First Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

PREAMENDED

This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 09-0847.01 Jerry Barry **HOUSE BILL 09-1293**

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A BILL FOR AN ACT

101 CONCERNING A HOSPITAL PROVIDER FEE, AND, IN CONNECTION
102 THEREWITH, AUTHORIZING THE DEPARTMENT OF HEALTH CARE
103 POLICY AND FINANCING TO CHARGE AND COLLECT A HOSPITAL
104 PROVIDER FEE, SPECIFYING THE ALLOWABLE USES OF THE FEES,
105 AND REQUIRING A POST-ENACTMENT REVIEW OF THE
106 IMPLEMENTATION OF THIS ACT.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Authorizes the department of health care policy and financing (department) to charge and collect from licensed or certified hospitals a

hospital provider fee (fee). Authorizes the medical services board to establish the amount of the fee that shall not exceed the federal limit and to promulgate rules governing the administration and collection of the fee. Specifies that the fee shall:

- ! Supplement and not supplant existing general fund appropriations to hospital providers unless payments to other medicaid providers are reduced;
- ! Be used for increasing reimbursements to hospitals under medicaid and the Colorado indigent care program, expanding eligibility for medicaid and the children's basic health plan (CHP+), and paying the costs of the department in administering the fee;
- ! Be returned if the federal government does not approve the fee; and
- ! Cease if the federal government no longer provides matching federal funds for the fee.

Establishes the hospital provider fee oversight and advisory board (board) to make recommendations to the department concerning the amount of the fee, procedures for collecting the fee, and changes to the eligibility requirements for assistance if moneys from the fee are insufficient to pay for all of the proposed eligibility expansions. Specifies membership of the board. Directs the board to report annually to specified committees of the general assembly, the governor, and the medical services board.

Establishes an additional hospital reimbursement based upon a hospital's performance in providing improved health outcomes for recipients.

Subject to sufficient moneys being received from the fee and the matching federal funds:

- ! Expands eligibility for medicaid to:
  - ! Parents of children eligible for medical assistance or CHP+ to up to 100% of the federal poverty level;
  - ! Disabled individuals participating in a medicaid buy-in program to up to 400% of the federal poverty level; and
  - ! Childless adults or adults without a dependent child in the home to up to 100% of the federal poverty level subject to federal authorization.
- ! Provides for continuous eligibility in medicaid for children for 12 months.
- ! Expands eligibility for children and pregnant women under CHP+ to up to 250% of the federal poverty level.

Directs that if moneys are insufficient to fully fund the proposed eligibility expansions, the state board, subject to the approval of the joint budget committee, by rule may reduce the medical benefits offered or

reduce the eligibility levels, but the state board may not reduce the eligibility levels below the current levels. Provides that any rule reducing medical benefits or eligibility expires on the following May 15 unless the general assembly acts by bill to extend the rule.

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1 *Be it enacted by the General Assembly of the State of Colorado:*

2 **SECTION 1.** Part 4 of article 4 of title 25.5, Colorado Revised
3 Statutes, is amended BY THE ADDITION OF A NEW SECTION to
4 read:

5 **25.5-4-402.3. Providers - hospital - provider fees - legislative**
6 **declaration - federal waiver - fund created - rules - advisory board -**
7 **repeal.** (1) **Short title.** THIS SECTION SHALL BE KNOWN AND MAY BE
8 CITED AS THE "HEALTH CARE AFFORDABILITY ACT OF 2009".

9 (2) **Legislative declaration.** THE GENERAL ASSEMBLY HEREBY
10 FINDS AND DECLARES THAT:

11 (a) THE STATE AND THE PROVIDERS OF PUBLICLY FUNDED MEDICAL
12 SERVICES, AND HOSPITAL PROVIDERS IN PARTICULAR, SHARE A COMMON
13 COMMITMENT TO COMPREHENSIVE HEALTH CARE REFORM;

14 (b) HOSPITAL PROVIDERS WITHIN THE STATE INCUR SIGNIFICANT
15 COSTS BY PROVIDING UNCOMPENSATED EMERGENCY DEPARTMENT CARE
16 AND OTHER UNCOMPENSATED MEDICAL SERVICES TO LOW-INCOME AND
17 UNINSURED POPULATIONS; AND

18 (c) THIS SECTION IS ENACTED AS PART OF A COMPREHENSIVE
19 HEALTH CARE REFORM AND IS INTENDED TO PROVIDE THE FOLLOWING
20 STATE SERVICES AND BENEFITS:

21 (I) PROVIDING A PAYER SOURCE FOR SOME LOW-INCOME AND
22 UNINSURED POPULATIONS WHO MAY OTHERWISE BE CARED FOR IN
23 EMERGENCY DEPARTMENTS AND OTHER SETTINGS IN WHICH

1 UNCOMPENSATED CARE IS PROVIDED;
2 (II) REDUCING THE UNDERPAYMENT TO COLORADO HOSPITALS
3 PARTICIPATING IN PUBLICLY FUNDED HEALTH INSURANCE PROGRAMS;
4 (III) REDUCING THE NUMBER OF PERSONS IN COLORADO WHO ARE
5 WITHOUT HEALTH CARE BENEFITS;
6 (IV) REDUCING THE NEED OF HEALTH CARE PROVIDERS TO SHIFT
7 THE COST OF PROVIDING UNCOMPENSATED CARE TO OTHER PAYERS; AND
8 (V) EXPANDING ACCESS TO HIGH-QUALITY, AFFORDABLE HEALTH
9 CARE FOR LOW-INCOME AND UNINSURED POPULATIONS.
10 (3) **Hospital provider fee.** (a) BEGINNING WITH THE FISCAL YEAR
11 COMMENCING JULY 1, 2009, AND EACH FISCAL YEAR THEREAFTER, THE
12 STATE DEPARTMENT IS AUTHORIZED TO CHARGE AND COLLECT HOSPITAL
13 PROVIDER FEES, AS DESCRIBED IN 42 CFR 433.68 (b), ON OUTPATIENT AND
14 INPATIENT SERVICES PROVIDED BY ALL LICENSED OR CERTIFIED HOSPITALS,
15 REFERRED TO IN THIS SECTION AS "HOSPITALS", FOR THE PURPOSE OF
16 OBTAINING FEDERAL FINANCIAL PARTICIPATION UNDER THE STATE
17 MEDICAL ASSISTANCE PROGRAM AS DESCRIBED IN THIS ARTICLE AND
18 ARTICLES 5 AND 6 OF THIS TITLE, REFERRED TO IN THIS SECTION AS THE
19 STATE MEDICAL ASSISTANCE PROGRAM, AND THE COLORADO INDIGENT
20 CARE PROGRAM DESCRIBED IN PART 1 OF ARTICLE 3 OF THIS TITLE,
21 REFERRED TO IN THIS SECTION AS THE "COLORADO INDIGENT CARE
22 PROGRAM". THE HOSPITAL PROVIDER FEES SHALL BE USED TO:
23 (I) INCREASE REIMBURSEMENT TO HOSPITALS FOR PROVIDING
24 MEDICAL CARE UNDER:
25 (A) THE STATE MEDICAL ASSISTANCE PROGRAM; AND
26 (B) THE COLORADO INDIGENT CARE PROGRAM;
27 (II) INCREASE THE NUMBER OF PERSONS COVERED BY PUBLIC

1 MEDICAL ASSISTANCE; AND

2 (III) PAY THE ADMINISTRATIVE COSTS TO THE STATE DEPARTMENT
3 IN IMPLEMENTING AND ADMINISTERING THIS SECTION.

4 (b) THE PROVIDER FEES SHALL BE ASSESSED PURSUANT TO RULES
5 ADOPTED BY THE STATE BOARD, PURSUANT TO SECTION 24-4-103, C.R.S.
6 THE AMOUNT OF THE FEE SHALL BE ESTABLISHED BY RULE OF THE STATE
7 BOARD BUT SHALL NOT EXCEED THE FEDERAL LIMIT FOR SUCH FEES. IN
8 ESTABLISHING THE AMOUNT OF THE FEE AND IN PROMULGATING THE RULES
9 GOVERNING THE FEE, THE STATE BOARD SHALL:

10 (I) CONSIDER RECOMMENDATIONS OF THE HOSPITAL PROVIDER FEE
11 OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO
12 SUBSECTION (6) OF THIS SECTION;

13 (II) ESTABLISH THE AMOUNT OF THE PROVIDER FEE SO THAT THE
14 AMOUNT COLLECTED FROM THE FEE AND FEDERAL MATCHING FUNDS
15 ASSOCIATED WITH THE FEE ARE SUFFICIENT TO PAY FOR THE ITEMS
16 DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (3), BUT NOTHING IN
17 THIS SUBPARAGRAPH (II) SHALL REQUIRE THE STATE BOARD TO INCREASE
18 THE PROVIDER FEE ABOVE THE AMOUNT RECOMMENDED BY THE ADVISORY
19 BOARD; AND

20 (III) ESTABLISH THE AMOUNT OF THE PROVIDER FEE SO THAT THE
21 AMOUNT COLLECTED FROM THE FEE IS APPROXIMATELY EQUAL TO OR LESS
22 THAN THE AMOUNT OF THE APPROPRIATION SPECIFIED FOR THE FEE IN THE
23 GENERAL APPROPRIATION ACT OR ANY SUPPLEMENTAL APPROPRIATION
24 ACT.

