment and seeks every opportunity to operate with the efficiency and creativity that is found in utilizing private sector systems and business practices while maintaining the highest level of accountability to the general assembly, the executive branch, and the public through administration of the plan by the department;

(d) That the children's basic health plan was designed as, and should continue to be, a community-based program that encourages local participation in enrolling children in and supporting its goals.

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1.

Editor's note: This section is similar to former § 26-19-102 as it existed prior to 2006.

25.5-8-103. Definitions. As used in this article 8, unless the context otherwise requires:

(1) "Child" means a person who is less than nineteen years of age.

(2) "Children's basic health plan" or "plan" means the subsidized health insurance product designed by the department of health care policy and financing and provided to enrollees, as defined in this section.

(3) "Department" means the department of health care policy and financing created in section 25.5-1-104.

(4) "Eligible person" means:

(a) (I) A person who is less than nineteen years of age, whose family income does not exceed two hundred fifty percent of the federal poverty line, adjusted for family size.

(II) Notwithstanding the provisions of subsection (4)(a)(I) of this section, if the money in the healthcare affordability and sustainability fee cash fund established pursuant to section 25.5-4-402.4 (5), together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for persons less than nineteen years of age, the state board may by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) reduce the percentage of the federal poverty line to below two hundred fifty percent, but the percentage shall not be reduced to below two hundred five percent.

(III) Repealed.

(b) (I) A pregnant woman whose family income does not exceed two hundred fifty percent of the federal poverty line, adjusted for family size, and who is not eligible for medicaid.

(II) Notwithstanding the provisions of subsection (4)(b)(I) of this section, if the money in the healthcare affordability and sustainability fee cash fund established pursuant to section 25.5-4-402.4 (5), together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for pregnant women, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the percentage of the federal poverty line to below two hundred fifty percent, but the percentage shall not be reduced to below two hundred five percent.

(III) Repealed.

(5) "Enrollee" means any eligible person that has enrolled in the plan.

(6) "Essential community provider" means a health care provider that:

(a) Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves the medically indigent patients within its medical capability; and

(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

(7) "Health care program" means any health care program in the state that is supported with state general fund or federal dollars.

(8) "Master settlement agreement" means the master settlement agreement, the smokeless tobacco master settlement agreement, and the consent decree approved and entered by the court in the case denominated *State of Colorado, ex rel. Gale A. Norton, Attorney General v. R.J. Reynolds Tobacco Co.; American Tobacco Co., Inc.; Brown & Williamson Tobacco Corp.; Liggett & Myers, Inc.; Lorillard Tobacco Co., Inc.; Philip Morris, Inc.; United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council For Tobacco Research--U.S.A., Inc.; and Tobacco Institute, Inc.*, Case No. 97 CV 3432, in the district court for the city and county of Denver.

(9) "Medical services board" means the medical services board created in section 25.5-1-301.

(10) "Subsidized enrollee" means an eligible person who receives a subsidy from the department to purchase coverage under the plan or a comparable health insurance.

(11) "Subsidy" means the amount paid by the department to assist an eligible person in purchasing coverage under the plan or a comparable health insurance product available to the eligible person through another coverage entity.

(12) "Trust" means the children's basic health plan trust created in section 25.5-8-105.

Source: L. 2006: Entire article added with relocations, p. 1975, § 7, effective July 1. **L. 2007:** (4) amended, p. 149, § 10, effective March 22. **L. 2008:** (4)(a) amended, p. 2019, § 1, effective March 1, 2009; (4)(b) amended, p. 2019, § 2, effective October 1, 2009. **L. 2009:** (4)(a) and (4)(b) amended, (SB 09-211), ch. 2, pp. 3, 4, § § 1, 2, 3, effective February 26; (4) amended, (HB 09-1293), ch. 152, p. 650, § 8, effective July 1; (4)(b) amended, (SB 09-292), ch. 369, p. 1985, § 130, effective August 5. **L. 2010:** (4)(a)(I), (4)(a)(II), (4)(a)(III)(A), (4)(a)(III)(B),

(4)(b)(I), (4)(b)(II), (4)(b)(III)(A), and (4)(b)(III)(B) amended, (HB 10-1422), ch. 419, p. 2114, § 150, effective August 11. **L. 2017:** IP, (4)(a)(II), and (4)(b)(II) amended, (SB 17-267), ch. 267, p. 1466, § 22, effective July 1.

Editor's note: (1) This section is similar to former § 26-19-103 as it existed prior to 2006.

(2) (a) Subsection (4)(a)(III)(C) and (4)(b)(III)(C) provided for the repeal of subsection (4)(a)(III) and (4)(b)(III), respectively, effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (4)(a)(III)(B) and (4)(b)(III)(B). (See L. 2010, p. 2114.) The revisor of statutes received said notice dated February 17, 2017.

(3) Section 34 of chapter 267 (SB 17-267), Session Laws of Colorado 2017, provides that the section of the act changing this section does not take effect if the centers for medicare and medicaid services determine that the amendments do not comply with federal law. For more information, see SB 17-267. (L. 2017, p. 1478.) The executive director of the department of health care policy and financing did not notify the revisor of statutes by June 1, 2017 of such determination; therefore, the amendments to this section took effect July 1, 2017.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-8-104. Children's basic health plan - rules. The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

Source: L. 2006: Entire article added with relocations, p. 1976, § 7, effective July 1.

Editor's note: This section is similar to former § 26-19-104 as it existed prior to 2006.

25.5-8-105. Trust - created. (1) A fund to be known as the children's basic health plan trust is hereby created and established in the state treasury. Except as provided for in subsection (8) of this section, all moneys deposited in the trust and all interest earned on moneys in the trust shall remain in the trust for the purposes set forth in this article, and no part thereof shall be expended or appropriated for any other purpose. The principal of the trust shall be expended, subject to annual appropriation by the general assembly, solely for the purposes set forth in this article.

(2) (a) Except as provided for in subsection (8) of this section, all or a portion of the moneys in the trust shall be annually appropriated by the general assembly for the purposes of this article and shall not be transferred to or revert to the general fund of the state at the end of any fiscal year.

(b) Notwithstanding the provisions of paragraph (a) of this subsection (2), moneys in the trust may be used to pay the state's portion of any computer system changes necessary to expand eligibility in the plan.

(3) (a) Pursuant to section 24-75-1104.5 (1.7)(b), C.R.S., and except as otherwise provided in section 24-75-1104.5 (5), C.R.S., beginning in the 2016-17 fiscal year and in each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement, the state treasurer shall transfer to the trust eighteen percent of the total amount of the moneys annually received by the state pursuant to the master settlement agreement, not including attorney fees and costs, during the preceding fiscal year. The state treasurer shall transfer the amount specified in this subsection (3) from moneys credited to the tobacco litigation settlement cash fund created in section 24-22-115, C.R.S. The amount transferred pursuant to this subsection (3) is in addition to and not in replacement of any general fund moneys appropriated to the trust.

(b) Repealed.

(4) Repealed.

(5) (a) Beginning in fiscal year 1998, appropriations to the trust may be made by the general assembly based on the savings achieved through reforms, consolidations, and streamlining of health care programs realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and not decreases in the number of caseloads of such programs. Beginning with and subsequent to fiscal year 2000-01, the general assembly may make annual appropriations to the trust.

(b) and (c) Repealed.

(6) As part of its annual savings report to the general assembly on November 1 of each year, the department may identify efficiencies and consolidations that produce savings in the department's annual budget request that result in actual reductions in administrative and programmatic costs associated with the implementation of this article and not decreases in the number of caseloads of such programs.

(7) The department may receive payment for coverage offered and may receive or contract for donations, gifts, and grants from any source. Such funds shall be transmitted to the state treasurer who shall credit the same to the trust. The department may expend such funds from the trust for the purposes of this article.

(8) (a) Beginning in the 2011-2012 fiscal year and for each fiscal year thereafter, moneys in the trust may be used for costs associated with children enrolled in the medical assistance program, articles 4, 5, and 6 of this title, whose family income is more than one hundred percent but does not exceed one hundred thirty-three percent of the federal poverty line and who would have been eligible for enrollment in the children's basic health plan prior to September 1, 2011.

(b) On July 1, 2016, the state treasurer shall transfer twenty million dollars from the children's basic health plan trust to the primary care provider sustainability fund created in section 25.5-5-418.

Source: L. 2006: (3) amended, p. 1040, § 10, effective May 25; entire article added with relocations, p. 1976, § 7, effective July 1. **L. 2007:** (1), (2), and (3) amended, p. 150, § 11, effective March 22; (3)(b) amended, p. 892, § 5, effective July 1. **L. 2008:** (2) amended, p. 2020, § 3, effective June 3. **L. 2009:** (1), (2), and (3) amended, (SB 09-210), ch. 124, p. 531, § 5, effective April 16; (3) amended, (SB 09-269), ch. 333, p. 1768, § 9, effective June 1. **L. 2011:** (1) and (2)(a) amended and (8) added, (SB 11-008), ch. 100, p. 293, § 3, effective September 1. **L. 2012:** (3)(b) amended, (HB 12-1247), ch. 53, p. 197, § 7, effective March 22. **L. 2015:** (1)

and (2)(a) amended and (4), (5)(b), and (5)(c) repealed, (SB 15-264), ch. 259, p. 962, § 79, effective August 5. **L. 2016:** (3)(a) and (8) amended and (3)(b) repealed, (HB 16-1408), ch. 153, pp. 469, 472, § § 20, 26, effective July 1; (6) amended, (HB 16-1081), ch. 22, p. 53, § 10, effective August 10.

Editor's note: (1) This section is similar to former § 26-19-105 as it existed prior to 2006.

(2) Subsection (3) was originally numbered as § 26-19-105 (2.5), and the amendments to it in House Bill 06-1310 were harmonized with subsection (3) as it appeared in Senate Bill 06-219.

(3) Amendments to subsection (3) by Senate Bill 09-210 and Senate Bill 09-269 were harmonized.

25.5-8-106. Annual savings report. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1977, § 7, effective July 1. **L. 2016:** Entire section repealed, (HB 16-1081), ch. 22, p. 52, § 8, effective August 10.

Editor's note: This section was similar to former § 26-19-106 as it existed prior to 2006.

25.5-8-107. Duties of the department - schedule of services - premiums - copayments - subsidies - purchase of childhood immunizations. (1) In addition to any other duties pursuant to this article, the department shall have the following duties:

(a) (I) To design, and from time to time revise, a schedule of health care services included in the plan and to propose said schedule to the medical services board for approval or modification. The schedule of health care services as proposed by the department and approved by the medical services board shall include, but shall not be limited to, preventive care, physician services, prenatal care and postpartum care, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be medically necessary for the health of enrollees; except that the department may modify the schedule of health care services to meet specific federal requirements or to accommodate those changes necessary for a program designed specifically for children.

(II) In addition to the items specified in subparagraph (I) of this paragraph (a) and any additional items approved by the medical services board, on and after January 1, 2001, the medical services board shall include dental services in the schedule of health care services upon a finding by the board that:

(A) An adequate number of dentists are willing to provide services to eligible children; and

(B) The financial resources available to the program are sufficient to fund such services.

(III) In addition to the items specified in subparagraphs (I) and (II) of this paragraph (a) and any additional items approved by the medical services board, the medical services board shall include mental health services that are at least as comprehensive as the mental health services provided to medicaid recipients in the schedule of health care services.

(IV) The schedule of health care services included in the plan shall not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 (1.4), C.R.S.

(b) To design and implement a system of cost-sharing with enrollees using an annual enrollment fee that is based on a sliding fee scale. The sliding fee scale shall be developed based on the enrollee's family income; except that no enrollment fee shall be assessed against an enrollee whose family income is at or below one hundred fifty percent of the federal poverty line and no enrollment fee shall be assessed against an enrollee who is a pregnant woman. As permitted by federal and state law, enrollees in the plan may use funds from a medical savings account to pay the annual enrollment fee. On or before November 1 of each year, the department shall submit for approval to the joint budget committee its annual proposal for cost sharing for the plan based upon a family's income.

(c) To design and implement a structure of copayments due to providers of managed health care plans from enrollees. Enrollees in the plan may use funds from a medical savings account to pay copayments.

(d) To design and propose to the medical services board for adoption detailed rules of eligibility and enrollment processes for the plan;

(e) To design a procedure whereby a financial sponsor may pay the annual enrollment fee or some portion thereof on behalf of a subsidized or nonsubsidized enrollee; except that the payment made on behalf of said enrollee shall not exceed the total enrollment fee due from the enrollee;

(f) To design a procedure whereby the plan may pay subsidies for eligible persons to purchase coverage under the plan or a comparable health insurance product;

(g) To establish criteria to allow a managed care plan, the department, or some other entity to verify eligibility pursuant to section 25.5-8-109;

(h) To conduct pilot projects including, but not limited to, testing models of marketing, enrollment, eligibility determination, and premium structures, to be implemented where appropriate and as approved by the joint budget committee.

(2) The department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203, C.R.S., for providing medical services on a managed care basis for children under this article. The department shall select more than one managed care contractor to serve counties in which there are providers contracting with more than one managed care plan. In counties where there is only one operational managed care plan, the department may contract with that managed care plan to serve children enrolled in the plan. The department shall assure the utilization of essential community providers for the provision of services including eligibility determination, enrollment, and outreach when reasonable. The department shall contract with managed care organizations for the delivery of health services pursuant to this article. The department may contract with essential community providers for health care services in areas of the state that are not adequately served by managed care organizations.

(3) The department may contract for billing and premium collection functions for the children's basic health plan with vendors who provide billing and premium collection functions for other state insurance programs in order to consolidate billing and premium collection functions among multiple state programs. Such contracts may be entered into if the department determines that the scope of work provided by the vendor is similar to the work requirements for the children's basic health plan and that it would be more efficient and cost-effective to contract with the same vendor on multiple programs.

(4) Commencing with fiscal year 2001-02, the annual administrative costs for the children's basic health plan shall not exceed ten percent of the total annual program costs.

(5) The department may purchase vaccines recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services, or its successor entity, through a vaccine purchasing system, if such a system is developed pursuant to section 25-4-2403 (1), C.R.S., for children enrolled in the children's basic health plan.

Source: L. 2006: (1)(a)(I) amended, p. 1505, § 51, effective June 1; entire article added with relocations, p. 1978, § 7, effective July 1; (1)(a)(I) amended, p. 1078, § 6, effective January 1, 2007. **L. 2008:** (2)(a)(III) added, p. 2020, § 4, effective January 1, 2009. **L. 2009:** (1)(a)(IV) added, (SB 09-244), ch. 391, p. 2118, § 5, effective July 1, 2010. **L. 2010:** (1)(b) amended, (HB 10-1422), ch. 419, p. 2115, § 151, effective August 11. **L. 2013:** (1)(a)(I) amended, (HB 13-1266), ch. 217, p. 993, § 64, effective May 13; (5) amended, (SB 13-222), ch. 350, p. 2033, § 5, effective May 28.

Editor's note: (1) This section is similar to former § 26-19-107 as it existed prior to 2006.

(2) Amendments to section 26-19-107 (1)(a)(I) by House Bill 06-1391 were harmonized with subsection (1)(a)(I) as it appeared in Senate Bill 06-219. Amendments to section 26-19-107 (1)(a)(I) by Senate Bill 06-036 were further harmonized with subsection (1)(a)(I), effective January 1, 2007.

Cross references: For the legislative declaration contained in the 2006 act amending subsection (1)(a)(I), see § 1 of chapter 236, Session Laws of Colorado 2006. For the legislative declaration contained in the 2009 act adding subsection (1)(a)(IV), see § 1 of chapter 391, Session Laws of Colorado 2009. For the legislative declaration in the 2013 act amending subsection (5), see section 1 of chapter 350, Session Laws of Colorado 2013.

25.5-8-108. Financial management - cash system of accounting. (1) The department shall propose rules for approval by the medical services board to implement financial management of the plan. Pursuant to such rules, the department shall adjust benefit levels, eligibility guidelines, and any other measure to ensure that sufficient funds are present to implement the provisions of this article. The department shall develop and use quality assurance measures, such as the health employer data information set (HEDIS) reports regarding provider compensation, adapted to children's needs, to ensure that appropriate health care outcomes are met and to justify the continued use of taxpayer dollars for the plan. The department shall implement performance-based contracting based on such quality assurance measures.

(2) The department shall make a quarterly assessment of the expected expenditures for the plan for the remainder of the current biennium and for the following biennium. The estimated expenditures, including minimum reserve requirements shall be compared to an estimate of the revenues that will be deposited in the trust fund. Based on this comparison, the department shall make adjustments as necessary to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and the following biennium.

(3) The department may, in addition to any other measure it determines to be necessary, decrease subsidies for annual enrollment fees or limit enrollment in the plan to ensure that the trust retains sufficient funds pursuant to subsection (1) of this section.

(4) (a) Nothing in this article or any rules promulgated pursuant to the plan shall be interpreted to create a legal entitlement in any person to coverage under the plan. If enrollment in the plan is limited, the department shall give priority to children with family incomes under one hundred thirty-three percent of the federal poverty line.

(b) The department shall report quarterly to the joint budget committee on any enrollment caps that have been instituted for the plan and the number of children who are on waiting lists.

(5) The department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the department relating to the financial administration of any nonadministrative expenditure for the plan.

