Title of Rule: Revision to the Medical Assistance Act Rule concerning Member Appeals, Sections 8.057.1 and 8.057.3-.5
Rule Number: MSB 23-11-29-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   County informal dispute resolution conferences are available to members and applicants who are found to be ineligible for the Colorado medical assistance program - i.e., eligibility appeals under Section 8.100. Counties have no involvement in utilization management and medical necessity reviews for benefit appeals, and informal dispute resolutions conferences are not, and have never been, available to members for such appeals. The purpose of the rule change is to clarify that county or service delivery agency informal dispute resolution conferences are only for eligibility appeals under Section 8.100.

   Separately, this proposed rule change removes language from Section 8.057 regarding possible recoupments from members who receive services during an unsuccessful appeal. This change is to comply with a Center for Medicare and Medicaid Services (CMS) waiver under Section 1902(e)(14)(A); and to harmonize with Department practices of not recouping in these circumstances.

   Finally, the language in Section 8.057.4 is being updated to align with C.R.S. § 25.5-4-207(1)(a)(II), which states, "The applicant or recipient has sixty days after the date of the notice to file an appeal."

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR Part 456; Social Security Act, Section 1902(e)(14)(A).

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-1-118(a), C.R.S. (2023);
   Section 25.5-4-207(1)(a)(II), C.R.S. (2023)

Initial Review	**06/14/24**	Final Adoption	**07/12/24**
Proposed Effective Date	**08/30/24**	Emergency Adoption	

DOCUMENT #04

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rule clarifies that a county or service agency dispute resolution conference is only available for eligibility determination appeals, which reflects current Department practice.

   The removal of recoupment language from the appeals rules, and clarifying the time for filing an appeal, impacts members filing appeals by clarifying that there will be no recoupment for the cost of services rendered to a member during the pendency of an unsuccessful appeal, and that the member has a full sixty days to file request for hearing after the Notice of Action.

   The change regarding timely appeals from language stating members have 60 days "from" the date of the Notice of Action to 60 days "after" the date of the Notice of Action ensures a member has the full period of time allotted to members to appeal timely.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   A county or service agency dispute resolution conference appealing eligibility determinations is not available to applicants and members appealing Department determinations not related to eligibility.

   Members appealing a notice of action have a full sixty days to file a request for hearing, in alignment with C.R.S. § 25.5-4-207(1)(a)(II), and no recoupment of services rendered during the pendency of an appeal will be recouped, in alignment with the CMS conditions for the grant of a Section 1902(e)(14)(A) waiver and with current Department practice.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   None.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

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The probable benefits of the proposed rule are: (1) compliance with federal law related to program benefits utilization management; (2) resolving confusion about the county dispute resolution conference process for medical assistance eligibility determinations; (3) removing outdated and impermissible language about recouping the costs of services from members who unsuccessfully appeal; and (4) aligning with C.R.S. § 25.5-4-207(1)(a)(II) concerning the timeframe for filing an appeal. There are no costs associated with the proposed rule changes. At the same time, there are no benefits of inaction. Costs of inaction include ongoing confusion related to the role of county dispute resolution – which is limited solely to medical assistance eligibility appeals – which has resulted in canceled appeal hearings while benefits and services continue to be rendered to members who may not meet medical necessity criteria. This situation risks future CMS audit findings and disallowances, as well as drawing limited resources away from members who have been determined to need ongoing services and benefits. Additional costs to inaction are: (1) continued misalignment between Department rules concerning recoupment of services rendered during the pendency of an unsuccessful appeal and with the Department's Section 1902(e)(14)(A) waiver, and (2) misalignment between Department rule and state statute concerning the time for filing a request for hearing after the Notice of Action.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   This is the least costly, least intrusive method for achieving the purposes of the rule change.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   Other resolution processes were discussed but were found not to be sufficient because they would lack the clinical judgment/medical necessity analysis required for utilization management.

8.057 RECIPIENT APPEALS

8.057.1 DEFINITIONS

1. Action means a termination, suspension or reduction of Medicaid, eligibility or covered services. It also means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations with regard to a Level II Screen finding for the preadmission screening and annual resident review requirements.

2. Adverse determination means a determination with regard to a Level II Screen finding for the preadmission screening and annual review requirements that the individual does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services.

3. Authorized representative means a person designated by the applicant or ~~recipient~~ member to act on ~~his/her~~their behalf. Such authorization shall be in writing in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations located at 45 C.F.R. parts 160 and 164. A written designated power of attorney may substitute for the HIPAA compliant release.

4. Date of action means the intended date on which a termination, suspension, reduction, transfer or discharge becomes effective. It also means the date of the preadmission screening and annual resident review determination.

5. Notice, other than that required to be provided by a nursing facility seeking to transfer or discharge a resident, means a written statement which contains:

    a. ~~1.~~ A statement of what action the Department or its designee intends to take;

    b. ~~2.~~ The reasons for the intended action;

    c. ~~3.~~ The specific regulations that support, or the change in federal or state law that requires the action;

    d. ~~4.~~ An explanation of

        i. ~~a.~~ The individual's right to request an evidentiary hearing if one is available; or

        ii. ~~b.~~ In cases of an action based on a change in law, the circumstances under which a hearing will be granted.

    e. ~~5.~~ The method by which the individual may obtain a hearing;

    f. ~~6.~~ That the individual may represent ~~himself/herself~~themselves or use legal counsel, a relative, a friend, or other ~~spokesman~~ representative at the hearing; and

    g. ~~7.~~ An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

    h. ~~8.~~ For notices concerning a medical assistance program~~n~~ eligibility determination under section 8.100, ~~A~~an explanation of the applicant's or ~~recipient's~~ member's right to a county or service delivery agency dispute resolution conference.