25 (c) (I) IN ACCORDANCE WITH THE REDISTRIBUTIVE METHOD SET
26 FORTH IN 42 CFR 433.68 (e) (1) AND (e) (2), THE STATE DEPARTMENT MAY
27 SEEK A WAIVER FROM THE BROAD-BASED PROVIDER FEES REQUIREMENT

1 OR THE UNIFORM PROVIDER FEES REQUIREMENT, OR BOTH. SUBJECT TO
2 FEDERAL APPROVAL AND TO MINIMIZE THE FINANCIAL IMPACT ON CERTAIN
3 HOSPITALS, THE STATE DEPARTMENT, IN CONSULTATION WITH THE
4 ADVISORY BOARD, MAY EXEMPT FROM PAYMENT OF THE PROVIDER FEE
5 CERTAIN TYPES OF HOSPITALS, INCLUDING BUT NOT LIMITED TO:
6 (A) PSYCHIATRIC HOSPITALS, AS LICENSED BY THE DEPARTMENT
7 OF PUBLIC HEALTH AND ENVIRONMENT;
8 (B) HOSPITALS THAT ARE LICENSED AS GENERAL HOSPITALS AND
9 CERTIFIED AS LONG-TERM CARE HOSPITALS BY THE DEPARTMENT OF
10 PUBLIC HEALTH AND ENVIRONMENT;
11 (C) CRITICAL ACCESS HOSPITALS THAT ARE LICENSED AS GENERAL
12 HOSPITALS AND ARE CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH
13 AND ENVIRONMENT UNDER 42 CFR PART 485, SUBPART F;
14 (D) INPATIENT REHABILITATION FACILITIES; OR
15 (E) HOSPITALS SPECIFIED FOR EXEMPTION UNDER 42 CFR 433.68
16 (e).
17 (II) IN DETERMINING WHETHER A HOSPITAL MAY BE EXCLUDED,
18 THE STATE DEPARTMENT SHALL USE ONE OR MORE OF THE FOLLOWING
19 CRITERIA:
20 (A) A HOSPITAL THAT IS LOCATED IN A RURAL AREA;
21 (B) A HOSPITAL WITH WHICH THE STATE DEPARTMENT DOES NOT
22 CONTRACT TO PROVIDE SERVICES UNDER THE STATE MEDICAL ASSISTANCE
23 PROGRAM;
24 (C) A HOSPITAL WHOSE INCLUSION OR EXCLUSION WOULD NOT
25 SIGNIFICANTLY AFFECT THE NET BENEFIT TO HOSPITALS PAYING THE
26 PROVIDER FEE; OR
27 (D) A HOSPITAL THAT MUST BE INCLUDED TO RECEIVE FEDERAL

1 APPROVAL.

2 (III) THE STATE DEPARTMENT MAY REDUCE THE AMOUNT OF THE
3 PROVIDER FEE FOR CERTAIN HOSPITALS TO OBTAIN FEDERAL APPROVAL
4 AND TO MINIMIZE THE FINANCIAL IMPACT ON CERTAIN HOSPITALS. IN
5 DETERMINING FOR WHICH HOSPITALS THE STATE DEPARTMENT MAY
6 REDUCE THE AMOUNT OF THE PROVIDER FEE, THE STATE DEPARTMENT
7 SHALL USE ONE OR MORE OF THE FOLLOWING CRITERIA:

8 (A) THE HOSPITAL IS A TYPE OF HOSPITAL DESCRIBED IN
9 SUBPARAGRAPH (I) OF THIS PARAGRAPH (c);

10 (B) THE HOSPITAL IS LOCATED IN A RURAL AREA;

11 (C) THE HOSPITAL SERVES A HIGHER PERCENTAGE THAN THE
12 AVERAGE HOSPITAL OF PERSONS COVERED BY THE STATE MEDICAL
13 ASSISTANCE PROGRAM, MEDICARE, OR COMMERCIAL INSURANCE OR
14 PERSONS ENROLLED IN A MANAGED CARE ORGANIZATION;

15 (D) THE HOSPITAL DOES NOT CONTRACT WITH THE STATE
16 DEPARTMENT TO PROVIDE SERVICES UNDER THE STATE MEDICAL
17 ASSISTANCE PROGRAM;

18 (E) IF THE HOSPITAL PAID A REDUCED PROVIDER FEE, THE REDUCED
19 PROVIDER FEE WOULD NOT SIGNIFICANTLY AFFECT THE NET BENEFIT TO
20 HOSPITALS PAYING THE PROVIDER FEE; OR

21 (F) THE HOSPITAL IS REQUIRED NOT TO PAY A REDUCED PROVIDER
22 FEE AS A CONDITION OF FEDERAL APPROVAL.

23 (d) THE STATE DEPARTMENT MAY, WITH THE APPROVAL OF THE
24 ADVISORY BOARD, ALTER THE PROCESS PRESCRIBED IN THIS SUBSECTION
25 (3) TO THE EXTENT NECESSARY TO MEET THE FEDERAL REQUIREMENTS
26 AND TO OBTAIN FEDERAL APPROVAL.

27 (e) (I) THE STATE BOARD, IN CONSULTATION WITH THE ADVISORY

1 BOARD, SHALL PROMULGATE RULES ON THE CALCULATION, ASSESSMENT,
2 AND TIMING OF THE PROVIDER FEE. THE STATE DEPARTMENT SHALL
3 ASSESS THE PROVIDER FEE ON A SCHEDULE TO BE SET BY THE STATE
4 BOARD THROUGH RULE. THE STATE BOARD RULES SHALL REQUIRE THAT
5 THE PERIODIC PROVIDER FEE PAYMENTS FROM A HOSPITAL AND THE STATE
6 DEPARTMENT'S REIMBURSEMENT TO THE HOSPITAL UNDER
7 SUBPARAGRAPHS (I) AND (II) OF PARAGRAPH (b) OF SUBSECTION (4) OF
8 THIS SECTION ARE DUE AS NEARLY SIMULTANEOUSLY AS FEASIBLE; EXCEPT
9 THAT THE STATE DEPARTMENT'S REIMBURSEMENT TO THE HOSPITAL SHALL
10 BE DUE NO MORE THAN TWO DAYS AFTER THE PERIODIC PROVIDER FEE
11 PAYMENT IS RECEIVED FROM THE HOSPITAL. THE PROVIDER FEE SHALL BE
12 IMPOSED ON EACH HOSPITAL EVEN IF MORE THAN ONE HOSPITAL IS OWNED
13 BY THE SAME ENTITY. THE FEE SHALL BE PRORATED AND ADJUSTED FOR
14 THE EXPECTED VOLUME OF SERVICE FOR ANY YEAR IN WHICH A HOSPITAL
15 OPENS OR CLOSES.
16 (II) THE STATE DEPARTMENT IS AUTHORIZED TO REFUND ANY
17 UNUSED PORTION OF THE PROVIDER FEE. FOR ANY PORTION OF THE
18 PROVIDER FEE THAT HAS BEEN COLLECTED BY THE STATE DEPARTMENT
19 BUT FOR WHICH THE STATE DEPARTMENT HAS NOT RECEIVED FEDERAL
20 MATCHING FUNDS, THE STATE DEPARTMENT SHALL REFUND BACK TO THE
21 HOSPITAL THAT PAID THE FEE THE AMOUNT OF SUCH PORTION OF THE FEE
22 WITHIN FIVE BUSINESS DAYS AFTER THE FEE IS COLLECTED.
23 (III) THE STATE BOARD, IN CONSULTATION WITH THE ADVISORY
24 BOARD, SHALL PROMULGATE RULES ON THE REPORTS THAT HOSPITALS
25 SHALL BE REQUIRED TO SUBMIT FOR THE STATE DEPARTMENT TO
26 CALCULATE THE AMOUNT OF THE PROVIDER FEE. NOTWITHSTANDING THE
27 PROVISIONS OF PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S., INFORMATION