Source: L. 2006: Entire article added with relocations, p. 1980, § 7, effective July 1. **L. 2007:** (5) added, p. 465, § 3, effective July 1. **L. 2008:** (4)(a) amended, p. 459, § 2, effective April 14. **L. 2010:** (4)(a) amended, (HB 10-1422), ch. 419, p. 2115, § 152, effective August 11.

Editor's note: This section is similar to former § 26-19-108 as it existed prior to 2006.

25.5-8-109. Eligibility - children - pregnant women. (1) To be eligible for a subsidy, a child must not be insured by a comparable health plan through an employer.

(2) If one child from a family is enrolled in the plan, all children must be enrolled, unless the other children have alternative health insurance coverage.

(3) The department may establish procedures such that children with family incomes that exceed the percent of the federal poverty guidelines specified in section 25.5-8-103 (4)(a) may enroll in the plan, but are not eligible for subsidies from the department.

(4) A child whose family income does not exceed the applicable level specified in section 25.5-8-103 (4)(a) shall be presumptively eligible for the plan. Children who are determined to be eligible for the plan shall remain eligible for twelve months subsequent to the last day of the month in which they were enrolled; except that a child shall no longer be eligible for the plan and shall be disenrolled from the plan if the department becomes aware of or is notified that any of the following has occurred:

(a) The child has moved out of the state; or

(b) Repealed.

(c) The child has been enrolled in a commercial health insurance plan during the twelve-month period following enrollment in the plan under this article.

(4.5) (a) (I) To the extent authorized by federal law, the department shall require an applicant to state only the applicant's family income and shall notify the applicant that the applicant's family income will be verified by federally approved electronic data sources. The department shall allow an applicant to provide income information more recent than the records of the federally approved electronic data sources.

(II) The department shall annually verify the recipient's income eligibility at reenrollment through federally approved electronic data sources. If a recipient meets all

eligibility requirements, a recipient remains enrolled in the plan. The department shall also allow a recipient to provide income information more recent than the records of federally approved electronic data sources.

(III) If the state department determines that a recipient was not eligible for medical benefits solely based upon the recipient's income after the recipient had been determined to be eligible based upon information verified through federally approved electronic data sources, the state department shall not pursue recovery from a county department for the cost of medical services provided to the recipient, and the county department is not responsible for any federal error rate sanctions resulting from such determination.

(IV) Notwithstanding any other provision in this paragraph (a), for applications that contain self-employment income, the state department shall not implement this paragraph (a) until it can verify self-employment income through federally approved electronic data sources as authorized by rules of the state department and federal law.

(V) The county department, state department, or other entity designated by the state department to make the eligibility determination shall automatically transfer to the state insurance marketplace through a system interface the application data and verifications of a child or pregnant woman who is determined ineligible for medical assistance benefits pursuant to this section.

(b) Repealed.

(c) Subject to the provisions and requirements of section 25.5-4-205 (3)(e), the department shall establish a process so that an enrollee or the parent or guardian of an enrollee may apply for reenrollment either over the telephone or through the internet.

(5) (a) (I) A pregnant woman whose family income does not exceed the applicable level specified in section 25.5-8-103 (4)(b) shall be presumptively eligible for the plan. Once determined eligible for the plan, a pregnant woman shall be considered to be continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income. Upon birth, a child born to a woman eligible for the plan shall be eligible for the plan and shall be automatically enrolled in the plan in accordance with the eligibility requirements for children specified in subsection (4) of this section.

(II) Repealed.

(b) (I) Under the plan, prenatal and postpartum primary health care providers shall implement policies regarding the integration of evidence-based tobacco use treatments into the regular health care delivery system, including, but not limited to:

(A) Assessment of tobacco use and exposure to second-hand smoke;

(B) Education on the dangers of tobacco use during pregnancy and postpartum;

(C) Referrals to appropriate cessation services.

(II) Health care providers may coordinate the implementation of such policies with the tobacco education, prevention, and cessation programs established in section 25-3.5-804, C.R.S.

(c) The addition of coverage under the plan for pregnant women shall only be implemented if the department obtains a waiver from the federal department of health and human services.

(d) Enrollment of a pregnant woman in the plan shall be limited based upon annual appropriations made out of the trust by the general assembly as described in section 25.5-8-105 and any grants and donations. The general assembly shall annually establish maximum

enrollment figures for pregnant women in the plan. The department shall not exceed the enrollment caps regardless of whether the funding comes from annual appropriations or grants and donations.

(6) Notwithstanding any other provision of law, but subject to the availability of sufficient appropriations and the receipt of federal financial participation, the department may provide benefits under this article to a pregnant woman who is a qualified alien and a child under nineteen years of age who is a qualified alien so long as such woman or child meets eligibility criteria other than citizenship.

Source: L. 2006: (5)(a) amended, p. 1121, § 1, effective May 25; entire article added with relocations, p. 1981, § 7, effective July 1. **L. 2007:** (5)(a)(I) and (5)(a)(II)(A) amended, p. 151, § 12, effective March 22; (3), IP(4), and (4)(b) amended, p. 1493, § 6, effective January 1, 2008. **L. 2008:** (4.5) added, p. 2026, § 2, effective June 3; (5)(a)(I) amended, p. 2020, § 5, effective October 1, 2009. **L. 2009:** (4.5)(c) added, (HB 09-1020), ch. 298, p. 1596, § 2, effective May 21; (6) added, (HB 09-1353), ch. 360, p. 1870, § 3, effective July 1, 2010. **L. 2012:** (4.5)(a)(I), (4.5)(a)(II), and (4.5)(a)(III) amended, (HB 12-1120), ch. 27, p. 109, § 26, effective June 1. **L. 2013:** (1) amended, (SB 13-008), ch. 78, p. 251, § 1, effective March 29. **L. 2014:** (4)(a) and (4.5)(a) amended and (4)(b) repealed, (SB 14-067), ch. 12, p. 114, § 8, effective February 27.

Editor's note: (1) This section is similar to former § 26-19-109 as it existed prior to 2006.

(2) Amendments to section 26-19-109 (5)(a) by Senate Bill 06-135 were harmonized with subsection (5)(a) as it appeared in Senate Bill 06-219.

(3) Subsection (5)(a)(II)(B) provided for the repeal of subsection (5)(a)(II), effective July 1, 2007. (See L. 2006, pp. 1121, 1981.)

(4) Subsection (4.5)(b)(II) provided for the repeal of subsection (4.5)(b), effective July 1, 2009. (See L. 2008, p. 2026.)

(5) The effective date for amendments to subsections (4.5)(a)(I), (4.5)(a)(II), and (4.5)(a)(III) by House Bill 12-1120 (chapter 27, Session Laws of Colorado 2012) was changed from August 8, 2012, to June 1, 2012, by House Bill 12S-1002 (First Extraordinary Session, chapter 2, p. 2432, Session Laws of Colorado 2012.)

Cross references: For the legislative declaration contained in the 2007 act amending subsections (3) and (4)(b) and the introductory portion to subsection (4), see section 1 of chapter 347, Session Laws of Colorado 2007.

25.5-8-109.5. Telehealth - interim therapeutic restorations - reimbursement - definitions. (1) Subject to federal authorization and financial participation, on or after July 1, 2016, in-person contact between a health care provider and an enrollee is not required under the children's basic health plan for the diagnosis, development of a treatment plan, instruction to perform an interim therapeutic restoration procedure, or supervision of a dental hygienist performing an interim therapeutic restoration procedure. A health care provider may provide these services through telehealth, including store-and-forward transfer, and is entitled to reimbursement for the delivery of those services via telehealth to the extent the services are

otherwise eligible for reimbursement under the plan. The services are subject to the reimbursement policies developed pursuant to the children's basic health plan.

(2) As used in this section:

(a) "Interim therapeutic restoration" has the same meaning as set forth in section 12-35-103 (10.5), C.R.S.

(b) "Store-and-forward transfer" means a telehealth by store-and-forward transfer, as defined in section 12-35-103 (16), C.R.S.

Source: L. 2015: Entire section added, (HB 15-1309), ch. 326, p. 1335, § 9, effective August 5.

25.5-8-110. Participation by managed care plans. (1) Managed care plans, as defined in section 10-16-102 (43), C.R.S., that participate in the plan shall do so by contract with the department and shall provide the health care services covered by the plan to each enrollee.

(2) Managed care plans participating in the plan shall not discriminate against any potential or current enrollee based upon health status, disability, sex, sexual orientation, marital status, race, creed, color, national origin, ancestry, ethnicity, or religion.

(3) Managed care plans that contract with the department to provide the plan to enrollees shall also be willing to contract with the medicaid managed care program, as administered by the department.

(4) (a) Managed care plans shall be selected by the department to participate in the children's basic health plan based upon the managed care plans' assurances and the department's verification that the managed care plan is utilizing within its network essential community providers to the extent that this action does not result in a net increase in the cost for providing services to the managed care plan.

(b) The managed care organization shall seek proposals from each essential community provider in a county in which the managed care organization is enrolling recipients for those services that the managed care organization provides or intends to provide and that an essential community provider provides or is capable of providing. To assist managed care organizations in seeking proposals, the department shall provide managed care organizations with a list of essential community providers in each county. The managed care organization shall consider such proposals in good faith and shall, when deemed reasonable by the managed care organization based on the needs of its enrollees, contract with essential community providers. Each essential community provider shall be willing to negotiate on reasonably equitable terms with each managed care organization. Essential community providers making proposals under this subsection (4) shall be able to meet the contractual requirements of the managed care organization. The requirement of this subsection (4) shall not apply to a managed care organization in areas in which the managed care organization operates entirely as a group model health maintenance organization.

(c) Any disputes between a managed care organization and an essential community provider that cannot be resolved through good faith negotiations may be resolved through an informal review by the department at the request of one of the parties, or through the department's aggrieved provider appeal process in accordance with section 25.5-1-107 (2), if requested by one of the parties.

(d) In selecting managed care organizations through competitive bidding, the department shall give preference to those managed care organizations that have executed contracts for services with one or more essential community providers. In selecting managed care organizations, the department shall not penalize a managed care organization for paying cost-based reimbursement to federally qualified health centers as defined in the federal "Social Security Act".

(5) The department may receive and act upon complaints from enrollees regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from eligible recipients.

(6) Parents or guardians of children shall choose a participating health maintenance organization before enrolling in the plan in areas of the state where a participating health maintenance organization is available. The department will assign children who are currently enrolled in the plan and whose parents or guardians have not selected a health maintenance organization within a time period determined by the department to a participating health maintenance organization with the child's primary care physician in the network. The department shall seek to maintain continuity of the health plan between medicaid and the children's basic health plan.

(7) In areas of the state in which a participating managed care plan does not have providers, the department may contract with essential community providers and other health care providers to provide health care services under the children's basic health plan using a managed care model.

(8) The department may contract with essential community providers or other providers or develop other administrative arrangements to provide health care services under the children's basic health plan to enrollees prior to the effective date of enrollment in the selected managed care plan.

(9) The department shall allow, at least annually, an opportunity for enrollees to transfer among participating managed care plans serving their respective geographic regions. The department shall establish a period of at least twenty days annually when this opportunity is afforded eligible recipients. In geographic regions served by more than one participating managed care plan, the department shall endeavor to establish a uniform period for such opportunity.

(10) (a) The department shall make a capitation payment to managed care plans based upon a defined scope of services at an agreed upon rate. The department shall only use market rate bids that do not discriminate and are adequate to assure quality, network sufficiency, and long-term competitiveness in the children's basic health plan managed care market. The department shall retain a qualified actuary to establish a lower limit for such bids. A certification by such actuary to the appropriate lower limit shall be conclusive evidence of the department's compliance with the requirements of this subsection (10). For the purposes of this subsection (10), a "qualified actuary" shall be a person deemed as such under rules promulgated by the commissioner of insurance.

(b) Repealed.

(11) All managed care plans participating in the plan shall meet standards regarding the quality of services to be provided, financial integrity, and responsiveness to the unmet health care needs of eligible persons that may be served.

Source: L. 2006: Entire article added with relocations, p. 1982, § 7, effective July 1. **L. 2008:** (2) amended, p. 1603, § 32, effective May 29. **L. 2009:** (10) amended, (SB 09-265), ch. 205, p. 936, § 7, effective May 1. **L. 2010:** (10)(b) repealed, (HB 10-1382), ch. 217, p. 940, § 6, effective May 6. **L. 2013:** (1) amended, (HB 13-1266), ch. 217, p. 993, § 65, effective May 13.

Editor's note: This section is similar to former § 26-19-110 as it existed prior to 2006.

Cross references: (1) For the legislative declaration contained in the 2008 act amending subsection (2), see section 1 of chapter 341, Session Laws of Colorado 2008.

(2) For the definition of "federally qualified health centers" in the federal Social Security Act, see 42 U.S.C. sec. 1395x.

25.5-8-111. Department - administration - outsourcing. (1) (a) The department may:

(I) Pursuant to section 24-50-504 (2)(a), C.R.S., enter into personal services contracts for the administration of the children's basic health plan. Any contracts established pursuant to this section shall contain performance measures that shall be monitored by the department.

(II) Use county departments of social services to perform functions relating to the administration of the children's basic health plan;

(III) Perform administrative functions at the department, including consolidation of functions with other administrative functions handled by the department.

(b) In deciding how to allocate functions relating to the administration of the children's basic health plan as allowed under paragraph (a) of this subsection (1), the department shall determine and base its decisions upon what is the most cost-effective method to handle the particular function and to deliver the services.

(2) The implementation of subparagraph (I) of paragraph (a) of subsection (1) of this section is contingent upon a finding by the state personnel director that any of the conditions of section 24-50-504 (2), C.R.S., have been met or that the conditions of section 24-50-503 (1), C.R.S., have been met.

Source: L. 2006: Entire article added with relocations, p. 1984, § 7, effective July 1.

Editor's note: This section is similar to former § 26-19-111 as it existed prior to 2006.

25.5-8-112. Authority to the department to apply for federal waivers. The department is hereby authorized and required to apply for any federal waivers necessary to implement the purposes of this article.

Source: L. 2006: Entire article added with relocations, p. 1985, § 7, effective July 1.

Editor's note: This section is similar to former § 26-19-112 as it existed prior to 2006.

25.5-8-113. Reports by contractors to medical services board. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1985, § 7, effective July 1. **L. 2016:** Entire section repealed, (HB 16-1081), ch. 22, p. 52, § 5, effective August 10.

Editor's note: This section was similar to former § 26-19-113 as it existed prior to 2006.

ARTICLE 10

Community Living

Editor's note: This article was added with relocations in 2013. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated. For a detailed comparison of this article, see the comparative tables located in the back of the index.

PART 1

OFFICE OF COMMUNITY LIVING

25.5-10-101. Office of community living - creation - transfer of duties and functions - rules - legislative declaration. (1) There is hereby created in the state department the office of community living, referred to in this article as the "office". The head of the office is the director of community living appointed by the executive director in accordance with section 13 of article XII of the state constitution. The director of community living reports directly to the executive director.

(2) (a) On and after March 1, 2014, the powers, duties, and functions relating to the programs, services, and supports contained in this article are transferred from the department of human services to the department of health care policy and financing by a type 2 transfer as such transfer is defined in the "Administrative Organization Act of 1968", article 1 of title 24, C.R.S., and allocated to the division of intellectual and developmental disabilities of the office, which division is created in part 2 of this article.

(b) (I) By March 1, 2014, all positions of employment in the department of human services related to the administration of community-based long-term services and supports are transferred to the division of intellectual and developmental disabilities of the office and become employment positions therein.

(II) All employees in positions transferred to the division of intellectual and developmental disabilities are considered employees of the division of intellectual and developmental disabilities of the office. Such employees retain all rights under the state personnel system and to retirement benefits pursuant to the laws of this state, and their services shall be deemed to have been continuous.

(c) By March 1, 2014, all items of property, real and personal, including office furniture and fixtures, books, documents, and records of the department of human services related to the administration of community-based long-term services and supports are transferred to the division of intellectual and developmental disabilities of the office and become the property thereof.

(d) On and after March 1, 2014, whenever the executive director of the department of human services or the department of human services is referred to or designated by any contract or other document in connection with the powers, duties, and functions transferred to the department of health care policy and financing, the reference or designation shall be deemed to apply to the department of health care policy and financing. All contracts entered into by the

executive director of the department of human services prior to March 1, 2014, in connection with the powers, duties, and functions transferred to the department of health care policy and financing are hereby validated, with the executive director of the department of health care policy and financing succeeding to all the rights and obligations of such contracts.

(3) All rules and orders of the department of human services, the executive director of the department of human services, and the state board of human services in connection with the programs transferred to the department of health care policy and financing shall continue to be effective until revised, amended, repealed, or nullified pursuant to law.

(4) Repealed.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1742, § 1, effective July 1.

Editor's note: Subsection (4)(b) provided for the repeal of subsection (4), effective July 1, 2014. (See L. 2013, p. 1742.)

