TITLE 25.5

HEALTH CARE POLICY AND FINANCING

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

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Art. 2. State-funded Health and Medical Care, 25.5-2-101 to 25.5-2-107.

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Art. 2.5. Prescription Drugs, 25.5-2.5-101 to 25.5-2.5-208.

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Art. 5. Colorado Medical Assistance Act - Services and Programs, 25.5-5-101 to 25.5-5-804.

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PART 1

GENERAL PROVISIONS

25.5-1-101. Short title.

This title shall be known and may be cited as the "State Health Care Policy and Financing Act".

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

25.5-1-102. Legislative declaration.

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

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

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

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

25.5-1-103. Definitions.

As used in this title 25.5, unless the context otherwise requires:

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

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

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

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

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

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

(a) Health maintenance and preventive care;

(b) Anticipatory guidance and health education;

(c) Acute and chronic illness care;

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

(e) Provider participation in hospital care; and

(f) Twenty-four-hour telephone care.

(6) "Member" means any person who has been determined eligible to receive benefits or services under this title 25.5.

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

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

(9) "State designated agency" means an agency designated to perform specified functions that would otherwise be performed by the county departments, including case management agencies, as defined in section 25.5-6-1702, and medical assistance sites.

Source: L. 93: Entire title added, p. 1098, § 15, effective July 1, 1994. **L. 95:** (2.5) added, p. 903, § 2, effective May 25. **L. 96:** (1) repealed, p. 1473, § 25, effective June 1. **L. 2006:** Entire part amended, p. 1782, § 1, effective July 1. **L. 2007:** (5.5) added, p. 1487, § 1, effective May 31. **L. 2018:** IP and (1) to (3) amended, (SB 18-092), ch. 38, p. 443, § 106, effective August 8. **L. 2021:** (9) amended, (HB 21-1187), ch. 83, p. 331, § 21, effective July 1, 2024. **L. 2024:** (6) amended, (SB 24-176), ch. 152, p. 615, § 1, effective August 7.

Cross references: For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018.

25.5-1-104. Department of health care policy and financing created - executive director - powers, duties, and functions - report.

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

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

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

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

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

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

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

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

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

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

(6) (a) (I) The state department shall collaborate with the department of education, the department of public health and environment, and the department of human services to develop an interagency resource guide pursuant to section 22-2-410 to assist facilities to become licensed or authorized as approved facility schools and to recommend changes related to the interagency resource guide to the state department's statute, rule, or administrative procedures.

(II) The state department shall prominently post the interagency resource guide created pursuant to subsection (6)(a)(I) of this section on the state department's website.

(b) On or before November 1, 2023, the state department, after consulting with the facility school work group created in section 22-2-407.5, shall recommend a plan to provide guidance to approved facility schools on the eligibility standards required to request and receive medicaid reimbursement funding for therapeutic services to the maximum extent possible to reduce reliance on school district revenues for tuition payments required pursuant to section 22-20-109. The plan must include best practices from other states, recommendations on required federal or state authority changes, cost estimates, and cost-saving potentials.

Source: L. 93: Entire title added, p. 1098, § 15, effective July 1, 1994. **L. 94:** (2) amended, p. 1559, § 4, effective July 1. **L. 96:** (2) amended, p. 1474, § 26, effective June 1. **L. 2006:** Entire part amended, p. 1783, § 1, effective July 1. **L. 2010:** (5) added, (SB 10-167), ch. 296, p. 1376, § 2, effective May 26. **L. 2023:** (6) added, (SB 23-219), ch. 88, p. 333, § 13, effective April 20. **L. 2024:** (6)(a)(II) amended, (HB 24-1450), ch. 490, p. 3418, § 55, effective August 7.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

25.5-1-105. Transfer of functions.

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

(2) All rules, regulations, and orders of the department of local affairs, the department of human services, the state board of human services, the department of regulatory agencies, and the university of Colorado health sciences center adopted prior to July 1, 1994, in connection with the powers, duties, and functions transferred to the state department continue to be effective until revised, amended, repealed, or nullified pursuant to law. On and after July 1, 1994, the state board or the executive director, whichever is appropriate, shall adopt rules necessary for the administration of the state department and the administration of the programs set forth in this title 25.5.

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

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

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

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

Source: L. 93: Entire title added, p. 1099, § 15, effective July 1, 1994. **L. 94:** (2) amended, p. 2610, § 12, effective July 1; (6) amended, p. 1559, § 5, effective July 1. **L. 2003:** (10) added, p. 2583, § 1, effective July 1. **L. 2005:** (1) amended, p. 772, § 50, effective June 1. **L. 2006:** Entire part amended, p. 1783, § 1, effective July 1. **L. 2011:** (6) amended, (SB 11-210), ch. 187, p. 721, § 6, effective July 15, 2012. **L. 2024:** (1), (2), (3) and (5) amended, (HB 24-1222), ch. 155, p. 690, § 16, effective August 7.

25.5-1-105.5. Chief medical officer - qualifications.

(1) The executive director shall appoint a chief medical officer who shall:

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

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

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

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

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

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

Cross references: For the legislative declaration contained in the 2007 act enacting this section, see section 1 of chapter 347, Session Laws of Colorado 2007. For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

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

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

25.5-1-107. Final agency action - administrative law judge - authority of executive director.

(1) The executive director may appoint one or more individuals to serve as administrative law judges for the state department pursuant to section 24-4-105 and pursuant to part 10 of article 30 of title 24 subject to appropriations made to the department of personnel. Except as provided in subsection (2) of this section, hearings conducted by the administrative law judge are considered initial decisions of the state department, and the executive director or the executive director's designee shall review the initial decisions. If exceptions to the initial decision are filed pursuant to section 24-4-105 (14)(a)(I), the review must be conducted in accordance with section 24-4-105 (15). In the absence of any exception filed pursuant to section 24-4-105 (14)(a)(I), the executive director or the executive director's designee shall review the initial decision in accordance with a procedure adopted by the state board. The procedure must be consistent with federal mandates concerning the single state agency requirement. Review by the executive director or the executive director's designee in accordance with section 24-4-105 (15) or the procedure adopted by the state board pursuant to this section constitutes final agency action. The administrative law judge may conduct hearings on appeals from decisions of county departments of human or social services brought by members of and applicants for medical assistance and welfare that are required by law in order for the state to qualify for federal funds, and the administrative law judge may conduct other hearings for the state department. Notice of any hearing must be served at least ten days prior to the hearing.

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

Source: L. 93: Entire title added, p. 1101, § 15, effective July 1, 1994. **L. 95:** (1)(a) and (2) amended, p. 903, § 3, effective May 25; (1)(a) and (1)(c) amended, p. 664, § 101, effective July 1. **L. 97:** (1)(b) amended, p. 1190, § 10, effective July 1. **L. 2005:** (1)(c) amended, p. 859, § 25, effective June 1. **L. 2006:** Entire part amended, p. 1785, § 1, effective July 1. **L. 2018:** (1) amended, (SB 18-092), ch. 38, p. 443, § 107, effective August 8. **L. 2024:** (1) amended, (SB 24-176), ch. 152, p. 615, § 2, effective August 7.

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

Cross references: For the legislative declaration contained in the 1995 act amending subsections (1)(a) and (1)(c), see section 112 of chapter 167, Session Laws of Colorado 1995. For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018.

ANNOTATION

Under the governing regulations, the department of health care policy and financing lacks authority to base its final agency decision on information that was not presented to the ALJ. Martelon v. Colo. Dept. of Health Care Policy & Fin., 124 P.3d 914 (Colo. App. 2005) (decided prior to the 2006 amendment).

25.5-1-108. Executive director - rules.

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

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

(b) Fiscal and personnel administration for the department;

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

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

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

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

25.5-1-109. Department of health care policy and financing cash fund.

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

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

25.5-1-109.5. Clinical standards - development.

(1) The general assembly finds that:

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

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

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

(b) Repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25.5-1-114. Grants-in-aid - county supervision.

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

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

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

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

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

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

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

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

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

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

25.5-1-114.5. Medicaid fraud detection - request for information. (Repealed)

Source: L. 2013: Entire section added, (SB 13-137), ch. 285, p. 1501, § 1, effective August 7. **L. 2024:** Entire section repealed, (SB 24-176), ch. 152, p. 676, § 105, effective August 7.

25.5-1-115. Locating violators - recoveries - repeal.

(1) The executive director of the state department, and a county contracted to administer the centralized member integrity service pursuant to section 25.5-1-210, or district attorneys may request and must receive from departments, boards, bureaus, or other agencies of the state or any of its political subdivisions, and the same are authorized to provide, the assistance and data as will enable the state department, county departments, and a county contracted to administer the centralized member integrity service pursuant to section 25.5-1-210 to properly carry out their powers and duties to locate and prosecute a person who has fraudulently obtained medical assistance under this title 25.5. Records established pursuant to the provisions of this section are available only to the state department, the department of human services, the county departments, a county contracted to administer the centralized member integrity service pursuant to section 25.5-1-210, the attorney general, and the district attorneys, county attorneys, and courts having jurisdiction in fraud or recovery proceedings or actions.

(2) (a) All departments and agencies of the state and local governments shall cooperate in the location and prosecution of a person who has fraudulently obtained medical assistance under this title 25.5, and, on request of the county board, the county director, the state department, or the district attorney of any judicial district in this state, shall supply all information on hand relative to the location, employment, income, and property of the persons, notwithstanding any other provision of law making such information confidential, except the laws pertaining to confidentiality of any tax returns filed pursuant to law with the department of revenue. The department of revenue shall furnish at no cost to inquiring departments and agencies information necessary to effectuate the purposes of this article 1. The procedures used to request and provide this information must be established by rule of the state department. The state department or county departments shall use the information only for the purposes of administering medical assistance under this title 1, and the district attorney shall use it only for the prosecution of persons who have fraudulently obtained medical assistance under this title, and shall not use the information, or disclose it, for any other purpose. The state department shall utilize the centralized member integrity service, established pursuant to section 25.5-1-210, to conduct

fraud investigations, fraud claims, fraud recovery, fraud dispute resolution conferences, state-level hearings, intentional program violation waivers, and criminal court proceedings concerning member eligibility in the medical assistance program.

(b) (I) Whenever the state department, a county department contracted to administer the centralized member integrity service pursuant to section 25.5-1-210, or a district attorney for the state department, or the state department on behalf of a county department, recovers any amount of fraudulently obtained medical assistance funds, the federal government is entitled to a share proportionate to the amount of federal funds paid unless a different amount is otherwise provided by federal law, the state is entitled to a share proportionate to the amount of state funds paid and additional amounts of federal funds recovered as provided by federal law, and the county department is entitled to a share proportionate to the amount of county funds paid unless a different amount is provided pursuant to federal law or this section.

(II) (A) Whenever a county department, a county board, a district attorney, a county contracted to administer the centralized member integrity service pursuant to section 25.5-1-210, or a state department on behalf of a county department recovers any amount of fraudulently obtained public assistance funds in the form of assistance payments, the recovered funds must be deposited in the county social services fund until the county has fully transitioned to utilizing the centralized member integrity service pursuant to section 25.5-1-210. When the county has fully transitioned to utilizing the centralized member integrity service, the county shall notify the state department of the full transition and the county shall transfer the money in the county social services fund to the state treasurer, who shall credit the money to the centralized member integrity service cash fund created in section 25.5-1-210. After the county has fully transitioned to utilizing the centralized member integrity service, an entity that recovers, on behalf of a county, an amount of fraudulently obtained public assistance funds shall transfer the recovered funds to the state treasurer, who shall credit the money to the centralized member integrity service cash fund. The federal government is entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, the state is entitled to a share proportionate to one-half the amount of state funds paid, and the county is entitled to a share proportionate to the amount of county funds paid and, in addition, a share proportionate to one-half the amount of state funds paid.

(B) Whenever a county department, a county board, a district attorney, a county contracted to administer the centralized member integrity service pursuant to section 25.5-1-210, or a state department on behalf of a county department recovers any amount of fraudulently obtained medical assistance, the recovered funds must be deposited in the county social services fund until the county has fully transitioned to utilizing the centralized member integrity service pursuant to section 25.5-1-210. When the county has fully transitioned to utilizing the centralized member integrity service, the county shall notify the state department of the full transition and the county shall transfer the money in the county social services fund to the state treasurer, who shall credit the money to the centralized member integrity service cash fund created in section 25.5-1-210.

After the county has fully transitioned to utilizing the centralized member integrity service, an entity that recovers, on behalf of a county, an amount of fraudulently obtained medical assistance funds shall transfer the recovered funds to the state treasurer, who shall credit the money to the centralized member integrity service cash fund. The federal government is entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, and the county is entitled to the remaining funds.

(C) This subsection (2)(b)(II) is repealed, effective July 1, 2028.

(III) (A) Beginning July 1, 2028, whenever a county department, a county board, a district attorney, a county contracted to administer the centralized member integrity service pursuant to section 25.5-1-210, or a state department on behalf of a county department recovers any amount of fraudulently obtained public assistance funds in the form of assistance payments, the fraudulent funds shall be transferred to the state treasurer, who shall credit the money to the centralized member integrity service cash fund created in section 25.5-1-210. The federal government is entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, the state is entitled to a share proportionate to one-half the amount of state funds paid, and the county is entitled to a share proportionate to the amount of county funds paid and, in addition, a share proportionate to one-half the amount of state funds paid.

(B) Beginning July 1, 2028, whenever a county department, a county board, a district attorney, a county contracted to administer the centralized member integrity service pursuant to section 25.5-1-210, or a state department on behalf of a county department recovers any amount of fraudulently obtained medical assistance, an amount from an individual for the value of the medical assistance benefits the individual fraudulently obtained shall be transferred to the state treasurer, who shall credit the money to the centralized member integrity service cash fund created in section 25.5-1-210. The federal government is entitled to a share proportionate to the amount of federal funds paid, unless a different amount is provided for by federal law, and the county is entitled to the remaining funds.

(3) and (4) (Deleted by amendment, L. 2026.)

(5) The state portion of the money recouped by the state department pursuant to this section must be deposited into the centralized member integrity service cash fund created in section 25.5-1-210.

Source: L. 2006: Entire part amended, p. 1788, § 1, effective July 1. **L. 2012:** (2)(b)(II) amended, (SB 12-060), ch. 166, p. 578, § 3, effective August 8. **L. 2024:** (3) amended, (SB 24-176), ch. 152, p. 616, § 3, effective August 7. **L. 2026:** Entire section amended, (HB 26-1429), ch. 374, p. 2308, § 8, effective June 4.

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

Cross references: For the legislative declaration in HB 26-1429, see section 1 of chapter 374, Session Laws of Colorado 2026.

25.5-1-115.5. Medical assistance fraud - report.

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

(a) Investigations of member fraud during the year;

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

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

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

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

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

Source: L. 2012: Entire section added, (SB 12-060), ch. 166, p. 577, § 1, effective August 8. **L. 2017:** IP(1) amended, (HB 17-1060), ch. 6, p. 14, § 2, effective March 1; IP(1), (1)(d), and (1)(e) amended and (1)(f) added, (SB 17-295), ch. 298, p. 1636, § 1, effective August 9. **L. 2024:** IP(1), (1)(a), (1)(b), and (1)(e) amended, (SB 24-176), ch. 152, p. 616, § 4, effective August 7. **L. 2026:** IP(1) amended, (SB 26-169), ch. 311, p. 1808, § 42, effective August 12.

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

25.5-1-116. Records confidential - authorization to obtain records of assets - release of location information to law enforcement agencies - outstanding felony arrest warrants.

(1) The state department may establish reasonable rules to provide safeguards restricting the use or disclosure of information concerning applicants, members, and former and potential members of medical assistance for purposes directly connected with the administration of medical assistance and related state department activities, including the custody, use, and preservation of the state's and the county departments' records, papers, files, and communications. Whenever, as required by law, the names and addresses of applicants for, members of, or former and potential members of medical assistance are furnished to or held by another agency or department of government, the agency or department shall prevent the publication of lists of the names and addresses and prevent using the names and addresses for purposes not directly connected with the administration of medical assistance.

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

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

(III) (A) Notwithstanding any provision of state law to the contrary and to the extent allowable under federal law, at the request of the Colorado bureau of investigation, the state department shall provide the bureau with information concerning the location of any person whose name appears in the department's records who is the subject of an outstanding felony arrest warrant. Upon receipt of such information, it shall be the responsibility of the bureau to provide appropriate law enforcement agencies with location information obtained from the state department. Location information provided pursuant to this section shall be used solely for law

enforcement purposes. The state department and the bureau shall determine and employ the most cost-effective method for obtaining and providing location information pursuant to this section. Neither the state department nor its employees or agents shall be liable in civil action for providing information in accordance with the provisions of this sub-subparagraph (A).

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

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

(c) (I) In order to determine if applicants for or members of medical assistance have assets within eligibility limits, the state department may provide a list of information identifying the applicants or members to any financial institution, as defined in section 15-15-201 (4), or to any insurance company. The information provided may include identification numbers or social security numbers. The state department may require a financial institution or insurance company to provide a written statement disclosing any assets held on behalf of individuals adequately identified on the list provided. Before a termination notice is sent to the member, the county department or the medical assistance site, in verifying the accuracy of the information obtained as a result of the match, shall contact the member and inform the member of the apparent results of the computer match and give the member the opportunity to explain or correct any erroneous information secured by the match. The requirement to run a computerized match applies only to information that is entered in the financial institution's or insurance company's data processing system on the date the match is run and does not require any financial institution or insurance company to change its data or make new entries for the purpose of comparing identifying information. The state department shall pay for the cost of providing a computerized match.

