

**First Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO**

REENGROSSED

*This Version Includes All Amendments
Adopted in the House of Introduction*

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 **REQUIRING A POST-ENACTMENT REVIEW OF THE**
106 **IMPLEMENTATION OF THIS ACT, AND MAKING AN**
107 **APPROPRIATION IN CONNECTION THEREWITH.**

Bill Summary

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

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.
Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

HOUSE
3rd Reading Unamended
March 25, 2009

HOUSE
Amended 2nd Reading
March 24, 2009

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.

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

1 EMERGENCY DEPARTMENTS AND OTHER SETTINGS IN WHICH
2 UNCOMPENSATED CARE IS PROVIDED;

3 (II) REDUCING THE UNDERPAYMENT TO COLORADO HOSPITALS
4 PARTICIPATING IN PUBLICLY FUNDED HEALTH INSURANCE PROGRAMS;

5 (III) REDUCING THE NUMBER OF PERSONS IN COLORADO WHO ARE
6 WITHOUT HEALTH CARE BENEFITS;

7 (IV) REDUCING THE NEED OF HEALTH CARE PROVIDERS TO SHIFT
8 THE COST OF PROVIDING UNCOMPENSATED CARE TO OTHER PAYERS; AND

9 (V) EXPANDING ACCESS TO HIGH-QUALITY, AFFORDABLE HEALTH
10 CARE FOR LOW-INCOME AND UNINSURED POPULATIONS.

11 (3) **Hospital provider fee.** (a) BEGINNING WITH THE FISCAL YEAR
12 COMMENCING JULY 1, 2009, AND EACH FISCAL YEAR THEREAFTER, THE
13 STATE DEPARTMENT IS AUTHORIZED TO CHARGE AND COLLECT HOSPITAL
14 PROVIDER FEES, AS DESCRIBED IN 42 CFR 433.68 (b), ON OUTPATIENT AND
15 INPATIENT SERVICES PROVIDED BY ALL LICENSED OR CERTIFIED HOSPITALS,
16 REFERRED TO IN THIS SECTION AS "HOSPITALS", FOR THE PURPOSE OF
17 OBTAINING FEDERAL FINANCIAL PARTICIPATION UNDER THE STATE
18 MEDICAL ASSISTANCE PROGRAM AS DESCRIBED IN THIS ARTICLE AND
19 ARTICLES 5 AND 6 OF THIS TITLE, REFERRED TO IN THIS SECTION AS THE
20 STATE MEDICAL ASSISTANCE PROGRAM, AND THE COLORADO INDIGENT
21 CARE PROGRAM DESCRIBED IN PART 1 OF ARTICLE 3 OF THIS TITLE,
22 REFERRED TO IN THIS SECTION AS THE "COLORADO INDIGENT CARE
23 PROGRAM". THE HOSPITAL PROVIDER FEES SHALL BE USED TO:

24 (I) INCREASE REIMBURSEMENT TO HOSPITALS FOR PROVIDING
25 MEDICAL CARE UNDER:

26 (A) THE STATE MEDICAL ASSISTANCE PROGRAM; AND

27 (B) THE COLORADO INDIGENT CARE PROGRAM;

1 (II) INCREASE THE NUMBER OF PERSONS COVERED BY PUBLIC
2 MEDICAL ASSISTANCE; AND

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

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

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

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

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

26 (c) (I) IN ACCORDANCE WITH THE REDISTRIBUTIVE METHOD SET
27 FORTH IN 42 CFR 433.68 (e) (1) AND (e) (2), THE STATE DEPARTMENT MAY

1 SEEK A WAIVER FROM THE BROAD-BASED PROVIDER FEES REQUIREMENT
2 OR THE UNIFORM PROVIDER FEES REQUIREMENT, OR BOTH. SUBJECT TO
3 FEDERAL APPROVAL AND TO MINIMIZE THE FINANCIAL IMPACT ON CERTAIN
4 HOSPITALS, THE STATE DEPARTMENT, IN CONSULTATION WITH THE
5 ADVISORY BOARD, MAY EXEMPT FROM PAYMENT OF THE PROVIDER FEE
6 CERTAIN TYPES OF HOSPITALS, INCLUDING BUT NOT LIMITED TO:

7 (A) PSYCHIATRIC HOSPITALS, AS LICENSED BY THE DEPARTMENT
8 OF PUBLIC HEALTH AND ENVIRONMENT;

9 (B) HOSPITALS THAT ARE LICENSED AS GENERAL HOSPITALS AND
10 CERTIFIED AS LONG-TERM CARE HOSPITALS BY THE DEPARTMENT OF
11 PUBLIC HEALTH AND ENVIRONMENT;

12 (C) CRITICAL ACCESS HOSPITALS THAT ARE LICENSED AS GENERAL
13 HOSPITALS AND ARE CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH
14 AND ENVIRONMENT UNDER 42 CFR PART 485, SUBPART F;

15 (D) INPATIENT REHABILITATION FACILITIES; OR

16 (E) HOSPITALS SPECIFIED FOR EXEMPTION UNDER 42 CFR 433.68
17 (e).

18 (II) IN DETERMINING WHETHER A HOSPITAL MAY BE EXCLUDED,
19 THE STATE DEPARTMENT SHALL USE ONE OR MORE OF THE FOLLOWING
20 CRITERIA:

21 (A) A HOSPITAL THAT IS LOCATED IN A RURAL AREA;

22 (B) A HOSPITAL WITH WHICH THE STATE DEPARTMENT DOES NOT
23 CONTRACT TO PROVIDE SERVICES UNDER THE STATE MEDICAL ASSISTANCE
24 PROGRAM;

25 (C) A HOSPITAL WHOSE INCLUSION OR EXCLUSION WOULD NOT
26 SIGNIFICANTLY AFFECT THE NET BENEFIT TO HOSPITALS PAYING THE
27 PROVIDER FEE; OR

1 (D) A HOSPITAL THAT MUST BE INCLUDED TO RECEIVE FEDERAL
2 APPROVAL.

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

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

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

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

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

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

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

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

1 (e) (I) THE STATE BOARD, IN CONSULTATION WITH THE ADVISORY
2 BOARD, SHALL PROMULGATE RULES ON THE CALCULATION, ASSESSMENT,
3 AND TIMING OF THE PROVIDER FEE. THE STATE DEPARTMENT SHALL
4 ASSESS THE PROVIDER FEE ON A SCHEDULE TO BE SET BY THE STATE
5 BOARD THROUGH RULE. THE STATE BOARD RULES SHALL REQUIRE THAT
6 THE PERIODIC PROVIDER FEE PAYMENTS FROM A HOSPITAL AND THE STATE
7 DEPARTMENT'S REIMBURSEMENT TO THE HOSPITAL UNDER
8 SUBPARAGRAPHS (I) AND (II) OF PARAGRAPH (b) OF SUBSECTION (4) OF
9 THIS SECTION ARE DUE AS NEARLY SIMULTANEOUSLY AS FEASIBLE; EXCEPT
10 THAT THE STATE DEPARTMENT'S REIMBURSEMENT TO THE HOSPITAL SHALL
11 BE DUE NO MORE THAN TWO DAYS AFTER THE PERIODIC PROVIDER FEE
12 PAYMENT IS RECEIVED FROM THE HOSPITAL. THE PROVIDER FEE SHALL BE
13 IMPOSED ON EACH HOSPITAL EVEN IF MORE THAN ONE HOSPITAL IS OWNED
14 BY THE SAME ENTITY. THE FEE SHALL BE PRORATED AND ADJUSTED FOR
15 THE EXPECTED VOLUME OF SERVICE FOR ANY YEAR IN WHICH A HOSPITAL
16 OPENS OR CLOSES.

17 (II) THE STATE DEPARTMENT IS AUTHORIZED TO REFUND ANY
18 UNUSED PORTION OF THE PROVIDER FEE. FOR ANY PORTION OF THE
19 PROVIDER FEE THAT HAS BEEN COLLECTED BY THE STATE DEPARTMENT
20 BUT FOR WHICH THE STATE DEPARTMENT HAS NOT RECEIVED FEDERAL
21 MATCHING FUNDS, THE STATE DEPARTMENT SHALL REFUND BACK TO THE
22 HOSPITAL THAT PAID THE FEE THE AMOUNT OF SUCH PORTION OF THE FEE
23 WITHIN FIVE BUSINESS DAYS AFTER THE FEE IS COLLECTED.