PART 2

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

25.5-10-201. Legislative declaration. (1) In recognition of the varied, extensive, and substantial needs of persons with intellectual and developmental disabilities, including the urgent need to enhance the development of children with intellectual and developmental disabilities, the general assembly, subject to available appropriations and subject to the existence of appropriate services and supports with available resources, hereby declares that the purposes of this article are:

(a) To provide appropriate services and supports to persons with intellectual and developmental disabilities throughout their lifetimes regardless of their age or degree of disability;

(b) To prohibit deprivation of liberty of persons with intellectual and developmental disabilities, except when such deprivation is for the purpose of providing services and supports which constitute the least restrictive available alternative adequate to meet the person's needs, and to ensure that these services and supports afford due process protections;

(c) To ensure the fullest measure of privacy, dignity, rights, and privileges to persons with intellectual and developmental disabilities;

(d) To ensure the provision of services and supports to all persons with intellectual and developmental disabilities on a statewide basis;

(e) To enable persons with intellectual and developmental disabilities to remain with their families and in the community of their choice, to minimize the likelihood of out-of-home placement, and to enhance the capacity of families to meet the needs of children with intellectual and developmental disabilities;

(f) To provide community services and supports for persons with intellectual and developmental disabilities which reflect typical patterns of everyday living;

(g) To encourage state and local agencies to provide a wide array of innovative and cost-effective services and supports for persons with intellectual and developmental disabilities;

(h) To ensure that persons with intellectual and developmental disabilities receive services and supports which encourage and build on existing social networks and natural sources of support, and result in increased interdependence, contribution to, and inclusion in community life; and

(i) To recognize the efficacy of early intervention services and supports in minimizing developmental delays and reducing the future education costs to our society.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1744, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-101 as it existed prior to 2013.

25.5-10-202. Definitions. As used in this article 10, unless the context otherwise requires:

(1) "Abuse" means any of the following acts or omissions committed against a person with an intellectual and developmental disability:

(a) The nonaccidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;

(b) Confinement or restraint that is unreasonable under generally accepted caretaking standards; or

(c) Subjection to sexual conduct or contact classified as a crime under the "Colorado Criminal Code", title 18, C.R.S.

(1.3) "Authorized representative" means a person designated by the person receiving services, or by the parent or guardian of the person receiving services, if appropriate, to assist the person receiving services in acquiring or utilizing services or supports pursuant to this article. The extent of the authorized representative's involvement shall be determined upon designation.

(1.6) "Caretaker" means a person who:

(a) Is responsible for the care of a person with an intellectual and developmental disability as a result of a family or legal relationship;

(b) Has assumed responsibility for the care of a person with an intellectual and developmental disability; or

(c) Is paid to provide care, services, or oversight of services to a person with an intellectual and developmental disability.

(1.8) (a) "Caretaker neglect" means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health and safety of a person with an intellectual and developmental disability is not secured for a person with an intellectual and developmental disability or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult with an intellectual and developmental disability.

(b) Notwithstanding the provisions of paragraph (a) of this subsection (1.8), the withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation,

dialysis, artificial nutrition and hydration, any medication or medical procedure or device, in accordance with any valid medical directive or order, or as described in a palliative plan of care, shall not be deemed caretaker neglect.

(c) As used in this subsection (1.8), "medical directive or order" includes a medical durable power of attorney, a declaration as to medical treatment executed pursuant to section 15-18-104, C.R.S., a medical order for scope of treatment form executed pursuant to article 18.7 of title 15, C.R.S., and a CPR directive executed pursuant to article 18.6 of title 15, C.R.S.

(1.9) "Case management agency" means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the state department to provide case management services pursuant to section 25.5-10-209.5. The case management agency shall provide case management services pursuant to a contract with the state department.

(2) "Case management services" means the following:

(a) Repealed.

(b) Service and support coordination; and

(c) The monitoring of all services and supports delivered pursuant to the individualized plan and the evaluation of results identified in the individualized plan.

(3) "Case manager" means a person who assists with case management services and supports provided pursuant to this article for persons with intellectual and developmental disabilities.

(4) "Community-centered board" means a private corporation, for-profit or not-for-profit, that is designated pursuant to section 25.5-10-209.

(5) "Community residential home" means a group living situation accommodating at least four but no more than eight persons, which is licensed by the state and in which services and supports are provided to persons with intellectual and developmental disabilities.

(5.5) "Competitive integrated employment" has the same meaning as set forth in section 8-84-301, C.R.S.

(5.7) "Conflict-free case management" means, pursuant to 42 CFR 441.301 (c)(1)(VI), case management services provided to a person with an intellectual and developmental disability enrolled in a home- and community-based services waiver that are provided by a case management agency that is not the same agency that provides services and supports to that person. Service agencies and case management agencies are responsible for ensuring persons who are employed by the agency meet the requirements of this article 10.

(6) "Consent" means an informed assent that is expressed in writing and freely given. Consent shall always be preceded by the following:

(a) A fair explanation of the procedures to be followed, including an identification of procedures that are experimental;

(b) A description of the attendant discomforts and risks;

(c) A description of the expected benefits;

(d) A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts, and risks;

(e) An offer to answer any inquiries concerning procedures;

(f) An instruction that the person giving consent is free to withdraw consent and to discontinue participation in the project or activity at any time; and

(g) A statement that withholding or withdrawal of consent shall not prejudice future provision of appropriate services and supports to persons.

(7) "Contribution" means the benefits gained by the household or community in which a person lives as the result of the person engaging in meaningful activities, including but not limited to income-producing work, volunteer work, continuing education, and participation in community activities.

(8) "Court" means a district court of the state of Colorado or the probate court in the appropriate jurisdiction.

(9) "Designated service area" means the geographical area specified by the executive director to be served by a designated community-centered board.

(10) "Developmental disabilities professional" has the same meaning as "intellectual and developmental disabilities professional" as set forth in subsection (25) of this section.

(11) (a) "Developmental disability" has the same meaning as "intellectual and developmental disability" as set forth in paragraph (a) of subsection (26) of this section.

(b) "Person with a developmental disability" or "individual with a developmental disability" has the same meaning as "person with an intellectual and developmental disability" as set forth in paragraph (b) of subsection (26) of this section.

(c) "Child with a developmental delay" has the same meaning as set forth in paragraph (c) of subsection (26) of this section.

(12) "Division" means the division of intellectual and developmental disabilities, created in this part 2.

(13) "Early intervention services and supports" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(13.5) "Eligible for home- and community-based services" means a "person with an intellectual and developmental disability", as defined in section 25.5-6-403, who meets the definition of an "eligible person", as defined in section 25.5-6-403.

(14) "Eligible for supports and services" refers to any person with an intellectual and developmental disability as determined by a community-centered board pursuant to section 25.5-10-211.

(15) "Enrolled" means that a person with an intellectual and developmental disability who is eligible for supports and services has been authorized, as defined by rules promulgated by the state board, to participate in the program funded pursuant to this section.

(15.5) "Exploitation" means an act or omission committed by a person who:

(a) Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person with an intellectual and developmental disability of the use, benefit, or possession of any thing of value;

(b) Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person with an intellectual and developmental disability;

(c) Forces, compels, coerces, or entices a person with an intellectual and developmental disability to perform services for the profit or advantage of the person or another person against the will of the person with an intellectual and developmental disability; or

(d) Misuses the property of a person with an intellectual and developmental disability in a manner that adversely affects the person with an intellectual and developmental disability's ability to receive health care or health care benefits or to pay bills for basic needs or obligations.

(16) (a) "Family" means the interdependent group of persons that consists of:

(I) A parent, child, sibling, grandparent, aunt, uncle, spouse, or any combination thereof and a family member with an intellectual and developmental disability;

(II) An adoptive parent of and a family member with an intellectual and developmental disability;

(III) One or more persons to whom legal custody of a person with an intellectual and developmental disability has been given by a court and in whose home such person resides; or

(IV) Any other family unit as may be defined in rules developed pursuant to section 25.5-10-306.

(b) State board rules must define the families that are eligible to receive services and supports pursuant to this article, and rules of the state board of human services must define the families that are eligible to receive services and supports pursuant to article 10.5 of title 27, C.R.S.

(17) "Family caregiver" means a family member of the person with an intellectual and developmental disability who provides care to the person with an intellectual and developmental disability in the family home, who meets the requirements for a qualified family caregiver, as established by rule of the state board, and who is working through a program-approved service agency, as established by rule of the state board.

(18) "Gastrostomy tube" means a tube that has been surgically inserted into the stomach through the abdominal wall, or a tube that has been inserted through the nasal passage into the stomach, or both.

(19) "Human rights committee" means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and reviewing investigations of allegations of mistreatment of persons with intellectual and developmental disabilities who are receiving services or supports under this article.

(20) "IDEA" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(21) "Inclusion" means:

(a) The use by persons with intellectual and developmental disabilities of the same community resources that are used by and available to other persons;

(b) The participation by persons with intellectual and developmental disabilities in the same community activities in which persons without intellectual and developmental disabilities participate. Participation includes regular contact with persons without intellectual and developmental disabilities.

(c) Vocational experiences for persons with intellectual and developmental disabilities in community settings that offer opportunities to associate with other persons who do not have intellectual and developmental disabilities; and

(d) Living in homes that are in residential neighborhoods and in proximity to community resources.

(22) "Independent residential support services" means a community living situation, defined by rule of the state board, in which services and supports are provided to no more than three persons with intellectual and developmental disabilities and for which a state license is not required.

(23) "Individualized family service plan" or "IFSP" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(24) (a) "Individualized plan" means a written plan designed by an interdisciplinary team for the purpose of identifying:

(I) The needs and preferences of the person or family receiving services;

(II) The specific services and supports appropriate to meet those needs and preferences;

(III) The projected date for initiation of services and supports; and

(IV) The anticipated results to be achieved by receiving the services and supports.

(b) Every individualized plan must include a statement of agreement with the plan, signed by the person receiving services or other such person legally authorized to sign on behalf of the person and by a representative of the community-centered board or case management agency.

(c) Any other service or support plan designated by the state department that meets all of the requirements of an individualized plan is considered to be an individualized plan pursuant to this article.

(d) (I) Every individualized plan that includes the provision of respite care for medical purposes, pursuant to section 25.5-10-205, shall include a process by which the person receiving services and supports may receive necessary care if the person's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or caregiver must be duly informed by the interdisciplinary team of these alternative care provisions at the time the individualized plan is initiated.

(II) Nothing in this paragraph (d) requires the provision of respite care. However, any individual plan that includes the provision of respite care for medical purposes must contain a contingency plan.

(25) "Intellectual and developmental disabilities professional" means a person who has professional training and experience in the intellectual and developmental disabilities field, as defined by rule of the state board.

(26) (a) "Intellectual and developmental disability" means a disability that manifests before the person reaches twenty-two years of age, that constitutes a substantial disability to the affected person, and that is attributable to mental retardation or related conditions, which include cerebral palsy, epilepsy, autism, or other neurological conditions when those conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15001 et seq. shall not apply.

(b) "Person with an intellectual and developmental disability" means a person determined by a community-centered board to have an intellectual and developmental disability and shall include a child with a developmental delay.

(c) "Child with a developmental delay" means:

(I) A person less than five years of age with delayed development as defined by rule of the state board; or

(II) A person less than five years of age who is at risk of having a developmental disability as defined by rule of the state board.

(27) "Interdependence" means those multiple interactive relationships that are necessary to create a sense of belonging and support between and among people that are mutually sought, sustained over time, and beneficial to those involved.

(28) "Interdisciplinary team" means a group of people convened by a designated community-centered board or by a case management agency that includes the person receiving services; the parents or guardian of a minor; a guardian or an authorized representative, as appropriate; the person who coordinates the provisions of services and supports; and others chosen by the person receiving services, who are assembled to work in a cooperative manner to develop or review the individualized plan.

(29) "Least restrictive environment" means an environment that represents the least departure from the typical patterns of living and that effectively meets the needs and preferences of the person receiving services. "Least restrictive environment" may include, but need not be limited to, receiving services from a community-centered board, service agency, case management agency, or a family caregiver in the family home.

(29.5) "Mistreated" or "mistreatment" means:

(a) Abuse;

(b) Caretaker neglect;

(c) Exploitation;

(d) An act or omission that threatens the health, safety, or welfare of a person with an intellectual and developmental disability; or

(e) An act or omission that exposes a person with an intellectual and developmental disability to a situation or condition that poses an imminent risk of bodily injury to the person with an intellectual and developmental disability.

(30) "Office" means the office of community living created in part 1 of this article.

(31) "Person receiving services" means a person with an intellectual and developmental disability who is enrolled in a program funded pursuant to this article.

(32) "Program" means a specific group of services or supports as defined by rules promulgated by the state board and for which funding is available pursuant to this article to a person with an intellectual and developmental disability who is eligible for supports and services.

(33) "Regional center" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(34) "Service agency" means a person or any publicly or privately operated program, organization, or business providing services or supports for persons with intellectual and developmental disabilities.

(35) "Service and support coordination" means planning, locating, facilitating access to, coordinating, and reviewing all aspects of needed services, supports, and resources that are provided in cooperation with the person receiving services, the person's family, as appropriate, the family of a child with a developmental delay, and the involved public or private agencies. Planning includes the development or review of an existing individualized plan. "Service and support coordination" also includes the reassessment of the needs and preferences of the person receiving services or the needs of the family of the person, with maximum participation of the person receiving services and the person's parents, guardian, or authorized representative, as appropriate.

(36) "Services and supports" or "supports and services" means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided:

(a) To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in

their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience personal security and self-respect;

(b) To enhance child development and healthy parent-child and family interaction for eligible persons and their families; and

(c) To enable families, who choose or desire to maintain a family member with an intellectual and developmental disability at home, to obtain support and to enjoy a typical lifestyle.

(37) "Sterilization" means any surgical or other medical procedure that has as its primary purpose to render a person permanently incapable of reproduction.

(37.5) "Undue influence" means the use of influence to take advantage of a person with an intellectual and developmental disability's vulnerable state of mind, neediness, pain, or emotional distress.

(38) "Waiting list" means the list of persons with intellectual and developmental disabilities who are waiting for enrollment into a program provided pursuant to this article.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1745, § 1, effective March 1, 2014. **L. 2016:** (1) and (19) amended and (1.3), (1.6), (1.8), (15.5), (29.5), and (37.5) added, (HB 16-1394), ch. 172, p. 562, § 14, effective July 1; (5.5) added, (SB 16-077), ch. 360, p. 1505, § 4, effective July 1. **L. 2017:** IP, (4), (14), (24)(b), (28), (29), and IP(36) amended, (1.9), (5.7), and (13.5) added, and (2)(a) repealed, (HB 17-1343), ch. 320, p. 1721, § 1, effective June 5.

Editor's note: This section is similar to former § 27-10.5-102 as it existed prior to 2013.

Cross references: For the legislative declaration in SB 16-077, see section 1 of chapter 360, Session Laws of Colorado 2016.

25.5-10-203. Division of intellectual and developmental disabilities - creation - functions - reporting - legislative declaration. (1) (a) The general assembly finds and declares that:

(I) An effective system of community-based services and supports is essential to enable children and adults with intellectual and developmental disabilities to live in their communities;

(II) The demand for high-quality intellectual and developmental disabilities services is expected to grow; and

(III) Persons with intellectual and developmental disabilities need a system that promotes self-direction of services and self-determination and that is designed to improve personal outcomes.

(b) (I) The general assembly further finds and declares that state agencies should be organized in a manner that allows for improved delivery of long-term services and supports for persons and providers; and

(II) The transfer pursuant to part 1 of this article of the powers, duties, and functions relating to the programs, services, and supports for persons with intellectual and developmental disabilities to the office for administration by the division of intellectual and developmental disabilities, created in this section, is an initial step in the process of redesigning Colorado's long-term care system.

(2) There is hereby created within the office the division of intellectual and developmental disabilities.

(3) The division shall administer the programs, services, and supports for persons with intellectual and developmental disabilities contained in this article.

(4) Because of the unique goal of the division in administering lifelong programs, services, and supports for persons with intellectual and developmental disabilities, as part of its annual briefing to the joint budget committee, the state department shall allow sufficient briefing time devoted solely to issues relating to the division and its administration of the programs, services, and supports contained in this article.

(5) Repealed.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1751, § 1, effective March 1, 2014.

Editor's note: Subsection (5)(b) provided for the repeal of subsection (5), effective July 1, 2015. (See L. 2013, p. 1751.)