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

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

(d) An applicant must not be denied or any member must not be discontinued due to the disclosure of assets unless and until the county department or medical assistance site has assured that the assets taken together with other assets exceed the limit for eligibility of countable assets. Any information concerning assets found may be used to determine if the applicant's or member's eligibility for other medical assistance is affected.

(3) The applicant for or member of medical assistance, or the applicant's or member's representative, has an opportunity to examine all applications and pertinent records concerning the applicant or member that constitute a basis for denial, modification, or termination of medical assistance or to examine the records in case of a fair hearing.

(4) Any person who violates subsection (1) or (2) of this section commits a petty offense.

Source: L. 2006: Entire part amended, p. 1790, § 1, effective July 1. **L. 2021:** (4) amended, (SB 21-271), ch. 462, p. 3240, § 481, effective March 1, 2022. **L. 2024:** (1), (2)(c)(I), (2)(c)(III), (2)(d), and (3) amended, (SB 24-176), ch. 152, p. 616, § 5, effective August 7.

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

25.5-1-117. County departments - district departments.

(1) Except as provided in subsection (2) of this section, there is established in each county of the state a county department of human or social services that consists of a county board of human or social services, a county director of human or social services, and any additional employees as may be necessary for the efficient performance of public assistance, as defined in section 26-2-103 (7), and medical assistance.

(2) Case management agencies established pursuant to part 17 of article 6 of this title 25.5 may act as state designated agencies and are authorized to carry out functions as specified in part 17 of article 6 of this title 25.5 that are otherwise performed by county departments of human or social services.

(3) With the approval of the state department of human services, two or more counties may jointly establish a district department of human or social services. All duties and responsibilities for county departments of human or social services set forth in this title 25.5 also apply to district departments of human or social services.

Source: L. 2006: Entire part amended, p. 1792, § 1, effective July 1. **L. 2018:** Entire section amended, (SB 18-092), ch. 38, p. 444, § 108, effective August 8. **L. 2021:** (2) amended, (HB 21-1187), ch. 83, p. 331, § 22, effective July 1, 2024.

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

Cross references: For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018.

25.5-1-118. Duties of county departments.

(1) The county departments or other state designated agencies, where applicable, serve as agents of the state department and, no later than July 1, 2028, shall utilize the centralized member integrity service, established in section 25.5-1-210, for the administration of medical assistance and related activities in the respective counties in accordance with the rules of the state department.

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

(3) Repealed.

Source: L. 2006: Entire part amended, p. 1793, § 1, effective July 1. **L. 2026:** (1) amended and (3) repealed, (HB 26-1429), ch. 374, p. 2311, § 9, effective June 4.

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

Cross references: For the legislative declaration in HB 26-1429, see section 1 of chapter 374, Session Laws of Colorado 2026.

25.5-1-119. County staff.

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

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

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

25.5-1-120. Appropriations.

(1) (a) For carrying out the duties and obligations of the state department and county departments under the provisions of this title and for matching such federal funds or meeting maintenance of effort requirements as may be available for public assistance and welfare activities in the state, including medical assistance administration and related activities, the general assembly, in accordance with the constitution and laws of the state of Colorado, shall make adequate appropriations for the payment of such costs, pursuant to the budget prepared by the executive director.

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

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

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

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

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

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

25.5-1-121. County expenditures - advancements - procedures.

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

(2) Notwithstanding any other provision of this article 1, the county department may spend in excess of twenty percent of actual costs for the purpose of matching federal funds for the administration of the child support enforcement program or for the administrative costs of activities involving food stamps or public assistance.

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

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

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

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

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

(4) Administrative costs do not include expenditures that are duplicative of costs covered by the centralized member integrity service, established in section 25.5-1-210, or shared services, as defined in section 26-1-802.

Source: L. 2006: Entire part amended, p. 1794, § 1, effective July 1. **L. 2011:** (3) added, (HB 11-1196), ch. 160, p. 555, § 6, effective August 10. **L. 2026:** (2) amended and (4) added, (HB 26-1429), ch. 374, p. 2311, § 10, effective June 4.

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

Cross references: For the legislative declaration in HB 26-1429, see section 1 of chapter 374, Session Laws of Colorado 2026.

25.5-1-122. County appropriation increases - limitations.

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

(2) For the purposes of this section:

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

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

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

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

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

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

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

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

(6) The limitation set forth in this section on the increase in the county share of the administrative costs of medical assistance will result in increased costs to the state. By making

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

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

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

25.5-1-123. Medical homes for children - legislative declaration - duties of the department.

(1) The general assembly hereby finds and declares that:

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

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

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

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

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

(3) Repealed.

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

25.5-1-124. Early intervention payment system - participation by state department - rules - definitions.

(1) The state department shall participate in the development and implementation of the coordinated system of payment for early intervention services authorized pursuant to part 4 of article 3 of title 26.5 and part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq., as amended.

(2) The state department shall ensure that the early intervention services and payments for members of medical assistance pursuant to this title 25.5 are integrated into the coordinated early intervention payment system developed pursuant to part 4 of article 3 of title 26.5. To the extent necessary to achieve the coordinated payment system and coverage of those early intervention services pursuant to this title 25.5, the state department shall amend the state plan for medical assistance or seek the necessary federal authorization, promulgate rules, and modify the billing system for medical assistance to facilitate the coordinated payment system.

(3) The state department shall also make any modifications necessary to the "Children's Basic Health Plan Act", article 8 of this title 25.5, including promulgating rules, to ensure that the children's basic health plan is integrated into the coordinated early intervention payment system developed pursuant to part 4 of article 3 of title 26.5.

(4) Repealed.

(5) (a) As used in this section, unless the context otherwise requires, "early intervention services" means those services defined as early intervention services by the department of early

childhood in accordance with section 26.5-3-402 (9) that are determined, through negotiation between the state department and the department of early childhood, to be medically necessary under medical assistance and cost-effective. After negotiating the scope of early intervention services to be covered under medical assistance, the state department and the department of early childhood shall submit to the joint budget committee of the general assembly, as part of each department's annual budget request, a proposal for the scope of coverage of early intervention services under medical assistance, including the anticipated costs of such coverage and whether the payment of such costs through medical assistance is cost-effective.

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

(I) Nonemergency medical transportation;

(II) Respite care;

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

(IV) (A) Assistive technology.

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

Source: L. 2007: Entire section added, p. 888, § 2, effective July 1. **L. 2008:** (5)(a) amended, p. 1468, § 14, effective August 5. **L. 2012:** (4) repealed, (HB 12-1247), ch. 53, p. 196, § 6, effective March 22. **L. 2022:** (1), (2), (3), and (5)(a) amended, (HB 22-1295), ch. 123, p. 847, § 74, effective July 1. **L. 2024:** (2) amended, (SB 24-176), ch. 152, p. 618, § 6, effective August 7.

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

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

25.5-1-126. Discounted prices for durable medical equipment and supplies.

(1) The state department shall work with one or more nonprofit organizations to develop a link of approved vendors who are willing to sell durable medical equipment and medical supplies at discounted prices to persons who have applied for, but are not yet receiving, benefits under the

"Colorado Medical Assistance Act". The state department shall provide the exclusive criteria for a nonprofit organization to use to approve a vendor for placement on the approved vendor list.

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

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

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

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

25.5-1-127. Third-party benefit denials information.

The state department shall provide information to members who receive benefits under this title 25.5 concerning the members' right to appeal a denial of benefits by a third party and shall post information on the state department's website concerning members' abilities to appeal a third party's denial of benefits, including but not limited to providing a link to information on the insurance commissioner's website regarding appeals.

Source: L. 2010: Entire section added, (SB 10-002), ch. 366, p. 1727, § 2, effective June 7. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 618, § 7, effective August 7.

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

25.5-1-128. Provider payments - compliance with state fiscal requirements - rules - definitions.

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

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

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

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

(III) Repealed.

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

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

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

(1.5) The state department shall maintain a list of enrolled school-based health centers and school-linked health-care services providers. The state department shall develop the list based on grant enrollment data pursuant to section 25-20.5-503 that is provided to the state department by the department of public health and environment. The state department shall establish a process for identifying claims for services provided in these settings.

(2) As used in this section, unless the context otherwise requires, "provider" means a health-care provider; a mental health-care provider; a pharmacist; a home health agency; a general hospital, birth center, or community clinic licensed or certified by the department of public health and environment pursuant to section 25-1.5-103 (1)(a)(I) or (1)(a)(II); a federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec 1395x (aa)(4); a rural health clinic, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(2); a health maintenance organization issued a certificate of authority pursuant to section 10-16-402; a school district as defined in section 25.5-5-318 (1)(a); or any other entity that provides health care, health-care coordination, outreach, enrollment, or administrative support services to members through fee-for-service, a managed care entity, a behavioral health organization, a medical home, or any system of care that coordinates health care or services as defined and authorized through rules promulgated by the state board or by the executive director.

Source: L. 2012: Entire section added, (HB 12-1054), ch. 14, p. 36, § 1, effective March 15. **L. 2024:** (1.5) added, (SB 24-034), ch. 404, p. 2775, § 4, effective August 7; (2) amended, (SB 24-176), ch. 152, p. 618, § 8, effective August 7; IP(1)(b) and (2) amended, (HB 24-1399), ch. 76, p. 256, § 21, effective July 1, 2025; and (1)(b)(III)(B) added by revision, (HB 24-1399), ch. 76, pp. 256, 260, §§ 21, 33.

Editor's note: (1) Amendments to subsection (2) by HB 24-1399 and SB 24-176 were harmonized, effective July 1, 2025.

(2) Subsection (1)(b)(III)(B) provided for the repeal of subsection (1)(b)(III), effective July 1, 2025. (See L. 2024, pp. 256, 260.)

25.5-1-129. State department proposal - state option for health-care coverage - report to general assembly - waiver authorization - legislative declaration.

(1) (a) The general assembly finds that:

(I) Every Coloradan deserves access to high-quality, affordable health care to help support his or her well-being and economic security;

(II) To achieve these goals, Colorado has successfully implemented provisions of the federal "Patient Protection and Affordable Care Act" that have helped expand access and increase affordability to thousands of Coloradans, including expanding medicaid coverage to more low-income adults and creating the Colorado health benefit exchange;

(III) Despite this success, in several regions of the state, health insurance is not affordable due to high health-care costs and limited or no competition among insurance carriers as well as other marketplace factors, and Coloradans cannot afford the health insurance premiums and out-of-pocket expenses;

(IV) Specifically, Coloradans in fourteen counties have access to only a single health insurance carrier participating in the Colorado health benefit exchange, and the number of uninsured Coloradans in those counties is rising;

(V) Colorado has historically been a national leader in health-care innovation;

(VI) Uncertainty at the federal level requires Colorado to be proactive and explore and implement its own innovative solutions to provide greater access to affordable, high-quality health-care coverage for Colorado residents; and

(VII) A state option for health-care coverage that uses existing state health-care infrastructure may decrease costs for Coloradans, increase competition, and improve access to high-quality, affordable, and efficient health care.

(b) Therefore, the general assembly declares that tasking the state department and the division of insurance in the department of regulatory agencies, referred to in this section as "the division", with developing a proposal that considers the feasibility and cost of implementing a state option for health-care coverage that leverages existing state health-care infrastructure, increases competition, improves quality, and provides stable access to affordable health

insurance will enable policymakers to consider and create an innovative state option for health insurance coverage to benefit Colorado.

(2) (a) On or before November 15, 2019, the state department and the division shall develop and submit a proposal to the joint budget committee; the public health care and human services and health and insurance committees of the house of representatives; and the health and human services committee of the senate, or any successor committees, for a state option for health-care coverage that leverages existing state infrastructure.

(b) In addition to submitting the proposal to the committees of the general assembly listed in subsection (2)(a) of this section, the state department and the division shall present a summary of the proposal at the annual joint meeting of the house and senate committees conducted during the legislative interim prior to the 2020 legislative session pursuant to section 2-7-203.

(3) The proposal must describe a state option for health-care coverage. The proposal must identify the most effective implementation of a state option based on affordability to consumers at different income levels, administrative and financial burden to the state, ease of implementation, and likelihood of success in meeting the objectives described in subsection (1) of this section.

(4) In developing the proposal, the state department and the division shall:

(a) Conduct actuarial research to identify the potential cost of premiums and cost sharing to pay claims in a plan that is, at a minimum, an essential health-benefit-compliant plan, as defined in section 10-16-102 (22);

(b) Evaluate provider rates necessary to incentivize participation and encourage network adequacy and high-quality health-care delivery;

(c) Evaluate eligibility criteria for individuals and small businesses to participate;

(d) Determine the impact, if any, on the state budget;

(e) Determine the impact on the stability of the individual market, the small group market, and the Colorado health benefit exchange created in article 22 of title 10;

(f) Evaluate the impact on consumers eligible for financial assistance for plans purchased on the exchange;

(g) Determine whether a state option plan should be offered on or off the exchange;

(h) Determine whether the state option plan should be a fully at-risk, managed care, fee-for-service, or accountable care collaborative plan, or a combination thereof;

(i) Determine whether the state option should be offered through the state department, and identify the expected impact, if any, to the Colorado medical assistance program established in articles 4, 5, and 6 of this title 25.5;

(j) Identify the expected impact, if any, to the children's basic health plan established in article 8 of this title 25.5;

(k) Investigate funding options, including but not limited to state funds and federal funds secured through available waivers;

(l) Evaluate the feasibility, legality, and scope of any necessary federal waivers;

(m) Repealed.

(n) Create a statewide definition of affordability for consumers.

(5) In developing the proposal, the state department and the division shall consult with the Colorado health benefit exchange and shall engage in a stakeholder process that includes public and private health insurance experts, as well as consumers, consumer advocates, employers, providers, and carriers.

(6) The proposal submitted to the committees of the general assembly pursuant to this section must include detailed analysis of the proposed state option and the various methods for implementing the proposed state option, as well as any identified statutory or rule changes necessary to implement the proposed state option.

(7) (a) (I) After the proposal created pursuant to this section is submitted and presented to the committees of the general assembly, the state department and the division shall prepare and submit any federal waivers or state plan amendments necessary to fund and implement the state option for health-care coverage as described in the proposal created pursuant to subsection (2)(a) of this section.

(II) The state department's and the division's requests for federal authorization must seek to obtain the maximum amount of federal money available to the state and to persons participating in the state option for health-care coverage.

(b) Notwithstanding the provisions of subsection (7)(a)(I) of this section to the contrary, the preparation and submission of federal waivers or amendments must be delayed if a member of the general assembly files a bill during the 2020 legislative session by the regular bill filing deadline of the house of representatives, as set forth in rule 23 of the joint rules of the senate and house of representatives, that substantially alters the federal authorization required pursuant to the proposal to implement the state option for health-care coverage, and such bill is not postponed indefinitely in the first committee of reference. The department's and the division's waiver preparation process shall resume after the bill is postponed indefinitely or, if passed by the general assembly, the requested waivers or state plan amendments must reflect the requirements in the passed legislation.

(c) Subject to the conditions described in subsection (7)(b) of this section, the state department and the division may promulgate rules, as necessary, for the preparation and

submission of federal waivers or state plan amendments necessary to fund and implement the proposal.

Source: L. 2019: Entire section added, (HB 19-1004), ch. 206, p. 2199, § 1, effective May 17. **L. 2021:** (4)(m) repealed, (SB 21-266), ch. 423, p. 2801, § 19, effective July 2.

25.5-1-130. Improving access to behavioral health services for individuals at risk of entering the criminal or juvenile justice system - duties of the state department.

(1) On or before March 1, 2020, the state department shall develop measurable outcomes to monitor efforts to prevent medicaid members from becoming involved in the criminal or juvenile justice system.

(2) On or before July 1, 2021, the state department shall work collaboratively with managed care entities to create incentives for behavioral health providers to accept medicaid members with severe behavioral health disorders. The incentives may include, but need not be limited to, higher reimbursement rates, quality payments to managed care entities for adequate networks, establishing performance measures and performance improvement plans related to network expansion, transportation solutions to incentivize medicaid members to attend health-care appointments, and incentivizing providers to conduct outreach to medicaid members to ensure that they are engaged in needed behavioral health services, including technical assistance with billing procedures. The state department may seek any federal authorization necessary to create the incentives described in this subsection (2).

Source: L. 2019: Entire section added, (SB 19-222), ch. 226, p. 2265, § 2, effective May 20. **L. 2020:** (2) amended, (SB 20-136), ch. 70, p. 300, § 56, effective September 14. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 618, § 9, effective August 7.

Cross references: For the legislative declaration in SB 19-222, see section 1 of chapter 226, Session Laws of Colorado 2019. For the legislative declaration in SB 20-136, see section 1 of chapter 70, Session Laws of Colorado 2020.

25.5-1-131. Insurance ombudsman - consumer advocate - duties.

(1) There is hereby created in the state department the office of the insurance ombudsman to act as the advocate for consumer interests in matters related to access to and the affordability of

the standardized health benefit plan created pursuant to section 10-16-1304. The ombudsman shall:

(a) Interact with consumers regarding their access to, the affordability of, and coverage issues with the standardized plan;

(b) Evaluate data to assess the standardized plan's network and affordability; and

(c) Represent the interests of consumers in public hearings held pursuant to section 10-16-1306.

(2) In the performance of the ombudsman's duties, the ombudsman shall act independently of the state department. Any recommendations made or positions taken by the ombudsman do not reflect those of the state department.

Source: L. 2021: Entire section added, (HB 21-1232), ch. 241, p. 1294, § 7, effective June 16.