1 PROVIDED TO THE STATE DEPARTMENT PURSUANT TO THIS SECTION SHALL
2 BE CONSIDERED CONFIDENTIAL AND SHALL NOT BE DEEMED A PUBLIC
3 RECORD. NONETHELESS, THE STATE DEPARTMENT, IN CONSULTATION
4 WITH THE ADVISORY BOARD, MAY PREPARE AND RELEASE SUMMARIES OF
5 THE REPORTS TO THE PUBLIC.
6 (f) A HOSPITAL SHALL NOT INCLUDE ANY AMOUNT OF THE
7 PROVIDER FEE AS A SEPARATE LINE ITEM IN ITS BILLING STATEMENTS.
8 (g) THE STATE BOARD SHALL PROMULGATE ANY RULES PURSUANT
9 TO THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE
10 24, C.R.S., NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION
11 OF THIS SECTION. PRIOR TO SUBMITTING ANY PROPOSED RULES
12 CONCERNING THE ADMINISTRATION OR IMPLEMENTATION OF THE
13 PROVIDER FEE TO THE STATE BOARD, THE STATE DEPARTMENT SHALL
14 CONSULT WITH THE ADVISORY BOARD ON THE PROPOSED RULES AS
15 SPECIFIED IN PARAGRAPH (e) OF SUBSECTION (6) OF THIS SECTION.
16 (4) **Hospital provider fee cash fund.** (a) ALL PROVIDER FEES
17 COLLECTED PURSUANT TO THIS SECTION BY THE STATE DEPARTMENT
18 SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT
19 THE SAME TO THE HOSPITAL PROVIDER FEE CASH FUND, WHICH FUND IS
20 HEREBY CREATED AND REFERRED TO IN THIS SECTION AS THE "FUND".
21 (b) ALL MONEYS IN THE FUND SHALL BE SUBJECT TO FEDERAL
22 MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND SUBJECT TO
23 ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE FOLLOWING
24 PURPOSES:
25 (I) TO MAXIMIZE THE INPATIENT AND OUTPATIENT HOSPITAL
26 REIMBURSEMENTS TO UP TO THE UPPER PAYMENT LIMITS AS DEFINED IN 42
27 CFR 447.272 AND 42 CFR 447.321;

1 (II) TO INCREASE HOSPITAL REIMBURSEMENTS UNDER THE
2 COLORADO INDIGENT CARE PROGRAM TO UP TO ONE HUNDRED PERCENT
3 OF THE HOSPITAL'S COSTS OF PROVIDING MEDICAL CARE UNDER THE
4 PROGRAM;
5 (III) TO PAY THE QUALITY INCENTIVE PAYMENTS PROVIDED IN
6 SECTION 25.5-4-402 (3);
7 (IV) SUBJECT TO AVAILABLE REVENUE FROM THE PROVIDER FEE
8 AND FEDERAL MATCHING FUNDS, TO EXPAND ELIGIBILITY FOR PUBLIC
9 MEDICAL ASSISTANCE BY:
10 (A) INCREASING THE ELIGIBILITY LEVEL FOR PARENTS OF
11 CHILDREN WHO ARE ELIGIBLE FOR MEDICAL ASSISTANCE OR THE
12 CHILDREN'S BASIC HEALTH PLAN TO UP TO ONE HUNDRED PERCENT OF THE
13 FEDERAL POVERTY LEVEL;
14 (B) INCREASING THE ELIGIBILITY LEVEL FOR CHILDREN AND
15 PREGNANT WOMEN UNDER THE CHILDREN'S BASIC HEALTH PLAN TO UP TO
16 TWO HUNDRED FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL;
17 (C) PROVIDING ELIGIBILITY UNDER THE STATE MEDICAL
18 ASSISTANCE PROGRAM FOR A CHILDLESS ADULT OR ADULTS WITHOUT A
19 DEPENDENT CHILD IN THE HOME WHO EARNS UP TO ONE HUNDRED
20 PERCENT OF THE FEDERAL POVERTY LEVEL;
21 (D) PROVIDING A BUY-IN PROGRAM IN THE STATE MEDICAL
22 ASSISTANCE PROGRAM FOR DISABLED ADULTS AND CHILDREN WHOSE
23 FAMILIES EARN UP TO FOUR HUNDRED FIFTY PERCENT OF THE FEDERAL
24 POVERTY LEVEL;
25 (V) TO PROVIDE CONTINUOUS ELIGIBILITY FOR TWELVE MONTHS
26 FOR CHILDREN ENROLLED IN THE STATE MEDICAL ASSISTANCE PROGRAM;
27 (VI) TO PAY THE STATE DEPARTMENT'S ACTUAL ADMINISTRATIVE

1 COSTS OF IMPLEMENTING AND ADMINISTERING THIS SECTION, INCLUDING
2 BUT NOT LIMITED TO THE FOLLOWING COSTS:
3 (A) EXPENSES OF THE ADVISORY BOARD, INCLUDING BUT NOT
4 LIMITED TO THE STATE DEPARTMENT'S PERSONAL SERVICES AND
5 OPERATING COSTS RELATED TO THE ADMINISTRATION OF THE ADVISORY
6 BOARD;
7 (B) THE STATE DEPARTMENT'S ACTUAL COSTS RELATED TO
8 IMPLEMENTING AND MAINTAINING THE PROVIDER FEE, INCLUDING
9 PERSONAL SERVICES, OPERATING, AND CONSULTING EXPENSES;
10 (C) THE STATE DEPARTMENT'S ACTUAL COSTS FOR THE CHANGES
11 AND UPDATES TO THE MEDICAID MANAGEMENT INFORMATION SYSTEM FOR
12 THE IMPLEMENTATION OF SUBPARAGRAPHS (I) TO (III) OF THIS PARAGRAPH
13 (b);
14 (D) THE STATE DEPARTMENT'S PERSONAL SERVICES AND
15 OPERATING COSTS RELATED TO PERSONNEL, CONSULTING SERVICES, AND
16 FOR REVIEW OF HOSPITAL COSTS NECESSARY TO IMPLEMENT AND
17 ADMINISTER THE INCREASES IN INPATIENT AND OUTPATIENT HOSPITAL
18 PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH
19 (b), INCREASES IN THE COLORADO INDIGENT CARE PROGRAM PAYMENTS
20 MADE PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH (b), AND
21 QUALITY INCENTIVE PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (III)
22 OF THIS PARAGRAPH (b);
23 (E) THE STATE DEPARTMENT'S ACTUAL COSTS FOR THE CHANGES
24 AND UPDATES TO THE COLORADO BENEFITS MANAGEMENT SYSTEM AND
25 MEDICAID MANAGEMENT INFORMATION SYSTEM TO IMPLEMENT AND
26 MAINTAIN THE EXPANDED ELIGIBILITY PROVIDED FOR IN SUBPARAGRAPHS
27 (IV) AND (V) OF THIS PARAGRAPH (b);

(F) THE STATE DEPARTMENT'S PERSONAL SERVICES AND OPERATING COSTS RELATED TO PERSONNEL NECESSARY TO IMPLEMENT AND ADMINISTER THE EXPANDED ELIGIBILITY FOR PUBLIC MEDICAL ASSISTANCE PROVIDED FOR IN SUBPARAGRAPHS (IV) AND (V) OF THIS PARAGRAPH (b), INCLUDING BUT NOT LIMITED TO ADMINISTRATIVE COSTS ASSOCIATED WITH THE DETERMINATION OF ELIGIBILITY FOR PUBLIC MEDICAL ASSISTANCE BY COUNTY DEPARTMENTS;

(G) THE STATE DEPARTMENT'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 THAT WOULD INCREASE ACCESS TO PUBLIC MEDICAL ASSISTANCE AND REDUCE THE NUMBER OF UNINSURED SERVED BY HOSPITALS; AND

(VII) TO OFFSET THE LOSS OF ANY FEDERAL MATCHING FUNDS 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.

(c) ANY MONEYS IN THE FUND NOT EXPENDED FOR THE PURPOSES DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (4) 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 SHALL BE

1 APPROPRIATED BY THE GENERAL ASSEMBLY FOR THE PURPOSES DESCRIBED
2 IN PARAGRAPH (b) OF THIS SUBSECTION (4) IN FUTURE FISCAL YEARS.
3 (5) **Appropriations.** (a) (I) THE PROVIDER FEE IS TO SUPPLEMENT,
4 NOT SUPPLANT, GENERAL FUND APPROPRIATIONS TO SUPPORT HOSPITAL
5 REIMBURSEMENTS AS OF THE EFFECTIVE DATE OF THIS SECTION. GENERAL
6 FUND APPROPRIATIONS FOR HOSPITAL REIMBURSEMENTS SHALL BE
7 MAINTAINED AT THE LEVEL OF APPROPRIATIONS IN THE MEDICAL SERVICES
8 PREMIUM LINE ITEM MADE FOR THE FISCAL YEAR COMMENCING JULY 1,
9 2008; EXCEPT THAT GENERAL FUND APPROPRIATIONS FOR HOSPITAL
10 REIMBURSEMENTS MAY BE REDUCED IF AN INDEX OF APPROPRIATIONS TO
11 OTHER PROVIDERS SHOWS THAT GENERAL FUND APPROPRIATIONS ARE
12 REDUCED FOR OTHER PROVIDERS. IF THE INDEX SHOWS THAT GENERAL
13 FUND APPROPRIATIONS ARE REDUCED FOR OTHER PROVIDERS, THE
14 GENERAL FUND APPROPRIATIONS FOR HOSPITAL REIMBURSEMENTS SHALL
15 NOT BE REDUCED BY A GREATER PERCENTAGE THAN THE REDUCTIONS OF
16 APPROPRIATIONS FOR THE OTHER PROVIDERS AS SHOWN BY THE INDEX.
17 (II) IF GENERAL FUND APPROPRIATIONS FOR HOSPITAL
18 REIMBURSEMENTS ARE REDUCED BELOW THE LEVEL OF APPROPRIATIONS
19 IN THE MEDICAL SERVICES PREMIUM LINE ITEM MADE FOR THE FISCAL
20 YEAR COMMENCING JULY 1, 2008, THE GENERAL FUND APPROPRIATIONS
21 WILL BE INCREASED BACK TO THE LEVEL OF APPROPRIATIONS IN THE
22 MEDICAL SERVICES PREMIUM LINE ITEM MADE FOR THE FISCAL YEAR
23 COMMENCING JULY 1, 2008, AT THE SAME PERCENTAGE AS THE
24 APPROPRIATIONS FOR OTHER PROVIDERS AS SHOWN BY THE INDEX. THE
25 GENERAL ASSEMBLY IS NOT OBLIGATED TO INCREASE THE GENERAL FUND
26 APPROPRIATIONS BACK TO THE LEVEL OF APPROPRIATIONS IN THE MEDICAL
27 SERVICES PREMIUM LINE ITEM IN A SINGLE FISCAL YEAR AND SUCH