25.5-10-204. Duties of the executive director - state board rules. (1) In order to implement the provisions of this article 10, the executive director shall, subject to available appropriations, carry out the following duties:

(a) Conduct monitoring and review activities that include community-centered boards, service agencies, and case management agencies;

(b) Provide or obtain training and technical assistance through community-centered boards, service agencies, and case management agencies in order to improve the quality of services and supports provided to persons with intellectual and developmental disabilities;

(c) Prepare and transmit annually to the governor and the joint budget committee of the general assembly, in the form and manner prescribed pursuant to section 24-1-136, C.R.S., a report detailing the following information, as available and appropriate, that is broken down into designated service areas as well as provided in an overall statewide format:

(I) The total number of persons receiving services pursuant to this article;

(II) The types of services and supports provided;

(III) The costs of services and supports regardless of funding source;

(IV) An evaluation of the quality of the services and supports rendered;

(V) An evaluation of the effectiveness of the services and supports rendered in implementing the individualized plans of persons receiving services;

(VI) The numbers, types, and resolution of appeals that were heard by the state department arising from disputes specified in section 25.5-10-212; and

(VII) The number of persons determined to be eligible to receive services and supports who are not receiving services or supports pursuant to this article along with an analysis of the reasons they are not receiving services and supports;

(d) Designate a community-centered board in each designated service area in the state;

(e) Implement the provision of home- and community-based services to eligible persons with intellectual and developmental disabilities and pursue other medicaid-funded services determined by the state department to be appropriate for persons with intellectual and

developmental disabilities, pursuant to part 4 of article 6 of this title and subject to available appropriations;

(f) Promote effective coordination with agencies serving persons with intellectual and developmental disabilities in order to improve continuity of services and supports for persons facing life transitions from toddler to preschool, school to adult life, and work to retirement; and

(g) Facilitate employment first policies and practices by:

(I) Developing practices that reflect a presumption that all persons with disabilities are capable of working in competitive integrated employment if they choose to do so, and ensuring that options for competitive integrated employment with appropriate supports are explored before consideration of segregated activities;

(II) Providing state department input and assistance to the employment first advisory partnership described in section 8-84-303, C.R.S., in carrying out its duties;

(III) Establishing annual reporting of the number of individuals employed, number of individuals employed in competitive integrated employment, wages per hour earned, and hours worked per week for individuals served by the division;

(IV) Maintaining Colorado's membership in the state employment leadership network that was founded as a joint partnership between the national association of state directors of developmental disabilities services and the institute for community inclusion at the university of Massachusetts Boston or another similar organization that facilitates collaboration with other states to share effective solutions to increase employment outcomes for persons with disabilities; and

(V) Presenting the reports and recommendations of the employment first advisory partnership to the state department's legislative committee of reference pursuant to section 8-84-303 (7), C.R.S.

(2) The state board shall adopt such rules, in accordance with section 24-4-103, C.R.S., as are necessary to carry out the provisions and purposes of this article, including but not limited to the following subjects:

(a) Standards for services and supports, including preparation of individualized plans;

(b) The designation of community-centered boards and the organization of those entities, including standards of organization, staff qualifications, and other factors necessary to ensure program integrity;

(c) Purchase of services and supports and financial administration;

(d) Procedures for resolving disputes over eligibility determination and the modification, denial, or termination of services;

(e) Eligibility determination, the criteria for determination, and admission to the program;

(f) Systems of quality assurance and data collection;

(g) The rights of a person receiving services;

(h) Confidentiality of records of a person receiving services;

(i) Designation of authorized representatives and delineation of their rights and duties pursuant to this article;

(j) (I) The establishment of guidelines and procedures for authorization of persons for administration of nutrition and fluids through gastrostomy tubes.

(II) The state department shall require that a service agency providing residential or day program services or supports have a staff member qualified pursuant to subparagraph (III) of this

paragraph (j) on duty at any time the facility administers said nutrition and fluids through gastrostomy tubes, and that the facility maintain a written record of each nutrient or fluid administered to each person receiving services, including the time and the amount of the nutrient or fluid.

(III) A person who is not otherwise authorized by law to administer nutrition and fluids through gastrostomy tubes is allowed to perform the duties only under the supervision of a licensed nurse or physician. A person who administers nutrition and fluids in compliance with the provisions of this paragraph (j) is exempt from the licensing requirements of the "Colorado Medical Practice Act", article 36 of title 12, C.R.S., and the "Nurse Practice Act", article 38 of title 12, C.R.S. Nothing in this paragraph (j) shall be deemed to authorize the administration of medications through gastrostomy tubes. A person administering medications through gastrostomy tubes is subject to the requirements of part 3 of article 1.5 of title 25, C.R.S.

(IV) For purposes of this paragraph (j), "administration" means assisting a person in the ingestion of nutrition or fluids according to the direction and supervision of a licensed nurse or physician.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1752, § 1, effective March 1, 2014. **L. 2016:** (1)(e) and (1)(f) amended and (1)(g) added, (SB 16-077), ch. 360, p. 1505, § 5, effective July 1. **L. 2017:** IP(1), (1)(a), and (1)(b) amended, (HB 17-1343), ch. 320, p. 1722, § 2, effective June 5.

Editor's note: This section is similar to former § 27-10.5-103 as it existed prior to 2013.

Cross references: For the legislative declaration in SB 16-077, see section 1 of chapter 360, Session Laws of Colorado 2016.

25.5-10-205. Community-centered boards and service agencies - local public procurement units. For purposes of entering into a cooperative purchasing agreement pursuant to section 24-110-201, C.R.S., a nonprofit community-centered board or a nonprofit service agency may be certified as a local public procurement unit as provided in section 24-110-207.5, C.R.S.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1754, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-103.5 as it existed prior to 2013.

25.5-10-206. Authorized services and supports - conditions of funding - purchase of services and supports - adult protective services data system check - boards of county commissioners - appropriation. (1) Subject to annual appropriations by the general assembly, the state department shall provide or purchase, pursuant to subsection (4) of this section, authorized services and supports from community-centered boards, case management agencies, or service agencies for persons who have been determined to be eligible for such services and

supports pursuant to section 25.5-10-211 and as specified in the eligible person's individualized plan. Those services and supports may include, but need not be limited to, the following:

(a) Family support services, including an array of supportive services provided to the person receiving services and the person's family, that enable the family to maintain the person in the family home, thereby preventing or delaying the need for out-of-home placement that is unwanted by the person or the family, pursuant to section 25.5-10-301;

(b) Case management services;

(c) Respite care services, including temporary care of a person with an intellectual and developmental disability to offer relief to the person's family or caregiver or to allow the family or caregiver to deal with emergency situations or to engage in personal, social, or routine activities and tasks that otherwise may be neglected, postponed, or curtailed due to the demands of supporting a person who has an intellectual and developmental disability;

(d) Day services and supports that offer opportunities for persons with intellectual and developmental disabilities to experience and actively participate in valued adult roles in the community. These services and supports will enable persons receiving services to access and participate in community activities, such as work, recreation, higher education, and senior citizen activities. Day services may also include the administration of nutrition or fluids through gastrostomy tubes, if administered by a person authorized pursuant to section 25.5-10-204 (2)(j) and supervised by a licensed nurse or physician.

(e) Residential services and supports, including an array of training, learning, experiential, and support activities provided in living alternatives designed to meet the individual needs and preferences of persons receiving services and may include the administration of nutrition or fluids through gastrostomy tubes, if administered by a person authorized pursuant to section 25.5-10-204 (2)(j) and supervised by a licensed nurse or physician; and

(f) Ancillary services, including activities that are secondary but integral to the provision of the services and supports specified in this subsection (1).

(2) Service agencies, community-centered boards, and case management agencies receiving funds pursuant to subsection (1) of this section shall comply with all of the provisions of this article 10 and the rules promulgated thereunder.

(3) Case management services must be purchased from the community-centered board designated pursuant to section 25.5-10-209 or the case management agency, except as otherwise provided in subsection (4) of this section.

(4) (a) The state department may purchase services and supports directly from service agencies and case management services from case management agencies if:

(I) Required by the federal requirements for the state to qualify for federal funds under Title XIX of the federal "Social Security Act", as amended, including programs authorized pursuant to part 4 of article 6 of this title; or

(II) The executive director has determined that a service or support provided or purchased by a designated community-centered board does not meet established standards and the continuation of purchase of the service or support through the community-centered board is not in the best interests of the persons receiving services.

(b) (I) The state department shall only purchase services and supports directly from those community-centered boards, case management agencies, or service agencies that meet established standards.

(II) The standards referenced in subsection (4)(b)(I) of this section must include a requirement that, on and after January 1, 2019, prior to employment, the name of a person who will be providing direct care, as defined in section 26-3.1-101 (3.5), to an at-risk adult, as defined in section 26-3.1-101 (1.5), as well as any other required identifying information, is submitted to the department of human services for a check of the Colorado adult protective services data system pursuant to section 26-3.1-111, to determine if the person is substantiated in a case of mistreatment of an at-risk adult.

(c) The state department may purchase services and supports, including service and support coordination, from a family caregiver if the executive director has determined that the provision of a service or support by a family caregiver in the family home would provide the person receiving the service or support with the least restrictive environment.

(d) Nothing in this section shall be construed to prohibit the provision of services and supports, including case management services, directly by the department of human services through regional centers, for persons receiving services in regional centers.

(e) Nothing in this section shall be construed to require the provision of services and supports, including case management services, directly by the state department.

(5) Governmental units, including but not limited to counties, municipalities, school districts, health service districts, and state institutions of higher education, are authorized at their own expense to furnish money, materials, or services and supports to persons with intellectual and developmental disabilities, or to purchase services and supports for such persons through designated community-centered boards, case management agencies, or service agencies, so long as no conditions or requirements imposed as a result of the provision or purchase conflict with the provisions of this article 10 or the rules promulgated thereunder.

(6) Boards of county commissioners may levy up to one mill for the purpose of purchasing services and supports for persons with intellectual and developmental disabilities. To the extent authorized by federal law, and subject to annual appropriation by the general assembly, and pursuant to rules established by the state board, a county may transfer the revenue raised pursuant to the mill levy to the state department to receive matching federal funds to provide medicaid-approved waiver services to persons with intellectual and developmental disabilities.

(7) (a) Each year the general assembly shall appropriate moneys to the state department to provide or purchase services and supports for persons with intellectual and developmental disabilities pursuant to this section. Unless specifically provided otherwise, services and supports shall be purchased on the basis of state funding less any federal or cash funds received for general operating expenses from any other state or federal source, less funds available to a person receiving residential services or supports after such person receives an allowance for personal needs or for meeting other obligations imposed by federal or state law, and less the required local school district funds specified in paragraph (b) of this subsection (7). The yearly appropriation, when combined with all other sources of funds, shall in no case exceed one hundred percent of the approved program costs as determined by the general assembly.

(b) Each school district shall pay to the community-centered board providing programs attended by a student with an intellectual and developmental disability, who is domiciled in the school district and may be counted in the district's pupil enrollment, an amount at least equal to the district's per pupil revenues as determined pursuant to the "Public School Finance Act of

1994", article 54 of title 22, C.R.S. This subsection (7) applies to students who are less than twenty-two years of age.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1754, § 1, effective March 1, 2014. **L. 2017:** (4)(b) amended, (HB 17-1284), ch. 272, p. 1505, § 12, effective May 31; IP(1), (2), (3), IP(4)(a), (4)(b), and (5) amended, (HB 17-1343), ch. 320, p. 1723, § 3, effective June 5.

Editor's note: (1) This section is similar to former § 27-10.5-104 as it existed prior to 2013.

(2) Amendments to subsection (4)(b) by HB 17-1284 and HB 17-1343 were harmonized.

25.5-10-207. Services and supports - waiting list reduction - cash fund - repeal. (1) There is hereby created in the state treasury the intellectual and developmental disabilities services cash fund, consisting of moneys appropriated thereto by the general assembly and any moneys transferred to the intellectual and developmental disabilities services cash fund pursuant to subsection (1.5) of this section. Any interest derived from the deposit and investment of moneys in the intellectual and developmental disabilities services cash fund shall be credited to the fund. Any moneys remaining in the fund at the end of a fiscal year shall remain in the fund and shall not revert to the general fund or any other fund.

(1.5) The state treasurer shall transfer to the intellectual and developmental disabilities services cash fund any available moneys that are appropriated by the general assembly for a fiscal year for adult comprehensive services, adult supported living services, children's extensive support services, and family support services for persons with intellectual and developmental disabilities provided pursuant to this article or part 4 of article 6 of this title that are unexpended and unencumbered at the end of a fiscal year.

(2) Repealed.

(3) The general assembly may annually appropriate money in the intellectual and developmental disabilities services cash fund to the state department for:

(a) Program costs for adult comprehensive services, adult supported living services, children's extensive support services, and family support services for persons with intellectual and developmental disabilities provided pursuant to this article or part 4 of article 6 of this title;

(b) Administrative expenses for renewal and redesign of medicaid home- and community-based services waivers relating to intellectual and developmental disabilities;

(c) Increasing system capacity for home- and community-based intellectual and developmental disabilities programs, services, and supports;

(d) The development of an assessment tool pursuant to section 25.5-6-104 (5); and

(e) Systems changes related to ensuring that the system of services and supports is compliant with conflict-free case management provisions pursuant to section 25.5-10-211.5.

(3.5) Repealed.

(4) Any moneys appropriated from the intellectual and developmental disabilities services cash fund pursuant to subsection (3) of this section that are unexpended at the end of a fiscal year shall revert to the fund.

(5) It is the intent of the general assembly that the moneys in the intellectual and developmental disabilities services cash fund be used to reduce the number of persons on the waiting lists for such services and the amount of time eligible persons wait for such services.

(6) Repealed.

(7) (a) On June 30, 2016, the state treasurer shall transfer two hundred fifty thousand dollars from the intellectual and developmental disabilities services cash fund to the general fund.

(b) On June 30, 2017, the state treasurer shall transfer two hundred fifty thousand dollars from the intellectual and developmental disabilities services cash fund to the general fund.

(c) This subsection (7) is repealed, effective July 1, 2018.

(8) The money in the fund shall be prioritized for the purpose set forth in subsection (3)(e) of this section.

(9) (a) This section is repealed, effective July 1, 2022.

(b) Prior to its repeal, any remaining money in the intellectual and developmental disabilities services cash fund shall be transferred to the general fund.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1757, § 1, effective March 1, 2014. **L. 2014:** (1.5), (2), and (3) amended and (3.5) added, (HB 14-1252), ch. 18, p. 135, § 1, effective March 1; (2) repealed, (HB 14-1051), ch. 33, p. 184, § 1, effective August 6. **L. 2015:** (6) added, (SB 15-168), ch. 16, p. 40, § 1, effective March 13. **L. 2016:** (7) added, (SB 16-196), ch. 226, p. 866, § 4, effective June 6; (3)(b) and (3)(c) amended and (3)(d) added, (SB 16-192), ch. 256, p. 1052, § 2, effective June 8. **L. 2017:** IP(3), (3)(c), and (3)(d) amended and (3)(e), (8), and (9) added, (HB 17-1343), ch. 320, p. 1724, § 4, effective June 5.

Editor's note: (1) This section is similar to former § 27-10.5-104.2 as it existed prior to 2013.

(2) Subsection (2) as amended by HB 14-1252 was harmonized with HB 14-1051 and relocated to § 25.5-10-207.5 (2).

(3) Subsection (3.5)(d) provided for the repeal of subsection (3.5), effective July 1, 2015. (See L. 2014, p. 135.)

(4) Subsection (6)(b) provided for the repeal of subsection (6), effective July 1, 2016. (See L. 2015, p. 40.)

25.5-10-207.5. Strategic plan for services and supports - joint hearing - reporting - legislative declaration. (1) (a) The general assembly finds that:

(I) Colorado has a long commitment to supporting persons with intellectual and developmental disabilities in communities of their choosing;

(II) Coloradans with intellectual and developmental disabilities who are eligible for state services and supports should be able to access services and supports in a timely manner to allow them to benefit from those services and supports and lead lives that build on their independence;

(III) Providing early and timely access to services and supports for persons with intellectual and developmental disabilities is an excellent and cost-effective investment that results in substantial future savings;

(IV) The presence of a waiting list as long as fifteen years for essential services and supports contradicts Colorado's commitment to supporting persons in the least restrictive environment of their choosing; and

(V) Colorado must have accurate data concerning the need for services and supports for persons with intellectual and developmental disabilities and their families and must regularly forecast this data to ensure that effective policy and programs are directed to meet these needs.

(b) Therefore, the general assembly declares that Colorado is committed to developing a strategic plan to ensure that Coloradans with intellectual and developmental disabilities and their families will be able to access the services and supports they need and want at the time that they need and want those services and supports.

(2) **[*Editor's note: This version of subsection (2) is effective until November 2, 2017.*]** During each regular session of the general assembly, the joint budget committee and the health and human services committees of the senate and the house of representatives, or any successor committees, shall hold a joint hearing and take public testimony on the status of the waiting lists for persons with intellectual and developmental disabilities who are waiting for enrollment into a home- and community-based services program or a program provided pursuant to this article and the availability of general fund moneys to reduce the number of persons on the waiting lists and the amount of time eligible persons wait for such services. The state department shall present testimony including the information provided in the report pursuant to subsection (3) of this section, as well as information concerning the ongoing implementation of the strategic plan required pursuant to subsection (4) of this section, including any revisions to the strategic plan. Additionally, the state department, community-centered boards, and providers shall report on the use and effectiveness of any moneys appropriated in the preceding state fiscal year for increasing system capacity. The goal of the hearing is to propose an appropriation from the general fund to the intellectual and developmental disabilities services cash fund.

(2) **[*Editor's note: This version of subsection (2) is effective November 2, 2017.*]** During each regular session of the general assembly, the joint budget committee and the health and human services committees of the senate and the house of representatives, or any successor committees, shall hold a joint hearing and take public testimony on the status of the waiting lists for persons with intellectual and developmental disabilities who are waiting for enrollment into a home- and community-based services program or a program provided pursuant to this article 10 and the availability of general fund money to reduce the number of persons on the waiting lists and the amount of time eligible persons wait for such services. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), the state department shall present testimony, including the information provided in the report pursuant to subsection (3) of this section, as well as information concerning the ongoing implementation of the strategic plan required pursuant to subsection (4) of this section, including any revisions to the strategic plan. Additionally, the state department, community-centered boards, and providers shall report on the use and effectiveness of any money appropriated in the preceding state fiscal year for increasing system capacity. The goal of the hearing is to propose an appropriation from the general fund to the intellectual and developmental disabilities services cash fund.