25.5-1-132. Report of medicaid reimbursement rates paid to comprehensive community behavioral health providers and independent providers - definition. (Repealed)

Source: L. 2022: Entire section added, (HB 22-1268), ch. 363, p. 2597, § 2, effective June 3. **L. 2025:** (1) amended, (HB 25-1326), ch. 309, p. 1611, § 3, effective August 6. **L. 2026:** Entire section repealed, (HB 26-1295), ch. 121, p. 528, § 31, effective August 12.

25.5-1-133. Access to behavioral health services for individuals under twenty-one years of age - rules - report - repeal.

(1) On or before July 1, 2024, the state department shall provide members under twenty-one years of age with access to limited services without requiring a diagnosis. The limited services must be provided as part of the statewide managed care system pursuant to part 4 of article 5 of this title 25.5 and the school health services detailed in section 25.5-5-318.

(2) The limited services must include:

(a) Family therapy;

(b) Group therapy;

(c) Individual therapy;

(d) Services related to prevention, promotion, education, or outreach;

(e) Evaluation, intake, case management, and treatment planning; and

(f) Any other service determined necessary by the state department based on feedback received from stakeholders.

(3) In providing the limited services pursuant to this section, the state department must notify patients, providers, the department of human services, county departments of human or social services, law enforcement agencies, schools, and any other entity that may be impacted that the limited services are available on and after July 1, 2024.

(4) In implementing this section, the state department shall engage with interested and impacted stakeholders to solicit feedback.

(5) (a) Notwithstanding section 24-1-136 (11)(a)(I), on or before November 1, 2025, and on or before November 1 each year thereafter, the state department shall report to the house of representatives health and human services committee and the senate health and human services committee, or their successor committees, regarding the utilization of the services described in subsection (2) of this section. The contents of the report must be determined through the stakeholder process described in subsection (4) of this section. At a minimum, the report must include data on the utilization of services, by code, and any differences in utilization within the school health services program authorized by section 25.5-5-318.

(b) This subsection (5) is repealed, effective July 1, 2031.

Source: L. 2023: Entire section added, (SB 23-174), ch. 232, p. 1219, § 1, effective August 7. **L. 2024:** (1) amended, (SB 24-176), ch. 152, p. 619, § 10, effective August 7; (3) amended, (HB 24-1450), ch. 490, p. 3419, § 56, effective August 7. **L. 2026:** (5)(a) amended, (SB 26-169), ch. 311, p. 1809, § 43, effective August 12.

25.5-1-134. Prescription benefits - department and pharmacy benefit manager - contracts - audit - rules.

(1) For contracts between a pharmacy benefit manager and the state department or one of its affiliated managed care organizations offering a prescription benefit plan that is issued or renewed on or after January 1, 2025, the amount charged by the pharmacy benefit manager to the state department or managed care organization for a prescription drug dispensed to an enrollee in the program of medical assistance created pursuant to section 25.5-4-104 must be equal to or less than the amount paid by the pharmacy benefit manager to a medicaid pharmacy for the prescription drug dispensed to the enrollee.

(2) The state board shall promulgate rules to implement this section, including rules guiding an audit of managed care or fee-for-service claims, to ensure that there is no violation of subsection (1) of this section.

Source: L. 2023: Entire section added, (HB 23-1201), ch. 158, p. 688, § 2, effective August 7.

25.5-1-135. Statewide health-care analysis collaborative - creation - membership - duties - repeal.

(1) (a) There is created in the state department the statewide health-care analysis collaborative, referred to in this section as the "analysis collaborative", for the purpose of advising the Colorado school of public health in completing the analysis required by section 23-20-146.

(b) The analysis collaborative is merely advisory, and the Colorado school of public health is the entity responsible for conducting the analysis pursuant to section 23-20-146.

(2) (a) On or before August 1, 2025, the executive director shall invite the following representatives to participate in the analysis collaborative:

(I) One member who represents a statewide hospital association;

(II) One member who represents organized labor;

(III) One member who represents an organization that advocates for communities with disabilities;

(IV) One member who is a reproductive health-care advocate;

(V) One member who represents a statewide association of physicians;

(VI) One member who represents a statewide association of mental health-care providers;

(VII) One member who is a state tax expert or an expert on section 20 of article X of the state constitution;

(VIII) One member who is a rural health-care advocate;

(IX) One member who is a registered nurse representing a statewide association of nurses;

(X) One member who represents a Colorado advocacy organization for people experiencing homelessness;

(XI) One member who represents an advocacy organization for health-care consumers;

(XII) One member who represents a statewide association of dentists;

(XIII) One member who represents an advocacy organization for historically marginalized communities;

(XIV) One member who represents an advocacy organization for lesbian, gay, bisexual, transgender, and queer communities;

(XV) One member who represents a statewide association of pharmacists;

(XVI) One member who represents small employer interests;

(XVII) One member who represents large employer interests;

(XVIII) One member who represents a pharmacy benefit management firm, as defined in section 10-16-102 (49);

(XIX) One member who represents a self-insured employer that provides health insurance to its employees under a health insurance plan covered by the federal "Employee Retirement Income Security Act of 1974", 29 U.S.C. sec. 1001 et seq.; and

(XX) One member who represents management of organized labor that provides health insurance coverage for individuals who are insured under a health insurance plan covered by the federal "Employee Retirement Income Security Act of 1974", 29 U.S.C. sec. 1001 et seq.

(b) In inviting representatives to participate in the analysis collaborative pursuant to subsection (2)(a) of this section, the executive director shall ensure that the invitees:

(I) Have demonstrated an ability to represent the interests of all Coloradans and, regardless of the invitees' backgrounds or affiliations, are able to present objective, nonpartisan, factual, and evidence-based ideas and to objectively advise the Colorado school of public health concerning a single-payer, nonprofit, universal health-care system, as defined in section 23-20-146 (2); and

(II) Reflect the social, demographic, and geographic diversity of the state, including historically marginalized communities.

(c) If a vacancy occurs on the analysis collaborative, the executive director may invite a new representative to fill the vacancy.

(3) The commissioner of insurance and the chief executive officer of the Colorado health benefit exchange created in article 22 of title 10, or the designee of the commissioner or the chief executive officer, shall serve on the analysis collaborative.

(4) (a) The chief executive officer of the Colorado health benefit exchange shall call the first meeting of the analysis collaborative.

(b) The analysis collaborative shall meet at least two times before October 1, 2026, and the chief executive officer of the Colorado health benefit exchange may convene additional meetings

of the analysis collaborative as determined by consulting with the members of the analysis collaborative and the Colorado school of public health.

(c) All meetings of the analysis collaborative must be open to the public, and the analysis collaborative shall post notice of a meeting at least one week in advance of the meeting on the Colorado school of public health's website and the state department's website.

(d) All meetings of the analysis collaborative must be held virtually and allow for attendance and participation by members of the analysis collaborative and members of the public virtually.

(e) The analysis collaborative may hold meetings without a quorum of the members present.

(5) At the first meeting of the analysis collaborative, a representative from the entity providing the draft model legislation selected by the Colorado school of public health pursuant to section 23-20-146 (3) shall present the draft model legislation to the analysis collaborative for feedback.

(6) Nonlegislative analysis collaborative members invited pursuant to subsection (2)(a) of this section are not entitled to receive per diem or other compensation for performance of services for the analysis collaborative but may be reimbursed for actual and necessary expenses incurred in the performance of official duties of the analysis collaborative. Legislators who serve on the analysis collaborative are reimbursed pursuant to section 2-2-307 (3).

(7) (a) The state department may seek, accept, and expend gifts, grants, or donations from private or public sources for the purpose of establishing the analysis collaborative.

(b) Unless the state department receives an amount of appropriations, gifts, grants, and donations sufficient to cover the costs of establishing the analysis collaborative, and the Colorado school of public health receives enough money pursuant to section 23-20-146 (8) to implement the costs of research and analysis to implement section 23-20-146, the state department shall not implement this section.

(8) This section is repealed, effective December 1, 2027.

Source: L. 2025: Entire section added, (SB 25-045), ch. 191, p. 852, § 2, effective May 14.

25.5-1-136. Billing manual.

Using existing resources allocated for billing manual reviews, the state department shall establish a process to review and update the general billing manual on an annual basis, which must ensure that the general billing manual includes all necessary CPT codes, or provides links to the state department's list of CPT codes.

Source: L. 2025: Entire section added, (HB 25-1213), ch. 276, p. 1435, § 3, effective August 6.

25.5-1-137. Transition of services provided in qualified residential treatment facilities and psychiatric residential treatment facilities to managed care system - steering committee - policies and recommendations - report.

(1) (a) No later than July 1, 2026, the state department shall convene a steering committee to support the transition of services provided in qualified residential treatment programs and psychiatric residential treatment facilities to the managed care system for members in the care and custody of a county department of human or social services. The steering committee may consult with other state departments and agencies, including the department of early childhood, and relevant stakeholders as necessary to fulfill its duties. The steering committee must include leadership representation from:

(I) The department of health care policy and financing;

(II) The department of human services;

(III) The behavioral health administration in the department of human services;

(IV) County departments of human or social services;

(V) Qualified residential treatment program providers and psychiatric residential treatment facility providers, including a statewide association representing providers; and

(VI) Managed care entities.

(b) Beginning July 1, 2026, the steering committee shall meet at least once per month until July 1, 2027.

(c) The steering committee shall identify, evaluate, and develop recommendations on policy and operational issues related to the transition described in subsection (1)(a) of this section and ensure that updates, potential decision points, and decisions made by the state department are communicated to and vetted with the leadership of each member's respective organization or constituency.

(2) No later than April 1, 2027, the state department, in collaboration with the steering committee, shall develop policies and recommendations in line with federal financial participation and managed care regulations and requirements to support the transition of qualified residential treatment programs and psychiatric residential treatment facilities to the managed care system for members in the care and custody of a county department of human or social services. The policies and recommendations must include, but are not limited to:

(a) Clearly defined roles, responsibilities, and decision-making authority across managed care entities, counties, providers, and state agencies, including accountability for medical necessity determinations, placement decisions, discharge planning, care coordination, and payment;

(b) Statewide standards for utilization management, including authorization, continued stay review, and discharge planning, with clarity on the application of medical necessity determinations and consideration of the unique clinical and placement-related needs of children and youth involved in the child welfare system;

(c) Requirements for timely engagement, authorization, and care coordination across entities, including defined time frames and expectations for real-time coordination for youth in crisis or at risk of placement disruption;

(d) Training and technical assistance needs for managed care entities, counties, and qualified residential treatment program and psychiatric residential treatment facility providers related to the consistent application of medical necessity criteria, including documentation expectations and authorization processes and timelines for each;

(e) Care coordination expectations across managed care entities, counties, and qualified residential treatment program and psychiatric residential treatment facility providers to improve communication, reduce duplication, and support continuity of care, including how families are integrated into the treatment process and processes to address care coordination and access to services for youth in detention, with clarity on eligibility, assignment to managed care entities, and roles and responsibilities for coverage, authorization, and coordination of behavioral health services during and following periods of detainment;

(f) Discharge planning requirements and after-care support for at least six months after discharge, including expectations that discharge planning begins at admission and that all relevant parties have a shared understanding of the discharge plan and of available step-down and community-based service options;

(g) Recommendations to address system barriers related to discharge planning, placement availability, and continuity of care, including alignment between clinical readiness for discharge and available placement or community-based service options;

(h) Processes for transitioning members receiving qualified residential treatment services and psychiatric residential treatment services prior to July 1, 2027, from fee-for-service to managed care on July 1, 2027, including timing and responsibility;

(i) Statewide requirements for managed care entities, including minimum expectations for processes, timelines, application of policies related to authorization, utilization management, care coordination, and service delivery; decision making; and application of the early and periodic screening, diagnostic, and treatment benefit;

(j) Data, reporting, and transparency needs necessary to support implementation, oversight, and ongoing evaluation of the transition; and

(k) Consideration of fiscal impacts and alignment across entities, including potential cost shifts, rate adequacy, and funding responsibilities associated with the transition.

(3) No later than July 1, 2027, the state department shall implement or initiate the transition of services provided in qualified residential treatment programs and psychiatric residential treatment facilities to the managed care system for members in the care and custody of a county department of human or social services according to the policies and recommendations developed pursuant to subsection (2) of this section.

(4) No later than October 1, 2026, December 31, 2026, and March 1, 2027, the state department shall submit a quarterly report to the joint budget committee that includes:

(a) The dates the steering committee met during the previous quarter;

(b) A list of attendees at each meeting;

(c) A summary of the topics discussed; and

(d) A summary of decisions made to date.

(5) No later than July 1, 2028, the state department shall submit a report to the joint budget committee outlining:

(a) The outcomes of the implemented policies;

(b) Any identified impacts to placement stability, care coordination, and system alignment; and

(c) Recommendations for any statutory or budgetary changes necessary to support ongoing implementation.

Source: L. 2026: Entire section added, (SB 26-188), ch. 316, p. 1856, § 1, effective June 2.

25.5-1-138. Data transparency and public reporting - definitions.

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

(a) "Adult financial programs" means a state-run benefit administered by the department of human services and includes the old age pension, aid to the needy disabled, and home care allowance.

(b) "Departments" means the department of health care policy and financing, the department of human services, and the department of early childhood.

(c) "Public assistance programs" means the medical assistance program established pursuant to articles 4 to 6 of this title 25.5; the children's basic health plan established pursuant to article 8 of this title 25.5; the supplemental nutrition assistance program established pursuant to part 3 of article 2 of title 26; the Colorado child care assistance program established pursuant to part 1 of article 4 of title 26.5; the temporary assistance for needy families program, as defined in section 26-2-703; the old age pension program established pursuant to article XXIV of the Colorado constitution; and adult financial programs.

(2) Beginning January 2027, and monthly thereafter, the department of health care policy and financing, in collaboration with the department of human services and the department of early childhood, shall establish a single, shared online dashboard used to publish county-level and statewide performance on the metrics for each of the public assistance programs:

(a) For the medical assistance program, established pursuant to articles 4 to 6 of this title 25.5 and the children's basic health plan established pursuant to article 8 of this title 25.5:

(I) The number of applications and renewal applications approved within the timelines required in federal law and regulation for all applications, including applications based on disability;

(II) The number of applications and renewal applications denied within the timelines required in federal law and regulation for all applications, including applications based on disability;

(III) The total number of renewal applications processed each month, including:

(A) The number of applications renewed using existing data sources and the number of applications renewed using additional completed documentation submitted by the recipients;

(B) The number of initial applications and renewal applications processed and determined ineligible;

(C) The number of initial applications and renewal applications denied for procedural reasons; and

(D) The number of initial applications and renewal applications pending review;

(IV) The number of formal complaints or appeals regarding eligibility, benefits, or services filed with the department of health care policy and financing; and

(V) The total number of initial applications and renewal applications that are pending determination and the total number deemed untimely based on the timelines required by federal law and regulation for applications based on disability, and for all other applications;

(b) For the supplemental nutrition assistance program, established pursuant to part 3 of article 2 of title 26:

(I) The rate of application processing timeliness for standard applications;

(II) The rate of application processing timeliness for expedited applications; and

(III) The rate of recertification processing timeliness;

(c) For the child care assistance program, established pursuant to part 1 of article 4 of title 26.5:

(I) The percentage of initial applications and applications for redetermination approved within the timelines required by rules adopted by the department of early childhood; and

(II) Enrollment in each of the following income eligibility tiers:

(A) One hundred thirty percent of the federal poverty line and below; and

(B) Above one hundred thirty percent of the federal poverty line;

(d) For the temporary assistance for needy families program, as defined in section 26-2-703, the percentage of applications and redeterminations approved within the timelines required by rules adopted by the department of human services;

(e) For adult financial programs, the percentage of applications and redeterminations approved within the timelines required by rules adopted by the department of human services; and

(f) For each of the public assistance programs:

(I) The monthly caseload;

(II) The percentage of applications, enrollments, and renewals processed through the state's online system for application and management of public assistance programs, and the percentage of applications, enrollments, and renewals processed by other methods; and

(III) On a quarterly basis, the number of appeals filed with the office of administrative courts that name a county as a party.

(3) Except as provided in subsection (2)(f)(III) of this section, the data reported pursuant to subsection (2) of this section must:

(a) Be published on each of the department's websites in a publicly accessible format;

(b) Be updated monthly and published in accordance with data privacy and confidentiality laws of the state; and

(c) Be maintained from previous months in a publicly accessible manner.

(4) Beginning in September 2026, and monthly thereafter, each county department shall provide the information detailed in subsection (2) of this section, other than the information detailed in subsection (2)(a)(V) of this section, to each respective department.

(5) The state department, in collaboration with the department of human services and the department of early childhood, shall provide technical support, technology assistance, and training to the county departments, as reasonably necessary, on how to provide the information required by subsection (2) of this section to the respective departments.

Source: L. 2026: Entire section added, (HB 26-1429), ch. 374, p. 2290, § 5, effective June 4.

Editor's note: Subsections IP(3), (3)(a), (3)(b), and (3)(c) were numbered as IP(3)(a), (3)(b), (3)(c), and (3)(d), respectively, in HB 26-1429 but were renumbered on revision for ease of location.

Cross references: For the legislative declaration in HB 26-1429, see section 1 of chapter 374, Session Laws of Colorado 2026.

25.5-1-139. State income tax refund offset - rules.

(1) (a) At any time prescribed by the department of revenue, but not less frequently than annually, the state department shall certify to the department of revenue information regarding persons who are obligated to the state for overpayment of benefits received pursuant to articles 4 to 6 of this title 25.5. The information must include certification of the amount of overpayment that has been determined by final agency action, has been ordered by a court as restitution, or has been reduced to judgment.