1 INCREASES MAY OCCUR OVER NONCONSECUTIVE FISCAL YEARS.
2 (III) FOR PURPOSES OF THIS PARAGRAPH (a), THE "INDEX OF
3 APPROPRIATIONS TO OTHER PROVIDERS" OR "INDEX" SHALL MEAN THE
4 AVERAGE PERCENT CHANGE IN REIMBURSEMENT RATES THROUGH
5 APPROPRIATIONS OR LEGISLATION ENACTED BY THE GENERAL ASSEMBLY
6 TO HOME HEALTH PROVIDERS, PHYSICIAN SERVICES, AND OUTPATIENT
7 PHARMACIES, EXCLUDING DISPENSING FEES. THE STATE BOARD, AFTER
8 CONSULTATION WITH THE ADVISORY BOARD, IS AUTHORIZED TO CLARIFY
9 THIS DEFINITION AS NECESSARY BY RULE.
10 (b) IF THE REVENUE FROM THE PROVIDER FEE IS INSUFFICIENT TO
11 FULLY FUND ALL OF THE PURPOSES DESCRIBED IN PARAGRAPH (b) OF
12 SUBSECTION (4) OF THIS SECTION:
13 (I) THE GENERAL ASSEMBLY IS NOT OBLIGATED TO APPROPRIATE
14 GENERAL FUND REVENUES TO FUND SUCH PURPOSES;
15 (II) THE HOSPITAL PROVIDER REIMBURSEMENT AND QUALITY
16 INCENTIVE PAYMENT INCREASES DESCRIBED IN SUBPARAGRAPHS (I) TO
17 (III) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION AND THE
18 COSTS DESCRIBED IN SUBPARAGRAPHS (VI) AND (VII) OF PARAGRAPH (b)
19 OF SUBSECTION (4) OF THIS SECTION SHALL BE FULLY FUNDED USING
20 REVENUE FROM THE PROVIDER FEE AND FEDERAL MATCHING FUNDS
21 BEFORE ANY ELIGIBILITY EXPANSION IS FUNDED; AND
22 (III) (A) IF THE STATE BOARD PROMULGATES RULES THAT EXPAND
23 ELIGIBILITY FOR MEDICAL ASSISTANCE TO BE PAID FOR PURSUANT TO
24 SUBPARAGRAPH (IV) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS
25 SECTION, AND THE STATE DEPARTMENT THEREAFTER NOTIFIES THE
26 ADVISORY BOARD THAT THE REVENUE AVAILABLE FROM THE PROVIDER
27 FEE AND THE FEDERAL MATCHING FUNDS WILL NOT BE SUFFICIENT TO PAY

1 FOR ALL OR PART OF THE EXPANDED ELIGIBILITY, THE ADVISORY BOARD
2 SHALL RECOMMEND TO THE STATE BOARD REDUCTIONS IN MEDICAL
3 BENEFITS OR ELIGIBILITY SO THAT THE REVENUE WILL BE SUFFICIENT TO
4 PAY FOR ALL OF THE REDUCED BENEFITS OR ELIGIBILITY. AFTER
5 RECEIVING THE RECOMMENDATIONS OF THE ADVISORY BOARD, THE STATE
6 BOARD SHALL ADOPT RULES PROVIDING FOR REDUCED BENEFITS OR
7 REDUCED ELIGIBILITY FOR WHICH THE REVENUE SHALL BE SUFFICIENT AND
8 SHALL FORWARD ANY ADOPTED RULES TO THE JOINT BUDGET COMMITTEE.
9 NOTWITHSTANDING THE PROVISIONS OF SECTION 24-4-103 (8) AND (12),
10 C.R.S., FOLLOWING THE ADOPTION OF RULES PURSUANT TO THIS
11 SUB-SUBPARAGRAPH (A), THE STATE BOARD SHALL NOT SUBMIT THE
12 RULES TO THE ATTORNEY GENERAL AND SHALL NOT FILE THE RULES WITH
13 THE SECRETARY OF STATE UNTIL THE JOINT BUDGET COMMITTEE APPROVES
14 THE RULES PURSUANT TO SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH
15 (III).
16 (B) THE JOINT BUDGET COMMITTEE SHALL PROMPTLY CONSIDER
17 ANY RULES ADOPTED BY THE STATE BOARD PURSUANT TO
18 SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (III). THE JOINT BUDGET
19 COMMITTEE SHALL PROMPTLY NOTIFY THE STATE DEPARTMENT, THE
20 STATE BOARD, AND THE ADVISORY BOARD OF ANY ACTION ON SUCH RULES.
21 IF THE JOINT BUDGET COMMITTEE DOES NOT APPROVE THE RULES, THE
22 JOINT BUDGET COMMITTEE SHALL RECOMMEND A REDUCTION IN BENEFITS
23 OR ELIGIBILITY SO THAT THE REVENUE FROM THE PROVIDER FEE AND THE
24 MATCHING FEDERAL FUNDS WILL BE SUFFICIENT TO PAY FOR THE REDUCED
25 BENEFITS OR ELIGIBILITY. AFTER APPROVING THE RULES PURSUANT TO
26 THIS SUB-SUBPARAGRAPH (B), THE JOINT BUDGET COMMITTEE SHALL
27 REQUEST THAT THE COMMITTEE ON LEGAL SERVICES, CREATED PURSUANT

1 TO SECTION 2-3-501, C.R.S., EXTEND THE RULES AS PROVIDED FOR IN
2 SECTION 24-4-103 (8), C.R.S., UNLESS THE COMMITTEE ON LEGAL
3 SERVICES FINDS AFTER REVIEW THAT THE RULES DO NOT CONFORM WITH
4 SECTION 24-4-103 (8) (a), C.R.S.
5 (C) AFTER THE STATE BOARD HAS RECEIVED NOTIFICATION OF THE
6 APPROVAL OF RULES ADOPTED PURSUANT TO SUB-SUBPARAGRAPH (A) OF
7 THIS SUBPARAGRAPH (III), THE STATE BOARD SHALL SUBMIT THE RULES TO
8 THE ATTORNEY GENERAL PURSUANT TO SECTION 24-4-103 (8) (b), C.R.S.,
9 AND SHALL FILE THE RULES AND THE OPINION OF THE ATTORNEY GENERAL
10 WITH THE SECRETARY OF STATE PURSUANT TO SECTION 24-4-103 (12),
11 C.R.S., AND WITH THE OFFICE OF LEGISLATIVE LEGAL SERVICES.
12 PURSUANT TO SECTION 24-4-103 (5), C.R.S., THE RULES SHALL BE
13 EFFECTIVE TWENTY DAYS AFTER PUBLICATION OF THE RULES AND SHALL
14 ONLY BE EFFECTIVE UNTIL THE FOLLOWING MAY 15 UNLESS THE RULES
15 ARE EXTENDED PURSUANT TO A BILL ENACTED PURSUANT TO SECTION
16 24-4-103 (8), C.R.S.
17 (c) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION,
18 IF, AFTER RECEIPT OF AUTHORIZATION TO RECEIVE FEDERAL MATCHING
19 FUNDS FOR MONEYS IN THE FUND, THE AUTHORIZATION IS WITHDRAWN OR
20 CHANGED SO THAT FEDERAL MATCHING FUNDS ARE NO LONGER
21 AVAILABLE, THE STATE DEPARTMENT SHALL CEASE COLLECTING THE
22 PROVIDER FEE AND SHALL REPAY TO THE HOSPITALS ANY MONEYS
23 RECEIVED BY THE FUND THAT ARE NOT SUBJECT TO FEDERAL MATCHING
24 FUNDS.
25 (6) **Hospital provider fee oversight and advisory board.**
26 (a) THERE IS HEREBY CREATED IN THE STATE DEPARTMENT THE HOSPITAL
27 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD, REFERRED TO IN THIS

1 SECTION AS THE "ADVISORY BOARD".

2 (b) (I) THE ADVISORY BOARD SHALL CONSIST OF TWELVE MEMBERS
3 APPOINTED BY THE GOVERNOR, WITH THE ADVICE AND CONSENT OF THE
4 SENATE, AS FOLLOWS:

5 (A) FOUR MEMBERS WHO ARE EMPLOYED BY HOSPITALS IN
6 COLORADO, INCLUDING AT LEAST ONE PERSON WHO IS EMPLOYED BY A
7 HOSPITAL IN A RURAL AREA, ONE PERSON WHO IS EMPLOYED BY A
8 SAFETY-NET HOSPITAL FOR WHICH THE PERCENT OF MEDICAID-ELIGIBLE
9 INPATIENT DAYS RELATIVE TO ITS TOTAL INPATIENT DAYS SHALL BE EQUAL
10 TO OR GREATER THAN ONE STANDARD DEVIATION ABOVE THE MEAN, AND
11 ONE PERSON WHO IS EMPLOYED BY A HOSPITAL IN AN URBAN AREA;

12 (B) ONE MEMBER WHO IS A REPRESENTATIVE OF A STATEWIDE
13 ORGANIZATION OF HOSPITALS;

14 (C) ONE MEMBER WHO REPRESENTS A STATEWIDE ORGANIZATION
15 OF HEALTH INSURANCE CARRIERS OR A HEALTH INSURANCE CARRIER
16 LICENSED PURSUANT TO TITLE 10, C.R.S., AND WHO IS NOT A
17 REPRESENTATIVE OF A HOSPITAL;

18 (D) ONE MEMBER OF THE HEALTH CARE INDUSTRY WHO DOES NOT
19 REPRESENT A HOSPITAL OR A HEALTH INSURANCE CARRIER;

20 (E) ONE MEMBER WHO IS A CONSUMER OF HEALTH CARE AND WHO
21 IS NOT A REPRESENTATIVE OR AN EMPLOYEE OF A HOSPITAL, HEALTH
22 INSURANCE CARRIER, OR OTHER HEALTH CARE INDUSTRY ENTITY;

23 (F) ONE MEMBER WHO IS A REPRESENTATIVE OF PERSONS WITH
24 DISABILITIES, WHO IS LIVING WITH A DISABILITY, AND WHO IS NOT A
25 REPRESENTATIVE OR AN EMPLOYEE OF A HOSPITAL, HEALTH INSURANCE
26 CARRIER, OR OTHER HEALTH CARE INDUSTRY ENTITY;

27 (G) ONE MEMBER WHO IS A REPRESENTATIVE OF A BUSINESS THAT

1 PURCHASES OR OTHERWISE PROVIDES HEALTH INSURANCE FOR ITS
2 EMPLOYEES; AND
3 (H) TWO EMPLOYEES OF THE STATE DEPARTMENT.
4 (II) THE GOVERNOR SHALL CONSULT WITH REPRESENTATIVES OF
5 A STATEWIDE ORGANIZATION OF HOSPITALS IN MAKING THE
6 APPOINTMENTS PURSUANT TO SUB-SUBPARAGRAPHS (A) AND (B) OF
7 SUBPARAGRAPH (I) OF THIS PARAGRAPH (b). NO MORE THAN SIX MEMBERS
8 OF THE ADVISORY BOARD MAY BE MEMBERS OF THE SAME POLITICAL
9 PARTY.
10 (III) MEMBERS OF THE ADVISORY BOARD SHALL SERVE AT THE
11 PLEASURE OF THE GOVERNOR. IN MAKING THE APPOINTMENTS, THE
12 GOVERNOR SHALL SPECIFY THAT FOUR MEMBERS SHALL SERVE INITIAL
13 TERMS OF TWO YEARS AND THREE MEMBERS SHALL SERVE INITIAL TERMS
14 OF THREE YEARS. ALL OTHER TERMS INCLUDING TERMS AFTER THE INITIAL
15 TERMS SHALL BE FOUR YEARS. A MEMBER WHO IS APPOINTED TO FILL A
16 VACANCY SHALL SERVE THE REMAINDER OF THE UNEXPIRED TERM OF THE
17 FORMER MEMBER.
18 (IV) THE GOVERNOR SHALL DESIGNATE A CHAIR FROM AMONG THE
19 MEMBERS OF THE ADVISORY BOARD APPOINTED PURSUANT TO
20 SUB-SUBPARAGRAPHS (A) TO (G) OF SUBPARAGRAPH (I) OF THIS
21 PARAGRAPH (b). THE CHAIR OF THE ADVISORY BOARD SHALL ONLY BE
22 ENTITLED TO VOTE IF THE VOTE OF THE OTHER MEMBERS OF THE ADVISORY
23 BOARD WHO ARE PRESENT AND VOTING ON AN ISSUE WOULD RESULT IN A
24 TIE VOTE. THE ADVISORY BOARD SHALL ELECT A VICE-CHAIR FROM
25 AMONG ITS MEMBERS.
26 (c) MEMBERS OF THE ADVISORY BOARD SHALL SERVE WITHOUT
27 COMPENSATION BUT SHALL BE REIMBURSED FROM MONEYS IN THE FUND

1 FOR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE
2 OF THEIR DUTIES PURSUANT TO THIS SECTION.
3 (d) THE ADVISORY BOARD MAY DIRECT THE STATE DEPARTMENT
4 TO CONTRACT FOR A GROUP FACILITATOR TO ASSIST THE MEMBERS OF THE
5 ADVISORY BOARD IN PERFORMING THEIR REQUIRED DUTIES.
6 (e) THE ADVISORY BOARD SHALL HAVE, AT A MINIMUM, THE
7 FOLLOWING DUTIES:
8 (I) TO RECOMMEND TO THE STATE DEPARTMENT THE TIMING AND
9 METHOD BY WHICH THE STATE DEPARTMENT SHALL ASSESS THE PROVIDER
10 FEE AND THE AMOUNT OF THE FEE;
11 (II) IF REQUESTED BY THE HEALTH AND HUMAN SERVICES
12 COMMITTEES OF THE SENATE OR HOUSE OF REPRESENTATIVES, OR ANY
13 SUCCESSOR COMMITTEES, TO CONSULT WITH THE COMMITTEES ON ANY
14 LEGISLATION THAT MAY IMPACT THE PROVIDER FEE OR HOSPITAL
15 REIMBURSEMENTS ESTABLISHED PURSUANT TO THIS SECTION;
16 (III) TO RECOMMEND TO THE STATE DEPARTMENT CHANGES IN THE
17 PROVIDER FEE THAT INCREASE THE NUMBER OF HOSPITALS BENEFITTING
18 FROM THE USES OF THE PROVIDER FEE DESCRIBED IN SUBPARAGRAPHS (I)
19 TO (V) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION OR THAT
20 MINIMIZE THE NUMBER OF HOSPITALS THAT SUFFER LOSSES AS A RESULT
21 OF PAYING THE PROVIDER FEE;
22 (IV) TO RECOMMEND TO THE STATE DEPARTMENT REFORMS OR
23 CHANGES TO THE INPATIENT HOSPITAL AND OUTPATIENT HOSPITAL
24 REIMBURSEMENTS AND QUALITY INCENTIVE PAYMENTS MADE UNDER THE
25 STATE MEDICAL ASSISTANCE PROGRAM TO INCREASE PROVIDER
26 ACCOUNTABILITY, PERFORMANCE, AND REPORTING;
27 (V) TO RECOMMEND TO THE STATE DEPARTMENT THE SCHEDULE

1 AND APPROACH TO THE IMPLEMENTATION OF SUBPARAGRAPHS (IV) AND
2 (V) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;
3 (VI) IF MONEYS IN THE FUND ARE INSUFFICIENT TO FULLY FUND
4 ALL OF THE PURPOSES SPECIFIED IN PARAGRAPH (b) OF SUBSECTION (4) OF
5 THIS SECTION, TO RECOMMEND TO THE STATE BOARD CHANGES TO THE
6 EXPANDED ELIGIBILITY PROVISIONS DESCRIBED IN SUBPARAGRAPH (IV) OF
7 PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;
8 (VII) TO PREPARE THE REPORTS SPECIFIED IN PARAGRAPH (f) OF
9 THIS SUBSECTION (6);
10 (VIII) TO MONITOR THE IMPACT OF THE HOSPITAL PROVIDER FEE
11 ON THE BROADER HEALTH CARE MARKETPLACE; AND
12 (IX) TO PERFORM ANY OTHER DUTIES REQUIRED TO FULFILL THE
13 ADVISORY BOARD'S CHARGE OR THOSE ASSIGNED TO IT BY THE STATE
14 BOARD OR THE EXECUTIVE DIRECTOR.
15 (f) ON OR BEFORE JANUARY 15, 2010, AND ON OR BEFORE
16 JANUARY 15 EACH YEAR THEREAFTER, THE ADVISORY BOARD SHALL
17 SUBMIT A WRITTEN REPORT TO THE HEALTH AND HUMAN SERVICES
18 COMMITTEES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES, OR
19 ANY SUCCESSOR COMMITTEES, THE JOINT BUDGET COMMITTEE OF THE
20 GENERAL ASSEMBLY, THE GOVERNOR, AND THE STATE BOARD. THE
21 REPORT SHALL INCLUDE, BUT NEED NOT BE LIMITED TO:
22 (I) THE RECOMMENDATIONS MADE TO THE STATE BOARD
23 PURSUANT TO THIS SECTION;
24 (II) A DESCRIPTION OF THE FORMULA FOR HOW THE PROVIDER FEE
25 IS CALCULATED AND THE PROCESS BY WHICH THE PROVIDER FEE IS
26 ASSESSED AND COLLECTED;
27 (III) AN ITEMIZATION OF THE TOTAL AMOUNT OF THE PROVIDER