(3) (a) **[*Editor's note: This version of paragraph (a) is effective until November 2, 2017.*]** On or before November 1, 2014, and November 1 of each year thereafter, in accordance with section 24-1-136 (9), C.R.S., the state department shall report to the general assembly the total number of persons with intellectual and developmental disabilities who are waiting at the

time of the report for enrollment into a home- and community-based services program or a program provided pursuant to this article. The report must also include information concerning the ongoing implementation of the strategic plan required pursuant to subsection (4) of this section, including any revisions to the strategic plan.

(3) (a) **[*Editor's note: This version of paragraph (a) is effective November 2, 2017.*]** Notwithstanding the provisions of section 24-1-136 (11)(a)(I), on or before November 1, 2014, and November 1 of each year thereafter, in accordance with section 24-1-136 (9), the state department shall report to the general assembly the total number of persons with intellectual and developmental disabilities who are waiting at the time of the report for enrollment into a home- and community-based services program or a program provided pursuant to this article 10. The report must also include information concerning the ongoing implementation of the strategic plan required pursuant to subsection (4) of this section, including any revisions to the strategic plan.

(b) The information reported pursuant to paragraph (a) of this subsection (3) relating to persons with intellectual and developmental disabilities who are waiting for enrollment into a home- and community-based services program or a program provided pursuant to this article shall be disaggregated by:

(I) The specific medicaid waiver program or other intellectual and developmental disabilities program, service, or support;

(II) The persons who need services immediately but who are not currently receiving services;

(III) The persons who need services immediately who are currently receiving some services; and

(IV) The persons who are eligible for services but who do not need services at this time.

(4) (a) On or before November 1, 2014, the state department shall develop, in consultation with intellectual and developmental disability system stakeholders, a comprehensive strategic plan including administrative procedures and adequate funding to enroll eligible persons with intellectual and developmental disabilities into home- and community-based services programs and programs provided pursuant to this article at the time those persons choose to enroll in the programs or need the services or supports. As part of developing the strategic plan, the state department shall review the statutory definition of "waiting list" set forth in section 25.5-10-202 and make recommendations concerning amendments to the definition. In engaging stakeholders, the state department shall include both persons and families receiving services, as well as persons and families waiting for enrollment into programs, services, or supports. These persons and families shall include, at a minimum, persons and families who reside in each community-centered, board-designated service area within the state. In developing the strategic plan, the state department shall review relevant recommendations from the community living advisory group created in the office pursuant to the governor's executive order D 2012-027, as well as other relevant information. The strategic plan shall include specific recommendations and annual benchmarks for achieving this enrollment goal by July 1, 2020, including recommendations relating to increasing system capacity. The state department shall review the strategic plan annually and revise the plan as needed to meet the enrollment goal. Nothing in this section precludes the state department from considering changes in the structure of the state's intellectual and developmental disabilities programs, including medicaid waiver modification.

(b) The state department shall submit the strategic plan to the general assembly in accordance with section 24-1-136 (9), C.R.S., and shall present the strategic plan to the joint budget committee on or before December 1, 2014.

(5) In its annual submission of the state department's budget request to the joint budget committee, the governor's office of state planning and budgeting shall reference the number of persons who are waiting at the time of the November 1 report for enrollment into a home- and community-based services program or a program provided pursuant to this article and shall indicate to the joint budget committee those budget requests related specifically to achieving the enrollment goal set forth in the strategic plan required pursuant to this section.

Source: L. 2014: Entire section added, (HB 14-1051), ch. 33, p. 184, § 2, effective August 6. **L. 2017:** (2) and (3)(a) amended, (HB 17-1060), ch. 6, p. 17, § 10, effective November 2.

Editor's note: Subsection (2) is similar to former § 25.5-10-207 (2) as it existed prior to 2014.

25.5-10-208. Service agencies and case management agencies - money - rules. (1) A service agency and a case management agency shall comply with the requirements set forth in this article 10 and the rules promulgated thereunder.

(2) The state board shall promulgate rules to implement the purchase of services and supports from a community-centered board, service agency, case management agency, or family caregiver. The rules must include, but need not be limited to:

(a) Terms and conditions necessary to promote the effective delivery of services and supports, including those services and supports delivered by a family caregiver;

(b) Procedures for obtaining an annual audit of designated community-centered boards, case management agencies, and service agencies to provide financial information deemed necessary by the state department to establish costs of services and supports and to ensure proper management of money received pursuant to section 25.5-10-206;

(c) Delineation of a system to resolve contractual disputes between the state department and designated community-centered boards, service agencies, or case management agencies, and between designated community-centered boards and service agencies, including the contesting of any rates that the designated community-centered boards charge to service agencies based upon a percentage of the rates that service agencies charge for services and supports;

(d) Specification of which services and supports are to be reimbursed by the state department and secondarily by the community-centered board, the source of reimbursement, actual service or support costs, incentives, and program service objectives that affect reimbursement;

(e) The methods of coordinating the purchase of services and supports, including but not limited to service and support coordination, with other federal, state, and local programs that provide funding for authorized services and supports; and

(f) Criteria for and limitations on any rates that designated community-centered boards charge to service agencies based upon a percentage of the rates that service agencies charge for services and supports.

(3) Any incorporated service agency that is registered in Colorado as a foreign corporation shall organize a local advisory board consisting of persons who reside within the designated service area. Such advisory board shall be representative of the community at large and persons receiving services and their families.

(4) Upon a determination by the executive director that services or supports have not been provided in accordance with the program or financial administration standards specified in this article 10 and the rules promulgated thereunder, the executive director may reduce, suspend, or withhold payment to a designated community-centered board, case management agency, service agency under contract with a designated community-centered board, or service agency from which the state department purchased services or supports directly. When the executive director decides to reduce, suspend, or withhold payment, the executive director shall specify the reasons therefor and the actions that are necessary to bring the designated community-centered board, case management agency, or service agency into compliance.

(5) Nothing in this article or in any rules promulgated pursuant thereto and no actions taken by the executive director pursuant to this article shall be construed to affect the obtaining of funds from local authorities, including those funds obtained from a mill levy assessed by a county or municipality for the purpose of purchasing services or supports for persons with intellectual and developmental disabilities, or to require that such funds from local authorities be used to supplant state or federal funds available for purchasing services and supports for persons with developmental disabilities.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1758, § 1, effective March 1, 2014. **L. 2017:** (1), IP(2), (2)(b), (2)(c), and (4) amended, (HB 17-1343), ch. 320, p. 1724, § 5, effective June 5.

Editor's note: This section is similar to former § 27-10.5-104.5 as it existed prior to 2013.

25.5-10-209. Community-centered boards - designation - purchase of services and supports - performance audits - Colorado local government audit law - public disclosure of board administration and operations. (1) In order to be designated as the community-centered board in a particular designated service area, a private for-profit or not-for-profit corporation shall annually apply for such designation to the state department in the form and manner specified by the executive director. Designation shall be based on the following factors:

(a) Utilization of existing service agencies or existing social networks or natural sources of support in the designated service area;

(b) Encouragement of competition among service agencies within the designated service area to provide newly identified services or supports, the variety of service agencies available to the person receiving services within the designated service area, and the demonstrated effort to purchase new or expanded services or supports from service agencies other than those affiliated with the community-centered board;

(c) Utilization of state-funded services and supports administered at the local level, including but not limited to public education, social services, public health, and rehabilitation programs;

(d) Quality of services and supports provided directly or by contract for persons with intellectual and developmental disabilities;

(e) The establishment of new services and supports for the prevention of institutionalization, the support of deinstitutionalization, and a commitment to innovative, effective, and inclusive services and supports for persons with intellectual and developmental disabilities; and

(f) The willingness of the applicant to pursue authorized services and supports from all eligible persons within the designated service area.

(2) Once a community-centered board has been designated pursuant to this section, it shall, subject to available appropriations:

(a) Be under the control and direction of a board of directors or trustees composed of one or more persons from each of the following categories:

(I) Interested persons representing the community at large;

(II) Family members of persons with intellectual and developmental disabilities who are receiving services or supports; and

(III) Persons with intellectual and developmental disabilities who are receiving services or supports;

(b) Adopt by-law provisions to ensure that:

(I) Members of the governing board are prohibited from voting on issues in which they have a conflict of interest;

(II) Staff members of the community-centered board and employees or board members of service agencies may not serve on the governing board;

(III) Staff members of the community-centered board and employees or board members of service agencies are prohibited from voting in elections for members of the governing board; and

(IV) Board meetings must be scheduled after adequate notice and must be open to the public; except that, by vote of a two-thirds majority of members present, the board may elect to address the following matters in executive session:

(A) The purchase, acquisition, lease, transfer, or sale of any real, personal, or other property interest;

(B) Conferences with an attorney for the purpose of receiving legal advice on specific legal questions;

(C) Matters required to be kept confidential by federal or state law or rules;

(D) Specialized details of security arrangements or investigations;

(E) Determining positions relative to matters that may be subject to negotiations;

(F) Developing strategy for negotiations and instructing negotiators; and

(G) Personnel matters;

(c) Determine the needs of eligible persons within the community-centered board designated service area and prepare and implement a long-range plan and annual updates to that plan for the development and coordination of services and supports to address those needs. The needs determination and designated service area plans or annual update shall be submitted to the state department.

(d) Determine eligibility and develop an individualized plan for each person who receives services or supports pursuant to section 25.5-10-211; except that, for a child from birth

through two years of age, eligibility determination and development of an individualized family service plan are made pursuant to the provisions of part 7 of article 10.5 of title 27, C.R.S.;

(e) Provide case management services and periodic reviews pursuant to section 25.5-10-211, for persons receiving services and families with children with intellectual and developmental disabilities or delays;

(f) Obtain or provide early intervention services and supports pursuant to the provisions of part 7 of article 10.5 of title 27, C.R.S.;

(g) Take steps to notify eligible persons, and their families as appropriate, regarding the availability of services and supports; and

(h) Establish a human rights committee. The human rights committee is composed, to the extent possible, of two professional persons trained in the application of behavior development techniques and three representatives of persons receiving services, their parents, legal guardians, or authorized representatives. An employee or board member of a service agency within the community-centered board's designated service area shall not serve as a member of the human rights committee.

(3) The executive director shall review each designated community-centered board program to ensure that the program complies with the requirements and standards set forth in this article and the rules promulgated thereunder.

(4) The state auditor shall conduct or cause to be conducted a performance audit that includes each community-centered board that receives more than seventy-five percent of its funding on an annual basis from the federal, the state, or a local government or from any combination of such governmental entities to determine whether such board is effectively and efficiently fulfilling its statutory obligations. A community-centered board becomes subject to the audit requirement under this subsection (4) at such time as the board initially satisfies the seventy-five percent funding requirement for any one year regardless of whether or not the funding level decreases below seventy-five percent in any subsequent year. Any performance audit that is required to be conducted under this subsection (4) must be completed in the first five-year period following August 10, 2016. Thereafter, a performance audit may be conducted of such community-centered boards described in this subsection (4) if requested by the state auditor in the exercise of his or her discretion. The state auditor shall submit a written report and recommendations on each audit conducted under this subsection (4) and shall present the report and recommendations to the legislative audit committee created in section 2-3-101 (1), C.R.S. The state auditor shall pay the costs of any performance audit conducted pursuant to this section.

(5) Each community-centered board is subject to the requirements of the "Colorado Local Government Audit Law", part 6 of article 1 of title 29, C.R.S.

(6) In connection with the board of directors of each community-centered board, in addition to any other requirements applicable to the operation of the board of directors pursuant to this section or as required elsewhere by law:

(a) The community-centered board shall post the date, time, and location of each regularly scheduled meeting of its board of directors on the website of the community-centered board not less than fourteen business days prior to the date of the meeting. The community-centered board shall post on the website of the community-centered board the date, time, and location of any special or emergency meeting of the board of directors not less than twenty-four hours before the meeting.

(b) Each community-centered board shall post the agenda for each meeting of its board of directors on the website of the community-centered board not less than seven business days prior to the date of the meeting. The community-centered board shall post on the website of the community-centered board the agenda of any special or emergency meeting of the board of directors not less than twenty-four hours before the meeting. Each meeting of the board must allow for public comment, and the agenda must reflect this requirement. Public comment must be reasonably permitted during the board meeting to accommodate community needs. Any documents related to functions of the community-centered board to be distributed at a meeting of the board of directors that are available for public dissemination at the time the agenda is posted must also be posted on the website of the community-centered board at the time the agenda is posted, and written copies of such documents must be made available for public dissemination at the board meeting; except that, the posting requirement specified in this paragraph (b) does not apply to any document, or any portion of such document, the disclosure of which requires the approval of the board of directors and which approval has not been obtained as of the time the agenda is posted or any other document, or any portion of such document, containing any information that is legally prohibited from being disclosed to the public pursuant to the privacy requirements specified in the health insurance portability and accountability act, any document that has been or will be discussed by the board of directors meeting in executive session, or any other document the disclosure of which is otherwise prohibited by law.

(c) Each community-centered board shall provide a direct e-mail address to each member of its board of directors on the website of the community-centered board. The e-mail address selected must specify the name of the individual board member and make reference to the particular community-centered board for which he or she serves as a member of the board of directors. An e-mail that is sent to a member of the board of directors of a community-centered board shall not be filtered by the community-centered board through an employee of the community-centered board before it is sent to the member of the board of directors.

(d) The board of directors of each community-centered board shall present the financial statements of the corporation for the approval of the board at each regularly scheduled meeting of the board of directors. The financial statements must reflect accurate and current financial information and be prepared using generally accepted accounting principles. Where exigent circumstances are present that materially affect the preparation of the financial statements on a monthly basis, such statements may be presented for the approval of the board of directors at the next regularly scheduled meeting of the board but not less than at least once each quarter of the calendar year.

(e) Each community-centered board shall require the person or entity that performs financial audits of the community-centered board to present and discuss the results of the audit to the board of directors not less than once each year at a regularly scheduled meeting of the board of directors.

(f) Each community-centered board shall provide to the incoming members of its board of directors training in such topics as the duties of a board member, the financial and fiduciary responsibilities assumed by board members, the intellectual and developmental disability system in the state, the overall business functions of the community-centered board, and any other matters that will, in the determination of the community-centered board, allow the board member to better understand and fulfill his or her obligations to the board of directors and the community-centered board and the role played by community-centered boards in the state in

connection with the delivery of services for persons with intellectual and developmental disabilities.

(g) Each community-centered board shall post on the website of the community-centered board the minutes of each meeting of its board of directors as such minutes are approved by the board of directors. Each community-centered board shall also post on the website of the community-centered board any additional documents that were distributed to the board at such meeting that were not, as of that date, already posted on the website of the community-centered board unless the public distribution of such documents, or any portion of such documents, is otherwise prohibited pursuant to the privacy requirements specified in the health insurance portability and accountability act or as otherwise prohibited by law. Minutes of special meetings of the board of directors must be posted after approval by the board of the same at the board's next regular meeting.

(7) With respect to financial information concerning the community-centered board, each community-centered board shall:

(a) Post the following on the website of the community-centered board in a place on the website that allows access to the public in a clear, accessible, easily operated, and uncomplicated manner:

(I) Each completed financial audit undertaken of the community-centered board not later than thirty days following acceptance by the corporation's board of directors of the audit; and

(II) The most current form 990 the community-centered board has filed with the federal internal revenue service not later than thirty days following filing of the form with the internal revenue service.

(b) Make the following information available upon reasonable request not later than five business days after the request is made:

(I) The annual budget of the community-centered board for each calendar or fiscal year, as applicable, not later than thirty days after final approval of the budget by the board of directors of the community-centered board;

(II) An annual summary of all revenues and expenditures of the community-centered board as have been appropriated by the state concerning capacity building, family support services, state general fund supported living services, and state general fund early intervention that is calculated by September 30 of each year for the prior year, as applicable; and

(III) A description of the policies and procedures it follows to track, manage, and report its financial resources and transactions, which policies and procedures are also known and may be referred to as its "financial controls".

(8) Any contract that each community-centered board enters into on or after August 10, 2016, with either the department of health care policy and financing created in section 25.5-1-104 (1) or the department of human services created in section 26-1-105, C.R.S., must be posted on the website of the community-centered board in a place on the website that allows access to the public in a clear, accessible, easily operated, and uncomplicated manner not later than thirty days following approval of the contract by the board of directors of the community-centered board.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1760, § 1, effective March 1, 2014. **L. 2016:** (4), (5), (6), (7), and (8) added, (SB 16-038), ch. 199, p.

702, § 2, effective August 10. **L. 2017:** (2)(e) amended, (HB 17-1343), ch. 320, p. 1725, § 6, effective June 5.

Editor's note: This section is similar to former § 27-10.5-105 as it existed prior to 2013.

Cross references: (1) For the federal "Health Insurance Portability and Accountability Act of 1996", (HIPAA), see 42 U.S.C. sec. 1320d et seq.

(2) For the legislative declaration in SB 16-038, see section 1 of chapter 199, Session Laws of Colorado 2016.