(b) The information regarding overpayment of benefits must also include the name and the social security number of the person obligated to the state for the overpayment, the amount of the overpayment, and any other identifying information required by the department of revenue.

(2) As a condition of certifying an overpayment to the department of revenue as provided in subsection (1) of this section, the state department must ensure that the obligated person has been afforded the opportunity for a conference at the county department level and afforded the opportunity for an appeal to the state department pursuant to section 25.5-4-207. In addition, the state department, prior to final certification of the information specified in subsection (1) of this section to the department of revenue, must notify the obligated person, in writing, at the obligated person's last-known address, that the state intends to refer the person's name to the

department of revenue in an attempt to offset the obligation against the person's state income tax refund. The notification must inform the obligated person of the opportunity for a conference with the county department, as described in section 25.5-4-207, or the county contracted to administer a centralized member integrity service pursuant to section 25.5-1-210, and of the opportunity for an appeal to the state department pursuant to section 25.5-4-207. In addition, the notice must specify issues that may be raised at an evidentiary conference or on appeal, as provided by this subsection (2), by the obligated person in objecting to the offset. The notice must specify that the obligated person may not object to the fact that an overpayment occurred. A person who has received a notice pursuant to this subsection (2) may request, within thirty days after the date the notice was mailed, an administrative review or evidentiary conference, as provided in this subsection (2).

(3) Upon notification by the department of revenue of amounts deposited to the state treasurer pursuant to section 39-21-108, the state department shall determine whether the amount deposited is related to the centralized member integrity service, established in section 25.5-1-210. If the amount is not related to the centralized member integrity service, the state department shall disburse the amounts to the appropriate county for processing for distribution to the federal, state, or local agency to which the person is obligated. If the amount is related to the centralized member integrity service, the county contracted to administer the centralized member integrity service, as described in section 25.5-1-210, shall determine the federal, state, or local agency to which the person is obligated, and the state department shall distribute the money to the federal, state, or local agency to which the person is obligated.

(4) The state department shall adopt rules pursuant to article 4 of title 24 establishing procedures to implement this section.

(5) For a program that is not subject to the centralized member integrity service described in section 25.5-1-210, the home addresses and social security numbers of persons subject to the income tax refund offset, provided to the state department by the department of revenue, must be sent to the respective county department of human or social services. For a program that is subject to the centralized member integrity service described in section 25.5-1-210, the home addresses and social security numbers of persons subject to the income tax refund offset, provided to the state department by the department of revenue, must be sent to the county contracted to administer the centralized member integrity service pursuant to section 25.5-1-210.

Source: L. 2026: Entire section added, (HB 26-1429), ch. 374, p. 2311, § 11, effective June 4.

Cross references: For the legislative declaration in HB 26-1429, see section 1 of chapter 374, Session Laws of Colorado 2026.

PART 2

PROGRAMS TO BE ADMINISTERED BY THE DEPARTMENT

25.5-1-201. Programs to be administered by the department of health care policy and financing.

(1) The state department shall administer the following programs and perform the following functions:

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

(b) Repealed.

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

(d) Repealed.

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

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

(f.5) The reproductive health-care program that provides reproductive health-care services, as specified in section 25.5-2-103;

(g) Programs, services, and supports for persons with intellectual and developmental disabilities, as specified in article 10 of this title 25.5; and

(h) Any program concerning the wholesale importation of prescription drugs pursuant to part 2 of article 2.5 of this title 25.5.

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

amended, (SB 11-210), ch. 187, p. 721, § 7, effective July 15, 2012. **L. 2013:** (1)(e) and (1)(f) amended and (1)(g) added, (HB 13-1314), ch. 323, p. 1808, § 42, effective March 1, 2014. **L. 2019:** IP(1), (1)(f), and (1)(g) amended and (1)(h) added, (SB 19-005), ch. 184, p. 2065, § 2, effective August 2. **L. 2021:** (1)(f.5) added, (SB 21-009), ch. 430, p. 2847, § 4, effective September 7. **L. 2023:** IP(1) and (1)(f.5) amended, (SB 23-189), ch. 69, p. 260, § 8, effective April 14. **L. 2024:** (1)(b)(II) added by revision, (HB 24-1399), ch. 76, pp. 257, 260, §§ 22, 33.

Editor's note: Subsection (1)(b)(II) provided for the repeal of subsection (1)(b), effective July 1, 2025. (See L. 2024, pp. 257, 260.)

Cross references: For the legislative declaration in SB 19-005, see section 1 of chapter 184, Session Laws of Colorado 2019. For the legislative declaration in SB 21-009, see section 1 of chapter 430, Session Laws of Colorado 2021.

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

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

25.5-1-203. Prescription drug information and technical assistance program - expansion.

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

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

25.5-1-204. Advisory committee to oversee the all-payer health claims database - creation - members - duties - legislative declaration - rules - report.

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

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

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

(II) A representative of:

(A) A statewide association of hospitals;

(B) An integrated multi-specialty organization;

(C) Physicians and surgeons;

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

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

(F) Dental insurers;

(G) Pharmacists or an affiliate society;

(H) Pharmacy benefit managers;

(I) A statewide association of ambulatory surgical centers;

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

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

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

(C) Self-insured employers;

(IV) A representative from a comprehensive community behavioral health provider, as defined in section 27-50-101, who has experience in behavioral health data collection;

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

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

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

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

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

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

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

(XII) Two members of the general assembly, one appointed by the majority leader of the senate and one appointed by the majority leader of the house of representatives; except that, if the majority leaders are from the same political party, the minority leader of the house of representatives shall appoint the second member. The two members of the general assembly shall serve as ex officio members.

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

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

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

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

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

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

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

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

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

(II) Public studies produced by the administrator;

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

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

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

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

(c) (I) By November 15, 2022, and by each November 15 thereafter, subject to available appropriations, the administrator shall provide a primary care spending report to the commissioner of insurance for use by the primary care payment reform collaborative established in section 10-16-150 regarding primary care spending:

(A) By carriers, as defined in sections 10-16-102 (8) and 24-50-603 (2);

(B) Under the "Colorado Medical Assistance Act", articles 4, 5, and 6 of this title 25.5; and

(C) Under the "Children's Basic Health Plan Act", article 8 of this title 25.5.

(II) The report prepared in accordance with this subsection (3)(c) must include:

(A) The percentage of the medical expenses allocated to primary care;

(B) The share of payments that are made through nationally recognized alternative payment models and the share of payments that are not paid on a fee-for-service or per-claim basis; and

(C) Data related to the aligned quality measure set determined by the division of insurance in accordance with section 10-16-157 (3).

(4) (a) The administrator shall seek funding for the creation of the all-payer health claims database and develop a plan for the financial stability of the database. If sufficient funding is received through gifts, grants, and donations on or before January 1, 2012, as determined by the executive director, the administrator shall, in consultation with the advisory committee, create the Colorado all-payer claims database.

(b) The general assembly may annually appropriate general fund money to the state department to pay for expenses related to the all-payer health claims database.

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

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

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

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

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

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

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

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

(h) Repealed.

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

(j) Subject to available appropriations and at the request of the commissioner of insurance, publish information to the public concerning dental loss ratio information collected by the division of insurance pursuant to section 10-16-165.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(10) Repealed.

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

Source: L. 2010: Entire section added, (HB 10-1330), ch. 299, p. 1406, § 1, effective August 11. **L. 2013:** (1), (2), and (3) R&RE, (SB 13-149), ch. 152, p. 495, § 1, effective July 1; (10) repealed, (HB 13-1300), ch. 316, p. 1689, § 80, effective August 7; (5)(a) amended, (HB 13-1115), ch. 338, p. 1973, § 16, effective March 31, 2015. **L. 2014:** (2)(a)(X) amended, (HB 14-1363), ch. 302, p. 1269, § 29, effective May 31; (2)(c) amended, (SB 14-153), ch. 390, p. 1965, § 24, effective June 6. **L. 2017:** (4) amended and (5)(h) repealed, (HB 17-1060), ch. 6, p. 15, § 4, effective March 1. **L. 2018:** (4) amended, (HB 18-1327), ch. 150, p. 942, § 1, effective April 23. **L. 2019:** (3)(c) added, (HB 19-1233), ch. 194, p. 2122, § 6, effective May 16. **L. 2022:** IP(3)(c)(I) and (3)(c)(II) amended, (HB 22-1325), ch. 181, p. 1209, § 3, effective August 10; (2)(a)(IV) amended, (HB 22-1278), ch. 222, p. 1593, § 231, effective July 1, 2024. **L. 2023:** (5)(j) added, (SB 23-179), ch. 332, p. 1993, § 5, effective August 7.

Cross references: For the legislative declaration in HB 19-1233, see section 1 of chapter 194, Session Laws of Colorado 2019. For the legislative declaration in SB 23-179, see section 1 of chapter 332, Session Laws of Colorado 2023.

25.5-1-204.5. All-payer health claims database scholarship grant program - creation - definitions.

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

(a) "Advisory committee" means the advisory committee to oversee the all-payer health claims database created pursuant to section 25.5-1-204.

(b) "Governmental entity" means a state or local governmental entity, including a state-supported institution of higher education, but does not include the state department.

(c) "Program" means the all-payer health claims database scholarship grant program established pursuant to this section.

(2) There is created in the state department the all-payer health claims database scholarship grant program to defray the costs of nonprofit and governmental entities in accessing the all-payer health claims database to conduct research.

(3) The state department shall:

(a) In consultation with the advisory committee, develop a grant application under the program consistent with the rules of the executive director;

(b) Accept applications for scholarship grants from any nonprofit or governmental entity needing access to the all-payer health claims database to conduct research;

(c) After considering the recommendations of the advisory committee, determine which grant applications to approve and the amount of each grant; and

(d) Distribute approved scholarship grants to nonprofit or governmental entities.

(4) The executive director shall, following recommendations of the state department and the advisory committee, adopt rules pursuant to section 24-4-103 governing the program, including procedures, criteria, and standards for awarding scholarship grants.

(5) The advisory committee shall:

(a) Consult with the state department on the development of a grant application form; and

(b) Review applications for scholarship grants and recommend which scholarship grants to approve and the amount of each recommended grant.

Source: L. 2018: Entire section added, (HB 18-1327), ch. 150, p. 942, § 2, effective April 23.

25.5-1-204.7. All-payer health claims database - creation of tool for review of data included in the database - definitions.

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

(a) "Administrator" means the administrator of the all-payer health claims database.

(b) "All-payer health claims database" or "database" means the all-payer health claims database created pursuant to section 25.5-1-204.

(c) "Code" means CPT code, HCPCS code, or other packaged services or industry standard procedure code that may include time units, base unit values, or modifiers.

(d) "CPT code" means the current procedural terminology code, or its successor code, as developed and copyrighted by the American Medical Association or its successor entity.

(e) "Healthcare common procedure coding system code" or "HCPCS code" means the code established by the federal centers for medicare and medicaid services' alpha-numeric editorial panel for identifying health-care services in a consistent and standardized manner.

(f) "Private health-care payer" means a carrier, as defined in section 10-16-102 (8), that reports claims received from an out-of-network provider pursuant to section 12-30-113 (4).

(g) "Tool" means the tool developed by the administrator pursuant to this section to enable users to review certain health claims reimbursement data in the database.

(2) (a) To facilitate the accurate determination of the reimbursement rates pursuant to sections 10-16-704 (3)(d) and (5.5)(b), 12-30-113 (4), and 25-3-122 (3) and to provide transparency in the process, subject to available appropriations, the administrator shall create and maintain a tool for implementation by January 1, 2023, that enables users to review certain health claims reimbursement data included in the all-payer health claims database. The tool must include 2018 health claims reimbursement data as the first year of data.

(b) To the extent practicable, the tool must, at a minimum:

(I) Include twenty-fifth, fiftieth, sixtieth, and seventy-fifth percentile of in-network reimbursement rates based on claims and the number of claims submitted for each code by payer type, for all codes with sufficient volume reported to the database, for three years of data; and

(II) Be viewable and searchable by:

(A) Year;

(B) County;

(C) Geographic rating area and statewide;

(D) Payer type, including medicaid, medicare, and private health-care payers;

(E) Setting, including inpatient and outpatient services; and

(F) Specialty.

(c) The administrator shall ensure that the viewing or reporting of health claims data through the tool complies with all state and federal data privacy laws and antitrust laws.

(3) Subject to available appropriations, the administrator shall update the tool annually and may update the tool more frequently as determined by the administrator.

Source: L. 2022: Entire section added, (SB 22-068), ch. 266, p. 1935, § 1, effective May 27.

25.5-1-205. Providing for the efficient provision of health care through state-supervised cooperative action - rules.

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

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

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

Source: L. 2012: Entire section added, (HB 12-1281), ch. 246, p. 1182, § 1, effective June 4. **L. 2024:** (2) amended, (SB 24-176), ch. 152, p. 619, § 11, effective August 7.

25.5-1-206. School-based substance abuse prevention and intervention program - creation - reporting - legislative declaration - definitions.

(1) (a) The general assembly finds and declares that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) Repealed.

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

Editor's note: Subsection (6)(b) provided for the repeal of subsection (6), effective November 2, 2017. (See L. 2017, p. 15.)

25.5-1-207. Rural provider access and affordability stimulus grant program - advisory committee - fund - reporting - rules - definitions - repeal. (Repealed)

Source: L. 2022: Entire section added, (SB 22-200), ch. 297, p. 2123, § 2, effective June 1. **L. 2024:** (6)(c) amended, (HB 24-1465), ch. 257, p. 1685, § 9, effective May 24; (2)(d) amended, (HB 24-1466), ch. 429, p. 2942, § 29, effective June 5. **L. 2025:** (1)(l) amended, (HB 25-1024), ch. 59, p. 249, § 7, effective August 6.

Editor's note: (1) HB 25-1024 amended subsection (1)(l), effective August 6, 2025, but those amendments did not take effect due to the repeal of this section, effective July 1, 2025.

(2) Subsection (9) provided for the repeal of this section, effective July 1, 2025. (See L. 2022, p. 2123.)

25.5-1-208. Direct care worker website and communication platform - enrollment of direct care workers - training, worker rights, employment matching - department of labor and employment access - gifts, grants, or donations - definitions.

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

(a) "Board" means the direct care workforce stabilization board created in section 8-7.5-103.

(b) "Direct care consumer" has the meaning set forth in section 8-7.5-102.

(c) "Direct care employer" has the meaning set forth in section 8-7.5-102.

(d) "Direct care services" has the meaning set forth in section 8-7.5-102.

(e) "Direct care worker" has the meaning set forth in section 8-7.5-102.

(f) "Medical assistance program" means the "Colorado Medical Assistance Act", articles 4 to 6 of this title 25.5.

(g) "Platform" or "communication platform" means the direct care worker communication platform created in this section.

(h) "Website" means the direct care worker website created in this section.

(i) "Worker organization" has the meaning set forth in section 8-7.5-102.

(2) On or before July 1, 2026, the state department shall collaborate with the board and establish a direct care worker website and communication platform for direct care workers. The state department shall ensure that the platform:

(a) Supports direct care consumers in identifying and employing qualified direct care workers;

(b) Facilitates recruitment and retention of direct care workers paid through reimbursement by the medical assistance program;

(c) Ensures access to care for all members;

(d) Supports the state department in monitoring access to and quality of care for direct care consumers who receive direct care services;

(e) Provides a regular cadence of communication by the state department, to be determined in consultation with the board, to workers who have opted in to the communication platform, including updates from the board, relevant state department initiatives, and potential changes to worker rights and benefits;

(f) Maintains an electronic employment matching system to help direct care consumers identify direct care workers with the right availability and skill set, experience with dementia, language proficiency, and specific certifications; and

(g) Provides each direct care worker with the opportunity to opt in to and opt out of the communication platform.

(3) The state department shall:

(a) In coordination with the board, develop a direct care worker-specific notice of rights for direct care employers to distribute to their employees pursuant to section 8-7.5-108 (3)(b); and

(b) Collaborate with direct care employers to inform direct care workers of the benefits of the platform.

(4) (a) The website must include:

(I) Training on direct care worker basic job duties, health and safety in the workplace, and how to provide culturally competent care;

(II) Information regarding direct care worker rights, including increases to the direct care worker base wage; the "Healthy Families and Workplaces Act", part 4 of article 13.3 of title 8; new labor laws, rules, regulations, and practices; or other laws, rules, regulations, and processes designed to stabilize the direct care workforce;

(III) A calendar of the training events that are provided by the state department and are free of charge to direct care workers concerning the rights of direct care workers and the information that can be learned in each training;

(IV) The ability for communication platform users to opt in to and opt out of platform communications;

(V) Communication on how direct care workers can access medical assistance program benefits, including:

(A) Medical assistance program buy-in for working adults with disabilities;

(B) Medical assistance for a family member in the direct care worker's household with a disability or who is sixty-five years of age or older; and

(C) Other benefits the department deems applicable;

(VI) Access to the state department's core curriculum training; and

(VII) A link to the state department's direct care worker survey.

(b) The state department shall review and approve all website and communication platform content for accuracy before it is posted publicly.

(5) (a) Within three months after the establishment of the communication platform and every three months thereafter, the state department shall allow the department of labor and employment, worker organizations, organizations representing direct care employers, and

organizations representing direct care consumers to have access to the full name, telephone number, and email address for each direct care worker who has opted in to the communication platform to inform the worker of their rights, to support the worker in engaging with the board, and to accomplish the communication platform's direct care consumer-matching functions.