6. Notice required to be provided by a nursing facility seeking to transfer or discharge a resident means a written statement which contains, in addition to the requirements above:

    a. ~~1.~~ The reason for transfer or discharge;

    b. ~~2.~~ The effective date of the transfer or discharge;

c. ~~3.~~ The location to which the resident is transferred or discharged;

d. ~~4.~~ The name, address and telephone number of the State long-~~-~~term care ombudsman;

e. ~~5.~~ For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

f. ~~6.~~ For nursing facility residents ~~who are mentally ill~~living with a mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of ~~mentally ill~~ individuals living with a mental illness established under the Protection and Advocacy for Mentally Ill Individuals Act.

7. Request for a hearing means a clear expression by the applicant or ~~recipient~~member, or ~~his/her~~their authorized representative that ~~he/she~~they want~~s~~ an opportunity to present ~~his/her~~their case to a reviewing authority.

8. Service delivery agency or designated service agency means a department-designated, certified medical assistance site contracted with the department to accept and process medical assistance applications approved by the federal Centers for Medicare and Medicaid Services, as authorized by C.R.S. § 25.5-4-205. Service delivery agencies utilize the Colorado Benefits Management System (CBMS) to determine eligibility for Child Health Plan Plus (CHP+) and Health First Colorado (Colorado Medicaid) medical assistance programs.

8.057.3 OPPORTUNITY FOR HEARING

8.057.3.A An individual shall have an opportunity for a hearing where:

1. An application for services is denied or is not acted upon with reasonable promptness;

2. The recipient requesting the hearing believes the action is erroneous, including a loss of coverage without notice;

3. The resident of a nursing facility believes the facility has erroneously determined that he/she must be discharged; and

4. An individual who believes the determination with regard to the preadmission and annual resident review requirements is erroneous.

8.057.3.F. Opportunity For County or Service Delivery Agency Dispute Resolution Conference. In addition to the opportunity for a hearing, an applicant or~~/recipient~~ member shall have an opportunity to have their ~~approval, denial, termination, suspension, or reduction of Medicaid benefits~~medical assistance program under section 8.100 resolved through an informal dispute resolution conference. An informal dispute resolution does not extend the period of time within which a member can timely file a formal appeal pursuant to 8.057.4.B.; nor does a request for an informal dispute resolution conference result in a continuation of benefits. Filing a formal appeal pursuant to 8.057.4. is the only way to receive a continuation of benefits, if applicable.

County and service delivery agencies shall afford ~~recipients~~ applicants and members the opportunity for informal dispute resolutions as follows:

1. An applicant~~/recipient~~ or member who disagrees with a decision regarding their eligibility may request dispute resolution either in writing or by phone ~~within~~ no later than 60 calendar days ~~of the eligibility determination~~after the date ~~listed on~~of the Notice of Action (NOA). If available

through the County or service delivery agencies, applicants~~/recipients~~ and members may use email to make a request.

2. ~~Within~~ No later than 10 calendar days after receipt of the request for dispute resolution the County or service delivery agency, after a review of the case ~~by~~ for accuracy and completeness, shall notify the applicant~~/recipient~~ or member, in writing, of the date, time, and location of the conference. The notification shall also include the applicant~~/recipient~~ or member's rights to a state level appeal and a deadline date for requesting such an appeal.

3. The County or service delivery agency shall hold the conference within no more than 25 calendar days from the date the request was received unless both parties agree, in writing, to extend the date of the conference.

4. The applicant~~/recipient~~ or member shall have the choice to have the dispute conference held in person or by phone.

5. The dispute resolution conference facilitator shall, within 3 business days, notify the applicant~~/recipient~~ or member of the finding from the conference via U.S. Mail.

6. If the finding is that the dispute has been resolved and the applicant or member has already filed an appeal, the County or service delivery agency shall inform the applicant or ~~recipient~~ member of the process for dismissing their appeal.

8.057.4 REQUEST FOR HEARING

8.057.4.B. The request for a hearing shall be filed with the Office of Administrative Courts:

1. ~~Within~~ No later than 60 calendar days ~~of~~ after the date of the ~~notice~~ Notice of ~~action~~Action.

8.057.5 MAINTAINING SERVICES

8.057.5.A. Where the ~~recipient~~ member requests a hearing ~~before the date of action~~no later than 60 calendar days after the date of the Notice, in accordance with Section 8.057.4.B.1., the ~~recipient's~~ member's services may not be terminated or reduced until a final agency decision is rendered after the hearing. ~~unless:~~

1. ~~It is determined at the hearing that the sole issue is one of federal or state law or policy; and~~If a member requests a hearing after the d~~D~~ate of action and no later than 60 calendar days after the date of Notice, in accordance with Section 8.057.4.B.1., benefits will be continued from the ~~D~~date of action.

2. A request for an informal dispute resolution conference concerning eligibility determinations, in accordance with Section 8.057.3.F., does not maintain services or continue benefits.~~The recipient is promptly informed that services are to be terminated or reduced pending the hearing decision.~~

~~8.057.5.B. Where the action of the Department or its designee is sustained by the final agency decision, the Department or its designee may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section regarding maintaining services.~~