24 (III) THE STATE BOARD, IN CONSULTATION WITH THE ADVISORY
25 BOARD, SHALL PROMULGATE RULES ON THE REPORTS THAT HOSPITALS
26 SHALL BE REQUIRED TO SUBMIT FOR THE STATE DEPARTMENT TO
27 CALCULATE THE AMOUNT OF THE PROVIDER FEE. NOTWITHSTANDING THE

1 PROVISIONS OF PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S., INFORMATION
2 PROVIDED TO THE STATE DEPARTMENT PURSUANT TO THIS SECTION SHALL
3 BE CONSIDERED CONFIDENTIAL AND SHALL NOT BE DEEMED A PUBLIC
4 RECORD. NONETHELESS, THE STATE DEPARTMENT, IN CONSULTATION
5 WITH THE ADVISORY BOARD, MAY PREPARE AND RELEASE SUMMARIES OF
6 THE REPORTS TO THE PUBLIC.

7 (f) A HOSPITAL SHALL NOT INCLUDE ANY AMOUNT OF THE
8 PROVIDER FEE AS A SEPARATE LINE ITEM IN ITS BILLING STATEMENTS.

9 (g) THE STATE BOARD SHALL PROMULGATE ANY RULES PURSUANT
10 TO THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE
11 24, C.R.S., NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION
12 OF THIS SECTION. PRIOR TO SUBMITTING ANY PROPOSED RULES
13 CONCERNING THE ADMINISTRATION OR IMPLEMENTATION OF THE
14 PROVIDER FEE TO THE STATE BOARD, THE STATE DEPARTMENT SHALL
15 CONSULT WITH THE ADVISORY BOARD ON THE PROPOSED RULES AS
16 SPECIFIED IN PARAGRAPH (e) OF SUBSECTION (6) OF THIS SECTION.

17 (4) **Hospital provider fee cash fund.** (a) ALL PROVIDER FEES
18 COLLECTED PURSUANT TO THIS SECTION BY THE STATE DEPARTMENT
19 SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT
20 THE SAME TO THE HOSPITAL PROVIDER FEE CASH FUND, WHICH FUND IS
21 HEREBY CREATED AND REFERRED TO IN THIS SECTION AS THE "FUND".

22 (b) ALL MONEYS IN THE FUND SHALL BE SUBJECT TO FEDERAL
23 MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND SUBJECT TO
24 ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE FOLLOWING
25 PURPOSES:

26 (I) TO MAXIMIZE THE INPATIENT AND OUTPATIENT HOSPITAL
27 REIMBURSEMENTS TO UP TO THE UPPER PAYMENT LIMITS AS DEFINED IN 42

1 CFR 447.272 AND 42 CFR 447.321;

2 (II) TO INCREASE HOSPITAL REIMBURSEMENTS UNDER THE
3 COLORADO INDIGENT CARE PROGRAM TO UP TO ONE HUNDRED PERCENT
4 OF THE HOSPITAL'S COSTS OF PROVIDING MEDICAL CARE UNDER THE
5 PROGRAM;

6 (III) TO PAY THE QUALITY INCENTIVE PAYMENTS PROVIDED IN
7 SECTION 25.5-4-402 (3);

8 (IV) SUBJECT TO AVAILABLE REVENUE FROM THE PROVIDER FEE
9 AND FEDERAL MATCHING FUNDS, TO EXPAND ELIGIBILITY FOR PUBLIC
10 MEDICAL ASSISTANCE BY:

11 (A) INCREASING THE ELIGIBILITY LEVEL FOR PARENTS OF
12 CHILDREN WHO ARE ELIGIBLE FOR MEDICAL ASSISTANCE OR THE
13 CHILDREN'S BASIC HEALTH PLAN TO UP TO ONE HUNDRED PERCENT OF THE
14 FEDERAL POVERTY LEVEL;

15 (B) INCREASING THE ELIGIBILITY LEVEL FOR CHILDREN AND
16 PREGNANT WOMEN UNDER THE CHILDREN'S BASIC HEALTH PLAN TO UP TO
17 TWO HUNDRED FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL;

18 (C) PROVIDING ELIGIBILITY UNDER THE STATE MEDICAL
19 ASSISTANCE PROGRAM FOR A CHILDLESS ADULT OR ADULTS WITHOUT A
20 DEPENDENT CHILD IN THE HOME WHO EARNS UP TO ONE HUNDRED
21 PERCENT OF THE FEDERAL POVERTY LEVEL;

22 (D) PROVIDING A BUY-IN PROGRAM IN THE STATE MEDICAL
23 ASSISTANCE PROGRAM FOR DISABLED ADULTS AND CHILDREN WHOSE
24 FAMILIES EARN UP TO FOUR HUNDRED FIFTY PERCENT OF THE FEDERAL
25 POVERTY LEVEL;

26 (V) TO PROVIDE CONTINUOUS ELIGIBILITY FOR TWELVE MONTHS
27 FOR CHILDREN ENROLLED IN THE STATE MEDICAL ASSISTANCE PROGRAM;

1 (VI) TO PAY THE STATE DEPARTMENT'S ACTUAL ADMINISTRATIVE
2 COSTS OF IMPLEMENTING AND ADMINISTERING THIS SECTION, INCLUDING
3 BUT NOT LIMITED TO THE FOLLOWING COSTS:

4 (A) EXPENSES OF THE ADVISORY BOARD, INCLUDING BUT NOT
5 LIMITED TO THE STATE DEPARTMENT'S PERSONAL SERVICES AND
6 OPERATING COSTS RELATED TO THE ADMINISTRATION OF THE ADVISORY
7 BOARD;

8 (B) THE STATE DEPARTMENT'S ACTUAL COSTS RELATED TO
9 IMPLEMENTING AND MAINTAINING THE PROVIDER FEE, INCLUDING
10 PERSONAL SERVICES, OPERATING, AND CONSULTING EXPENSES;

11 (C) THE STATE DEPARTMENT'S ACTUAL COSTS FOR THE CHANGES
12 AND UPDATES TO THE MEDICAID MANAGEMENT INFORMATION SYSTEM FOR
13 THE IMPLEMENTATION OF SUBPARAGRAPHS (I) TO (III) OF THIS PARAGRAPH
14 (b);

15 (D) THE STATE DEPARTMENT'S PERSONAL SERVICES AND
16 OPERATING COSTS RELATED TO PERSONNEL, CONSULTING SERVICES, AND
17 FOR REVIEW OF HOSPITAL COSTS NECESSARY TO IMPLEMENT AND
18 ADMINISTER THE INCREASES IN INPATIENT AND OUTPATIENT HOSPITAL
19 PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH
20 (b), INCREASES IN THE COLORADO INDIGENT CARE PROGRAM PAYMENTS
21 MADE PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH (b), AND
22 QUALITY INCENTIVE PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (III)
23 OF THIS PARAGRAPH (b);

24 (E) THE STATE DEPARTMENT'S ACTUAL COSTS FOR THE CHANGES
25 AND UPDATES TO THE COLORADO BENEFITS MANAGEMENT SYSTEM AND
26 MEDICAID MANAGEMENT INFORMATION SYSTEM TO IMPLEMENT AND
27 MAINTAIN THE EXPANDED ELIGIBILITY PROVIDED FOR IN SUBPARAGRAPHS

1 (IV) AND (V) OF THIS PARAGRAPH (b);

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

9 (G) THE STATE DEPARTMENT'S PERSONAL SERVICES, OPERATING,
10 AND SYSTEMS COSTS RELATED TO EXPANDING THE OPPORTUNITY FOR
11 INDIVIDUALS TO APPLY FOR PUBLIC MEDICAL ASSISTANCE DIRECTLY AT
12 HOSPITALS OR THROUGH ANOTHER ENTITY OUTSIDE THE COUNTY
13 DEPARTMENTS THAT WOULD INCREASE ACCESS TO PUBLIC MEDICAL
14 ASSISTANCE AND REDUCE THE NUMBER OF UNINSURED SERVED BY
15 HOSPITALS; AND

16 [REDACTED]

17 (VII) TO OFFSET THE LOSS OF ANY FEDERAL MATCHING FUNDS DUE
18 TO A DECREASE IN THE CERTIFICATION OF THE PUBLIC EXPENDITURE
19 PROCESS FOR OUTPATIENT HOSPITAL SERVICES FOR MEDICAL SERVICES
20 PREMIUMS THAT WERE IN EFFECT AS OF JULY 1, 2008.