(b) In fulfilling the obligations of this section, the state department, worker organizations, organizations representing direct care employers, and organizations representing direct care consumers must comply with applicable laws and rules protecting personal identifying information, including part 1 of article 74 of title 24 and part 13 of article 1 of title 6. Worker organizations and organizations representing direct care consumers shall not have access to the name or private data of any direct care consumer or direct care consumer's representative or indicate that an individual direct care worker is a direct care consumer's relative or has the same address as a direct care consumer. An organization or individual who receives direct care worker contact information shall not share, sell, or otherwise distribute the information except for the purposes in subsection (5)(a) of this section.

Source: L. 2025: Entire section added, (HB 25-1328), ch. 263, p. 1349, § 4, effective August 6.

Cross references: For the legislative declaration in HB 25-1328, see section 1 of chapter 263, Session Laws of Colorado 2025.

25.5-1-209. Prohibition on payment for AI-delivered psychotherapy services.

[*Editor's note: This section is effective January 1, 2027.*] A payer of mental or behavioral health-care services provided under the "Colorado Medical Assistance Act", as specified in articles 4, 5, and 6 of this title 25.5, or the "Children's Basic Health Plan Act", as specified in article 8 of this title 25.5, shall not pay for services that constitute psychotherapy services, as defined in section 12-245-202 (14), that are provided directly to an individual and that are conducted by an artificial intelligence system, as that term is defined in section 10-16-112.7 (1)(b).

Source: L. 2026: Entire section added, (HB 26-1139), ch. 325, p. 1893, § 3, effective January 1, 2027.

Editor's note: Section 4(2) of chapter 325 (HB 26-1139), Session Laws of Colorado 2026, provides that the act adding this section applies to actions taken on or after January 1, 2027.

Cross references: For the legislative declaration in HB 26-1139, see section 1 of chapter 325, Session Laws of Colorado 2026.

25.5-1-210. Centralized member integrity service - transition plan - member integrity service fund.

(1) The state department, in coordination with the department of human services and the department of early childhood, shall contract with a single county department to administer the centralized member integrity service. Pursuant to the terms of the contract, the county administering the centralized member integrity service may subcontract with other counties to fulfill its obligations. The centralized member integrity service must be operational and utilized on July 1, 2027.

(2) The centralized member integrity service is responsible for conducting fraud investigations for fraud claims, fraud recovery, fraud dispute resolution conferences, and state-level fraud hearings, intentional program violation waivers, and criminal court proceedings, concerning program eligibility or fraud affecting electronic benefits transfer cards or similar credit-card-type devices through which food stamp or cash assistance benefits may be delivered.

(3) The centralized member integrity service must be utilized for the following public assistance programs:

(a) The medical assistance program established pursuant to articles 4 to 6 of this title 25.5;

(b) The children's basic health plan established pursuant to article 8 of title 25.5;

(c) The supplemental nutrition assistance program established pursuant to part 3 of article 2 of title 26;

(d) The Colorado child care assistance program established pursuant to part 1 of article 4 of title 26.5;

(e) The temporary assistance for needy families program, as defined in section 26-2-703; and

(f) Adult financial programs established pursuant to part 1 of article 2 of title 26, which include the old age pension, aid to the needy disabled, and home care allowance.

(4) (a) By January 1, 2027, the state departments shall collaborate with the county departments to create a transition plan that must be used to transition counties to the centralized member integrity service.

(b) The transition plan must outline the parameters for county department fraud and program integrity functions, including fraud claims, fraud recovery, fraud dispute resolution conferences, and state-level fraud hearings, related to the programs detailed in subsection (3) of this section.

(c) The transition plan must include a phased transition process, which begins July 1, 2027, and concludes with all fraud and program integrity functions being conducted through the centralized member integrity service by July 1, 2028.

(d) A county department shall continue to conduct and complete fraud program integrity functions in accordance with all applicable state and federal laws and regulations until the county department has transitioned to the centralized member integrity service in accordance with the transition plan. All fraud and program integrity functions, including open investigations, unworked referrals, recoveries, fraud dispute resolution conferences, state-level fraud hearings, intentional program violation waivers, and criminal court proceedings, must be transferred to the centralized member integrity service by July 1, 2028.

(5) (a) The centralized member integrity service cash fund is created in the state treasury. The fund consists of recouped money by the state department that results from member fraud investigations and any other money that the general assembly may appropriate or transfer to the fund. Subject to annual appropriation by the general assembly, money in the fund may be used for the administration of centralized member integrity service functions as required by this section, including contractor expenses.

(b) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the centralized member integrity service cash fund to the fund.

Source: L. 2026: Entire section added, (HB 26-1429), ch. 374, p. 2283, § 2, effective June 4.

Cross references: For the legislative declaration in HB 26-1429, see section 1 of chapter 374, Session Laws of Colorado 2026.

PART 3

MEDICAL SERVICES BOARD

25.5-1-301. Medical services board - creation.

(1) (a) There is created in the state department the medical services board, referred to in this part 3 as the "board". The board consists of members appointed by the governor with the consent of the senate as follows:

(I) One member from each congressional district in the state; and

(II) Three members from the state at large.

(b) The governor shall appoint persons to the board who have knowledge of medical assistance programs, and one or more of the appointments may include a person or persons who have received services through programs administered by the department within two years of the date of appointment.

(c) No more than a minimum majority of the members of the board may be affiliated with the same political party.

(d) In making appointments to the board, the governor shall include:

(I) One member from the private sector who has experience with the delivery of health care;

(II) One member who has experience or expertise in caring for medically underserved children; and

(III) Representation by at least one member who is a person with a disability, as defined in section 24-34-301, a family member of a person with a disability, or a member of an advocacy group for persons with disabilities, provided that the other requirements of this subsection (1) are met.

(2) Each member serves at the pleasure of the governor for a term of four years; except that the terms shall be staggered so that no more than a minimum majority of members' terms expire in the same year.

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

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

(5) The board is a **type 1** entity, as defined in section 24-1-105.

Source: L. 94: Entire part added, p. 1557, § 2, effective July 1. **L. 2001:** (1) and (2) amended, p. 916, § 12, effective August 8. **L. 2006:** Entire part amended, p. 1797, § 3, effective July 1. **L. 2009:** (1) amended, (HB 09-1281), ch. 399, p. 2154, § 4, effective August 5. **L. 2011:** (1) amended, (SB 11-183), ch. 132, p. 465, § 2, effective August 10. **L. 2018:** (1) amended, (HB 18-1364), ch. 351, p. 2082, § 7, effective July 1. **L. 2022:** (1) and (2) amended, (SB 22-013), ch. 2, p. 62, § 85, effective February 25; (5) added, (SB 22-162), ch. 469, p. 3371, § 59, effective August 10. **L. 2023:** (1)(d)(III) amended, (HB 23-1296), ch. 269, p. 1600, § 9, effective May 25.

Cross references: For the short title (the "Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

25.5-1-302. Medical services board - organization.

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

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

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

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

25.5-1-303. Powers and duties of the board - scope of authority - rules.

(1) The board shall have the authority set forth in subsection (3) of this section over the following programs administered by the state department:

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

(b) and (c) Repealed.

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

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

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

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

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

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

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

(c) The establishment of the type of benefits that are available to an applicant if eligibility requirements are met, subject to the authorization, requirements, and availability of the benefits;

(d) The requirements, obligations, and rights of members and applicants;

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

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

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

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

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

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

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

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

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

Source: L. 94: Entire part added, p. 1558, § 2, effective July 1. **L. 95:** (3)(e) to (3)(g) amended, p. 928, § 32, effective May 25. **L. 99:** (1)(c) amended and (1)(e) added, p. 701, § 7, effective July 1. **L. 2001:** (1)(f) and (7) added, pp. 916, 917, §§ 13, 14, effective August 8. **L. 2003:** (7) amended, p. 2009, § 90, effective May 22; (4) amended and (8) added, p. 2584, § 4, effective July 1. **L. 2006:** Entire part amended, p. 1798, § 3, effective July 1. **L. 2007:** (1)(c) repealed, p. 2042, § 71, effective June 1. **L. 2011:** (1)(e) and (6) amended, (SB 11-210), ch. 187, p. 722, § 8, effective July 15, 2012. **L. 2013:** (1)(f) and (9) added, (HB 13-1314), ch. 323, p. 1808, § 43, effective March 1, 2014. **L. 2024:** (3)(b) to (3)(f) amended, (SB 24-176), ch. 152, p. 619, § 12, effective August 7; (1)(b)(II) added by revision, (HB 24-1399), ch. 76, pp. 257, 260, §§ 23, 33.

Editor's note: Subsection (1)(b)(II) provided for the repeal of subsection (1)(b), effective July 1, 2025. (See L. 2024, pp. 257, 260.)

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

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

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

PART 4

HEALTH CARE COVERAGE COOPERATIVE RULE-MAKING AUTHORITY

25.5-1-401. (Repealed)

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

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

PART 5

COOPERATIVE HEALTH CARE AGREEMENTS INVOLVING HOSPITALS

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

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

Editor's note: This part 5 was added in 1995. For amendments to this part 5 prior to its repeal in 2006, consult the Colorado statutory research explanatory note and the table itemizing the replacement volumes and supplements to the original volume of C.R.S. 1973 beginning on page vii in the front of this volume.

PART 6

COMMISSION ON FAMILY MEDICINE

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

25.5-1-601. Legislative declaration.

(1) The general assembly hereby finds and declares that:

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

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

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

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

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

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

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

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

25.5-1-601.5. Definitions.

As used in this part 6, unless the context otherwise requires:

(1) "Commission" means the commission on family medicine created in section 25.5-1-602 (1).

Source: L. 2025: Entire section added, (SB 25-275), ch. 377, p. 2081, § 223, effective August 6.

25.5-1-602. Commission created - composition - terms of office.

(1) There is created, in the department of health care policy and financing, the commission on family medicine. The commission consists of the following members:

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

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

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

(d) A health-care consumer to be appointed by the governor from each congressional district in the state. No more than a minimum majority of the members of the commission appointed by the governor pursuant to this subsection (1)(d) may be affiliated with the same political party. A vacancy on the commission occurs whenever any health-care consumer member moves out of the congressional district from which the member was appointed. A health-care consumer member who moves out of the congressional district shall promptly notify the governor of the date of the move, but notice is not necessary for the vacancy to occur. The governor shall fill the vacancy in accordance with subsection (2) of this section.

(2) The members appointed under subsection (1)(d) of this section serve three-year terms. All members serve at the pleasure of the governor. The governor shall fill any vacancy by appointment for the remainder of the unexpired term.

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

Source: L. 2017: Entire part added, (HB 17-1024), ch. 7, p. 20, § 1, effective August 9. **L. 2022:** IP(1), (1)(d), and (2) amended, (SB 22-013), ch. 2, p. 63, § 86, effective February 25. **L. 2025:** IP (1) amended, (SB 25-275), ch. 377, p. 2081, § 224, effective August 6.

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

25.5-1-603. Duties of commission - reporting.

(1) The commission shall:

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

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

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

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

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

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

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

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

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

PART 7

HEALTH-CARE PROVIDERS' ACCOUNTABILITY TO COMMUNITIES

25.5-1-701. Definitions.

As used in this part 7, unless the context otherwise requires:

(1) "Community" means the community that a hospital has defined as the community that it serves pursuant to 26 CFR 1.501(r)-3 (b)(3).

(2) "Community benefit implementation plan" means a plan that satisfies the requirements of an implementation strategy, as set forth in 26 CFR 1.501(r)-3 (c).

(3) "Community health needs assessment" means a community health needs assessment that satisfies the requirements of 26 CFR 1.501(r)-3.

(4) "Community-identified health need" means a health need of a community that is identified in a community health needs assessment.

(5) (a) "Reporting hospital" means:

(I) A hospital licensed as a general hospital pursuant to part 1 of article 3 of title 25 and exempt from federal taxation pursuant to section 501 (c)(3) of the federal internal revenue code;

(II) A hospital established pursuant to section 25-29-103; or

(III) A hospital established pursuant to section 23-21-503.

(b) Notwithstanding subsection (5)(a) of this section, "reporting hospital" does not include a hospital that is licensed as a general hospital with the department of public health and environment and that is:

(I) Federally certified or undergoing federal certification as a long-term care hospital pursuant to 42 CFR 412.23 (e); or

(II) Federally certified or undergoing federal certification as a critical access hospital pursuant to 42 CFR 485 subpart F.

Source: L. 2019: Entire part added, (HB 19-1320), ch. 191, p. 2106, § 1, effective August 2.

25.5-1-702. Hospitals - public community meeting requirement - rules.

(1) At least once each year, each reporting hospital shall convene a public meeting to seek feedback regarding the reporting hospital's community benefit activities during the previous year and the reporting hospital's community benefit implementation plan for the following year. The presentation of the community benefit activities for the previous year must include the reporting hospital's discrete community benefit activities, the amount funded for each activity, and a description of how the activities and funding amounts align with the community's identified priorities.

(2) (a) Each reporting hospital shall invite, at a minimum, representatives from the following entities to participate in the meeting described in subsection (1) of this section, if any such entities operate in the reporting hospital's community:

(I) Local public health agencies;

(II) Local chambers of commerce and economic development organizations;

(III) Local health-care consumer organizations;

(IV) School districts;

(V) County governments;

(VI) City and town governments;

(VII) Community health centers;

(VIII) Certified rural health clinics or primary care clinics located in a county that has been designated by the federal office of management and budget as a rural or frontier county;

(IX) Area agencies on aging;

(X) Health-care consumer advocacy organizations;

(XI) A member of the tribal council or the member's designee for a hospital whose community includes one of Colorado's land-based tribes;

(XII) A member from the urban Indian organization for a hospital whose community includes a federally designated urban Indian health center or urban Indian organization; and

(XIII) A member from an institution of higher education for a hospital whose community includes such institutions.

(b) In addition to the entities described in subsection (2)(a) of this section, each reporting hospital shall invite, at a minimum, representatives from the following state agencies to participate in the meeting described in subsection (1) of this section:

(I) The state department;

(II) The department of public health and environment;

(III) The department of human services;

(IV) The Colorado commission on higher education; and

(V) The office of saving people money on healthcare in the lieutenant governor's office.

(c) In addition to the entities described in subsections (2)(a) and (2)(b) of this section, each reporting hospital shall invite the general public to the annual meeting described in subsection (1) of this section. The reporting hospital shall issue such invitation in an advertisement placed in any major newspaper published in the reporting hospital's community, posted on the reporting hospital's public website and social media accounts or other online presence, distributed through the reporting hospital's electronic newsletter or email lists, and distributed by any other means through which the reporting hospital regularly communicates with the community it serves. The invitation must be published at least thirty days prior to the scheduled meeting.

(2.5) When presenting the proposed community benefit implementation plan described in subsection (1) of this section, the reporting hospital must:

(a) Present priority areas identified in the reporting hospital's most recent community health needs assessment and any other community benefit investment option recommended by the reporting hospital. Each priority recommendation presented must clearly identify the source of the recommendation.

(b) Solicit public input for any additional community benefit investment priority; and

(c) Review and incorporate the public feedback received before the reporting hospital finalizes its annual community benefit implementation plan.

(2.7) A reporting hospital may only add community benefit priorities to the reporting hospital's implementation plan if the community benefit priorities were presented at the annual meeting and the public was provided an opportunity to provide feedback. The reporting hospital must indicate that the implemented community benefit priorities are a result of reporting hospital recommendations and not from community feedback.

(2.8) The state board shall promulgate rules to define terms and establish specific processes regarding the requirements for reporting hospitals to solicit, review, and incorporate public input pursuant to subsections (2.5) and (2.7) of this section.

(3) To satisfy the requirements of this section, a reporting hospital may convene a joint public meeting with one or more other reporting hospitals that share some or all of the hospital's community.

(4) For each public meeting and community health needs assessment community engagement meeting held, each reporting hospital shall submit a report to the state department and make the report available to community members by making the report publicly available on the reporting hospital's website. The report must include, at a minimum, the following:

(a) Meeting minutes;

(b) A list of the meeting attendees;

(c) The content of the meeting discussion, including any community benefit priorities discussed and the decisions made regarding those discussed community benefit priorities;

(d) Community feedback received and how the hospital plans to incorporate the feedback into the reporting hospital's community benefit implementation plan; and

(e) Any data collected from attendees, such as data concerning race, ethnicity, or income.

(5) The state department must conduct a stakeholder meeting with consumer advocates, community organizers, community organizations, and hospital representatives to identify and develop, at a minimum, best practices to ensure low-income residents, residents of color, people with serious mental illness, people with disabilities, and other populations experiencing disproportionate health outcomes in local communities are meaningfully engaged and to ensure

their input is incorporated into the data used to identify community priorities for the community health needs assessment and community benefit implementation plan. This stakeholder engagement must also include best practices for hospitals to collaborate with local public health agencies and community organizations to reduce redundant community needs assessments.

(6) The state board shall promulgate rules to establish accommodation standards for the annual community benefit public meetings and community health needs assessment that include language accessibility, adequate advanced public notice, and any other type of accessibility measures deemed necessary by the state board, and to implement the best practices identified and developed pursuant to subsection (5) of this section.

(7) The state board shall promulgate any additional rules that may be necessary for conducting the annual community benefit public meetings described in this section.

Source: L. 2019: Entire part added, (HB 19-1320), ch. 191, p. 2107, § 1, effective August 2. **L. 2023:** (1), (2), and (3) amended and (2.5), (2.7), (2.8), (4), (5), (6), and (7) added, (HB 23-1243), ch. 156, p. 670, § 2, effective August 7. **L. 2024:** (2)(a)(XIII) amended, (HB 24-1450), ch. 490, p. 3419, § 57, effective August 7.