1 FEE PAID BY EACH HOSPITAL AND ANY PROJECTED REVENUE THAT EACH
2 HOSPITAL IS EXPECTED TO RECEIVE DUE TO:
3 (A) THE INCREASED REIMBURSEMENTS MADE PURSUANT TO
4 SUBPARAGRAPHS (I) AND (II) OF PARAGRAPH (b) OF SUBSECTION (4) OF
5 THIS SECTION AND THE QUALITY INCENTIVE PAYMENTS MADE PURSUANT
6 TO SUBPARAGRAPH (III) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS
7 SECTION; AND
8 (B) THE INCREASED ELIGIBILITY DESCRIBED IN SUBPARAGRAPHS
9 (IV) AND (V) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;
10 (IV) AN ITEMIZATION OF THE COSTS INCURRED BY THE STATE
11 DEPARTMENT IN IMPLEMENTING AND ADMINISTERING THE HOSPITAL
12 PROVIDER FEE; AND
13 (V) ESTIMATES OF THE DIFFERENCES BETWEEN THE COST OF CARE
14 PROVIDED AND THE PAYMENT RECEIVED BY HOSPITALS ON A PER-PATIENT
15 BASIS, AGGREGATED FOR ALL HOSPITALS, FOR PATIENTS COVERED BY EACH
16 OF THE FOLLOWING:
17 (A) MEDICAID;
18 (B) MEDICARE; AND
19 (C) ALL OTHERS PAYERS.
20 (g) (I) THIS SUBSECTION (6) IS REPEALED, EFFECTIVE JULY 1, 2019.
21 (II) PRIOR TO SAID REPEAL, THE ADVISORY BOARD SHALL BE
22 REVIEWED AS PROVIDED IN SECTION 2-3-1203, C.R.S.
23 (7) **Notice to revisor of statutes - repeal.** (a) WITHIN SIXTY
24 DAYS AFTER THE STATE DEPARTMENT RECEIVES AUTHORIZATION TO
25 RECEIVE FEDERAL MATCHING FUNDS FOR THE MONEYS IN THE FUND, THE
26 EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF
27 STATUTES AND TO THE STATE TREASURER INFORMING THEM OF THE

AUTHORIZATION.

(b) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (3) OF THIS SECTION, IF THE STATE TREASURER HAS NOT RECEIVED THE NOTICE REQUIRED BY PARAGRAPH (a) OF THIS SUBSECTION (7) BY JULY 1, 2011, THE STATE TREASURER SHALL RETURN ALL MONEYS CONTAINED IN THE FUND TO THE HOSPITALS THAT PAID THE PROVIDER FEE, TOGETHER WITH ANY INTEREST OR INCOME EARNED ON SUCH MONEYS.

(c) IF THE REVISOR OF STATUTES DOES NOT RECEIVE THE NOTICE REQUIRED BY PARAGRAPH (a) OF THIS SUBSECTION (7) BY JULY 1, 2012, THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2012.

(d) IF THE REVISOR OF STATUTES RECEIVES THE NOTICE REQUIRED BY PARAGRAPH (a) OF THIS SUBSECTION (7), THIS SUBSECTION (7) IS REPEALED, EFFECTIVE JULY 1 OF THE YEAR FOLLOWING THE RECEIPT OF THE NOTICE.

SECTION 2. 2-3-1203 (3), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

2-3-1203. Sunset review of advisory committees. (3) The following dates are the dates for which the statutory authorization for the designated advisory committees is scheduled for repeal:

(ff) JULY 1, 2019: THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD, CREATED IN SECTION 25.5-4-402.3, C.R.S.

SECTION 3. 25.5-3-108, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25.5-3-108. Responsibility of the department of health care policy and financing - provider reimbursement. (17) SUBJECT TO ADEQUATE FUNDING MADE AVAILABLE UNDER SECTION 25.5-4-402.3, THE STATE DEPARTMENT SHALL INCREASE HOSPITAL REIMBURSEMENTS UP TO

ONE HUNDRED PERCENT OF HOSPITAL COSTS FOR PROVIDING MEDICAL CARE UNDER THE PROGRAM.

SECTION 4. 25.5-4-402 (1), Colorado Revised Statutes, is amended, and the said 25.5-4-402 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

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 ~~all licensed or certified hospitals under this article and articles 5 and 6 of this title, except those hospitals operated by the department of human services,~~ FOR INPATIENT HOSPITAL SERVICES pursuant to a system of prospective payment, generally based on the elements of ~~the medicare system of~~ A diagnosis-related ~~groups~~ GROUP SYSTEM. The state department shall develop and administer a system for ~~assuring~~ ENSURING appropriate utilization and quality of care provided by those providers who are reimbursed ~~pursuant to the system of prospective payment developed~~ 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.

(3) (a) IN ADDITION TO THE REIMBURSEMENT RATE PROCESS DESCRIBED IN SUBSECTION (1) OF THIS SECTION AND SUBJECT TO ADEQUATE FUNDING MADE AVAILABLE PURSUANT TO SECTION 25.5-4-402.3, THE STATE DEPARTMENT SHALL PAY AN ADDITIONAL

1 AMOUNT BASED UPON PERFORMANCE TO THOSE HOSPITALS THAT PROVIDE
2 SERVICES THAT IMPROVE HEALTH CARE OUTCOMES FOR THEIR PATIENTS.
3 THIS AMOUNT SHALL BE DETERMINED BY THE STATE DEPARTMENT BASED
4 UPON NATIONALLY RECOGNIZED PERFORMANCE MEASURES ESTABLISHED
5 IN RULES ADOPTED BY THE STATE BOARD. THE STATE QUALITY
6 STANDARDS SHALL BE CONSISTENT WITH FEDERAL QUALITY STANDARDS
7 PUBLISHED BY AN ORGANIZATION WITH EXPERTISE IN HEALTH CARE
8 QUALITY, INCLUDING BUT NOT LIMITED TO, THE CENTERS FOR MEDICARE
9 AND MEDICAID SERVICES, THE AGENCY FOR HEALTHCARE RESEARCH AND
10 QUALITY, OR THE NATIONAL QUALITY FORUM.
11 (b) THE AMOUNT OF THE PAYMENTS MADE PURSUANT TO THIS
12 SUBSECTION (3) SHALL BE COMPUTED ANNUALLY. FOR THE FIRST TWO
13 FISCAL YEARS THAT PAYMENTS ARE MADE PURSUANT TO THIS SUBSECTION
14 (3), THE TOTAL AMOUNT OF THE PAYMENTS SHALL BE UP TO FIVE PERCENT
15 OF THE TOTAL REIMBURSEMENTS MADE TO HOSPITALS IN THE PREVIOUS
16 YEAR. FOR EACH FISCAL YEAR AFTER THE FIRST TWO FISCAL YEARS, THE
17 TOTAL AMOUNT OF THE PAYMENTS SHALL BE UP TO SEVEN PERCENT OF THE
18 TOTAL REIMBURSEMENTS MADE TO HOSPITALS IN THE PREVIOUS YEAR.
19 **SECTION 5.** 25.5-5-201 (1) (m) (I) and (1) (o), Colorado
20 Revised Statutes, are amended, and the said 25.5-5-201 (1) is further
21 amended BY THE ADDITION OF THE FOLLOWING NEW
22 PARAGRAPHS, to read:
23 **25.5-5-201. Optional provisions - optional groups - repeal.**
24 (1) The federal government allows the state to select optional groups to
25 receive medical assistance. Pursuant to federal law, any person who is
26 eligible for medical assistance under the optional groups specified in this
27 section shall receive both the mandatory services specified in sections

1 25.5-5-102 and 25.5-5-103 and the optional services specified in sections
2 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial
3 aid funds, the following are the individuals or groups that Colorado has
4 selected as optional groups to receive medical assistance pursuant to this
5 article and articles 4 and 6 of this title:

6 (m) (I) (A) Parents of children who are eligible for the medical
7 assistance program or the children's basic health plan, article 8 of this
8 title, whose family income does not exceed a specified percent of the
9 federal poverty level, adjusted for family size, as set by the state board by
10 rule, which percentage shall be not less than ~~sixty~~ ONE HUNDRED percent.

