First Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO

REREVISEDREVISED

This Version Includes All Amendments Adopted in the Second House

LLS NO. 09-0847.01 Jerry Barry

HOUSE BILL 09-1293

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SENATE
3rd Reading Unamended
April 6, 2009

SENATE
Amended 2nd Reading
April 3, 2009

HOUSE
3rd Reading Unamended
March 25, 2009

HOUSE
Amended 2nd Reading
March 24, 2009

House Committees
Health and Human Services
Finance
Appropriations

Senate Committees
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A BILL FOR AN ACT

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

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.

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

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

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

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

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

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

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

(I) PROVIDING A PAYER SOURCE FOR SOME LOW-INCOME AND UNINSURED POPULATIONS WHO MAY OTHERWISE BE CARED FOR IN

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

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

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

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

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

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

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

(A) THE STATE MEDICAL ASSISTANCE PROGRAM; AND

(B) THE COLORADO INDIGENT CARE PROGRAM;

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

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

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

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

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

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

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

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

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

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

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

(D) INPATIENT REHABILITATION FACILITIES; OR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CFR 447.272 AND 42 CFR 447.321;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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, IN CONNECTION WITH SECTION 25.5-4-205, THAT WOULD INCREASE ACCESS TO PUBLIC MEDICAL ASSISTANCE AND REDUCE THE NUMBER OF UNINSURED SERVED BY HOSPITALS; 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 APPROPRIATED BY THE GENERAL ASSEMBLY FOR THE PURPOSES DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (4) IN FUTURE FISCAL YEARS.

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) **Hospital provider fee oversight and advisory board.** (a) THERE IS HEREBY CREATED IN THE STATE DEPARTMENT THE HOSPITAL

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

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

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

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

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

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

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

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

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

(H) TWO EMPLOYEES OF THE STATE DEPARTMENT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) MEDICAID;

(B) MEDICARE; AND

(C) ALL OTHERS PAYERS.

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

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

(7) **Notice to revisor of statutes - repeal.** (a) WITHIN SIXTY DAYS AFTER THE STATE DEPARTMENT RECEIVES AUTHORIZATION TO RECEIVE FEDERAL MATCHING FUNDS FOR THE MONEYS IN THE FUND, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF STATUTES, TO THE STATE AUDITOR, 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 AMOUNT BASED UPON PERFORMANCE TO THOSE HOSPITALS THAT PROVIDE SERVICES THAT IMPROVE HEALTH CARE OUTCOMES FOR THEIR PATIENTS.

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

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

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

25.5-5-201. Optional provisions - optional groups - repeal. (1) The federal government allows the state to select optional groups to receive medical assistance. Pursuant to federal law, any person who is eligible for medical assistance under the optional groups specified in this section shall receive both the mandatory services specified in sections 25.5-5-102 and 25.5-5-103 and the optional services specified in sections 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial

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

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

(B) NOTWITHSTANDING THE PROVISIONS OF SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (I), 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 PARENTS OF CHILDREN ELIGIBLE FOR THE MEDICAL ASSISTANCE PROGRAM OR THE CHILDREN'S BASIC HEALTH PLAN, 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 TO SUCH PARENT WHOSE FAMILY INCOME EXCEEDS SIXTY PERCENT OF THE FEDERAL POVERTY LEVEL OR REDUCE THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL TO BELOW ONE HUNDRED PERCENT, BUT THE PERCENTAGE SHALL NOT BE REDUCED TO BELOW SIXTY PERCENT.

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

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

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

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (o), 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 INDIVIDUALS WITH DISABILITIES WHO ARE PARTICIPATING IN THE MEDICAID BUY-IN PROGRAM ESTABLISHED IN PART 14 OF ARTICLE 6 OF THIS TITLE, 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 TO BELOW FOUR HUNDRED FIFTY PERCENT OR MAY ELIMINATE THIS ELIGIBILITY GROUP.

(III) (A) NOTWITHSTANDING THE PROVISION OF SUBPARAGRAPH

(I) OF THIS PARAGRAPH (o), INDIVIDUALS WITH DISABILITIES WHO ARE PARTICIPATING IN THE MEDICAID BUY-IN PROGRAM ESTABLISHED IN PART 14 OF ARTICLE 6 OF THIS TITLE 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 INDIVIDUALS WITH DISABILITIES WHO ARE PARTICIPATING IN THE MEDICAID BUY-IN PROGRAM ESTABLISHED IN PART 14 OF ARTICLE 6 OF THIS TITLE, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.

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

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

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (p), 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 CHILDLESS PERSONS OR FOR PERSONS

WITHOUT A DEPENDENT CHILD IN THE HOME, 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 TO BELOW ONE HUNDRED PERCENT OR MAY ELIMINATE THIS ELIGIBILITY GROUP.

(III) (A) NOTWITHSTANDING THE PROVISION OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (p), PERSONS OVER EIGHTEEN YEARS OF AGE WHO ARE CHILDLESS OR WITHOUT A DEPENDENT CHILD IN THE HOME 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 OVER EIGHTEEN YEARS OF AGE WHO ARE CHILDLESS OR WITHOUT A DEPENDENT CHILD IN THE HOME, THE EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.

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

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

(r) (I) PERSONS ELIGIBLE FOR A MEDICAID BUY-IN PROGRAM ESTABLISHED PURSUANT TO SECTION 25.5-5-206 WHOSE FAMILY INCOME DOES NOT EXCEED A SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY 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.

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

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

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

(2) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF THIS SECTION, IF THE 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), THE STATE BOARD BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY ELIMINATE THE CONTINUOUS ENROLLMENT REQUIREMENT PURSUANT TO THIS SECTION.

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

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

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

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

(I) DISABLED CHILDREN; OR

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

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

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

SECTION 7. 25.5-6-1403 (2), Colorado Revised Statutes, is 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~~

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (a), 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 LESS THAN NINETEEN YEARS OF AGE, THE STATE BOARD MAY BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) 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 (a), UNTIL THE STATE DEPARTMENT RECEIVES FEDERAL 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 REVISOR OF STATUTES INFORMING HIM OR HER OF THE AUTHORIZATION.

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

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

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

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

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

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

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

2-3-119. Audit of hospital provider fee - cost shift. (1) STARTING WITH THE SECOND FULL STATE FISCAL YEAR FOLLOWING THE RECEIPT OF THE NOTICE FROM THE EXECUTIVE DIRECTOR OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING PURSUANT TO SECTION 25.5-4-402.3 (7), C.R.S.,AND THEREAFTER AT THE DISCRETION OF THE LEGISLATIVE AUDIT COMMITTEE, THE STATE AUDITOR SHALL CONDUCT OR CAUSE TO BE CONDUCTED A PERFORMANCE AND FISCAL AUDIT OF THE HOSPITAL PROVIDER FEE ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3, C.R.S.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Section 13 of this act shall take effect on April 1, 2010, but only if on or before March 31, 2010, the executive director of the department of health care policy and financing has not submitted written notice to the revisor of statutes that the federal government has approved the waiver establishing the provider fees created in section 25.5-4-402.3 (3), Colorado Revised Statutes.

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