21 (c) ANY MONEYS IN THE FUND NOT EXPENDED FOR THE PURPOSES
22 DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (4) MAY BE INVESTED
23 BY THE STATE TREASURER AS PROVIDED BY LAW. ALL INTEREST AND
24 INCOME DERIVED FROM THE INVESTMENT AND DEPOSIT OF MONEYS IN THE
25 FUND SHALL BE CREDITED TO THE FUND. ANY UNEXPENDED AND
26 UNENCUMBERED MONEYS REMAINING IN THE FUND AT THE END OF ANY
27 FISCAL YEAR SHALL REMAIN IN THE FUND AND SHALL NOT BE CREDITED OR

1 TRANSFERRED TO THE GENERAL FUND OR ANY OTHER FUND BUT SHALL BE
2 APPROPRIATED BY THE GENERAL ASSEMBLY FOR THE PURPOSES DESCRIBED
3 IN PARAGRAPH (b) OF THIS SUBSECTION (4) IN FUTURE FISCAL YEARS.

4 (5) **Appropriations.** (a) (I) THE PROVIDER FEE IS TO SUPPLEMENT,
5 NOT SUPPLANT, GENERAL FUND APPROPRIATIONS TO SUPPORT HOSPITAL
6 REIMBURSEMENTS AS OF THE EFFECTIVE DATE OF THIS SECTION. GENERAL
7 FUND APPROPRIATIONS FOR HOSPITAL REIMBURSEMENTS SHALL BE
8 MAINTAINED AT THE LEVEL OF APPROPRIATIONS IN THE MEDICAL SERVICES
9 PREMIUM LINE ITEM MADE FOR THE FISCAL YEAR COMMENCING JULY 1,
10 2008; EXCEPT THAT GENERAL FUND APPROPRIATIONS FOR HOSPITAL
11 REIMBURSEMENTS MAY BE REDUCED IF AN INDEX OF APPROPRIATIONS TO
12 OTHER PROVIDERS SHOWS THAT GENERAL FUND APPROPRIATIONS ARE
13 REDUCED FOR OTHER PROVIDERS. IF THE INDEX SHOWS THAT GENERAL
14 FUND APPROPRIATIONS ARE REDUCED FOR OTHER PROVIDERS, THE
15 GENERAL FUND APPROPRIATIONS FOR HOSPITAL REIMBURSEMENTS SHALL
16 NOT BE REDUCED BY A GREATER PERCENTAGE THAN THE REDUCTIONS OF
17 APPROPRIATIONS FOR THE OTHER PROVIDERS AS SHOWN BY THE INDEX.

18 (II) IF GENERAL FUND APPROPRIATIONS FOR HOSPITAL
19 REIMBURSEMENTS ARE REDUCED BELOW THE LEVEL OF APPROPRIATIONS
20 IN THE MEDICAL SERVICES PREMIUM LINE ITEM MADE FOR THE FISCAL
21 YEAR COMMENCING JULY 1, 2008, THE GENERAL FUND APPROPRIATIONS
22 WILL BE INCREASED BACK TO THE LEVEL OF APPROPRIATIONS IN THE
23 MEDICAL SERVICES PREMIUM LINE ITEM MADE FOR THE FISCAL YEAR
24 COMMENCING JULY 1, 2008, AT THE SAME PERCENTAGE AS THE
25 APPROPRIATIONS FOR OTHER PROVIDERS AS SHOWN BY THE INDEX. THE
26 GENERAL ASSEMBLY IS NOT OBLIGATED TO INCREASE THE GENERAL FUND
27 APPROPRIATIONS BACK TO THE LEVEL OF APPROPRIATIONS IN THE MEDICAL

1 SERVICES PREMIUM LINE ITEM IN A SINGLE FISCAL YEAR AND SUCH
2 INCREASES MAY OCCUR OVER NONCONSECUTIVE FISCAL YEARS.

3 (III) FOR PURPOSES OF THIS PARAGRAPH (a), THE "INDEX OF
4 APPROPRIATIONS TO OTHER PROVIDERS" OR "INDEX" SHALL MEAN THE
5 AVERAGE PERCENT CHANGE IN REIMBURSEMENT RATES THROUGH
6 APPROPRIATIONS OR LEGISLATION ENACTED BY THE GENERAL ASSEMBLY
7 TO HOME HEALTH PROVIDERS, PHYSICIAN SERVICES, AND OUTPATIENT
8 PHARMACIES, EXCLUDING DISPENSING FEES. THE STATE BOARD, AFTER
9 CONSULTATION WITH THE ADVISORY BOARD, IS AUTHORIZED TO CLARIFY
10 THIS DEFINITION AS NECESSARY BY RULE.

11 (b) IF THE REVENUE FROM THE PROVIDER FEE IS INSUFFICIENT TO
12 FULLY FUND ALL OF THE PURPOSES DESCRIBED IN PARAGRAPH (b) OF
13 SUBSECTION (4) OF THIS SECTION:

14 (I) THE GENERAL ASSEMBLY IS NOT OBLIGATED TO APPROPRIATE
15 GENERAL FUND REVENUES TO FUND SUCH PURPOSES;

16 (II) THE HOSPITAL PROVIDER REIMBURSEMENT AND QUALITY
17 INCENTIVE PAYMENT INCREASES DESCRIBED IN SUBPARAGRAPHS (I) TO
18 (III) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION AND THE
19 COSTS DESCRIBED IN SUBPARAGRAPHS (VI) AND (VII) OF PARAGRAPH (b)
20 OF SUBSECTION (4) OF THIS SECTION SHALL BE FULLY FUNDED USING
21 REVENUE FROM THE PROVIDER FEE AND FEDERAL MATCHING FUNDS
22 BEFORE ANY ELIGIBILITY EXPANSION IS FUNDED; AND

23 (III) (A) IF THE STATE BOARD PROMULGATES RULES THAT EXPAND
24 ELIGIBILITY FOR MEDICAL ASSISTANCE TO BE PAID FOR PURSUANT TO
25 SUBPARAGRAPH (IV) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS
26 SECTION, AND THE STATE DEPARTMENT THEREAFTER NOTIFIES THE
27 ADVISORY BOARD THAT THE REVENUE AVAILABLE FROM THE PROVIDER

1 FEE AND THE FEDERAL MATCHING FUNDS WILL NOT BE SUFFICIENT TO PAY
2 FOR ALL OR PART OF THE EXPANDED ELIGIBILITY, THE ADVISORY BOARD
3 SHALL RECOMMEND TO THE STATE BOARD REDUCTIONS IN MEDICAL
4 BENEFITS OR ELIGIBILITY SO THAT THE REVENUE WILL BE SUFFICIENT TO
5 PAY FOR ALL OF THE REDUCED BENEFITS OR ELIGIBILITY. AFTER
6 RECEIVING THE RECOMMENDATIONS OF THE ADVISORY BOARD, THE STATE
7 BOARD SHALL ADOPT RULES PROVIDING FOR REDUCED BENEFITS OR
8 REDUCED ELIGIBILITY FOR WHICH THE REVENUE SHALL BE SUFFICIENT AND
9 SHALL FORWARD ANY ADOPTED RULES TO THE JOINT BUDGET COMMITTEE.
10 NOTWITHSTANDING THE PROVISIONS OF SECTION 24-4-103 (8) AND (12),
11 C.R.S., FOLLOWING THE ADOPTION OF RULES PURSUANT TO THIS
12 SUB-SUBPARAGRAPH (A), THE STATE BOARD SHALL NOT SUBMIT THE
13 RULES TO THE ATTORNEY GENERAL AND SHALL NOT FILE THE RULES WITH
14 THE SECRETARY OF STATE UNTIL THE JOINT BUDGET COMMITTEE APPROVES
15 THE RULES PURSUANT TO SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH
16 (III).