11 (B) NOTWITHSTANDING THE PROVISIONS OF SUB-SUBPARAGRAPH
12 (A) OF THIS SUBPARAGRAPH (I), IF THE MONEYS IN THE HOSPITAL
13 PROVIDER FEE CASH FUND ESTABLISHED PURSUANT TO SECTION
14 25.5-4-402.3 (4), TOGETHER WITH THE CORRESPONDING FEDERAL
15 MATCHING FUNDS, ARE INSUFFICIENT TO FULLY FUND ALL OF THE
16 PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4) (b), AFTER RECEIVING
17 RECOMMENDATIONS FROM THE HOSPITAL PROVIDER FEE OVERSIGHT AND
18 ADVISORY BOARD ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (6),
19 FOR PARENTS OF CHILDREN ELIGIBLE FOR THE MEDICAL ASSISTANCE
20 PROGRAM OR THE CHILDREN'S BASIC HEALTH PLAN, THE STATE BOARD BY
21 RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3
22 (5) (b) (III) MAY REDUCE THE MEDICAL BENEFITS OFFERED TO SUCH
23 PARENT WHOSE FAMILY INCOME EXCEEDS SIXTY PERCENT OF THE FEDERAL
24 POVERTY LEVEL OR REDUCE THE PERCENTAGE OF THE FEDERAL POVERTY
25 LEVEL TO BELOW ONE HUNDRED PERCENT, BUT THE PERCENTAGE SHALL
26 NOT BE REDUCED TO BELOW SIXTY PERCENT.

27 (C) NOTWITHSTANDING THE PROVISIONS OF SUB-SUBPARAGRAPH

1 (A) OF THIS SUBPARAGRAPH (I), UNTIL THE STATE DEPARTMENT RECEIVES
2 FEDERAL AUTHORIZATION TO INCREASE THE PERCENTAGE OF THE FEDERAL
3 POVERTY RATE FOR PARENTS OF CHILDREN ELIGIBLE FOR THE MEDICAL
4 ASSISTANCE PROGRAM OR THE CHILDREN'S BASIC HEALTH PLAN, THE
5 PERCENTAGE OF THE FEDERAL POVERTY LEVEL SHALL BE NOT LESS THAN
6 SIXTY PERCENT. WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT
7 RECEIVES AUTHORIZATION TO INCREASE THE PERCENTAGE OF THE
8 FEDERAL POVERTY LEVEL, THE EXECUTIVE DIRECTOR SHALL SEND
9 WRITTEN NOTICE TO THE REVISOR OF STATUTES INFORMING HIM OR HER OF
10 THE AUTHORIZATION. THIS SUB-SUBPARAGRAPH (C) IS REPEALED,
11 EFFECTIVE THE JULY 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE
12 REVISOR OF STATUTES.
13 (o) (I) Individuals with disabilities who are participating in the
14 medicaid buy-in program established in part 14 of article 6 of this title.
15 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
16 THIS PARAGRAPH (o), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH
17 FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER
18 WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT
19 TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3
20 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL
21 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT
22 TO SECTION 25.5-4-402.3 (6), FOR INDIVIDUALS WITH DISABILITIES WHO
23 ARE PARTICIPATING IN THE MEDICAID BUY-IN PROGRAM ESTABLISHED IN
24 PART 14 OF ARTICLE 6 OF THIS TITLE, THE STATE BOARD BY RULE ADOPTED
25 PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY
26 REDUCE THE MEDICAL BENEFITS OFFERED OR THE PERCENTAGE OF THE
27 FEDERAL POVERTY LEVEL TO BELOW FOUR HUNDRED FIFTY PERCENT OR

1 MAY ELIMINATE THIS ELIGIBILITY GROUP.

2 (III) (A) NOTWITHSTANDING THE PROVISION OF SUBPARAGRAPH
3 (I) OF THIS PARAGRAPH (o), INDIVIDUALS WITH DISABILITIES WHO ARE
4 PARTICIPATING IN THE MEDICAID BUY-IN PROGRAM ESTABLISHED IN PART
5 14 OF ARTICLE 6 OF THIS TITLE SHALL ONLY BE ELIGIBLE FOR BENEFITS
6 UNDER THE MEDICAL ASSISTANCE PROGRAM IF THE STATE DEPARTMENT
7 RECEIVES FEDERAL AUTHORIZATION FOR SUCH ELIGIBILITY.

8 (B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
9 AUTHORIZATION TO PROVIDE MEDICAL BENEFITS TO INDIVIDUALS WITH
10 DISABILITIES WHO ARE PARTICIPATING IN THE MEDICAID BUY-IN PROGRAM
11 ESTABLISHED IN PART 14 OF ARTICLE 6 OF THIS TITLE, THE EXECUTIVE
12 DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF STATUTES
13 INFORMING HIM OR HER OF THE AUTHORIZATION.

14 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
15 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.

16 (p) (I) SUBJECT TO FEDERAL APPROVAL, PERSONS OVER EIGHTEEN
17 YEARS OF AGE WHO ARE CHILDLESS OR WITHOUT A DEPENDENT CHILD IN
18 THE HOME WHOSE FAMILY INCOME DOES NOT EXCEED A SPECIFIED
19 PERCENTAGE OF THE FEDERAL POVERTY LEVEL, ADJUSTED FOR FAMILY
20 SIZE AND AS SET BY THE STATE BOARD BY RULE, WHICH PERCENTAGE
21 SHALL BE NOT LESS THAN ONE HUNDRED PERCENT.

22 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
23 THIS PARAGRAPH (p), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH
24 FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER
25 WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT
26 TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3
27 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL

1 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT
2 TO SECTION 25.5-4-402.3 (6), FOR CHILDLESS PERSONS OR FOR PERSONS
3 WITHOUT A DEPENDENT CHILD IN THE HOME, THE STATE BOARD BY RULE
4 ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b)
5 (III) MAY REDUCE THE MEDICAL BENEFITS OFFERED OR THE PERCENTAGE
6 OF THE FEDERAL POVERTY LEVEL TO BELOW ONE HUNDRED PERCENT OR
7 MAY ELIMINATE THIS ELIGIBILITY GROUP.
8 (III) (A) NOTWITHSTANDING THE PROVISION OF SUBPARAGRAPH
9 (I) OF THIS PARAGRAPH (p), PERSONS OVER EIGHTEEN YEARS OF AGE WHO
10 ARE CHILDLESS OR WITHOUT A DEPENDENT CHILD IN THE HOME SHALL
11 ONLY BE ELIGIBLE FOR BENEFITS UNDER THE MEDICAL ASSISTANCE
12 PROGRAM IF THE STATE DEPARTMENT RECEIVES FEDERAL AUTHORIZATION
13 FOR SUCH ELIGIBILITY.
14 (B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
15 AUTHORIZATION TO PROVIDE MEDICAL BENEFITS TO PERSONS OVER
16 EIGHTEEN YEARS OF AGE WHO ARE CHILDLESS OR WITHOUT A DEPENDENT
17 CHILD IN THE HOME, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN
18 NOTICE TO THE REVISOR OF STATUTES INFORMING HIM OR HER OF THE
19 AUTHORIZATION.
20 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
21 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.
22 (q) CHILDREN WHO ARE CONTINUOUSLY ELIGIBLE FOR TWELVE
23 MONTHS PURSUANT TO SECTION 25.5-5-204.5.
24 (r) (I) PERSONS ELIGIBLE FOR A MEDICAID BUY-IN PROGRAM
25 ESTABLISHED PURSUANT TO SECTION 25.5-5-206 WHOSE FAMILY INCOME
26 DOES NOT EXCEED A SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY
27 LEVEL, 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 SUBPARAGRAPH (I) OF THIS PARAGRAPH (r), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (6), 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 25.5-4-402.3 (5) (b) (III) MAY REDUCE THE MEDICAL BENEFITS OFFERED, OR THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL, OR MAY ELIMINATE THIS ELIGIBILITY GROUP.

(III) (A) NOTWITHSTANDING THE PROVISION OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (r), PERSONS ELIGIBLE FOR A MEDICAID BUY-IN PROGRAM ESTABLISHED PURSUANT TO SECTION 25.5-5-206 SHALL ONLY BE ELIGIBLE FOR BENEFITS UNDER THE MEDICAL ASSISTANCE PROGRAM IF THE STATE DEPARTMENT RECEIVES FEDERAL AUTHORIZATION FOR SUCH ELIGIBILITY.

(B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES AUTHORIZATION TO PROVIDE MEDICAL BENEFITS TO PERSONS ELIGIBLE FOR A MEDICAID BUY-IN PROGRAM ESTABLISHED PURSUANT TO SECTION 25.5-5-206, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE OF TO THE REVISOR OF STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.