25.5-10-209.5. Case management agencies - certification - purchase of services and supports - rules. (1) In order to be certified as a case management agency, a public or private for-profit or not-for-profit agency shall apply for certification to the state department in the form and manner specified by the executive director. The state board shall promulgate rules for certification and decertification of case management agencies.

(2) Once certified pursuant to this section, a case management agency shall, subject to available appropriations:

(a) Determine the needs of a person enrolled in home- and community-based services who selects the case management agency; and

(b) Provide case management services and periodic reviews pursuant to section 25.5-10-211.

(3) The executive director or his or her designee shall review each case management agency to ensure that the agency complies with the requirements and standards set forth in this article 10 and the rules promulgated pursuant to this article 10.

(4) The state board shall promulgate rules to ensure that:

(a) Each enrolled person with an intellectual and developmental disability has access to case management services;

(b) A person who is enrolled in home- and community-based services and other programs, as defined in section 25.5-10-202, is not required to have multiple case managers; and

(c) There is an established process for a person to select the case management agency of his or her choice.

(5) The state board shall begin promulgating rules for case management agencies on the June 5, 2017.

Source: L. 2017: Entire section added, (HB 17-1343), ch. 320, p. 1725, § 7, effective June 5.

25.5-10-210. Revocation of designation. (1) The executive director may revoke the designation of a community-centered board upon a finding that the community-centered board is in violation of the provisions of this article and the rules promulgated thereunder. Such revocation shall conform to the provisions and procedures specified in article 4 of title 24, C.R.S., and shall be made only after a hearing is provided as specified in that article.

(2) Once a designation has been revoked pursuant to subsection (1) of this section, the executive director may designate a service agency to perform the case management services of

the designated community-centered board pending designation of a new community-centered board.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1762, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-105.5 as it existed prior to 2013.

25.5-10-211. Eligibility determination - individualized plan - periodic review - rules. (1) (a) Any person may request an evaluation to determine whether he or she has an intellectual and developmental disability and is eligible to receive services and supports pursuant to this article 10. The person must apply for eligibility determination to the designated community-centered board in the designated service area where the person resides.

(b) Pursuant to the contract with the state department, designated community-centered boards shall determine whether a person is eligible to receive services and supports pursuant to this article 10. For persons eligible for services and supports other than home- and community-based services, the designated community-centered board shall develop an individualized plan for him or her as part of his or her enrollment into a program.

(c) For a person eligible for and authorized to receive home- and community-based services, designated community-centered boards shall refer the person to a third-party entity for selection of a case management agency.

(2) (a) Following intake and assessment, pursuant to subsection (2)(b) of this section, the designated community-centered board or the case management agency chosen by the person shall develop an individualized plan as provided by rules promulgated by the state board. The designated community-centered board shall develop an individualized family service plan for a child with disabilities from birth through two years of age pursuant to section 27-10.5-703.

(b) (I) The case management agency shall develop an individualized plan for persons enrolled in home- and community-based services.

(II) The designated community-centered board shall develop an individualized plan for persons eligible for other programs, as defined in section 25.5-10-202, and for a child with disabilities from birth through two years of age pursuant to section 27-10.5-703.

(2.5) The state board shall promulgate rules pursuant to article 4 of title 24 setting forth the procedure and criteria for determination of eligibility and individualized plan development. The procedure and criteria must be uniform in nature and applied throughout the state in a consistent manner. The procedure and criteria established by the state board must conform with the provisions of section 25.5-10-211.5 relating to conflict-free case management.

(3) Subject to available appropriations pursuant to section 25.5-10-206 and to the capacity of an individual service agency, the person with an intellectual and developmental disability must be provided options for services and supports within the designated service area that can appropriately meet the person's identified needs, as identified pursuant to subsection (2) of this section, and may select the case management agency and service agency from which to receive services or supports.

(4) (a) Each person receiving services must receive periodic and adequate reviews to ascertain whether the services and supports specified in his or her individualized plan have been

provided, determine the appropriateness of current services and supports, identify whether the outcomes specified in the person's individualized plan have been achieved, and modify and revise current services or supports to meet the identified needs and preferences of the person receiving services. The designated community-centered board shall develop modifications or revisions to the individualized family service plan for a child with disabilities from birth through two years of age pursuant to section 27-10.5-703, C.R.S.

(b) In order to accurately review the services and supports being provided, the community-centered board or regional center may make cognitive, physical, medical, behavioral, social, vocational, educational, or other necessary types of evaluations of a person receiving services. An intellectual and developmental disabilities professional shall supervise the reviews. The person receiving services, the parents or guardian of a minor, or the guardian of the person receiving services, and the authorized representative of the person receiving services may attend and shall receive adequate advance notice of the reviews. Parental or legal guardian consent must be obtained prior to administering evaluations for program review to minors. The results of a review must be given to the person receiving services and to the person's parent, or guardian, as appropriate, and must be made a part of the person's record.

(c) A person's individualized plan must be reviewed at least annually; except that an individualized family service plan for a child with disabilities from birth through two years of age must be reviewed as required pursuant to part 7 of article 10.5 of title 27, C.R.S.

(5) An individualized plan is not required for a person with intellectual and developmental disabilities who is eligible for supports and services and who is on a waiting list for enrollment into a program funded pursuant to this article. Each community-centered board shall provide information and referral services to each person on the waiting list for enrollment in a program, at the time of his or her eligibility and annually thereafter, regarding services and supports that are relevant to persons and are commonly used by persons with intellectual and developmental disabilities as provided by rules promulgated by the state board. The criteria for information and referral shall be uniform in nature and applied throughout the state in a consistent manner.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1762, § 1, effective March 1, 2014. **L. 2017:** (1), (2), and (3) amended and (2.5) added, (HB 17-1343), ch. 320, p. 1726, § 8, effective June 5.

Editor's note: This section is similar to former § 27-10.5-106 as it existed prior to 2013.

25.5-10-211.5. Conflict-free case management - implementation - legislative declaration - definition. (1) The general assembly acknowledges the rights of individuals to make choices regarding their case management agency and service agency. Therefore, the general assembly believes there exists the need to ensure conflict-free case management services within the medicaid waivers for persons with intellectual and developmental disabilities.

(2) As used in this section, unless the context otherwise requires, "rural community-centered board" means a community-centered board comprised primarily of counties designated by the state office of rural health as a rural or frontier county.

(3) A conflict-free case management system shall be implemented in Colorado as follows:

(a) No later than July 1, 2017, the state department shall determine the options for community-centered boards to become compliant with conflict-free case management;

(b) No later than January 1, 2018, the state department shall publish guidance on the components of a business continuity plan;

(c) No later than July 1, 2018, each community-centered board shall submit a business continuity plan to the state department based on the best option for the community-centered board pursuant to subsection (3)(a) of this section;

(d) Once a community-centered board has submitted its business continuity plan, on or before June 30, 2019, the state department shall complete an analysis of the adequacy of the continuity plan, unreimbursed transition costs, and community impacts of the transition to conflict-free case management;

(e) No later than June 30, 2020, a community-centered board shall complete any necessary changes to its business operation that are required to implement its business continuity plan;

(f) No later than June 30, 2021, at least twenty-five percent of clients receiving home- and community-based services must be served through a system of conflict-free case management; and

(g) No later than June 30, 2022, all clients receiving home- and community-based services must be served through a system of conflict-free case management.

(4) **Rural-based services - exemption.** (a) The state department is authorized to seek a federal exemption from conflict-free case management requirements for geographic areas within the state where the only willing and qualified entity to provide case management services is also the only willing and qualified entity to provide home- and community-based services in that geographic area.

(b) A rural community-centered board must initially notify the state department in writing, no later than July 1, 2017, to request that the state department seek a federal exemption for its designated service area, as defined in section 25.5-10-202. Upon receipt of the notice, the state department shall evaluate case management service provider capacity, and, if the state department determines that it is supported, the state department shall seek a federal exemption for its designated service area within a reasonable period of time.

(c) Upon notification of federal approval or denial of a federal exemption from conflict-free case management requirements, the rural community-centered board shall submit a business continuity plan and commence any necessary changes to its business operation pursuant to subsection (3)(e) of this section.

(d) The state board shall promulgate rules for the provision of services and supports, including services and supports coordination, when there are multiple agencies operating in a specified geographic area.

(e) If the state department has not received notification by July 1, 2019, regarding approval or denial for a federal exemption from conflict-free case management requirements, the state board shall promulgate rules for the provision of services and supports, including services and supports coordination, for designated service areas where a federal exemption from conflict-free case management is pending.

(f) In order to ensure stability, client choice, and access to services in rural communities, the state board shall promulgate rules, as permitted under federal law, that allow a qualified entity to provide both case management services and home- and community-based services to

the same individual if there is insufficient choice or capacity among existing service agencies or case management agencies serving a designated service area of a rural community-centered board.

(5) The state board shall amend its rules consistent with changes in federal law as set forth in 42 CFR (c)(1)(VI), including changes relating to allowable exemptions.

Source: L. 2017: Entire section added, (HB 17-1343), ch. 320, p. 1727, § 9, effective June 5.

25.5-10-212. Procedure for resolving disputes over eligibility, modification of services or supports, and termination of services or supports. (1) Every state or local service agency receiving state moneys pursuant to section 25.5-10-206 shall adopt a procedure for the resolution of disputes arising between the service agency and any recipient of, or applicant for, services or supports authorized under section 25.5-10-206. Procedures for the resolution of disputes regarding early intervention services must comply with IDEA and with part 7 of article 10.5 of title 27, C.R.S. The procedures must be consistent with rules promulgated by the state board pursuant to article 4 of title 24, C.R.S., and must apply to the following disputes:

(a) A contested decision that the applicant is not eligible for services or supports;

(b) A contested decision to provide, modify, reduce, or deny services or supports set forth in the individualized plan or individualized family service plan of the person receiving services;

(c) A contested decision to terminate services or supports;

(d) A contested decision that the person receiving services is no longer eligible for services or supports.

(2) The state board shall promulgate rules pursuant to article 4 of title 24, C.R.S., setting forth procedures for the resolution of disputes specified in subsection (1) of this section that must:

(a) Require that all applicants for services and supports and the parents or guardian of a minor, the guardian, or an authorized representative be informed orally and in writing, in their native language, of the dispute resolution procedures at the time of application, at the time the individualized plan is developed, and any time changes in the plan are contemplated;

(b) Require that a service agency keep a written record of all proceedings specified pursuant to this section;

(c) Require that no person receiving services be terminated from such services or supports during the resolution process;

(d) Require that utilizing the dispute resolution procedure must not prejudice the future provision of appropriate services or supports to persons; and

(e) Require that the intended action not occur until after reasonable notice has been provided to the person, the parents or guardian of a minor, the guardian, or an authorized representative, along with an opportunity to utilize the resolution process, except in emergency situations, as determined by the state department.

(3) The resolution process need not conform to the requirements of section 24-4-105, C.R.S., as long as the rules adopted by the state board include provisions specifically setting forth procedures, time frames, notice, an opportunity to be heard and to present evidence, and the

opportunity for impartial review of the decision in dispute by the executive director or designee, if the resolution process has failed.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1764, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-107 as it existed prior to 2013.

25.5-10-213. Discharge. (1) A person receiving services must be discharged from services or supports upon a determination, made pursuant to the individualized planning process, that the services or supports are no longer appropriate. At least ten days prior to effectuation of the discharge, notification of discharge must be given to the person receiving services, the parents or guardian of such a person who is a minor, and the person's legal guardian and authorized representative when applicable.

(2) When a person receiving services notifies a service agency that the person no longer wishes to receive a service or support, the person must be discharged from the service or support unless the person is subject to a petition to impose a legal disability or to remove a legal right, filed pursuant to section 25.5-10-216, or for whom a legal guardian has been appointed, affecting the person's ability to voluntarily terminate services or supports. The parents of the person receiving services who is a minor and such person's guardian must be notified of the person's wish to terminate services or supports, but no minor will be discharged without the consent of the parent or legal guardian.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1765, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-108 as it existed prior to 2013.

25.5-10-214. Community residential home - licenses - rules. (1) The department of public health and environment and the state department shall implement a system of joint licensure and certification of community residential homes. Independent residential support services provided by the state department do not require licensure by the department of public health and environment.

(2) (a) The department of public health and environment and the state department shall develop standards for the licensure and certification of community residential homes. The standards shall include health, life, and fire safety, as well as standards to ensure the effective delivery of services and supports to residents; except that any community residential home must comply with local codes.

(b) (I) The state department or the state board of health, as appropriate, shall adopt the standards by rule and shall specify the responsibilities of each department in the program. Surveys undertaken to ensure compliance with these standards shall, as appropriate, be undertaken as joint surveys by the departments.

(II) If a service agency operates a community residential home and provides personal care services, as defined in section 25-27.5-102, C.R.S., the department of public health and environment or the state department, as appropriate, is responsible for surveying those services

provided by the service agency, which survey shall be conducted simultaneously with the survey of the community residential home.

(3) Any community residential home applying for a license or certification on or after January 1, 1986, shall accommodate at least four but no more than eight persons with intellectual and developmental disabilities. All licenses and certificates issued by the department of public health and environment or the state department shall bear the date of issuance and shall be valid for not more than a twenty-four-month period.

(4) The issuance, suspension, revocation, modification, renewal, or denial of a license or certification shall be governed by the provisions of section 24-4-104, C.R.S. The failure of a community residential home to comply with the provisions of this article and the rules promulgated thereunder, or any local fire, safety, and health codes shall be sufficient grounds for the department of public health and environment or the state department to deny, suspend, revoke, or modify the community residential home's license or certification.

(5) The state department and the state board of health shall promulgate such rules as are necessary to implement this section, pursuant to the provisions specified in article 4 of title 24, C.R.S. The rules shall include, but shall not be limited to, the following:

(a) Requirements concerning the distance between the location of community residential homes and factors to be considered in waiving such requirements for existing community residential homes;

(b) Procedures to secure the health and safety of persons receiving services or supports residing in a community residential home in the event the community residential home closes or its license is denied, suspended, or revoked pursuant to this section; and

(c) Prohibiting the cultivation, use, or consumption of retail marijuana on the premises of a community residential home.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1765, § 1, effective March 1, 2014.

Editor's note: (1) This section is similar to former § 27-10.5-109 as it existed prior to 2013.

(2) Subsection (5)(c) was numbered as § 27-10.5-109 (6)(d) in Senate Bill 13-283 (see L. 2013, p. 1896). That provision was harmonized with subsection (5)(c) as it appears in House Bill 13-1314, effective March 1, 2014.

25.5-10-215. Compliance with local government zoning regulations - notice to local governments - provisional licensure. (1) The state department shall require any community residential home seeking licensure pursuant to section 25.5-10-214 to comply with any applicable zoning regulations of the municipality, city and county, or county where the home is situated. Failure to comply with applicable zoning regulations shall constitute grounds for the denial of a license to a home; except that nothing in this section shall be construed to supersede the provisions of sections 30-28-115 (2), 31-23-301 (4), and 31-23-303 (2), C.R.S.

(2) The state department shall ensure that timely written notice is provided to the municipality, city and county, or county where a community residential home is situated, including the address of the home and the population and number of persons to be served by the home, when any of the following occurs:

(a) An application for a license to operate a community residential home pursuant to section 25.5-10-214 is made;

(b) A license is granted to a community residential home pursuant to section 25.5-10-214;

(c) A change in the license of a community residential home occurs; or

(d) The license of a community residential home is revoked or otherwise terminated for any reason.

(3) In the event of a zoning or other delay or dispute between a community residential home and the municipality, city and county, or county where the home is situated, the state department may grant a provisional license to the home for up to one hundred twenty days pending resolution of the delay or dispute.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1767, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-109.5 as it existed prior to 2013.

25.5-10-216. Imposition of legal disability - removal of legal right. (1) Any interested person may petition the court to impose a legal disability on or to remove a legal right from a person with an intellectual and developmental disability as defined in section 25.5-10-202. The petition must set forth the disability to be imposed or the legal right to be removed and the reasons therefor. The petition may affect the right to contract, the right to determine place of abode or provisions of services and supports, the right to operate a motor vehicle, and other similar rights.

(2) (a) Prior to granting the petition, the court must find:

(I) That the person subject to the petition has been determined to be a person with an intellectual and developmental disability pursuant to the provisions of this article; and

(II) That the requested disability or removal is both necessary and desirable to implement the individualized plan developed for the person receiving services or supports under the supervision of an intellectual and developmental disabilities professional and the interdisciplinary team. Such professional must have an understanding of the rights of persons receiving services as set forth in sections 25.5-10-218 to 25.5-10-229. Such plan must be submitted to the court and must be signed by the intellectual and developmental disabilities professional.

(b) When a petition filed pursuant to subsection (1) of this section seeks to impose a disability or to remove a legal right, related to the selection of place of abode by the person with an intellectual and developmental disability, the court must also find:

(I) That, based on the recent overt actions or omissions of the person subject to the petition, and because of the presence of an intellectual and developmental disability, without the relief requested in the petition such person poses a probable threat of serious physical harm to such person or others or is unable to care for such person's own needs to the extent that such person's own life or safety is seriously threatened; and

(II) That the place of abode requested in the petition is the least restrictive residential setting that is appropriate for the individual needs of the person with an intellectual and developmental disability.