17 (B) THE JOINT BUDGET COMMITTEE SHALL PROMPTLY CONSIDER
18 ANY RULES ADOPTED BY THE STATE BOARD PURSUANT TO
19 SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (III). THE JOINT BUDGET
20 COMMITTEE SHALL PROMPTLY NOTIFY THE STATE DEPARTMENT, THE
21 STATE BOARD, AND THE ADVISORY BOARD OF ANY ACTION ON SUCH RULES.
22 IF THE JOINT BUDGET COMMITTEE DOES NOT APPROVE THE RULES, THE
23 JOINT BUDGET COMMITTEE SHALL RECOMMEND A REDUCTION IN BENEFITS
24 OR ELIGIBILITY SO THAT THE REVENUE FROM THE PROVIDER FEE AND THE
25 MATCHING FEDERAL FUNDS WILL BE SUFFICIENT TO PAY FOR THE REDUCED
26 BENEFITS OR ELIGIBILITY. AFTER APPROVING THE RULES PURSUANT TO
27 THIS SUB-SUBPARAGRAPH (B), THE JOINT BUDGET COMMITTEE SHALL

1 REQUEST THAT THE COMMITTEE ON LEGAL SERVICES, CREATED PURSUANT
2 TO SECTION 2-3-501, C.R.S., EXTEND THE RULES AS PROVIDED FOR IN
3 SECTION 24-4-103 (8), C.R.S., UNLESS THE COMMITTEE ON LEGAL
4 SERVICES FINDS AFTER REVIEW THAT THE RULES DO NOT CONFORM WITH
5 SECTION 24-4-103 (8) (a), C.R.S.

6 (C) AFTER THE STATE BOARD HAS RECEIVED NOTIFICATION OF THE
7 APPROVAL OF RULES ADOPTED PURSUANT TO SUB-SUBPARAGRAPH (A) OF
8 THIS SUBPARAGRAPH (III), THE STATE BOARD SHALL SUBMIT THE RULES TO
9 THE ATTORNEY GENERAL PURSUANT TO SECTION 24-4-103 (8) (b), C.R.S.,
10 AND SHALL FILE THE RULES AND THE OPINION OF THE ATTORNEY GENERAL
11 WITH THE SECRETARY OF STATE PURSUANT TO SECTION 24-4-103 (12),
12 C.R.S., AND WITH THE OFFICE OF LEGISLATIVE LEGAL SERVICES.
13 PURSUANT TO SECTION 24-4-103 (5), C.R.S., THE RULES SHALL BE
14 EFFECTIVE TWENTY DAYS AFTER PUBLICATION OF THE RULES AND SHALL
15 ONLY BE EFFECTIVE UNTIL THE FOLLOWING MAY 15 UNLESS THE RULES
16 ARE EXTENDED PURSUANT TO A BILL ENACTED PURSUANT TO SECTION
17 24-4-103 (8), C.R.S.

18 (c) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION,
19 IF, AFTER RECEIPT OF AUTHORIZATION TO RECEIVE FEDERAL MATCHING
20 FUNDS FOR MONEYS IN THE FUND, THE AUTHORIZATION IS WITHDRAWN OR
21 CHANGED SO THAT FEDERAL MATCHING FUNDS ARE NO LONGER
22 AVAILABLE, THE STATE DEPARTMENT SHALL CEASE COLLECTING THE
23 PROVIDER FEE AND SHALL REPAY TO THE HOSPITALS ANY MONEYS
24 RECEIVED BY THE FUND THAT ARE NOT SUBJECT TO FEDERAL MATCHING
25 FUNDS.

26 (6) **Hospital provider fee oversight and advisory board.**

27 (a) THERE IS HEREBY CREATED IN THE STATE DEPARTMENT THE HOSPITAL

1 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD, REFERRED TO IN THIS
2 SECTION AS THE "ADVISORY BOARD".

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

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

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

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

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

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

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

1 (G) ONE MEMBER WHO IS A REPRESENTATIVE OF A BUSINESS THAT
2 PURCHASES OR OTHERWISE PROVIDES HEALTH INSURANCE FOR ITS
3 EMPLOYEES; AND

4 (H) TWO EMPLOYEES OF THE STATE DEPARTMENT.

5 (II) THE GOVERNOR SHALL CONSULT WITH REPRESENTATIVES OF
6 A STATEWIDE ORGANIZATION OF HOSPITALS IN MAKING THE
7 APPOINTMENTS PURSUANT TO SUB-SUBPARAGRAPHS (A) AND (B) OF
8 SUBPARAGRAPH (I) OF THIS PARAGRAPH (b). NO MORE THAN SIX MEMBERS
9 OF THE ADVISORY BOARD MAY BE MEMBERS OF THE SAME POLITICAL
10 PARTY.

11 (III) MEMBERS OF THE ADVISORY BOARD SHALL SERVE AT THE
12 PLEASURE OF THE GOVERNOR. IN MAKING THE APPOINTMENTS, THE
13 GOVERNOR SHALL SPECIFY THAT FOUR MEMBERS SHALL SERVE INITIAL
14 TERMS OF TWO YEARS AND THREE MEMBERS SHALL SERVE INITIAL TERMS
15 OF THREE YEARS. ALL OTHER TERMS INCLUDING TERMS AFTER THE INITIAL
16 TERMS SHALL BE FOUR YEARS. A MEMBER WHO IS APPOINTED TO FILL A
17 VACANCY SHALL SERVE THE REMAINDER OF THE UNEXPIRED TERM OF THE
18 FORMER MEMBER.

19 (IV) THE GOVERNOR SHALL DESIGNATE A CHAIR FROM AMONG THE
20 MEMBERS OF THE ADVISORY BOARD APPOINTED PURSUANT TO
21 SUB-SUBPARAGRAPHS (A) TO (G) OF SUBPARAGRAPH (I) OF THIS
22 PARAGRAPH (b). THE ADVISORY BOARD SHALL ELECT A VICE-CHAIR FROM
23 AMONG ITS MEMBERS.

24 (c) MEMBERS OF THE ADVISORY BOARD SHALL SERVE WITHOUT
25 COMPENSATION BUT SHALL BE REIMBURSED FROM MONEYS IN THE FUND
26 FOR ACTUAL AND NECESSARY EXPENSES INCURRED IN THE PERFORMANCE
27 OF THEIR DUTIES PURSUANT TO THIS SECTION.

1 (d) THE ADVISORY BOARD MAY DIRECT THE STATE DEPARTMENT
2 TO CONTRACT FOR A GROUP FACILITATOR TO ASSIST THE MEMBERS OF THE
3 ADVISORY BOARD IN PERFORMING THEIR REQUIRED DUTIES.

4 (e) THE ADVISORY BOARD SHALL HAVE, AT A MINIMUM, THE
5 FOLLOWING DUTIES:

6 (I) TO RECOMMEND TO THE STATE DEPARTMENT THE TIMING AND
7 METHOD BY WHICH THE STATE DEPARTMENT SHALL ASSESS THE PROVIDER
8 FEE AND THE AMOUNT OF THE FEE;

9 (II) IF REQUESTED BY THE HEALTH AND HUMAN SERVICES
10 COMMITTEES OF THE SENATE OR HOUSE OF REPRESENTATIVES, OR ANY
11 SUCCESSOR COMMITTEES, TO CONSULT WITH THE COMMITTEES ON ANY
12 LEGISLATION THAT MAY IMPACT THE PROVIDER FEE OR HOSPITAL
13 REIMBURSEMENTS ESTABLISHED PURSUANT TO THIS SECTION;

14 (III) TO RECOMMEND TO THE STATE DEPARTMENT CHANGES IN THE
15 PROVIDER FEE THAT INCREASE THE NUMBER OF HOSPITALS BENEFITTING
16 FROM THE USES OF THE PROVIDER FEE DESCRIBED IN SUBPARAGRAPHS (I)
17 TO (V) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION OR THAT
18 MINIMIZE THE NUMBER OF HOSPITALS THAT SUFFER LOSSES AS A RESULT
19 OF PAYING THE PROVIDER FEE;

20 (IV) TO RECOMMEND TO THE STATE DEPARTMENT REFORMS OR
21 CHANGES TO THE INPATIENT HOSPITAL AND OUTPATIENT HOSPITAL
22 REIMBURSEMENTS AND QUALITY INCENTIVE PAYMENTS MADE UNDER THE
23 STATE MEDICAL ASSISTANCE PROGRAM TO INCREASE PROVIDER
24 ACCOUNTABILITY, PERFORMANCE, AND REPORTING;