Cross references: For the legislative declaration in HB 23-1243, see section 1 of chapter 156, Session Laws of Colorado 2023.

25.5-1-703. Hospitals - community health needs assessments - community benefit implementation plans - reports - rules.

(1) On or before a date to be determined by rules promulgated by the state board, and on or before such date every three years thereafter, each reporting hospital shall complete a community health needs assessment.

(2) On or before a date to be determined by rules promulgated by the state board, and on or before such date each year thereafter, each reporting hospital shall complete a community benefit implementation plan that:

(a) Addresses the needs described by the reporting hospital's community health needs assessment;

(b) Includes an explanation of the community served by the reporting hospital; and

(c) Describes how the community was determined pursuant to 26 CFR 1.501(r)-3 (b).

(3) On or before a date to be determined by rules promulgated by the state board, and on or before such date each year thereafter, each reporting hospital shall prepare and submit to the state department a report on certain community benefits, costs, and shortfalls. The report must include:

(a) The reporting hospital's most recent community health needs assessment completed pursuant to subsection (1) of this section;

(b) The reporting hospital's community benefit implementation plan for the coming year completed pursuant to subsection (2) of this section;

(c) A copy of the reporting hospital's most recent form 990 submitted to the federal internal revenue service; and

(d) A description of certain spending and investments made by the reporting hospital during the preceding year, including:

(I) A list of the investments made by the reporting hospital that were included in part I, part II, and part III of schedule H of the reporting hospital's form 990. For each such investment, the reporting hospital shall:

(A) Indicate the cost of the investment;

(B) Indicate whether the investment addressed a community-identified health need;

(C) For any investment that addressed a community-identified health need, identify any of the following categories, which may be further defined by rules promulgated by the state board, that are applicable: Free or discounted health-care services; behavioral health; community-based health care; social determinants of health spending, including spending to address individuals' needs, such as housing, food, transportation, interpersonal violence, education, and job opportunities; and provider recruitment, education, and research and training. In identifying these categories, the reporting hospital shall distinguish direct or cash expenditures from in-kind contributions.

(D) For any investment that addressed a community-identified health need, provide evidence showing how the investment improves community health outcomes and how the investment directly corresponds to community-identified needs.

(II) The reporting hospital's total expenses included in line 18 of section 1 of the form 990 submitted by the reporting hospital or by the reporting hospital's ownership entity; and

(III) The reporting hospital's revenue less expenses included in line 19 of section 1 of the form 990 submitted by the reporting hospital or by the reporting hospital's ownership entity.

(3.5) On or before a date to be determined by rules promulgated by the state board, and on or before such date every three years thereafter, the state department shall review each reporting

hospital's community health needs assessment and each reporting hospital's annual community benefit implementation plan to identify the highest priority areas as reported by communities as compared to the reporting hospital's reported spending. The state department shall include such information in the report described in subsection (7) of this section.

(4) A reporting hospital that prepares and submits a report pursuant to subsection (3) of this section shall post the report to the reporting hospital's public website.

(5) (a) The state board shall promulgate rules that establish:

(I) Reporting requirements for reporting hospitals that are not required to complete schedule H of the form 990. The rules must promote uniformity with the requirements set forth in subsection (3) of this section.

(II) Requirements for the evidence-based supporting documentation that is required pursuant to subsection (3)(d)(I)(D) of this section.

(b) A general hospital that is licensed as a general hospital pursuant to part 1 of article 3 of title 25 and that is not a reporting hospital may submit a report on certain community benefits, costs, and shortfalls that is consistent with this section.

(6) To facilitate the submission of the reports described in subsection (3) of this section, the state department shall develop and provide a website at which each reporting hospital shall submit the reports. The state department shall ensure that the website and the reports remain available to the public.

(7) As part of the report authorized in section 25.5-4-402.8, the state department shall include a summary of the reports submitted to the state department pursuant to subsection (3) of this section during the preceding year. The summary must include:

(a) The amount that each reporting hospital invested in:

(I) Free or reduced-cost health-care services that addressed community-identified health needs;

(II) Programs that addressed health behaviors or risks;

(III) Programs that addressed social determinants of health; and

(IV) All services and programs that addressed community-identified health needs;

(b) A summary of the reporting hospitals' investments that have been effective in improving community health outcomes;

(c) Any legislative recommendations the state department has for the general assembly; and

(d) The estimated federal and state income tax exemptions and the property tax exemptions received by each hospital, which shall be calculated by the department of revenue.

(8) The state department shall post the reports completed pursuant to subsection (7) of this section to a public web page that the state department creates for this sole purpose.

Source: L. 2019: Entire part added, (HB 19-1320), ch. 191, p. 2108, § 1, effective August 2. **L. 2023:** (2), (3)(d)(I)(C), (3)(d)(I)(D), (5)(a), (7)(b), and (7)(c) amended and (3.5) and (7)(d) added, (HB 23-1243), ch. 156, p. 673, § 3, effective August 7. **L. 2024:** (2)(b) amended, (HB 24-1450), ch. 490, p. 3419, § 58, effective August 7.

Cross references: For the legislative declaration in HB 23-1243, see section 1 of chapter 156, Session Laws of Colorado 2023.

25.5-1-704. Hospital community investment compliance - rules.

(1) (a) If the state department finds that a reporting hospital is not in compliance with the community benefit requirements of this part 7, the state department shall notify the reporting hospital of its noncompliance and identify the information that needs to be provided. If a reporting hospital does not comply, the state department shall require the reporting hospital to submit to the state department a corrective action plan within one hundred and twenty days for approval by the state department.

(b) If noncompliance continues or a reporting hospital fails to submit a corrective action plan, or if the state department determines a hospital's noncompliance with this section is knowing or willful or a repeated pattern of noncompliance exists, the state department shall consider the size of the hospital and the seriousness of the violation in setting a fine amount. For a reporting hospital owned by or affiliated with a hospital system comprised of three or more hospitals, the fine must be not more than twenty thousand dollars per week per violation. For all other reporting hospitals, the fine must be not more than five thousand dollars per week per violation.

(2) Reporting hospitals shall expend the amount fined pursuant to subsection (1)(b) of this section on community benefit investment priorities described in the hospital's current community benefit implementation plan within one year after the fine is imposed. Each reporting hospital shall report on how the money collected through fines is expended in the reporting hospital's annual report to the state department pursuant to section 25.5-1-703.

(3) The state board shall promulgate any rules necessary for the implementation of this section.

Source: L. 2023: Entire section added, (HB 23-1243), ch. 156, p. 674, § 4, effective August 7.

Cross references: For the legislative declaration in HB 23-1243, see section 1 of chapter 156, Session Laws of Colorado 2023.

PART 8

MEDICAID NONMEDICAL AND NONEMERGENCY MEDICAL TRANSPORTATION

25.5-1-801. Definitions.

As used in this part 8, unless the context otherwise requires:

(1) "Nonemergency medical transportation" or "NEMT" means transportation to or from medically necessary nonemergency treatment.

(2) "Nonmedical transportation" means transportation to enable passengers who are medicaid members to gain access to waiver and other community services, activities, and resources.

(3) "Transportation broker" means an entity contracted with the department of health care policy and financing to administer nonemergency medical transportation for medicaid members.

(4) (a) "Transportation provider" means an individual or entity, including, but not limited to, a nonprofit, public, or business entity, that:

(I) Provides transportation services to medicaid members; or

(II) Arranges the facilitation of transportation services for medicaid members by an individual.

(b) "Transportation provider" does not include a transportation broker or a transportation network company, as defined in section 40-10.1-602.

(5) "Transportation services" means nonemergency medical transportation or nonmedical transportation services provided to medicaid members.

(6) "Transportation community advisory board" or "board" means the transportation community advisory board described in section 25.5-1-802 (4).

(7) "Trip caps" means numerical limits on the number of trips a transportation provider is assigned and may accept within a specified period of time that are not based on transportation provider capacity, performance, safety, or compliance considerations.

Source: L. 2021: Entire part added, (HB 21-1206), ch. 381, p. 2551, § 1, effective June 29. **L. 2024:** (2) and (5) amended, (SB 24-176), ch. 152, p. 620, § 13, effective August 7. **L. 2026:** IP, (1), (3), and (4) amended and (6) and (7) added, (HB 26-1328), ch. 388, p. 2432, § 1, effective July 1.

25.5-1-802. Medicaid transportation services - transportation community advisory board - safety and oversight - rules.

(1) The state department shall collaborate with the transportation community advisory board to establish rules and processes for the safety and oversight of nonmedical transportation services and nonemergency medical transportation services provided to medicaid members pursuant to articles 4 to 6 of this title 25.5.

(2) and (3) (Deleted by amendment, L. 2026.)

(4) The transportation broker shall establish the transportation community advisory board, which is composed of representatives of a cross-section of NEMT stakeholders, including members, transportation providers, health-care treatment providers, and disability advocates. The board membership must include:

(a) Medicaid members from both rural and urban areas who utilize NEMT services;

(b) Behavioral health, primary care, and other treatment providers serving medicaid members;

(c) NEMT providers representing:

(I) Rural and urban service areas; and

(II) Large, medium, and small provider organizations;

(d) NEMT providers with experience in management, dispatch, driving, and compliance;

(e) Consumer and disability advocates representing populations with diverse mobility, health, and access needs;

(f) Hospital and health system representatives, including entities involved in discharge planning and care transitions for members;

(g) A representative from the state department with knowledge and specialization in NEMT; and

(h) A nonprofit or public transportation provider representing both rural and urban service areas.

(5) (a) To ensure that the composition of the board represents active transportation providers, forty percent of board members must be providers with direct NEMT operational experience, including management, dispatch, driving, or compliance.

(b) The board shall elect a chair from among its members.

(c) When appointing or approving NEMT provider representatives to the board, the transportation broker and the state department shall ensure equitable representation among:

(I) For-profit transportation providers;

(II) Nonprofit transportation providers; and

(III) Public transportation providers, including local government or public transit agencies.

(6) Board members serve two-year terms. Board members serve without compensation and without reimbursement for expenses.

(7) The board chair and state department shall circulate meeting agendas to the board members at least ten days in advance of meetings. The board shall document meeting minutes and approve meeting minutes within fifteen business days after each meeting. The board must give board members the opportunity to submit written recommendations or comments to the board prior to board action or advice.

(8) The board is an advisory body. The board does not replace or limit the state department's collaboration with NEMT providers when developing rules, processes, or policies.

(9) The board shall provide recommendations to the state department about the state department's rules, processes, and policies that govern NEMT. Final decisions regarding rules, processes, and policies remain the responsibility of the state department.

(10) The state department, in collaboration with the board, shall adopt rules that:

(a) Establish driver, vehicle, and transportation provider credentialing requirements;

(b) Prohibit trip caps, market-share restrictions, or other policies that limit transportation provider participation in the market, except as allowed pursuant to subsection (11) of this section;

(c) Require the state department to host meetings with the board no less than quarterly to review program performance, identify and address program challenges, discuss progress toward program goals, and identify opportunities to enhance efficiency and outcomes of the program;

(d) Require reasonable accommodation of member requests for an alternate or specific transportation provider when operationally feasible;

(e) Create a process for members and transportation providers to file concerns with the state department and for the state department to report to the board the number of concerns filed;

(f) Establish processes for claim submission from transportation providers and payment of transportation providers;

(g) Establish policies regarding the storage, access, retention, and deletion of video recordings of members made during nonemergency medical transportation. The policies must not prohibit the use of video recording for safety or driver accountability purposes.

(h) Develop billing procedures and requirements for the payment of transportation providers;

(i) Develop a process for transportation providers to resolve billing issues with the state department or transportation broker;

(j) Establish policies and procedures to verify member eligibility prior to a member receiving transportation services;

(k) Establish policies requiring transportation providers or the transportation broker, or both, to utilize a digital dispatch software system that automatically records pick-up and drop-off addresses, GPS coordinates, times of pick-up and drop-off, routes driven, miles driven, and the driver and vehicle that performed the trip; and

(l) Establish that members have a right to receive NEMT services that are accessible and appropriate to their individual medical and functional needs, including mobility and communication accommodations.

(11) The state department may impose trip caps or market-share restrictions on a transportation provider as corrective action as part of a corrective action plan based on a transportation provider's documented material performance deficiencies that are supported by objective, measurable criteria applied on an individualized, proportional, and time-limited basis following prior written notice of the deficiencies and a meaningful opportunity to cure.

(12) The state department shall ensure all transportation providers, drivers, and vehicles are credentialed in a manner sufficient to protect member safety and ensure program integrity. The state department shall establish requirements for transportation provider, driver, and vehicle credentialing through contract or program policy. The transportation broker shall verify compliance with credentialing requirements.

(13) Services provided by noncompliant or noncredentialed drivers or in noncompliant or noncredentialed vehicles are not eligible for reimbursement.

(14) For the primary purpose of safety, driver accountability, and fraud prevention, transportation providers shall use vehicles equipped with two-way video dash cameras and a video recording system when transporting members. The video dash camera and video recording system must capture visual documentation of trips, including images of pick-up and drop-off of a member. The policies regarding the use of video recording during transportation services established pursuant to subsection (10)(g) of this section must address member privacy,

operational feasibility, and compliance with applicable federal and state laws and related regulatory standards, including medicaid requirements. Video recordings of members are not required for billing purposes but may be used for auditing purposes. This subsection (14) does not apply to transportation providers operating fleets of five or fewer vehicles.

(15) The data collected pursuant to subsection (10)(k) of this section must only be made available to the state department or the transportation broker in digital format.

(16) The state department shall, in accordance with the "State Administrative Procedure Act", article 4 of title 24, provide advanced notice and the opportunity for public comment prior to the implementation of an NEMT rule change.

(17) The state department shall establish billing procedures, documentation requirements, and payment standards for transportation providers pursuant to subsection (10)(f) of this section. The procedures must be consistent with state and federal medicaid requirements and must not require payment for claims that do not meet applicable program integrity, documentation, or eligibility standards. The procedures must establish:

(a) Required claim formats and supporting documents;

(b) Claim denial criteria; and

(c) Reimbursement requirements.

(18) The state department may issue interim operational guidance to clarify procedures, improve administrative efficiency, or provide technical instructions to transportation providers. Interim guidance must not substantively change billing, documentation, or payment standards identified in the procedures adopted pursuant to subsection (17) of this section, except as necessary to address program integrity risks, including fraud, waste, or abuse, or to ensure compliance with state or federal law. In instances of fraud, waste, or abuse of NEMT services, the state department may provide immediate interim operational guidance if the state department includes the justification for the interim operational guidance in the guidance and provides reasonable advanced notice to affected transportation providers, unless immediate action is required to prevent ongoing fraud. If the state department takes immediate action, the actions must be:

(a) Limited in scope and duration;

(b) Include prompt written notice explaining the change;

(c) Applied prospectively to the extent permitted by state and federal law and must not alter claims submitted prior to the effective date of the interim operational guidance, except as required to address fraud, waste, or abuse.

(19) The state department shall notify transportation providers of new billing or documentation requirements or substantive changes, whether issued by rule or by interim

guidance, at least thirty days before the changes become effective. Forms, templates, or documentation that was valid prior to the effective date of a new rule continues to be valid through its expiration or until the end of the notice period, whichever is later.

(20) Nothing in this section entitles a provider to payment or limits the state department's authority to deny, recoup, or adjust claims in accordance with state or federal law.

(21) Matters outside the scope of the board or that cannot be resolved among board members must be directed to the state department.

Source: L. 2021: Entire part added, (HB 21-1206), ch. 381, p. 2552, § 1, effective June 29. **L. 2024:** IP(1) amended, (SB 24-176), ch. 152, p. 620, § 14, effective August 7. **L. 2026:** Entire section amended, (HB 26-1238), ch. 388, p. 2433, § 2, effective July 1.

25.5-1-803. Transportation provider data reporting requirements.

(1) On or before December 1, 2026, and on or before each December 1 thereafter, each transportation broker shall report the following information to the state department:

(a) Regarding each transportation provider that the transportation broker contracts with:

(I) The total number of rides requested;

(II) The total number of rides completed;

(III) The total number of rides canceled by members and the transportation provider;

(IV) The total cost of rides completed categorized by procedure code; and

(V) The total number of calls received from members requesting nonemergency medical transportation and the average time a member spent on hold;

(b) The number of grievances submitted by members regarding a transportation provider that were substantiated and the transportation provider that the grievance concerns; and

(c) The total number of transportation providers terminated from the transportation broker's network, on a corrective action plan, or on a performance improvement plan.

(2) Beginning January 1, 2027, the state department shall include as part of the state department's "SMART Act" presentation required by section 2-7-203 the information submitted to the state department by the transportation brokers as required by subsection (1) of this section.

Source: L. 2026: Entire section added, (HB 26-1235), ch. 361, p. 2168, § 1, effective August 12.

25.5-1-804. State nonemergency transportation broker - transportation providers - repeal.

(1) (a) The state department may contract with a transportation broker.

(b) A transportation broker shall create a publicly available contingency plan to ensure uninterrupted NEMT services in the event the transportation broker experiences system outages or is otherwise unable to perform required functions. The transportation broker shall share the contingency plan with transportation providers.

(c) If the state department contracts with a transportation broker, the state department shall designate regions within the state for implementation of a brokered NEMT program.