1 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
2 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.
3 **SECTION 6.** Part 2 of article 5 of title 25.5, Colorado Revised
4 Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW
5 SECTIONS to read:
6 **25.5-5-204.5. Continuous eligibility - children - repeal.** (1) A
7 CHILD WHO IS DETERMINED TO BE ELIGIBLE FOR BENEFITS UNDER THIS
8 ARTICLE OR UNDER ARTICLE 4 OR 6 OF THIS TITLE SHALL REMAIN ELIGIBLE
9 FOR TWELVE MONTHS SUBSEQUENT TO THE LAST DAY OF THE MONTH IN
10 WHICH THE CHILD WAS ENROLLED; EXCEPT THAT A CHILD SHALL NO
11 LONGER BE ELIGIBLE AND SHALL BE DISENROLLED FROM THE STATE
12 MEDICAL ASSISTANCE PROGRAM IF THE STATE DEPARTMENT BECOMES
13 AWARE OF OR IS NOTIFIED THAT THE CHILD HAS MOVED OUT OF THE STATE
14 OR HAS REACHED NINETEEN YEARS OF AGE.
15 (2) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF
16 THIS SECTION, IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND
17 ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH
18 THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO
19 FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4)
20 (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER
21 FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO
22 SECTION 25.5-4-402.3 (6), THE STATE BOARD BY RULE ADOPTED PURSUANT
23 TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY ELIMINATE
24 THE CONTINUOUS ENROLLMENT REQUIREMENT PURSUANT TO THIS
25 SECTION.
26 (3) (a) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF
27 THIS SECTION, CONTINUOUS ELIGIBILITY FOR CHILDREN SHALL ONLY BE

1 EFFECTIVE IF THE STATE DEPARTMENT RECEIVES FEDERAL AUTHORIZATION
2 FOR SUCH ELIGIBILITY.
3 (b) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
4 AUTHORIZATION TO PROVIDE CONTINUOUS ELIGIBILITY FOR CHILDREN, THE
5 EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF
6 STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.
7 (c) THIS SUBSECTION (3) IS REPEALED, EFFECTIVE THE JULY 1
8 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.
9 **25.5-5-206. Medicaid buy-in program - disabled children -**
10 **disabled adults - federal authorization - rules.** (1) (a) SUBJECT TO
11 AVAILABLE APPROPRIATIONS, THE STATE DEPARTMENT IS AUTHORIZED TO
12 SEEK FEDERAL AUTHORIZATION TO AND TO ESTABLISH A MEDICAID BUY IN
13 PROGRAM OR PROGRAMS FOR:
14 (I) DISABLED CHILDREN; OR
15 (II) DISABLED ADULTS WHO DO NOT QUALIFY FOR THE MEDICAID
16 BUY-IN PROGRAM ESTABLISHED PURSUANT TO PART 14 OF ARTICLE 6 OF
17 THIS TITLE.
18 (b) THE MEDICAID BUY-IN PROGRAM OR PROGRAMS ESTABLISHED
19 PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (1) MAY PROVIDE FOR
20 PREMIUM AND COST-SHARING CHARGES ON A SLIDING FEE SCALE BASED
21 UPON A FAMILY'S INCOME.
22 (2) THE STATE BOARD SHALL PROMULGATE RULES CONSISTENT
23 WITH ANY FEDERAL AUTHORIZATION TO IMPLEMENT AND ADMINISTER THE
24 MEDICAID BUY-IN PROGRAM OR PROGRAMS ESTABLISHED PURSUANT TO
25 PARAGRAPH (a) OF SUBSECTION (1) OF THIS SECTION.
26 **SECTION 7.** 25.5-6-1403 (2), Colorado Revised Statutes, is
27 amended to read:

25.5-6-1403. Waivers and amendments. (2) If approved by the joint budget committee following its review of the report and subject to available appropriations, the state department shall submit to the federal ~~health care financing administration~~ 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.

SECTION 8. 25.5-8-103 (4), Colorado Revised Statutes, as amended by Senate Bill 09-211, enacted at the First Regular Session of the Sixty-seventh General Assembly, is amended to read:";

25.5-8-103. Definitions - repeal. As used in this article, unless the context otherwise requires:

(4) "Eligible person" means:

(a) (I) A person who is less than nineteen years of age, whose family income does not exceed two hundred ~~five~~ FIFTY percent of the federal poverty level, adjusted for family size; ~~except that, subject to available appropriations, the department may increase the percentage of the federal poverty level for purposes of eligibility to up to two hundred fifty percent; or~~

1 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
2 THIS PARAGRAPH (a), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH
3 FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER
4 WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT
5 TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3
6 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL
7 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT
8 TO SECTION 25.5-4-402.3 (6), FOR PERSONS LESS THAN NINETEEN YEARS
9 OF AGE, THE STATE BOARD MAY BY RULE ADOPTED PURSUANT TO THE
10 PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) REDUCE THE
11 PERCENTAGE OF THE FEDERAL POVERTY LEVEL TO BELOW TWO HUNDRED
12 FIFTY PERCENT, BUT THE PERCENTAGE SHALL NOT BE REDUCED TO BELOW
13 TWO HUNDRED FIVE PERCENT;
14 (III) (A) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH
15 (I) OF THIS PARAGRAPH (a), UNTIL THE STATE DEPARTMENT RECEIVES
16 FEDERAL AUTHORIZATION TO INCREASE THE PERCENTAGE OF THE FEDERAL
17 POVERTY RATE FOR A PERSON WHO IS LESS THAN NINETEEN YEARS OF AGE,
18 THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL SHALL NOT EXCEED
19 TWO HUNDRED FIVE PERCENT.
20 (B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
21 AUTHORIZATION TO INCREASE THE PERCENTAGE OF FEDERAL POVERTY
22 LEVEL, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE
23 REVISOR OF STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.
24 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
25 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.
26
27 (b) (I) A pregnant woman whose family income does not exceed

two hundred ~~five~~ FIFTY percent of the federal poverty level, adjusted for family size, and who is not eligible for medicaid. ~~except that, subject to available appropriations, the department may increase the percentage of the federal poverty level for purposes of eligibility to up to two hundred fifty percent.~~

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (b), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (6), FOR PREGNANT WOMEN, THE STATE BOARD BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY REDUCE THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL TO BELOW TWO HUNDRED FIFTY PERCENT, BUT THE PERCENTAGE SHALL NOT BE REDUCED TO BELOW TWO HUNDRED FIVE PERCENT.

(III) (A) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (b), UNTIL THE STATE DEPARTMENT RECEIVES AUTHORIZATION TO INCREASE THE PERCENTAGE OF THE FEDERAL POVERTY RATE FOR A PERSON WHO IS LESS THAN NINETEEN YEARS OF AGE, THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL SHALL NOT EXCEED TWO HUNDRED FIVE PERCENT.

(B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES AUTHORIZATION TO INCREASE THE PERCENTAGE OF FEDERAL POVERTY LEVEL, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE

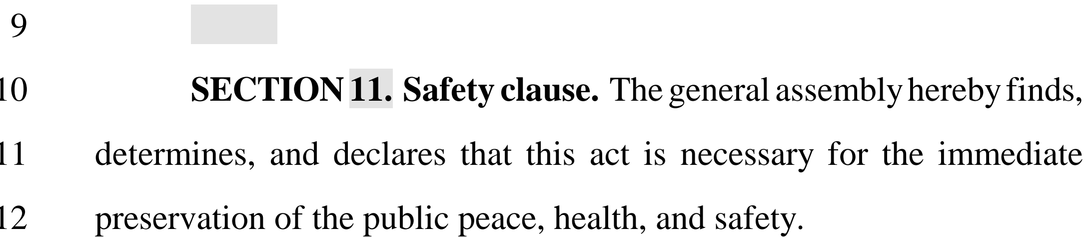
1 REVISOR OF STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.

2 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
3 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.

4 **SECTION 9.** 24-4-103 (8) (c) (I), Colorado Revised Statutes, is
5 amended to read:

6 **24-4-103. Rule-making - procedure - repeal.**
7 (8) (c) (I) Notwithstanding any other provision of law to the contrary
8 and the provisions of section 24-4-107, all rules adopted or amended on
9 or after January 1, 1993, and before November 1, 1993, shall expire at
10 11:59 p.m. on May 15 of the year following their adoption unless the
11 general assembly by bill acts to postpone the expiration of a specific rule,
12 and commencing with rules adopted or amended on or after November 1,
13 1993, all rules adopted or amended during any one-year period that begins
14 each November 1 and continues through the following October 31 shall
15 expire at 11:59 p.m. on the May 15 that follows such one-year period
16 unless the general assembly by bill acts to postpone the expiration of a
17 specific rule; EXCEPT THAT A RULE ADOPTED PURSUANT TO SECTION
18 25.5-4-402.3 (5) (b) (III), C.R.S., SHALL EXPIRE AT 11:59 P.M. ON THE
19 MAY 15 FOLLOWING THE ADOPTION OF THE RULE UNLESS THE GENERAL
20 ASSEMBLY ACTS BY BILL TO POSTPONE THE EXPIRATION OF A SPECIFIC
21 RULE. The general assembly, in its discretion, may postpone such
22 expiration, in which case, the provisions of section 24-4-108 or
23 24-34-104 shall apply, and the rules shall expire or be subject to review
24 as provided in said sections. The postponement of the expiration of a rule
25 shall not constitute legislative approval of the rule nor be admissible in
26 any court as evidence of legislative intent. The postponement of the
27 expiration date of a specific rule shall not prohibit any action by the

1 general assembly pursuant to the provisions of paragraph (d) of this
2 subsection (8) with respect to such rule.


3 **SECTION 10. Accountability.** Five years after this act becomes
4 law and in accordance with section 2-2-1201, Colorado Revised Statutes,
5 the legislative service agencies of the Colorado General Assembly shall
6 conduct a post-enactment review of the implementation of this act
7 utilizing the information contained in the legislative declaration set forth
8 in section 25.5-4-402.3 (2), Colorado Revised Statutes.
9

10 **SECTION 11. Safety clause.** The general assembly hereby finds,
11 determines, and declares that this act is necessary for the immediate
12 preservation of the public peace, health, and safety.