25 (V) TO RECOMMEND TO THE STATE DEPARTMENT THE SCHEDULE
26 AND APPROACH TO THE IMPLEMENTATION OF SUBPARAGRAPHS (IV) AND
27 (V) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;

1 (VI) IF MONEYS IN THE FUND ARE INSUFFICIENT TO FULLY FUND
2 ALL OF THE PURPOSES SPECIFIED IN PARAGRAPH (b) OF SUBSECTION (4) OF
3 THIS SECTION, TO RECOMMEND TO THE STATE BOARD CHANGES TO THE
4 EXPANDED ELIGIBILITY PROVISIONS DESCRIBED IN SUBPARAGRAPH (IV) OF
5 PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;

6 (VII) TO PREPARE THE REPORTS SPECIFIED IN PARAGRAPH (f) OF
7 THIS SUBSECTION (6);

8 (VIII) TO MONITOR THE IMPACT OF THE HOSPITAL PROVIDER FEE
9 ON THE BROADER HEALTH CARE MARKETPLACE; AND

10 (IX) TO PERFORM ANY OTHER DUTIES REQUIRED TO FULFILL THE
11 ADVISORY BOARD'S CHARGE OR THOSE ASSIGNED TO IT BY THE STATE
12 BOARD OR THE EXECUTIVE DIRECTOR.

13 (f) ON OR BEFORE JANUARY 15, 2010, AND ON OR BEFORE
14 JANUARY 15 EACH YEAR THEREAFTER, THE ADVISORY BOARD SHALL
15 SUBMIT A WRITTEN REPORT TO THE HEALTH AND HUMAN SERVICES
16 COMMITTEES OF THE SENATE AND THE HOUSE OF REPRESENTATIVES, OR
17 ANY SUCCESSOR COMMITTEES, THE JOINT BUDGET COMMITTEE OF THE
18 GENERAL ASSEMBLY, THE GOVERNOR, AND THE STATE BOARD. THE
19 REPORT SHALL INCLUDE, BUT NEED NOT BE LIMITED TO:

20 (I) THE RECOMMENDATIONS MADE TO THE STATE BOARD
21 PURSUANT TO THIS SECTION;

22 (II) A DESCRIPTION OF THE FORMULA FOR HOW THE PROVIDER FEE
23 IS CALCULATED AND THE PROCESS BY WHICH THE PROVIDER FEE IS
24 ASSESSED AND COLLECTED;

25 (III) AN ITEMIZATION OF THE TOTAL AMOUNT OF THE PROVIDER
26 FEE PAID BY EACH HOSPITAL AND ANY PROJECTED REVENUE THAT EACH
27 HOSPITAL IS EXPECTED TO RECEIVE DUE TO:

1 (A) THE INCREASED REIMBURSEMENTS MADE PURSUANT TO
2 SUBPARAGRAPHS (I) AND (II) OF PARAGRAPH (b) OF SUBSECTION (4) OF
3 THIS SECTION AND THE QUALITY INCENTIVE PAYMENTS MADE PURSUANT
4 TO SUBPARAGRAPH (III) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS
5 SECTION; AND

6 (B) THE INCREASED ELIGIBILITY DESCRIBED IN SUBPARAGRAPHS
7 (IV) AND (V) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;

8 (IV) AN ITEMIZATION OF THE COSTS INCURRED BY THE STATE
9 DEPARTMENT IN IMPLEMENTING AND ADMINISTERING THE HOSPITAL
10 PROVIDER FEE; AND

11 (V) ESTIMATES OF THE DIFFERENCES BETWEEN THE COST OF CARE
12 PROVIDED AND THE PAYMENT RECEIVED BY HOSPITALS ON A PER-PATIENT
13 BASIS, AGGREGATED FOR ALL HOSPITALS, FOR PATIENTS COVERED BY EACH
14 OF THE FOLLOWING:

15 (A) MEDICAID;

16 (B) MEDICARE; AND

17 (C) ALL OTHERS PAYERS.

18 (g) (I) THIS SUBSECTION (6) IS REPEALED, EFFECTIVE JULY 1, 2019.

19 (II) PRIOR TO SAID REPEAL, THE ADVISORY BOARD SHALL BE
20 REVIEWED AS PROVIDED IN SECTION 2-3-1203, C.R.S.

21 (7) **Notice to revisor of statutes - repeal.** (a) WITHIN SIXTY
22 DAYS AFTER THE STATE DEPARTMENT RECEIVES AUTHORIZATION TO
23 RECEIVE FEDERAL MATCHING FUNDS FOR THE MONEYS IN THE FUND, THE
24 EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF
25 STATUTES, TO THE STATE AUDITOR, AND TO THE STATE TREASURER
26 INFORMING THEM OF THE AUTHORIZATION.

27 (b) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (3) OF

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

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

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

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

15 **2-3-1203. Sunset review of advisory committees.** (3) The
16 following dates are the dates for which the statutory authorization for the
17 designated advisory committees is scheduled for repeal:

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

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

22 **25.5-3-108. Responsibility of the department of health care**
23 **policy and financing - provider reimbursement.** (17) **SUBJECT TO**
24 **ADEQUATE** FUNDING MADE AVAILABLE UNDER SECTION 25.5-4-402.3, THE
25 STATE DEPARTMENT SHALL INCREASE HOSPITAL REIMBURSEMENTS UP TO
26 ONE HUNDRED PERCENT OF HOSPITAL COSTS FOR PROVIDING MEDICAL
27 CARE UNDER THE PROGRAM.

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

4 **25.5-4-402. Providers - hospital reimbursement - rules.**

5 (1) FOR ALL LICENSED OR CERTIFIED HOSPITALS CONTRACTING FOR
6 SERVICES UNDER THIS ARTICLE AND ARTICLES 5 AND 6 OF THIS TITLE,
7 EXCEPT THOSE HOSPITALS OPERATED BY THE DEPARTMENT OF HUMAN
8 SERVICES OR THOSE HOSPITALS DEEMED EXEMPT BY THE STATE BOARD, the
9 state department shall pay ~~all licensed or certified hospitals under this~~
10 ~~article and articles 5 and 6 of this title, except those hospitals operated by~~
11 ~~the department of human services,~~ FOR INPATIENT HOSPITAL SERVICES
12 pursuant to a system of prospective payment, generally based on the
13 elements of ~~the medicare system of~~ A diagnosis-related ~~groups~~ GROUP
14 SYSTEM. The state department shall develop and administer a system for
15 ~~assuring~~ ENSURING appropriate utilization and quality of care provided by
16 those providers who are reimbursed ~~pursuant to the system of prospective~~
17 ~~payment developed~~ under this section. SUBJECT TO AVAILABLE
18 APPROPRIATIONS, THE STATE DEPARTMENT MAY ALSO MAKE
19 SUPPLEMENTAL MEDICAID PAYMENTS TO CERTAIN HOSPITALS. The state
20 board shall promulgate rules to provide for the implementation of this
21 section.

22 (3) (a) IN ADDITION TO THE REIMBURSEMENT RATE PROCESS
23 DESCRIBED IN SUBSECTION (1) OF THIS SECTION AND SUBJECT TO
24 ADEQUATE FUNDING MADE AVAILABLE PURSUANT TO SECTION
25 25.5-4-402.3, THE STATE DEPARTMENT SHALL PAY AN ADDITIONAL
26 AMOUNT BASED UPON PERFORMANCE TO THOSE HOSPITALS THAT PROVIDE
27 SERVICES THAT IMPROVE HEALTH CARE OUTCOMES FOR THEIR PATIENTS.

1 THIS AMOUNT SHALL BE DETERMINED BY THE STATE DEPARTMENT BASED
2 UPON NATIONALLY RECOGNIZED PERFORMANCE MEASURES ESTABLISHED
3 IN RULES ADOPTED BY THE STATE BOARD. THE STATE QUALITY
4 STANDARDS SHALL BE CONSISTENT WITH FEDERAL QUALITY STANDARDS
5 PUBLISHED BY AN ORGANIZATION WITH EXPERTISE IN HEALTH CARE
6 QUALITY, INCLUDING BUT NOT LIMITED TO, THE CENTERS FOR MEDICARE
7 AND MEDICAID SERVICES, THE AGENCY FOR HEALTHCARE RESEARCH AND
8 QUALITY, OR THE NATIONAL QUALITY FORUM.