(3) Within six months after a legal disability has been imposed or a legal right has been removed, the court shall hold a hearing to review its order and either reaffirm the findings made pursuant to subsection (2) of this section and continue the legal disability or removal or remove the legal disability or restore the legal rights to the person subject to the petition. The court may remove a legal disability from or restore a legal right to a person without a hearing upon the filing of a motion requesting such relief containing affidavits in support of the motion signed by all of the parties.

(4) Any interested person may move that the court remove a legal disability or restore a legal right. If such motion is contested, it must be served on the person whose rights are affected and upon the party who filed the original petition if the person is not the moving party.

(5) The following procedures must apply to any proceedings instituted pursuant to this section:

(a) When a petition is filed pursuant to subsection (1) of this section, the person subject to the petition shall be advised by the court of such person's right to retain and consult with an attorney at any time, and that if such person cannot afford to pay an attorney, one will be appointed by the court without cost. Attorney fees for court-appointed counsel shall be paid by the court.

(b) Upon the request of an indigent respondent or such respondent's attorney, the court shall appoint one or more intellectual and developmental disabilities professionals of the respondent's choice to assist the respondent in the preparation of the respondent's case. The court shall pay the fees for such intellectual and developmental disabilities professionals.

(c) The court may issue a temporary order imposing a legal disability or removing a legal right, pending a hearing, for a period not to exceed ten days, based upon the standards required for issuance of a temporary restraining order. No individualized plan shall be required by the court to support the issuance of such order.

(d) The burden of proof is at all times upon the party seeking imposition of a disability or removal of a legal right or opposing removal of a disability or restoration of a legal right, and the standard of proof is by clear and convincing evidence.

(e) Except as otherwise provided in this subsection (5), all proceedings must be held in conformance with the Colorado rules of civil procedure, but no costs must be assessed against the respondent.

(6) In order to provide representation to eligible persons as provided in this section, the judicial department may pay moneys, out of appropriations made therefor by the general assembly, directly to appointed counsel or intellectual and developmental disabilities professionals on a case-by-case basis or, on behalf of the state, to contract with individual attorneys, legal partnerships, legal professional corporations, public interest law firms, or nonprofit legal services corporations to provide legal representation for an agreed-upon lump sum.

(7) A person shall not be admitted to a regional center, as defined in section 27-10.5-102, C.R.S., without a court order issued pursuant to this section except in an emergency or for the purpose of temporary respite care.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1767, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-110 as it existed prior to 2013.

25.5-10-217. Conduct of court proceedings. All court proceedings arising under section 25.5-10-216 shall be conducted by the district attorney of the county where the proceeding is held or by a qualified attorney acting for the district attorney appointed by the district court for that purpose; except that, in any county or in any city and county having a population exceeding one hundred thousand persons, the proceedings shall be conducted by the county attorney or by a qualified attorney acting for the county attorney appointed by the district court. In any case in which there has been a change of venue to a county other than the county of residence of the respondent or the county in which the proceeding was commenced, the county from which the proceeding was transferred shall either reimburse the county in which the proceeding was held for the reasonable costs incurred in conducting the proceeding or conduct the proceeding itself using its own personnel and resources, including its own district or county attorney, as the case may be.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1769, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-111 as it existed prior to 2013.

25.5-10-218. Persons' rights. (1) Unless a person's rights are modified by court order, a person with an intellectual and developmental disability has the same legal rights and responsibilities guaranteed to all other persons under the federal and state constitutions and federal and state laws. No otherwise qualified person, by reason of having an intellectual and developmental disability, may be excluded from participation in, denied the benefits of, or subjected to discrimination under any program or activity which receives public funds.

(2) The receipt of services and supports pursuant to this article does not deprive any person of any other rights, benefits, or privileges or cause the person to be declared legally incompetent.

(3) The rights of any person receiving services which are specified in this article may be suspended to protect the person receiving services from endangering such person, others, or property. Such rights may be suspended only by the intellectual and developmental disabilities professional with subsequent review by the interdisciplinary team and by the human rights committee in order to provide specific services or supports to the person receiving services, which will promote the least restriction on the person's rights. Such person's legal rights may be removed by a court pursuant to section 25.5-10-216.

(4) None of the rights established pursuant to this article shall be construed to interfere with the rights and privileges of parents regarding their minor child.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1770, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-112 as it existed prior to 2013.

25.5-10-219. Right to individualized plan or individualized family service plan. (1) Each person receiving services shall have an individualized plan, an individualized family service plan, or a similar plan specified by the state department that qualifies as an individualized plan that is developed by the person's interdisciplinary team. The individualized family service plan for a child with disabilities from birth through two years of age shall be developed in compliance with part 7 of article 10.5 of title 27, C.R.S.

(2) Pursuant to section 25.5-10-211, the individualized plan for each person who receives services or supports shall be reviewed at least annually and modified as necessary or appropriate; except that an individualized family service plan for a child with disabilities from birth through two years of age shall be reviewed as required pursuant to part 7 of article 10.5 of title 27, C.R.S. A review shall consist of, but is not limited to, the determination by the interdisciplinary team as to whether the needs and preferences of the person receiving services or supports are accurately reflected in the plan, whether the services and supports provided pursuant to the plan are appropriate to meet the person's needs and preferences, and what actions are necessary for the plan to be achieved.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1770, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-113 as it existed prior to 2013.

25.5-10-220. Right to medical care and treatment. (1) Each person receiving services must have access to appropriate dental and medical care and treatment for any physical ailments and for the prevention of any illness or disability.

(2) No medication for which a prescription is required shall be administered without the written order of a physician. A physician shall conduct a review of all prescriptions and other orders for medications in order to determine the appropriateness of the person's medication regimen annually, or more often, if required by law.

(3) All service agencies which administer medication shall require that notation of the medication of a person receiving services be kept in the person's medical records. All medications must be administered pursuant to part 3 of article 1.5 of title 25, C.R.S.

(4) Persons receiving services must have a right to be free from unnecessary or excessive medication. The service agency's records must state the effects of psychoactive medication if administered to the person receiving services. When dosages of such are changed or other psychoactive medications are prescribed, a notation must be made in such person's record concerning the effect of the new medication or new dosages and the behavior changes, if any, which occur.

(5) Medication must not be used for the convenience of the staff, for punishment, as a substitute for a treatment program, or in quantities that interfere with the treatment program of the person receiving services.

(6) Only appropriately trained staff shall be allowed to administer medications.

(7) The executive director has the power to direct the administration or monitoring of medications to persons receiving services and supports in centers for persons with intellectual and developmental disabilities pursuant to section 25-1.5-301 (2)(h), C.R.S.

(8) No person receiving services may be subjected to any experimental research or hazardous treatment procedures without the consent of such person, if the person is over eighteen years of age and is able to give such consent, or of the person's parent, if the person is under eighteen years of age, or of the person's legal guardian. Such consent may be given only after consultation with the interdisciplinary team and an intellectual and developmental disabilities professional not affiliated with the facility or community residential home in which the person receiving services resides. However, no such person of any age may be subjected to experimental research or hazardous treatment procedures if said person implicitly or expressly objects to such procedure.

(9) No person receiving services may have any organs removed for the purpose of transplantation without the consent of such person, if the person is over eighteen years of age and is able to give such consent. If the person's ability to give consent to the medical procedure is challenged by the physician, the same procedures as those set forth in section 25.5-10-232 shall be followed. Consent for the removal of organs for transplantation may be given by the parents of a person receiving services, if the person is under eighteen years of age, or by the person's legal guardian. Such consent may be given only after consultation with the interdisciplinary team and an intellectual and developmental disabilities professional not affiliated with the facility or community residential home in which the person receiving services resides. However, no person receiving services of any age may be a donor of an organ if the person implicitly or expressly objects to such procedure.

(10) (a) As used in subsections (8) and (9) of this section, consent also requires that the person whose consent is sought has been adequately and effectively informed as to the:

(I) Method of experimental research, hazardous treatment, or transplantation;

(II) Nature and consequence of such procedures; and

(III) Risks, benefits, and purposes of such procedures.

(b) The consent of any person may be revoked at any time.

(11) Subsections (8), (9), and (10) of this section do not apply when a physician renders emergency medical care or treatment to any resident.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1771, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-114 as it existed prior to 2013.

25.5-10-221. Right to humane treatment. (1) Corporal punishment of persons with an intellectual and developmental disability is not permitted.

(2) All service agencies shall prohibit mistreatment, exploitation, neglect, or abuse in any form of any person receiving services.

(3) Service agencies shall provide every person receiving services with a humane physical environment.

(4) Each person receiving services must be attended to by qualified staff in numbers sufficient to provide appropriate services and supports.

(5) Seclusion, defined as the placement of a person receiving services alone in a closed room for the purpose of punishment, is prohibited.

(6) "Time out" procedures, defined as separation from other persons receiving services and group activities, may be employed under close and direct professional supervision, as defined by rule by the state board, and only as a technique in behavior-shaping programs. Behavior-shaping programs utilizing a "time out" procedure may be implemented only when it incorporates a positive approach designed to result in the acquisition of adaptive behaviors. Such behavior programs may only be implemented following the completion of a comprehensive functional analysis, when alternative nonrestrictive procedures have been proven to be ineffective, and only with the informed consent of the person, parents, or legal guardian. Such behavior programs may be implemented only following the review and approval process defined in rules. Behavior development programs must be developed in conjunction with the interdisciplinary team and implemented only following review by the human rights committee. Behavior development programs involving the use of the procedure in a "time out room" are prohibited.

(7) Behavior development programs involving the use of aversive or noxious stimuli are prohibited.

(8) Physical restraint, defined as the use of manual methods intended to restrict the movement or normal functioning of a portion of a person's body through direct contact by staff, may be employed only when necessary to protect the person receiving services from injury to self or others. Physical restraint may not be employed as punishment, for the convenience of staff, or as a substitute for a program of services and supports. Physical guidance or prompting techniques of short duration such as those employed in training techniques are not considered physical restraint. Physical restraint may be applied only if alternative techniques have failed and only if such restraint imposed the least possible restriction consistent with its purpose. If physical restraint is used in an emergency or on a continuing basis its use shall be reviewed by the interdisciplinary team and the human rights committee in accordance with the rules of the state board.

(9) The use of a mechanical restraint, defined as the use of mechanical devices intended to restrict the movement or normal functioning of a portion of a person's body, is subject to special review and oversight, as defined in rules. Use of mechanical restraints may be applied only in an emergency if alternative techniques have failed and in conjunction with a behavior development program. Mechanical restraints must be designed and used so as not to cause physical injury to the person receiving services and so as to cause the least possible discomfort. The use of mechanical restraints shall be reviewed by the human rights committee. The use of posey vests, straight jackets, ankle and wrist restraints, and other devices defined in rules is prohibited.

(10) A record must be maintained of all physical injuries to any person receiving services, all incidents of mistreatment, exploitation, neglect, or abuse, and all uses of physical or mechanical restraint. All records are subject to review by the human rights committee.

(11) Behavior development programs must be supervised by an intellectual and developmental disabilities professional having specific knowledge and skills to develop and implement positive behavioral intervention strategies.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1772, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-115 as it existed prior to 2013.

25.5-10-222. Right to religious belief, practice, and worship. No person receiving services is required to perform any act or be subject to any procedure whatsoever which is contrary to the person's religious belief, and each such person has the right to practice such religious belief and be accorded the opportunity for religious worship. Provisions for religious worship must be made available to all persons receiving services on a nondiscriminatory basis. No such person shall be coerced into engaging in or refraining from any religious activity, practice, or belief.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1773, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-116 as it existed prior to 2013.

25.5-10-223. Rights to communications and visits. (1) Each person receiving services has the right to communicate freely and privately with others of the person's own choosing.

(2) Each person receiving services has the right to receive and send sealed, unopened correspondence. No such person's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person.

(3) Each person receiving services shall have the right to receive and send packages. No such person's outgoing packages shall be opened, delayed, held, or censored by any person.

(4) Each person receiving services must have reasonable access to telephones, both to make and to receive calls in privacy, and must be afforded reasonable and frequent opportunities to meet with visitors.

(5) All service agencies shall ensure that persons receiving services have suitable opportunities for interaction with persons of their choice. Nothing in this section will limit the protections provided under article 3.1 of title 26, C.R.S.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1774, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-117 as it existed prior to 2013.

25.5-10-224. Right to fair employment practices. (1) No person receiving services shall be required to perform labor; except that persons receiving services may voluntarily engage in such labor if the labor is compensated in accordance with applicable minimum wage laws.

(2) No person receiving services shall be involved in the physical care, care and treatment, training, or supervision of other persons receiving services unless such person has volunteered, has been specifically trained in the necessary skills, and has the judgment required for such activities, is adequately supervised, and is reimbursed in accordance with the applicable minimum wage laws.

(3) Each person receiving services may perform vocational training tasks, subject to a presumption that an assignment longer than three months to any task is not a training task, if the specific task or any change in task assignment is an integral part of such person's individualized plan. If such person performs vocational training tasks for which the service agency is receiving compensation from any outside source, the person shall be compensated in accordance with the applicable minimum wage laws.

(4) Each person receiving services may voluntarily engage in labor for which the service agency would otherwise have to pay an employee if the specific labor or any change in labor is an integral part of such person's individualized plan and the person is compensated in accordance with the applicable minimum wage laws.

(5) Each person receiving services may be required to perform tasks of a personal housekeeping nature or tasks oriented to improving community living skills in accordance with the person's individualized plan.

(6) Payment to persons receiving services pursuant to this section shall not be collected by the service agency to offset the costs of providing services and supports to such person.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1774, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-118 as it existed prior to 2013.

25.5-10-225. Right to vote. Each person receiving services who is eligible to vote according to law has the right to vote in all primary and general elections. As necessary, all service agencies shall assist such persons to register to vote, to obtain mail ballots, to comply with other requirements that are prerequisite to voting, and to vote.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1775, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-119 as it existed prior to 2013.

25.5-10-226. Records and confidentiality of information pertaining to eligible persons or their families. (1) A record for each person receiving services shall be diligently maintained by the community-centered board. The record must include, but not be limited to, information pertaining to the determination of eligibility for services and the individualized plan. The record is not a public record.

(2) Except as otherwise provided by law, all information obtained and any records prepared in the course of determining eligibility or providing services and supports pursuant to this article are confidential and subject to the evidentiary privileges established by law. The disclosure of this information and these records in any manner shall be permitted only:

(a) To the applicant or person receiving services, to the parents of a minor, to such person's legal guardian, and to any person authorized by the above named person;

(b) In communications between qualified professional personnel, including the board of directors of community-centered boards and service agencies providing services to persons with

intellectual and developmental disabilities, to the extent necessary for the acquisition, provision, oversight, or referral of services and supports;

(c) To the extent necessary to make claims for aid, insurance, or medical assistance to which a person receiving services may be entitled, or to access services and supports pursuant to the individualized plan;

(d) For the purposes of evaluation, gathering statistics, or research when no identifying information concerning an individual person or family is disclosed. Identifying information is information which could reasonably be expected to identify a specific person and includes, but is not limited to, name, address, telephone number, social security number, medicaid number, household number, and photograph.

(e) To the court when necessary to implement the provisions of this article;

(f) To persons authorized by an order of court issued after a hearing, notice of which was given to the person, parents or legal guardian, where appropriate, and the custodian of the information;

(g) To the agency designated pursuant to 42 U.S.C. sec. 6012 as the protection and advocacy system for Colorado when:

(I) A complaint has been received by the protection and advocacy system from or on behalf of a person with an intellectual and developmental disability; and

(II) Such person does not have a legal guardian or the state or the designee of the state is the legal guardian of such person;

(h) To the state department or its designees as deemed necessary by the executive director to fulfill the duties prescribed by this article.

(3) Nothing in this section shall be construed to limit access by a person receiving services to such person's records.

(4) Nothing in this section shall be construed to interfere with the protections afforded to a person under the federal "Health Insurance Portability and Accountability Act of 1996", 42 U.S.C. sec. 1320d, and the federal "Family Educational Rights and Privacy Act of 1974", 20 U.S.C. sec. 1232g.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1775, § 1, effective March 1, 2014. **L. 2017:** (4) amended, (SB 17-294), ch. 264, p. 1409, § 93, effective May 25.

Editor's note: This section is similar to former § 27-10.5-120 as it existed prior to 2013.

25.5-10-227. Right to personal property. (1) Each person receiving services has the right to the possession and use of such person's own clothing and personal effects. If the service agency holds any of such person's personal effects for any reason, such retention shall be promptly recorded in such person's record and the reason for retention shall also be recorded.

(2) Upon the request of a person receiving services, a service agency may hold money or funds belonging to the person receiving services, received by such person, or received by the service agency for such person. All such money or funds shall be held by the service agency as trustee for the person receiving services. Upon request, an accounting shall be rendered by the service agency.

(3) Upon request, a person receiving services is entitled to receive reasonable amounts of such person's money or funds held in trust.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1776, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-121 as it existed prior to 2013.

25.5-10-228. Right to influence policy. The persons receiving services of a service agency are entitled to establish a committee to hear the views and represent the interests of all such persons served by the agency and to attempt to influence the policies of the agency to the extent that they influence provision of services and supports.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1776, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-122 as it existed prior to 2013.

25.5-10-229. Right to notification. Each person receiving services has the right to read or have explained, in each person's or family's native language, any rules adopted by the service agency and pertaining to such person's activities.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1777, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-123 as it existed prior to 2013.