(2) The transportation broker shall implement a brokered NEMT program on a phased basis, one region at a time, and shall not begin implementation in a subsequent region until the program is fully implemented in the prior region. For purposes of this section, a program is fully implemented in a region when:

(a) Technology systems for scheduling, eligibility verification, trip assignment, provider payment, and customer support are fully operational;

(b) Transportation providers in the region are provided a reasonable opportunity to complete the broker onboarding process, including provider training, system access, and required vehicle and driver verification;

(c) A sufficient network of transportation providers is available to meet members' medical needs and ensure timely access to NEMT services; and

(d) The state department has verified that provider payment processes and customer support functions operate effectively.

(3) The state department and transportation broker shall provide timely notice and technical assistance to transportation providers regarding the onboarding process. Providers may continue to complete onboarding during the implementation period.

(4) For trips originating in regions that have not yet been designated by the state department for implementation of a brokered NEMT program, transportation providers may continue to provide transportation services and bill the state department directly. Once a region has been designated for implementation of a brokered NEMT program, transportation services provided to members in that region must be scheduled and authorized through the transportation broker in accordance with state department rules.

(5) Nothing in this section limits member access to transportation services or creates service gaps during implementation of a brokered program.

(6) Transportation providers may communicate with members regarding transportation services, including trip scheduling, service delivery, and operational questions. The state department and board shall develop policies regarding when and how transportation providers can communicate with members.

(7) The state department shall develop and provide transportation providers a provider communication toolkit to assist transportation providers in discussing the transition to transportation broker control or other program changes. The provider communication toolkit must include talking points, scripts, and guidance to ensure accurate and consistent information is communicated to members. The state department shall make the provider communication toolkit available to transportation providers at least ninety days prior to the implementation of a brokered NEMT program in the region in which the provider operates.

(8) At least ninety days prior to the implementation of a brokered NEMT program in a region, the transportation broker, in coordination with the state department, shall provide training and technical support to transportation providers that provide services in the region. The state department may extend the ninety-day period as needed based on provider readiness or delays in materials or instruction. The transportation broker shall provide training and technical support to transportation providers, with support and oversight by the state department.

(9) The transportation broker shall provide all transportation providers in a brokered NEMT program region with software to facilitate NEMT services. The transportation broker shall not require transportation providers to pay the cost of software licensing, implementation, maintenance, upgrades, or training.

(10) The transportation broker may encourage a member to schedule transportation services at least two days prior to their requested transportation date. The transportation broker shall accept and make reasonable efforts to fulfill same-day and next-day transportation requests, including requests for urgent medical and behavioral health outpatient, specialty, and hospital visits; time-sensitive in-state and out-of-state transfers; and discharges from health-care facilities, when feasible, and shall not require advanced notice that would unreasonably limit access to medically necessary services. The transportation broker shall allow members to schedule single and recurring transportation services. The transportation broker shall allow members, prior to the requested transportation services, to request a transportation provider or request a different transportation provider. The transportation broker shall not direct members away from their preferred transportation provider. The transportation broker shall document and retain all provider preference requests for audit purposes. The transportation broker may only provide members the option to request a specific provider after all service regions have been implemented. The prohibition on directing members away from preferred transportation

providers does not apply when the provider is subject to trip caps or market-share restrictions as part of a corrective action plan pursuant to section 25.5-1-802 (11).

(11) A transportation broker, or a transportation provider if there is no transportation broker, shall verify a member's eligibility for NEMT services immediately upon a member's request for NEMT transportation services using real-time access to the state department's eligibility system. If verification cannot be completed due to system issues or incomplete information, the transportation broker shall notify the member and the state department as soon as practicable and take action to resolve the issue promptly. Once eligibility is verified, the member is immediately eligible to schedule trips, in accordance with program rules.

(12) The transportation broker shall ensure all transportation providers meet the credentialing requirements established by state department rule. Nothing in this subsection (12) prohibits a transportation broker from imposing additional credentialing, training, or safety requirements necessary to ensure member safety, program integrity, or quality of service.

(13) (a) The transportation broker shall not operate, own, or control an NEMT transportation provider that operates in Colorado. The transportation broker shall maintain policies concerning preventing conflicts of interest and ensure that trip assignments are made consistent with safety, compliance, and operational standards. Nothing in this subsection (13) limits provider participation or imposes trip caps.

(b) A transportation broker that entered into a contract with the state department prior to January 1, 2026, to provide transportation services as a transportation provider may continue providing transportation services as a transportation provider until September 1, 2026. A transportation broker who has contracted with the state department to provide transportation services as a transportation provider and whose contract is executed, amended, or renewed on or after January 1, 2026, shall not operate, own, or control an NEMT transportation provider that operates in Colorado pursuant to subsection (13)(a) of this section.

(c) Subsection (13)(b) of this section and this subsection (13)(c) are repealed, effective January 1, 2027.

(14) The transportation broker, or the state department if there is no transportation broker, shall not restrict the number of vehicles a transportation provider can utilize or restrict the areas where or types of services a transportation provider operates.

(15) A transportation broker shall provide their trip assignment rules and procedures to the state department for approval. Upon approval, the state department shall make the transportation broker trip assignment rules and procedures publicly available on the state department's website.

(16) Transportation providers have sole authority over driver scheduling, vehicle dispatching, and driver management.

(17) NEMT drivers and vehicles must meet safety, licensing, and program compliance requirements. NEMT trips conducted by noncompliant drivers or vehicles are not eligible for reimbursement.

(18) To ensure continuity of care, transportation providers may bill the state department directly for compliant transportation services provided to members during the implementation of a brokered NEMT program in a region or in the event of transportation broker termination. Direct billing outside of these circumstances is not permitted.

(19) (a) Transportation network companies, as defined in section 40-10.1-602, may provide NEMT services if:

(I) The transportation provider originally assigned to complete a trip is unable to fulfill the assignment and no other enrolled transportation provider is available to complete the trip within the time frame necessary to ensure the member arrives at their appointment; or

(II) No transportation provider is available to serve the member in the member's county or service area at the time the trip is requested.

(b) Each use of a transportation network company in accordance with this subsection must be documented by the transportation broker in writing or an electronic record, including the reason for using the transportation network company, the reason a transportation provider was unable to complete the trip, and the date and time of the request. The transportation broker shall make the documentation available to the state department or its designee upon request for audit purposes.

(c) The transportation network company providing NEMT services must meet the driver, vehicle, safety, and credentialing requirements established by the state department for transportation network companies participating in the NEMT program, as applicable.

(20) A licensed ambulance service provider is not subject to the requirements of this section.

Source: L. 2026: Entire section added, (HB 26-1328), ch. 388, p. 2438, § 3, effective July 1.

25.5-1-805. Medicaid member eligibility and verification.

(1) The transportation broker, or a transportation provider if there is no broker, shall ensure during scheduling that individuals who sign up to receive transportation services are members who are eligible to receive nonemergency medical transportation services.

(2) The member eligibility verification process must protect member privacy. Member eligibility verification must not require displaying a member identification card on camera or the video recording of members for routine billing purposes. Nothing in this subsection (2) prohibits

the use of video recording for driver or member safety, operational monitoring, or complaint resolution purposes. The state department may request video recordings for program integrity review without advanced notice to the transportation provider, provided that requests are narrowly tailored to specific issues under review. The use of video recordings must comply with applicable privacy and confidentiality requirements. Transportation providers are not required to retain or produce video recordings beyond the standard retention period established in their operating procedures. Absence of video recordings outside a retention period does not constitute noncompliance, and adverse action shall not be taken against a transportation provider on this basis.

(3) If a transportation provider provides scheduled transportation services in good faith based on information provided by a transportation broker or the state department, the state department shall not deny payment solely because the broker or the state department later determines that the member's eligibility or trip information was inaccurate, if:

(a) The provider had no knowledge of the inaccuracy at the time of service; and

(b) The provider followed all applicable rules, procedures, and documentation requirements for claim submission.

(4) Nothing in this section alters or supersedes federal medicaid requirements. If it is later determined that a member was not eligible for medicaid at the time of service, the state department may be required to adjust or retract payment, even if the provider rendered services in good faith.

(5) The state department shall provide transportation providers with access to eligibility verification tools via the transportation broker or other authorized systems to reduce the likelihood of ineligible trips.

Source: L. 2026: Entire section added, (HB 26-1328), ch. 388, p. 2442, § 4, effective July 1.

25.5-1-806. Nonemergency medical transportation provider and broker audits - reporting.

(1) The state department shall, subject to available appropriations, audit transportation providers to ensure reimbursement is made only for trips performed by credentialed drivers operating credentialed vehicles pursuant to the rules adopted pursuant to section 25.5-1-802.

(2) The state department may use data analytics, complaints by members, and other program integrity indicators to prioritize which transportation providers to audit. The state department is not required to annually perform audits but must perform audits as resources allow. An audit of a transportation provider may include a review of the following, as they relate to the provider:

(a) Claims submitted;

(b) The provider's policies and procedures;

(c) Driver and vehicle credentials;

(d) Compliance with state department and broker requirements;

(e) Trip records;

(f) Member grievances, complaints, and incidents, including their resolution; or

(g) Other data necessary to evaluate safety, timeliness, and quality of the services provided by the provider.

(3) The state department shall, subject to available appropriations, conduct audits of each transportation broker at least annually. The department may use third-party contractors to conduct audits of transportation brokers. An audit of a transportation broker may include a review of the broker's:

(a) Policies and procedures;

(b) Trip distribution among transportation providers, including analysis by geography and trip type;

(c) Compliance with prohibitions on trip caps established in state department rule;

(d) Compliance with driver, vehicle, and provider credentialing requirements established in state department rule; and

(e) Response to member requests for specific transportation providers, including whether they were honored and, if not, the reason for denial.

Source: L. 2026: Entire section added, (HB 26-1328), ch. 388, p. 2443, § 5, effective July 1.

PART 9

HOSPITAL PRICE TRANSPARENCY

Editor's note: This part 9 was added with relocations 2023. Former C.R.S. section numbers are shown in editor's notes following those sections that were relocated.

25.5-1-901. Legislative declaration.

(1) The general assembly finds and declares that:

(a) Section 1001 of the "Patient Protection and Affordable Care Act", Pub.L. 111-148, as amended by the "Health Care and Education Reconciliation Act of 2010", Pub.L. 111-152, amended Title XXVII of the "Public Health Service Act", Pub.L. 78-410, in part, by adding a new section 2718 (e), requiring, in part, that each hospital operating within the United States establish, update, and make public a list of the hospital's standard charges for the items and services that the hospital provides;

(b) Effective January 1, 2021, the federal centers for medicare and medicaid services published the final rule to implement the law, codified at 45 CFR 180;

(c) In its summary of the final rule, CMS states that information on hospital standard charges is necessary for the public to "make more informed decisions about their care" and that the "impact of these final policies will help to increase market competition, and ultimately drive down the cost of health care services, making them more affordable for all patients";

(d) On July 9, 2021, President Biden, building upon efforts of past presidents, issued the "Executive Order on Promoting Competition in the American Economy", directing the secretary of the United States department of health and human services to support new and existing price transparency initiatives for hospitals;

(e) Health-care price transparency is in the best interest of all Coloradans, including:

(I) The state government, which purchases health-care services for almost one-fourth of all Coloradans;

(II) Colorado businesses, which fund employee medical expenses; and

(III) Colorado residents, who ultimately bear the brunt of high health-care costs in the form of higher taxes, lower wages, and residents' own out-of-pocket spending;

(f) Moreover, health-care prices in Colorado are among the highest in the nation;

(g) However, not all Colorado hospitals are in compliance with all of the disclosure requirements under federal law and other state laws governing health-care price transparency; and

(h) This lack of compliance with health-care price transparency laws by Colorado hospitals decreases the likelihood that Colorado consumers will be fully aware of affordable health-care options before purchasing items and services from hospitals, placing health-care consumers at greater risk of collection actions and other adverse actions relating to unpaid medical bills.

(2) Therefore, the general assembly finds and declares that it is imperative to protect Colorado health-care consumers from collection actions and other adverse actions taken by

Colorado hospitals during the time when the hospital was not in material compliance with hospital price transparency laws intended to protect health-care consumers.

Source: L. 2023: Entire part added with relocations, (SB 23-252), ch. 305, p. 1864, § 3, effective August 7.

Editor's note: This section is similar to former § 25-3-801 as it existed prior to 2023.

25.5-1-902. Definitions.

As used in this part 9, unless the context otherwise requires:

(1) "Collection action" means any of the following actions taken with respect to a debt for items and services that were purchased from or provided to a patient by a hospital on a date during which the hospital was not in material compliance with hospital price transparency laws:

(a) Attempting to collect a debt from a patient or patient guarantor by referring the debt, directly or indirectly, to a debt collector, a collection agency, or other third party retained by or on behalf of the hospital;

(b) Suing the patient or patient guarantor or enforcing an arbitration or mediation clause in any hospital documents, including contracts, agreements, statements, or bills; or

(c) Directly or indirectly causing a report to be made to a consumer reporting agency.

(2) (a) "Collection agency" means any:

(I) Person who engages in a business, the principal purpose of which is the collection of debts; or

(II) Person who:

(A) Regularly collects or attempts to collect, directly or indirectly, debts owed or due or asserted to be owed or due to another;

(B) Takes assignment of debts for collection purposes;

(C) Directly or indirectly solicits for collection debts owed or due or asserted to be owed or due to another; or

(D) Collects debt for the department of personnel.

(b) "Collection agency" does not include:

(I) Any officer or employee of a creditor while, in the name of the creditor, collecting debts for such creditor;

(II) Any person while acting as a collection agency for another person, both of whom are related by common ownership or affiliated by corporate control, if the person acting as a collection agency does so only for creditors to whom it is so related or affiliated and if the principal business of the person is not the collection of debts;

(III) Any officer or employee of the United States or any state to the extent that collecting or attempting to collect any debt is in the performance of the officer's or employee's official duties;

(IV) Any person while serving or attempting to serve legal process on any other person in connection with the judicial enforcement of any debt;

(V) Any debt-management services provider operating in compliance with or exempt from the "Uniform Debt-Management Services Act", part 2 of article 19 of title 5;

(VI) Any person collecting or attempting to collect any debt owed or due or asserted to be owed or due another to the extent that:

(A) The activity is incidental to a bona fide fiduciary obligation or a bona fide escrow arrangement;

(B) The activity concerns a debt that was extended by the person;

(C) The activity concerns a debt that was not in default at the time it was obtained by the person; or

(D) The activity concerns a debt obtained by the person as a secured party in a commercial credit transaction involving the creditor;

(VII) Any person whose principal business is the making of loans or the servicing of debt not in default and who acts as a loan correspondent, seller and servicer for the owner, or holder of a debt that is secured by a deed of trust on real property, whether or not the debt is also secured by an interest in personal property; or

(VIII) A limited gaming or racing licensee acting pursuant to article 33 of title 44.

(c) Notwithstanding the provisions of subsection (2)(b) of this section, "collection agency" includes any person who, in the process of collecting the person's own debts, uses another name that would indicate that a third person is collecting or attempting to collect such debts.

(3) (a) "Consumer reporting agency" means any person that, for monetary fees or dues or on a cooperative nonprofit basis, regularly engages, in whole or in part, in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties. "Consumer reporting agency" includes any person defined in 15 U.S.C. sec. 1681a (f) or section 5-18-103 (4).

(b) "Consumer reporting agency" does not include any business entity that provides check verification or check guarantee services only.

(4) (a) "Debt" means any obligation or alleged obligation of a consumer to pay money arising out of a transaction, whether or not the obligation has been reduced to judgment.

(b) "Debt" does not include a debt for business, investment, commercial, or agricultural purposes or a debt incurred by a business.

(5) "Debt collector" means any person employed or engaged by a collection agency to perform the collection of debts owed or due or asserted to be owed or due to another.

(6) "Federal centers for medicare and medicaid services" or "CMS" means the centers for medicare and medicaid services in the United States department of health and human services.

(7) "Hospital" means, consistent with 45 CFR 180.20, a hospital:

(a) Licensed or certified by the department of public health and environment pursuant to section 25-1.5-103 (1)(a); or

(b) Approved by the department of public health and environment as meeting the standards established for licensing a hospital.

(8) "Hospital price transparency laws" means section 2718 (e) of the "Public Health Service Act", Pub.L. 78-410, as amended, and rules adopted by the United States department of health and human services implementing section 2718 (e).

(9) "Items and services" or "items or services" means "items and services" as defined in 45 CFR 180.20.

Source: L. 2023: Entire part added with relocations, (SB 23-252), ch. 305, p. 1866, § 3, effective August 7.

Editor's note: This section is similar to former § 25-3-802 as it existed prior to 2023.

25.5-1-903. Failure to comply with hospital price transparency laws - prohibiting collection of debt - penalty.

(1) A hospital that is not in material compliance with hospital price transparency laws on the date that items or services are purchased from or provided to a patient by the hospital shall not initiate or pursue a collection action against the patient or patient guarantor for a debt owed for the items or services.

(2) If a patient believes that a hospital was not in material compliance with hospital price transparency laws on the date that items or services were purchased by or provided to the patient, and the hospital takes a collection action against the patient or patient guarantor, the patient or patient guarantor may file suit to determine if:

(a) The hospital was materially out of compliance with hospital price transparency laws, rules, or regulations on the date the items or services were provided; and

(b) The noncompliance is related to the items or services. The hospital shall not take a collection action against the patient or patient guarantor while the lawsuit is pending.