9 (b) THE AMOUNT OF THE PAYMENTS MADE PURSUANT TO THIS
10 SUBSECTION (3) SHALL BE COMPUTED ANNUALLY. FOR THE FIRST TWO
11 FISCAL YEARS THAT PAYMENTS ARE MADE PURSUANT TO THIS SUBSECTION
12 (3), THE TOTAL AMOUNT OF THE PAYMENTS SHALL BE UP TO FIVE PERCENT
13 OF THE TOTAL REIMBURSEMENTS MADE TO HOSPITALS IN THE PREVIOUS
14 YEAR. FOR EACH FISCAL YEAR AFTER THE FIRST TWO FISCAL YEARS, THE
15 TOTAL AMOUNT OF THE PAYMENTS SHALL BE UP TO SEVEN PERCENT OF THE
16 TOTAL REIMBURSEMENTS MADE TO HOSPITALS IN THE PREVIOUS YEAR.

17 **SECTION 5.** 25.5-5-201 (1) (m) (I) and (1) (o), Colorado
18 Revised Statutes, are amended, and the said 25.5-5-201 (1) is further
19 amended BY THE ADDITION OF THE FOLLOWING NEW
20 PARAGRAPHS, to read:

21 **25.5-5-201. Optional provisions - optional groups - repeal.**

22 (1) The federal government allows the state to select optional groups to
23 receive medical assistance. Pursuant to federal law, any person who is
24 eligible for medical assistance under the optional groups specified in this
25 section shall receive both the mandatory services specified in sections
26 25.5-5-102 and 25.5-5-103 and the optional services specified in sections
27 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial

1 aid funds, the following are the individuals or groups that Colorado has
2 selected as optional groups to receive medical assistance pursuant to this
3 article and articles 4 and 6 of this title:

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

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

25 (C) NOTWITHSTANDING THE PROVISIONS OF SUB-SUBPARAGRAPH
26 (A) OF THIS SUBPARAGRAPH (I), UNTIL THE STATE DEPARTMENT RECEIVES
27 FEDERAL AUTHORIZATION TO INCREASE THE PERCENTAGE OF THE FEDERAL

1 POVERTY RATE FOR PARENTS OF CHILDREN ELIGIBLE FOR THE MEDICAL
2 ASSISTANCE PROGRAM OR THE CHILDREN'S BASIC HEALTH PLAN, THE
3 PERCENTAGE OF THE FEDERAL POVERTY LEVEL SHALL BE NOT LESS THAN
4 SIXTY PERCENT. WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT
5 RECEIVES AUTHORIZATION TO INCREASE THE PERCENTAGE OF THE
6 FEDERAL POVERTY LEVEL, THE EXECUTIVE DIRECTOR SHALL SEND
7 WRITTEN NOTICE TO THE REVISOR OF STATUTES INFORMING HIM OR HER OF
8 THE AUTHORIZATION. THIS SUB-SUBPARAGRAPH (C) IS REPEALED,
9 EFFECTIVE THE JULY 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE
10 REVISOR OF STATUTES.

11 (o) (I) Individuals with disabilities who are participating in the
12 medicaid buy-in program established in part 14 of article 6 of this title.

13 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
14 THIS PARAGRAPH (o), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH
15 FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER
16 WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT
17 TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3
18 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL
19 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT
20 TO SECTION 25.5-4-402.3 (6), FOR INDIVIDUALS WITH DISABILITIES WHO
21 ARE PARTICIPATING IN THE MEDICAID BUY-IN PROGRAM ESTABLISHED IN
22 PART 14 OF ARTICLE 6 OF THIS TITLE, THE STATE BOARD BY RULE ADOPTED
23 PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY
24 REDUCE THE MEDICAL BENEFITS OFFERED OR THE PERCENTAGE OF THE
25 FEDERAL POVERTY LEVEL TO BELOW FOUR HUNDRED FIFTY PERCENT OR
26 MAY ELIMINATE THIS ELIGIBILITY GROUP.

27 (III) (A) NOTWITHSTANDING THE PROVISION OF SUBPARAGRAPH

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

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

12 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
13 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.

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

20 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
21 THIS PARAGRAPH (p), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH
22 FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER
23 WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT
24 TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3
25 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL
26 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT
27 TO SECTION 25.5-4-402.3 (6), FOR CHILDLESS PERSONS OR FOR PERSONS

1 WITHOUT A DEPENDENT CHILD IN THE HOME, THE STATE BOARD BY RULE
2 ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b)
3 (III) MAY REDUCE THE MEDICAL BENEFITS OFFERED OR THE PERCENTAGE
4 OF THE FEDERAL POVERTY LEVEL TO BELOW ONE HUNDRED PERCENT OR
5 MAY ELIMINATE THIS ELIGIBILITY GROUP.

6 (III) (A) NOTWITHSTANDING THE PROVISION OF SUBPARAGRAPH
7 (I) OF THIS PARAGRAPH (p), PERSONS OVER EIGHTEEN YEARS OF AGE WHO
8 ARE CHILDLESS OR WITHOUT A DEPENDENT CHILD IN THE HOME SHALL
9 ONLY BE ELIGIBLE FOR BENEFITS UNDER THE MEDICAL ASSISTANCE
10 PROGRAM IF THE STATE DEPARTMENT RECEIVES FEDERAL AUTHORIZATION
11 FOR SUCH ELIGIBILITY.

12 (B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
13 AUTHORIZATION TO PROVIDE MEDICAL BENEFITS TO PERSONS OVER
14 EIGHTEEN YEARS OF AGE WHO ARE CHILDLESS OR WITHOUT A DEPENDENT
15 CHILD IN THE HOME, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN
16 NOTICE TO THE REVISOR OF STATUTES INFORMING HIM OR HER OF THE
17 AUTHORIZATION.

18 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
19 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.

20 (q) CHILDREN WHO ARE CONTINUOUSLY ELIGIBLE FOR TWELVE
21 MONTHS PURSUANT TO SECTION 25.5-5-204.5.

22 (r) (I) PERSONS ELIGIBLE FOR A MEDICAID BUY-IN PROGRAM
23 ESTABLISHED PURSUANT TO SECTION 25.5-5-206 WHOSE FAMILY INCOME
24 DOES NOT EXCEED A SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY
25 LEVEL, ADJUSTED FOR FAMILY SIZE AND AS SET BY THE STATE BOARD BY
26 RULE, WHICH PERCENTAGE SHALL BE NOT MORE THAN FOUR HUNDRED
27 FIFTY PERCENT.

1 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
2 THIS PARAGRAPH (r), 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 ELIGIBLE FOR A MEDICAID
9 BUY-IN PROGRAM ESTABLISHED PURSUANT TO SECTION 25.5-5-206, THE
10 STATE BOARD BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF
11 SECTION 25.5-4-402.3 (5) (b) (III) MAY REDUCE THE MEDICAL BENEFITS
12 OFFERED, OR THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL, OR MAY
13 ELIMINATE THIS ELIGIBILITY GROUP.

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

20 (B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
21 AUTHORIZATION TO PROVIDE MEDICAL BENEFITS TO PERSONS ELIGIBLE FOR
22 A MEDICAID BUY-IN PROGRAM ESTABLISHED PURSUANT TO SECTION
23 25.5-5-206, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE OF
24 TO THE REVISOR OF STATUTES INFORMING HIM OR HER OF THE
25 AUTHORIZATION.

26 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
27 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.

1 **SECTION 6.** Part 2 of article 5 of title 25.5, Colorado Revised
2 Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW
3 SECTIONS to read:

4 **25.5-5-204.5. Continuous eligibility - children - repeal.** (1) A
5 CHILD WHO IS DETERMINED TO BE ELIGIBLE FOR BENEFITS UNDER THIS
6 ARTICLE OR UNDER ARTICLE 4 OR 6 OF THIS TITLE SHALL REMAIN ELIGIBLE
7 FOR TWELVE MONTHS SUBSEQUENT TO THE LAST DAY OF THE MONTH IN
8 WHICH THE CHILD WAS ENROLLED; EXCEPT THAT A CHILD SHALL NO
9 LONGER BE ELIGIBLE AND SHALL BE DISENROLLED FROM THE STATE
10 MEDICAL ASSISTANCE PROGRAM IF THE STATE DEPARTMENT BECOMES
11 AWARE OF OR IS NOTIFIED THAT THE CHILD HAS MOVED OUT OF THE STATE
12 OR HAS REACHED NINETEEN YEARS OF AGE.