25.5-10-230. Discrimination. No person who has received services or supports under any provision of this article shall be discriminated against because of such status. For purposes of this section, "discrimination" means the giving of any unfavorable weight to the fact that a person has received such services or supports.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1777, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-124 as it existed prior to 2013.

25.5-10-231. Sterilization rights. (1) It is the intent of the general assembly that the procedures set forth in the following subsections be utilized when sterilization is being considered for the primary purpose of rendering the person incapable of reproduction.

(2) Any person with an intellectual and developmental disability over eighteen years of age who has given informed consent has the right to be sterilized, subject to the following:

(a) Prior to the procedure, competency to give informed consent and assurance that such consent is voluntarily and freely given shall be evaluated by the following:

(I) A psychiatrist, psychologist, or physician who does not provide services or supports to the person and who has consulted with and interviewed the person with an intellectual and developmental disability; and

(II) An intellectual and developmental disabilities professional who does not provide services or supports in which said person participates, and who has consulted with and interviewed the person with an intellectual and developmental disability.

(b) The professionals who conducted the evaluation pursuant to paragraph (a) of this subsection (2) shall consult with the physician who is to perform the operation concerning each professional's opinion in regard to the informed consent of the person requesting the sterilization.

(3) Any person with an intellectual and developmental disability whose capacity to give an informed consent is challenged by the intellectual and developmental disabilities professional or the physician may file a petition with the court to declare competency to give consent pursuant to the procedures set forth in section 25.5-10-232.

(4) No person with an intellectual and developmental disability who is over eighteen years of age and has the capacity to participate in the decision-making process regarding sterilization shall be sterilized in the absence of the person's informed consent. No minor may be sterilized without a court order pursuant to section 25.5-10-233.

(5) Sterilization conducted pursuant to this section shall be legal. Consent given by any person pursuant to subsection (2) of this section is not revocable after sterilization, and no person shall be liable for acting pursuant to such consent.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1777, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-128 as it existed prior to 2013.

25.5-10-232. Competency to give consent to sterilization. (1) If the competency of the person with an intellectual and developmental disability to give consent to sterilization is disputed by the intellectual and developmental disabilities professional, the psychiatrist or psychologist, or physician, said person may file a petition for declaration of competency to give consent to sterilization with the court. Upon the filing of a petition which shows that said person is over eighteen years of age and desires to give consent to sterilization, the court shall immediately set a hearing to determine the person's competency to give such consent. For the purpose of determining competency, the court shall appoint two or more independent professional persons with expertise in the field of intellectual and developmental disabilities who do not provide services and supports to said person to examine said person and to present their findings as to said person's competency to give consent to sterilization at the competency hearing.

(2) If the court determines that the person has given consent to sterilization and is competent to give such consent, the court may order that the sterilization be performed unless the person withdraws consent to sterilization prior to the sterilization being performed. If the court determines that the person is incompetent to give consent to sterilization, the court shall order that no sterilization be performed without further court proceedings pursuant to section 25.5-10-233.

(3) Determination of competency in these proceedings is specific to the ability to give consent to sterilization and does not determine legal competency for any other purpose.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1778, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-129 as it existed prior to 2013.

25.5-10-233. Court-ordered sterilization. (1) A person with an intellectual and developmental disability who has been determined to be incompetent to give consent, the person's legal guardian, or the parents of a minor with an intellectual and developmental disability, may petition the court to hold a hearing to determine whether said person should be ordered to be sterilized. The petition shall set forth the following:

(a) The name, age, and residence of the person to be sterilized;

(b) The name, address, and relation to said person of the petitioner;

(c) The names and addresses of any parents, spouse, legal guardian, or custodian of said person;

(d) The mental condition of the person to be sterilized;

(e) A statement that the sterilization is medically necessary to preserve the life or physical or mental health of the person, including a short and plain description of the reasons behind the determination of medical necessity;

(f) A statement that other less intrusive measures were considered and the reasons behind the determination that less intrusive means would not protect the interests of the person.

(2) Upon petition to the court, the court shall appoint an attorney who will represent the interests of the person with an intellectual and developmental disability and one or more experts in the intellectual and developmental disability field to examine the person and to give testimony at the hearing regarding the person's mental and physical status and other relevant matters.

(3) The hearing on the petition must be held promptly. The person with an intellectual and developmental disability must be represented by an attorney and must have the opportunity to present testimony and to cross-examine witnesses.

(4) Copies of the petition and notices of the time and place of the hearing shall be mailed, not less than ten days prior to the hearing, to the person with an intellectual and developmental disability, that person's attorney, a parent or next of kin, and legal guardian or custodian.

(5) Reasonable fees and costs incurred pursuant to this section shall be paid by the court for a person who is indigent.

(6) Prior to ordering sterilization, the court must find:

(a) That the person lacks the capacity to effectively participate in the decision-making process regarding sterilization or is a minor with an intellectual and developmental disability;

(b) That the court has heard from the person regarding that person's desires, if possible, and the court has considered the desires of the person;

(c) That the person lacks the capacity to make a decision regarding sterilization and that the person's capacity to make such a decision is unlikely to improve in the future;

(d) That the person is capable of reproduction and is likely to engage in activities at the present or in the near future which could result in pregnancy;

(e) By clear and convincing evidence, that the sterilization is medically necessary to preserve the life or physical or mental health of the person, including a short and plain description of the reasons behind the determination of medical necessity;

(f) That other less intrusive measures were considered and the reasons behind the determination that less intrusive means would not protect the interests of the person.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1778, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-130 as it existed prior to 2013.

25.5-10-234. Confidentiality of sterilization proceedings. All records, hearings, and proceedings pursuant to sections 25.5-10-231 to 25.5-10-233 are strictly confidential unless requested to be open to the public by the person with an intellectual and developmental disability or the person's legal guardian.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1779, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-131 as it existed prior to 2013.

25.5-10-235. Limitations on sterilization. (1) Consent to sterilization shall be made neither a condition for release from any institution nor a condition for the exercise of any right, privilege, or freedom.

(2) Nothing in this article requires any hospital or any person to participate in any sterilization, nor shall any hospital or any person be civilly or criminally liable for refusing to participate in any sterilization.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1779, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-132 as it existed prior to 2013.

25.5-10-236. Civil action and attorney fees. A violation of any provision of this article gives rise to a civil cause of action by the person adversely affected by such violation, and any judgment may include plaintiff's reasonable attorney fees.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-134 as it existed prior to 2013.

25.5-10-237. Terminology. (1) Whenever the terms "insane", "insanity", "mentally or mental incompetent", "mental incompetency", or "of unsound mind" are used in the laws of the state of Colorado, they shall be deemed to refer to the insane, as defined in section 16-8-101,

C.R.S., or to a person with an intellectual and developmental disability, as defined in section 25.5-10-202, as the context of the particular law requires.

(2) Whenever the term "mentally deficient person" is used in the laws of the state of Colorado, it shall be deemed to mean and be included with the term "person with an intellectual and developmental disability", as defined in section 25.5-10-202.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-135 as it existed prior to 2013.

25.5-10-238. Federal funds. The state department is authorized to accept, on behalf of the state, any grants of federal funds made available for any purposes consistent with the provisions of this article. The executive director of the state department, with the approval of the governor, shall have power to direct the disposition of any such grants so accepted in conformity with the terms and conditions under which they are given.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-137 as it existed prior to 2013.

25.5-10-239. Evaluations to determine whether a defendant is mentally retarded for purposes of class 1 felony trials. Upon request of the court, the executive director, or his or her designee, shall recommend specific professionals who are qualified to perform an evaluation to determine whether a defendant is mentally retarded, as defined in section 18-1.3-1101, C.R.S. Any professional who is recommended shall be licensed as a psychologist in the state of Colorado and shall have experience in and shall have demonstrated competence in determination and evaluation of persons with mental retardation. The executive director shall convene a panel of not fewer than three persons with expertise in mental retardation who shall assess the qualifications of licensed psychologists and make recommendations to the executive director.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-139 as it existed prior to 2013.

25.5-10-240. Retaliation prohibited. No person shall be discriminated against because he or she has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing pursuant to this article, including the dispute resolution procedures in section 25.5-10-212 and section 27-10.5-107, C.R.S. A service agency, including the state department and any community-centered board, shall not coerce, intimidate, threaten, or interfere with any person in the exercise or enjoyment of any right pursuant to this article, or on account of his or her having exercised or enjoyed any right pursuant to this article, or on account

of his or her having aided or encouraged any other person in the exercise or enjoyment of any right pursuant to this article.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-141 as it existed prior to 2013.

PART 3

FAMILY SUPPORT SERVICES

25.5-10-301. Legislative declaration. (1) It is the intent of the general assembly that the service delivery system for persons with intellectual and developmental disabilities emphasize community living for persons with intellectual and developmental disabilities and provide supports to persons that enable them to enjoy typical lifestyles. One way to accomplish this is to recognize that families are the greatest resource available to persons who have an intellectual and developmental disability and that families must be supported in their role as primary care givers. The general assembly finds that supporting families in their effort to provide supports for their family members at home is more efficient, cost-effective, and humane than maintaining persons with intellectual and developmental disabilities in out-of-home residential settings. In recognition of the importance of families, the general assembly states that the following principles should be used as guidelines in developing programs to support a family that has a child with disabilities:

(a) Families of persons with intellectual and developmental disabilities are best able to determine their own needs and preferences and should be empowered to make decisions concerning necessary, desirable, and appropriate services and supports;

(b) Families must receive the services and supports necessary to care for their children at home;

(c) Family support must be responsive to the needs of the entire family unit;

(d) Family support must be sensitive to the unique strengths and needs of individual families;

(e) Family support must build on existing social networks and natural sources of support;

(f) Family support is needed throughout the life span of the person who has a disability;

(g) Family support must encourage the inclusion of people with intellectual and developmental disabilities within the community;

(h) Family support services must be flexible enough to accommodate unique needs of families as they evolve over time;

(i) Family support services must be consistent with the cultural preferences and orientations of individual families;

(j) Family support services should be comprehensive and coordinated across the numerous agencies likely to provide resources, supports, or services to families;

(k) Family support services should be based on the principles of sharing ordinary places, developing meaningful relationships, learning things that are useful, making choices, as well as increasing the status and enhancing the reputation of people served;

(l) Supports should be developed by the state that are necessary, desirable, and appropriate to support families;

(m) Intellectual and developmental disabilities programs and policies must enhance the development of the person with an intellectual and developmental disability and the family;

(n) State programs should provide sufficient services and supports to enable families to keep their family members with intellectual and developmental disabilities at home;

(o) A comprehensive, coordinated system of supports to families effectively uses existing resources and minimizes gaps in supports to families and persons in all areas of the state;

(p) Services and supports provided through the family support program must be closely coordinated with early intervention services and must foster collaboration and cooperation with all agencies providing services and supports to infants and preschool children; and

(q) Any rights, entitlements, services, or supports created by this part 3 are not to be considered a limitation, modification, or infringement on any existing rights, entitlements, services, or supports, otherwise expressly provided by this article.

(2) In addition, the general assembly recognizes that the state department has for several years developed and maintained a family resource service program that provides support services to families of children with intellectual and developmental disabilities who are at risk of out-of-home placement. Because of the success of this program the general assembly recommends that this valuable program be continued and expanded so that more families in this state are able to receive appropriate services, supports, and assistance needed to stabilize the family unit. In recognition of the basic goal to support families, on an individual family basis, in maintaining a person with an intellectual and developmental disability at home and in recognition of the principles stated in subsection (1) of this section, the general assembly declares that its purpose in enacting this part 3 is to create, subject to annual appropriation, a comprehensive statewide family support service program.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1781, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-401 as it existed prior to 2013.

25.5-10-302. Purpose. The purpose of the family support services program created in this part 3 is to provide support to families in their role as primary care givers for a family member with an intellectual and developmental disability.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1782, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-402 as it existed prior to 2013.

25.5-10-303. Administration - duties of department. (1) Subject to annual appropriation by the general assembly, the state department shall administer the family support services program and shall coordinate family support services with other existing services provided to families and individuals. Family support services must be provided in a manner that develops comprehensive, responsive, and flexible support to families in their role as the primary care givers for a family member with an intellectual and developmental disability.

(2) The state department may contract with community-centered boards and other service providers approved by the state department to provide family support services in accordance with this part 3. Programs developed shall be flexible in order to address individual family needs.

(3) In administering the family support services program, the state department shall have the following duties:

(a) To design the program;

(b) To pursue a family support model 200 waiver for approval by the federal health care financing administration in order to utilize medicaid funds for the provision of family support services, implemented subject to appropriation;

(c) To develop rules to be promulgated by the state board pursuant to section 25.5-10-306, with consultation from service providers, including representatives of families of persons with intellectual and developmental disabilities;

(d) To allocate funds;

(e) To coordinate training and provide technical assistance to community-centered boards and service providers;

(f) To monitor and evaluate the program;

(g) To coordinate contracts, expenditures, and billing of the program; and

(h) To recommend changes in the program.

(4) Subject to annual appropriation by the general assembly, out of the appropriation to the state department for community programs in the general appropriation act, the state department is authorized to use up to seven percent of such appropriation allocated for family support services to pay for administrative costs within the state department and the community-centered boards.

(5) The state department shall take any necessary action relating to the termination and wind up of the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal. The state department shall receive payments relating to outstanding loans made from the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal, which payments shall be transferred to the state treasurer and credited to the family support services fund created in section 25.5-10-303.5.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1783, § 1, effective March 1, 2014. **L. 2017:** (5) added, (HB 17-1078), ch. 27, p. 82, § 4, effective July 1.

Editor's note: This section is similar to former § 27-10.5-404 as it existed prior to 2013.

25.5-10-304. Family support councils. (1) The state department shall ensure that each community-centered board establishes a family support council in each community-centered board designated service area. The family support councils shall consist of professionals,

interested citizens, family members of persons with an intellectual and developmental disability, and persons with an intellectual and developmental disability with a majority of the council being made up of family members.

(2) The family support council shall:

(a) Provide direction and assistance to the community-centered board in the development of a family support plan for the designated service area;

(b) Make recommendations regarding other family supports or services not specifically listed in this part 3;

(c) Monitor the implementation of the supports or services provided pursuant to the plan; and

(d) Provide a written report to the state department of its involvement in the duties specified in this subsection (2).

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1783, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-405 as it existed prior to 2013.

25.5-10-305. Authorized family support services. (1) The family support services included in this program include, but are not limited to, family support grants, family support services coordination, information and referral, educational materials, emergency and outreach services, and other person- and family-centered assistance services such as:

(a) Medical and dental expenses not covered by medical or health insurance or other programs;

(b) Insurance expenses;

(c) Respite;

(d) Mobility aids; adaptive equipment; assistive technology, including the cost of therapies essential for a child's development, as prescribed by a physician or specialized therapist; and home adaptations;

(e) Home health services and therapies;

(f) Family counseling, training, and support groups;

(g) Recreation and leisure needs;

(h) Transportation;

(i) Special diets, clothing, materials, and equipment; and

(j) Homemaker services.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1784, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-406 as it existed prior to 2013.

25.5-10-305.5. Family support services fund - creation. (1) The family support services fund, referred to in this section as the "fund", is hereby created in the state treasury. The fund consists of money transferred to the fund from the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal, payments relating to outstanding loans made

from the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal, and any other money that the general assembly may appropriate or transfer to the fund.

(2) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the fund.

(3) Subject to annual appropriation by the general assembly, the state department may expend money from the fund for necessary expenditures relating to the administration of outstanding loans made from the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal, and to provide family support services pursuant to this part 3.

Source: L. 2017: Entire section added, (HB 17-1078), ch. 27, p. 81, § 3, effective July 1.

25.5-10-306. Rules. (1) The state board shall develop rules concerning:

(a) Further definition of services and supports to be provided by the family support services program described in this part 3;

(b) The requirements for eligibility for services and supports;

(c) The manner of providing services and supports; and

(d) The size, makeup, and duties of family support councils.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1784, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-407 as it existed prior to 2013.

PART 4

COLORADO FAMILY SUPPORT LOAN FUND

25.5-10-401. Legislative declaration. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1785, § 1, effective March 1, 2014. **L. 2017:** Entire section repealed, (HB 17-1078), ch. 27, p. 81, § 1, effective July 1.

Editor's note: This section was similar to former § 27-10.5-501 as it existed prior to 2013.

25.5-10-402. Colorado family support loan fund - creation - loans to families - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1785, § 1, effective March 1, 2014. **L. 2017:** (6) added, (HB 17-1078), ch. 27, p. 81, § 2, effective July 1.

Editor's note: (1) This section was similar to former § 27-10.5-502 as it existed prior to 2013.

(2) Subsection (6)(a) provided for the repeal of this section, effective July 1, 2017. (See L. 2017, p. 81.) Subsection (6)(b) provided for the transfer of any money remaining in the fund on July 1, 2017. For additional information, see chapter 27, Session Laws of Colorado 2017. (See L. 2017, p. 81.)

25.5-10-403. Duties relating to the fund. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1786, § 1, effective March 1, 2014. **L. 2017:** Entire section repealed, (HB 17-1078), ch. 27, p. 81, § 1, effective July 1.

Editor's note: This section was similar to former § 27-10.5-503 as it existed prior to 2013.