13 (2) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF
14 THIS SECTION, IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND
15 ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH
16 THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO
17 FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4)
18 (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER
19 FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO
20 SECTION 25.5-4-402.3 (6), THE STATE BOARD BY RULE ADOPTED PURSUANT
21 TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY ELIMINATE
22 THE CONTINUOUS ENROLLMENT REQUIREMENT PURSUANT TO THIS
23 SECTION.

24 (3) (a) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF
25 THIS SECTION, CONTINUOUS ELIGIBILITY FOR CHILDREN SHALL ONLY BE
26 EFFECTIVE IF THE STATE DEPARTMENT RECEIVES FEDERAL AUTHORIZATION
27 FOR SUCH ELIGIBILITY.

1 (b) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
2 AUTHORIZATION TO PROVIDE CONTINUOUS ELIGIBILITY FOR CHILDREN, THE
3 EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF
4 STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.

5 (c) THIS SUBSECTION (3) IS REPEALED, EFFECTIVE THE JULY 1
6 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.

7 **25.5-5-206. Medicaid buy-in program - disabled children -**
8 **disabled adults - federal authorization - rules.** (1) (a) SUBJECT TO
9 AVAILABLE APPROPRIATIONS, THE STATE DEPARTMENT IS AUTHORIZED TO
10 SEEK FEDERAL AUTHORIZATION TO AND TO ESTABLISH A MEDICAID BUY IN
11 PROGRAM OR PROGRAMS FOR:

12 (I) DISABLED CHILDREN; OR

13 (II) DISABLED ADULTS WHO DO NOT QUALIFY FOR THE MEDICAID
14 BUY-IN PROGRAM ESTABLISHED PURSUANT TO PART 14 OF ARTICLE 6 OF
15 THIS TITLE.

16 (b) THE MEDICAID BUY-IN PROGRAM OR PROGRAMS ESTABLISHED
17 PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (1) MAY PROVIDE FOR
18 PREMIUM AND COST-SHARING CHARGES ON A SLIDING FEE SCALE BASED
19 UPON A FAMILY'S INCOME.

20 (2) THE STATE BOARD SHALL PROMULGATE RULES CONSISTENT
21 WITH ANY FEDERAL AUTHORIZATION TO IMPLEMENT AND ADMINISTER THE
22 MEDICAID BUY-IN PROGRAM OR PROGRAMS ESTABLISHED PURSUANT TO
23 PARAGRAPH (a) OF SUBSECTION (1) OF THIS SECTION.

24 **SECTION 7.** 25.5-6-1403 (2), Colorado Revised Statutes, is
25 amended to read:

26 **25.5-6-1403. Waivers and amendments.** (2) If approved by the
27 joint budget committee following its review of the report and subject to

1 available appropriations, the state department shall submit to the federal
2 ~~health care financing administration~~ CENTERS FOR MEDICARE AND
3 MEDICAID SERVICES an amendment to the state medical assistance plan,
4 and shall request any necessary waivers from the secretary of the federal
5 department of health and human services, to permit the state department
6 to expand medical assistance eligibility as provided in this part 14 for the
7 purpose of implementing a medicaid buy-in program for people with
8 disabilities who are in the basic coverage group or the medical
9 improvement group. In addition, the state department shall apply to the
10 secretary of the federal department of health and human services for a
11 medicaid infrastructure grant, if available, to develop and implement the
12 federal "Ticket to Work and Work Incentives Improvement Act of 1999",
13 Pub.L. 106-170.

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

17 **25.5-8-103. Definitions - repeal.** As used in this article, unless
18 the context otherwise requires:

19 (4) "Eligible person" means:

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

26 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
27 THIS PARAGRAPH (a), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH

1 FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER
2 WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT
3 TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3
4 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL
5 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT
6 TO SECTION 25.5-4-402.3 (6), FOR PERSONS LESS THAN NINETEEN YEARS
7 OF AGE, THE STATE BOARD MAY BY RULE ADOPTED PURSUANT TO THE
8 PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) REDUCE THE
9 PERCENTAGE OF THE FEDERAL POVERTY LEVEL TO BELOW TWO HUNDRED
10 FIFTY PERCENT, BUT THE PERCENTAGE SHALL NOT BE REDUCED TO BELOW
11 TWO HUNDRED FIVE PERCENT;

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

18 (B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
19 AUTHORIZATION TO INCREASE THE PERCENTAGE OF FEDERAL POVERTY
20 LEVEL, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE
21 REVISOR OF STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.

22 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY
23 1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.

24

25 (b) (I) A pregnant woman whose family income does not exceed
26 two hundred ~~five~~ FIFTY percent of the federal poverty level, adjusted for
27 family size, and who is not eligible for medicaid. ~~except that, subject to~~

1 available appropriations, the department may increase the percentage of
2 the federal poverty level for purposes of eligibility to up to two hundred
3 fifty percent.

4 (II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF
5 THIS PARAGRAPH (b), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH
6 FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER
7 WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT
8 TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3
9 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL
10 PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT
11 TO SECTION 25.5-4-402.3 (6), FOR PREGNANT WOMEN, THE STATE BOARD
12 BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION
13 25.5-4-402.3 (5) (b) (III) MAY REDUCE THE PERCENTAGE OF THE FEDERAL
14 POVERTY LEVEL TO BELOW TWO HUNDRED FIFTY PERCENT, BUT THE
15 PERCENTAGE SHALL NOT BE REDUCED TO BELOW TWO HUNDRED FIVE
16 PERCENT.

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

23 (B) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES
24 AUTHORIZATION TO INCREASE THE PERCENTAGE OF FEDERAL POVERTY
25 LEVEL, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE
26 REVISOR OF STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.

27 (C) THIS SUBPARAGRAPH (III) IS REPEALED, EFFECTIVE THE JULY

1 FOLLOWING THE RECEIPT OF THE NOTICE TO THE REVISOR OF STATUTES.

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

4 **24-4-103. Rule-making - procedure - repeal.**

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

1 **SECTION 10.** Part 1 of article 3 of title 2, Colorado Revised
2 Statutes, is amended BY THE ADDITION OF A NEW SECTION to
3 read:

4 **2-3-119. Audit of hospital provider fee - cost shift.**

5 (1) STARTING WITH THE SECOND FULL STATE FISCAL YEAR FOLLOWING
6 THE RECEIPT OF THE NOTICE FROM THE EXECUTIVE DIRECTOR OF THE
7 DEPARTMENT OF HEALTH CARE POLICY AND FINANCING PURSUANT TO
8 SECTION 25.5-4-402.3 (7), C.R.S., AND THEREAFTER AT THE DISCRETION
9 OF THE LEGISLATIVE AUDIT COMMITTEE, THE STATE AUDITOR SHALL
10 CONDUCT OR CAUSE TO BE CONDUCTED A PERFORMANCE AND FISCAL
11 AUDIT OF THE HOSPITAL PROVIDER FEE ESTABLISHED PURSUANT TO
12 SECTION 25.5-4-402.3, C.R.S.

13 **SECTION 11. Accountability.** Five years after this act becomes
14 law and in accordance with section 2-2-1201, Colorado Revised Statutes,
15 the legislative service agencies of the Colorado General Assembly shall
16 conduct a post-enactment review of the implementation of this act
17 utilizing the information contained in the legislative declaration set forth
18 in section 25.5-4-402.3 (2), Colorado Revised Statutes.

19 **SECTION 12. Appropriation - adjustments to the 2009 long**
20 **bill.** (1) For the implementation of this act, appropriations made in the
21 annual general appropriation act for the fiscal year beginning July 1,
22 2009, to the department of health care policy and financing shall be
23 adjusted as follows:

24 (a) The appropriation to the executive director's division is
25 increased by six million nine hundred fifty-eight thousand three hundred
26 eighteen dollars (\$6,958,318) and 12.0 FTE. Of said sum, two million
27 four hundred twenty-two thousand seven hundred twenty-five dollars

1 (\$2,422,725) shall be from the hospital provider fee cash fund created in
2 section 25.5-4-402.3 (4), Colorado Revised Statutes, one hundred
3 forty-six thousand one hundred seventy-three dollars (\$146,173) shall be
4 cash funds from local certified funds, and four million three hundred
5 eighty-nine thousand four hundred twenty dollars (\$4,389,420) shall be
6 from federal funds.

7 (b) The appropriation to the medical services premiums division
8 is increased by three hundred twenty-seven million one hundred
9 seventy-one thousand four hundred sixty dollars (\$327,171,460). Of said
10 sum, one hundred sixty-three million five hundred eighty-five thousand
11 seven hundred thirty dollars (\$163,585,730) shall be from the hospital
12 provider fee cash fund created in section 25.5-4-402.3 (4), Colorado
13 Revised Statutes, and one hundred sixty-three million five hundred
14 eighty-five thousand seven hundred thirty dollars (\$163,585,730) shall be
15 from federal funds.

16 (c) The appropriation to the medicaid mental health community
17 programs division is increased by three million three hundred forty-five
18 thousand one hundred ten dollars (\$3,345,110). Of said sum, one million
19 six hundred seventy-two thousand five hundred fifty-five dollars
20 (\$1,672,555) shall be from the hospital provider fee cash fund created in
21 section 25.5-4-402.3 (4), Colorado Revised Statutes and one million six
22 hundred seventy-two thousand five hundred fifty-five dollars
23 (\$1,672,555) shall be from federal funds.

24 (d) The appropriation to the indigent care program for safety net
25 provider payments is increased by three hundred twenty-two million two
26 hundred thousand dollars (\$322,200,000). Of said sum, one hundred
27 sixty-one million one hundred thousand (\$161,100,000) shall be from the

1 hospital provider fee cash fund created in section 25.5-4-402.3 (4),
2 Colorado Revised Statutes and one hundred sixty-one million one
3 hundred thousand (\$161,100,000) shall be federal funds.

4 (e) The appropriation to the indigent care program for safety net
5 provider payments is decreased by two hundred seventy million seven
6 thousand sixty-six dollars (\$270,007,066). Of said sum, one hundred
7 thirty-five million three thousand five hundred thirty-three dollars
8 (\$135,003,533) shall be from public certified funds representing
9 expenditures incurred by public hospitals and one hundred thirty-five
10 million three thousand five hundred thirty-three dollars (\$135,003,533)
11 shall be from federal funds.

12 (f) The appropriation to the indigent care program for the
13 children's basic health plan administration is increased by nine thousand
14 eight hundred dollars (\$9,800). Of said sum, three thousand four hundred
15 thirty dollars (\$3,430) shall be shall be from the hospital provider fee
16 cash fund created in section 25.5-4-402.3 (4), Colorado Revised Statutes,
17 and six thousand three hundred seventy dollars (\$6,370) shall be from
18 federal funds.

19 (g) The appropriation to the indigent care program for the
20 children's basic health plan premium costs is increased by twenty million
21 two hundred ninety-eight thousand six hundred forty-one dollars
22 (\$20,298,641). Of said sum, seven million sixty-six thousand three
23 hundred twelve dollars (\$7,066,312) shall be from the hospital provider
24 fee cash fund created in section 25.5-4-402.3 (4), Colorado Revised
25 Statutes, one hundred nine thousand one hundred seventy-nine dollars
26 (\$109,179) shall be from the children's basic health plan trust fund
27 created in section 25.5-8-105 (1), Colorado Revised Statutes, and thirteen

1 million one hundred twenty-three thousand one hundred fifty dollars
2 (\$13,123,150) shall be from federal funds.

3 (h) The appropriation to the indigent care program for the
4 children's basic health plan dental costs is increased by one million
5 sixteen thousand eight hundred twenty dollars (\$1,016,820). Of said sum,
6 three hundred fifty-five thousand eight hundred eighty-seven dollars
7 (\$355,887) shall be from the hospital provider fee cash fund
8 created in section 25.5-4-402.3 (4), Colorado Revised Statutes, and six
9 hundred sixty thousand nine hundred thirty-three dollars (\$660,933) shall
10 be from federal funds.

11 (i) The appropriation to the department of human services
12 medicaid-funded programs, office of information technology services -
13 medicaid funding, Colorado benefits management system, is increased by
14 one hundred fifty-nine thousand three dollars (\$159,003). Of said sum,
15 seventy-nine thousand six hundred twelve dollars (\$79,612) shall be from
16 the hospital provider fee cash fund created in section 25.5-4-402.3 (4),
17 Colorado Revised Statutes, and seventy-nine thousand three hundred
18 ninety-one dollars (\$79,391) shall be from federal funds.

19 (2) For the implementation of this act, appropriations made in the
20 annual general appropriation act for the fiscal year beginning July 1,
21 2009, to the department of human services for allocation to the office of
22 information technology services, Colorado benefits management system
23 is increased by four hundred fifteen thousand ninety-seven dollars
24 (\$415,097). Of said amount, one hundred seventeen thousand sixty-five
25 dollars (\$117,065) shall be from the hospital provider fee cash fund
26 created in section 25.5-402.3 (4), Colorado Revised Statutes, one hundred
27 fifty-nine thousand three dollars (\$159,003) shall be reappropriated funds

1 transferred from the department of health care policy and financing, and
2 one hundred thirty-nine thousand and twenty-nine dollars (\$139,029)
3 shall be from federal funds.

4 **SECTION 13. Appropriation - adjustments to the 2009 long**
5 **bill.** (1) For the implementation of this act, appropriations made in the
6 annual general appropriation act for the fiscal year beginning July 1,
7 2009, to the department of health care policy and financing shall be
8 adjusted as follows:

9 (a) The appropriation to the executive director's division is
10 increased by five million one hundred fifty-seven thousand four hundred
11 fifty dollars (\$5,157,450) and 12.0 FTE. Of said sum, one million eight
12 hundred fifteen thousand seven hundred twenty-three dollars
13 (\$1,815,723) shall be from general fund and three million three hundred
14 forty-one thousand seven hundred twenty-seven dollars (\$3,341,727) shall
15 be from federal funds.

16 (b) The appropriation to the department of human services
17 medicaid-funded programs, office of information technology services -
18 medicaid funding, Colorado benefits management system is increased by
19 one hundred twenty-three thousand two hundred twenty-eight dollars
20 (\$123,228). Of said sum, sixty-one thousand six hundred fourteen dollars
21 (\$61,614) shall be general fund and sixty-one thousand six hundred
22 fourteen dollars (\$61,614) shall be from federal funds.

23 (2) For the implementation of this act, appropriations made in the
24 annual general appropriation act for the fiscal year beginning July 1,
25 2009, to the department of human services for allocation to the office of
26 information technology services, Colorado benefits management system
27 is increased by three hundred twenty-four thousand two hundred

1 eighty-two dollars (\$324,282). Of said amount, ninety-two thousand
2 thirty-one dollars (\$92,031) shall be from the general fund, one hundred
3 twenty-three thousand two hundred twenty-eight dollars (\$123,228) shall
4 be reappropriated funds transferred from the department of health care
5 policy and financing, and one hundred nine thousand and twenty-three
6 dollars (\$109,023) shall be from federal funds.

7 **SECTION 14. Effective date.** (1) Except as provided in
8 subsection (2) and (3) of this section, this act shall take effect July 1,
9 2009.

10 (2) Section 11 of this act shall take effect on April 1, 2010, but
11 only if, by March 31, 2010, the executive director of the department of
12 health care policy and financing has submitted written notice to the
13 revisor of statutes that the federal government has approved the waiver
14 establishing the hospital provider fee created in section 25.5-4-402.3 (3),
15 Colorado Revised Statutes.

16 (3) Section 12 of this act shall take effect on April 1, 2010, but
17 only if on or before March 31, 2010, the executive director of the
18 department of health care policy and financing has not submitted written
19 notice to the revisor of statutes that the federal government has approved
20 the waiver establishing the provider fees created in section 25.5-4-402.3
21 (3), Colorado Revised Statutes.

22

23 **SECTION 15. Safety clause.** The general assembly hereby finds,
24 determines, and declares that this act is necessary for the immediate
25 preservation of the public peace, health, and safety.