(3) If a judge or jury, considering compliance standards issued by the federal centers for medicare and medicaid services, finds a hospital to be materially out of compliance with hospital price transparency laws, rules, or regulations, the hospital shall:

(a) Refund the payer any amount of the debt the payer has paid and shall pay a penalty to the patient or patient guarantor in an amount equal to the total amount of the debt;

(b) Dismiss or cause to be dismissed any court action with prejudice and pay any attorney fees and costs incurred by the patient or patient guarantor relating to the action;

(c) Remove or cause to be removed from the patient's or patient guarantor's credit report any report made to a consumer reporting agency relating to the debt; and

(d) Notify the state department of the material noncompliance with hospital price transparency laws, rules, or regulations.

(4) Nothing in this part 9:

(a) Prohibits a hospital from billing a patient, patient guarantor, or third-party payer, including a health insurer, for items or services provided to the patient; or

(b) Requires a hospital to refund any payment made to the hospital for items or services provided to the patient, so long as no collection action is taken in violation of this part 9.

Source: L. 2023: Entire part added with relocations, (SB 23-252), ch. 305, p. 1868, § 3, effective August 7.

Editor's note: This section is similar to former § 25-3-803 as it existed prior to 2023.

25.5-1-904. Transparency - hospitals - standard charges - shoppable services - enforcement.

(1) On or before October 1, 2023, each hospital shall make public and post the hospital's medicare reimbursement rates, if applicable.

(2) (a) The state department shall conduct performance assessments for adherence to federal transparency rules by:

(I) Reviewing relevant information provided to the state department concerning a hospital's performance assessment in connection with this section;

(II) Auditing hospital websites for performance relative to federal price transparency rules, and in evaluating performance, the state department shall follow rules, standards, and guidance published by the federal centers for medicare and medicaid; and

(III) Confirming that each hospital submitted the lists required by this section.

(b) If the state department determines that a hospital has performed poorly in its performance assessment, the state department may:

(I) Issue a written notice to the hospital that clearly explains the manner in which the state department determined that the hospital performed poorly on the adherence to price transparency; and

(II) Provide technical assistance to the hospital to improve performance.

(3) On or before February 1, 2024, the state department shall create and maintain a publicly available list on its website of hospitals that perform poorly on the state department's performance assessment. Such notices and communications are subject to public disclosure under 5 U.S.C. sec. 552, as amended, notwithstanding any exemptions or exclusions to the contrary, in full without redaction. The state department shall update the list at least annually.

(4) A person that violates subsection (1) of this section commits a deceptive trade practice under section 6-1-105.

Source: L. 2023: Entire part added with relocations, (SB 23-252), ch. 305, p. 1869, § 3, effective August 7. **L. 2024:** (2)(a)(II), (2)(b)(I), and (3) amended, (HB 24-1450), ch. 490, p. 3419, § 59, effective August 7.

PART 10

HOSPITAL COLLABORATIVE AGREEMENTS

25.5-1-1001. Hospital collaborative agreements - review of proposed collaborative agreements - immunity - legislative declaration - definitions - rules.

(1) The general assembly finds and declares that:

(a) (I) Frontier and rural hospitals continue to struggle to deliver high-quality, accessible, low-cost care due to the rising costs of medications, supplies, medical equipment, and contract labor;

(II) Frontier and rural hospitals are largely independent governmental facilities that are governed by local community boards;

(III) Frontier and rural hospitals are generally separated by large distances and are challenged by the need to provide essential services to local communities due to the sparse population in rural areas;

(IV) Frontier and rural hospitals are increasingly challenged by complex requirements imposed by government and private payers that disproportionately negatively impact these providers and unnecessarily drive up administrative costs; and

(V) In cases where the state department, the division of insurance, if applicable, and the attorney general approve collaborative arrangements, it is the general assembly's intent to provide protection to frontier and rural hospitals from certain antitrust scrutiny that impedes frontier and rural hospitals from working collaboratively to improve quality, increase access, and reduce costs of care to the communities they serve;

(b) (I) Forty-seven of Colorado's sixty-four counties include rural and frontier communities yet contain only twelve percent of Colorado's population;

(II) Thirty-two counties are served by critical access hospitals that have twenty-five or fewer beds and are generally located more than thirty-five miles from the next closest hospital; eleven counties lack any hospital;

(III) The scarcity of nearby hospitals causes many residents to struggle to find quality, affordable health care near their homes;

(IV) Further, many residents in Colorado's rural and frontier communities forgo preventive and behavioral health care and lack comprehensive or specialized care or choice in health-care services, and twenty-four counties in Colorado are considered maternal care "deserts";

(V) Where hospitals do exist in rural and frontier areas, those hospitals receive low reimbursement rates due to a preponderance of government payers and declining local tax

dollars, which results in a reduced amount of money available to invest in expanding or upgrading facilities or to purchase necessary, new, or innovative medical supplies, equipment, or technology;

(VI) Many hospitals in rural and frontier communities have difficulty recruiting and retaining qualified health-care professionals and making available needed services; and

(VII) County public hospitals, health service districts, and hospital affiliates perform essential public functions on behalf of the state;

(c) As part of the government's interest in providing needed health-care services in Colorado's rural and frontier communities, it is important for the government to support efforts to find collaborative, innovative solutions to the many problems confronting rural health care, including collaborative or coordinated activities that offer the opportunity to expand health-care options through joint purchasing and staffing, shared services, and joint acquisition of new and expensive diagnostic and treatment solutions;

(d) It is the general assembly's intent to exempt from state antitrust laws, and to provide state action immunity from federal antitrust laws for, certain activities that might be characterized as anticompetitive or that might result in the displacement of competition in the provision of hospital, physician, or other health-care-related services or administrative or general business services; and

(e) In order to promote improved quality of, increase access to, and reduce costs of health-care services in rural and frontier communities through collaborative agreements authorized by this section, the general assembly further intends to provide a system of review of relevant collaborative agreements by the state department, the division of insurance, if applicable, and the attorney general to ensure that any potential benefits of such collaborative agreements are not outweighed by the harm to competition in rural and frontier communities.

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

(a) "Collaborative agreement" means an agreement or similar arrangement between two or more hospitals or hospital affiliates that complies with the requirements set forth in this section.

(b) "County public hospital" means a public hospital established pursuant to section 25-3-301.

(c) "Division of insurance" means the division of insurance in the department of regulatory agencies.

(d) "Health service district" has the same meaning as set forth in section 32-1-103 (9).

(e) "Hospital" means a facility, which is not owned by or affiliated with a health system that is comprised of three or more hospitals, that is:

(I) A county public hospital;

(II) A hospital established, maintained, or operated directly or indirectly by a health service district;

(III) A hospital affiliate; or

(IV) A private, nonprofit hospital.

(f) "Hospital affiliate" means an affiliate of a county public hospital or health service district that is under the sole control of the county public hospital or health service district.

(3) Except as provided in subsection (4) of this section, and subject to the requirements in subsections (5), (6), and (7) of this section, a hospital is authorized to enter into collaborative agreements with one or more hospitals or hospital affiliates to engage in the following activities:

(a) Ancillary clinical services, acquisition of equipment, clinic management, or health-care provider recruitment;

(b) Joint purchasing or leasing arrangements, including the joint purchasing or leasing of:

(I) Medical and general supplies;

(II) Medical and general equipment;

(III) Pharmaceuticals; or

(IV) Temporary staffing through a staffing agency;

(c) Consulting services with a focus on public health in rural or frontier communities and non-hospital-specific innovations in health-care delivery in those communities;

(d) Purchasing joint professional, general liability, or property insurance;

(e) Sharing back-office services, such as sharing a business office, accounting and finance services, human resources, and risk management and compliance services, but not including sharing service charging expenses or rates among hospitals;

(f) Sharing data services, including shared services for electronic health records and data extraction and analysis services, charge management, and population health analysis; and

(g) Negotiating with health insurance or government payers, which negotiations are limited to:

(I) Shared care protocols intended to improve patient management and outcomes, including implementation of evidence-based protocols, clinical pathways, and recognized best practices in the care and treatment of patients, including clinical therapies, nutrition, exercise, diagnostic testing, and medication management;

(II) Collaborative efforts with payers to promote appropriate and essential services to be provided in the local community;

(III) Management of prior authorization requests; and

(IV) Analysis of aggregate data to compare costs of procedures and to analyze patient outcomes.

(4) Notwithstanding any collaborative agreements described in subsection (3) of this section, the immunity and protections granted to hospitals and hospital affiliates entering into collaborative agreements pursuant to this section do not extend to collaborative agreements with another hospital or hospital affiliate that have the effect of:

(a) Setting reimbursement rates or other compensation from any commercial self-insured or commercial health insurance or government payer;

(b) Dividing or allocating among hospitals or hospital affiliates specific markets for the delivery of any general acute care or specialty lines of health-care services; or

(c) Negotiating or agreeing to compensation under health-care staffing arrangements for hospital employees that results in a reduction of wages of hospital staff, whether employed by the hospital, a staffing agency, or other employer.

(5) Prior to engaging in any joint activity described by a proposed collaborative agreement executed pursuant to subsection (3) of this section, the hospitals or hospital affiliates shall jointly submit the proposed collaborative agreement to the state department and to the division of insurance, if the proposed collaborative agreement includes negotiating with health insurance payers as described in subsection (3)(g) of this section, pursuant to rules that may be promulgated for the submission and review of proposals by the state department and by the division of insurance, if applicable. The state department and the division of insurance, if applicable, may request additional information necessary to review the proposal.

(6) Within fifteen days after receipt of a proposed collaborative agreement and the receipt of additional information requested by the state department and by the division of insurance, if applicable, if the state department and the division of insurance, if applicable, conclude that a proposed collaborative activity will result in cost savings or other efficiencies that will improve or expand the delivery of health-care services in rural and frontier communities in Colorado, the state department and the division of insurance, if applicable, shall refer the proposal to the attorney general to determine, pursuant to rules that may be promulgated for such purpose, that the benefits of the collaborative activity are not outweighed by any anticompetitive harm that may arise from the collaborative activity.

(7) Within forty-five days after receiving a referral and review from the state department and the division of insurance, if applicable, the attorney general shall review the proposed collaborative agreement and either approve or deny the proposed collaborative agreement or

request additional information related to the proposal. If a request for additional information is made, the attorney general has an additional forty-five days to complete the review following receipt of the requested information.

(8) (a) A collaborative agreement is approved if:

(I) The state department and the division of insurance, if applicable, conclude that the proposed collaborative agreement will result in improved quality, increased access or cost savings, or other efficiencies that will improve or expand the delivery of health-care services in rural and frontier communities in Colorado; and

(II) The attorney general concludes that the benefits identified by the state department and by the division of insurance, if applicable, are outweighed by any competitive concerns identified by the attorney general, or the attorney general does not respond within the time frames specified in subsection (7) of this section.

(b) (I) Except as provided in subsection (8)(b)(III) of this section, if a proposed collaborative agreement is denied, the hospitals or hospital affiliates may request reconsideration by resubmitting the proposed agreement to the attorney general within thirty days after the denial along with additional materials, information, or other evidence that was not previously submitted relating to the determination of the benefits or anticompetitive harm associated with the proposed collaborative agreement.

(II) The attorney general has forty-five days from the date of the request to reconsider the denial and may consult with the state department and the division of insurance as part of the reconsideration. The proposed collaborative agreement is not deemed approved if the attorney general fails to respond within the forty-five-day reconsideration period.

(III) A request for reconsideration of a proposed collaborative agreement may be made only once within the thirty-day period following the denial of the proposed collaborative agreement. The attorney general's decision on a proposed collaborative agreement that is not submitted for reconsideration within thirty days or that is denied upon reconsideration is final and non-appealable.

(c) The state department, the division of insurance, if applicable, or the attorney general may review a collaborative agreement annually to ensure the outcomes related to the collaborative agreement are consistent with this section.

Source: L. 2023: Entire part added, (SB 23-298), ch. 343, p. 2053, § 1, effective August 7. **L. 2025:** IP(2)(e), (2)(e)(II), and (2)(e)(III) amended and (2)(e)(IV) added, (SB 25-078), ch. 56, p. 235, § 1, effective August 6.

PART 11

COMMUNITY INTEGRATION

25.5-1-1101. Legislative declaration.

(1) The general assembly finds and declares that:

(a) The United States supreme court decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), referred to in this part 11 as "*Olmstead*", enshrined in law the duty upon states to actively work toward helping individuals with disabilities transition out of institutions and into the community and to have community-based services available to decrease the risk of institutionalization;

(b) *Olmstead* placed on states the obligation to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities;

(c) Segregating individuals with disabilities in institutions denies those individuals the freedom to make decisions, keeps them apart from family and friends, and denies them opportunities that exist in their communities. Segregation also denies communities the contributions that individuals with disabilities make to their communities.

(d) Community-based services are cheaper in the long run than institutionalization services.

(2) The general assembly further declares that codifying in state law the rights that were legally recognized as federal law through *Olmstead* is crucial because:

(a) The fundamental rights for individuals with disabilities to live in the least restrictive setting and to have access to services in the community is consistent with Colorado's recognition of the humanity and dignity of all individuals;

(b) The *Olmstead* decision required states to develop an *Olmstead* plan. Colorado's plan, called the "Colorado community living plan", was developed more than ten years ago as a collaboration between the state departments of health care policy and financing, human services, and local affairs. The plan's effectiveness has never been evaluated or updated, and the plan is insufficient; and

(c) Federal law under *Olmstead* currently provides a private right of action to enforce the law. Therefore, the general assembly does not see a need to create a new right of action. However, if the *Olmstead* protections are weakened, we urge a future general assembly to strengthen these rights by creating a private right of action to further enforce this law for individuals with disabilities.

Source: L. 2025: Entire part added, (HB 25-1017), ch. 231, p. 1092, § 2, effective August 6.

25.5-1-1102. Definitions.

As used in this part 11, unless the context otherwise requires:

(1) "Community-based services" means any of the following:

(a) Home health-care services authorized pursuant to paragraph (7) of section 1905(a) of the "Social Security Act", 42 U.S.C. sec. 1396d(a);

(b) Personal care services authorized pursuant to paragraph (24) of section 1905(a) of the "Social Security Act", 42 U.S.C. sec. 1396d(a);

(c) PACE services authorized pursuant to paragraph (26) of section 1905(a) of the "Social Security Act", 42 U.S.C. sec. 1396d(a);

(d) Home- and community-based services authorized pursuant to subsections (b), (c), (i), (j), and (k) of section 1915 of the "Social Security Act", 42 U.S.C. sec. 1396n; services authorized pursuant to a waiver under section 1115 of the "Social Security Act", 42 U.S.C. sec. 1315; and services through coverage authorized under section 1937 of the "Social Security Act", 42 U.S.C. sec. 1396u-7;

(e) Case management services authorized under section 1905(a)(19) of the "Social Security Act", 42 U.S.C. sec. 1396d(a)(19), and section 1915(g) of the "Social Security Act", 42 U.S.C. sec. 1396n(g);

(f) Rehabilitative services, including those related to behavioral health, described in section 1905(a)(13) of the "Social Security Act", 42 U.S.C. sec. 1396d(a)(13); and

(g) Any other services specified by the United States secretary of health and human services.

(2) "Disability" has the same meaning as set forth in the federal "Americans with Disabilities Act of 1990", 42 U.S.C. sec. 12101 et seq.

(3) "Fundamental alteration" means a modification that alters the essential nature of the goods, services, facilities, privileges, advantages, or accommodations offered by a state or public entity.

(4) "Most integrated setting" and "least restrictive setting" both mean the setting that enables a qualified individual with a disability to interact to the fullest extent possible with persons who do not have a disability.

(5) "Plan" means the state's comprehensive community integration plan, developed pursuant to section 8-88-102.5.

(6) "Public or governmental entity" means:

(a) The state or any department, board, agency, instrumentality, authority, or commission of the state; and

(b) Any political subdivision of the state, including:

(I) A county, city, or city and county;

(II) A school district as defined in section 22-36-107;

(III) A local improvement district as defined in section 32-7-103;

(IV) A law enforcement authority;

(V) A water, sanitation, fire protection, metropolitan, irrigation, drainage, or other special district created pursuant to title 32;

(VI) Any other municipal, quasi-municipal, or public corporation organized pursuant to the state constitution or other law; and

(VII) Any department, board, agency, instrumentality, authority, or commission of a political subdivision of the state.

(7) "Qualified individual with a disability" has the same meaning as set forth in the federal "Americans with Disabilities Act of 1990", 42 U.S.C. sec. 12101 et seq.

Source: L. 2025: Entire part added, (HB 25-1017), ch. 231, p. 1093, § 2, effective August 6.

25.5-1-1103. Case management-based services and activities.

Each public and governmental entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of a qualified individual with a disability.

Source: L. 2025: Entire part added, (HB 25-1017), ch. 231, p. 1094, § 2, effective August 6.

25.5-1-1104. Community-based services - cutting services by state or public entity - plan to ameliorate risk of institutionalization for qualified individuals with disabilities.

(1) Each public and governmental entity shall provide community-based services to a qualified individual with a disability when:

(a) The services are appropriate, as determined by the state's treating professionals;

(b) The affected individual does not oppose receiving community-based services; and

(c) Community-based services can be reasonably accommodated, taking into account the resources available to the public or governmental entity and the needs of other qualified individuals with disabilities.

(2) If the public or governmental entity cuts services, it shall assess whether the service cuts increase the risk of institutionalization for those individuals who are receiving services. In making such budget cuts, public and governmental entities have a duty to take all reasonable steps to avoid placing qualified individuals with disabilities at risk of institutionalization.

Source: L. 2025: Entire part added, (HB 25-1017), ch. 231, p. 1095, § 2, effective August 6.

25.5-1-1105. Exception for fundamental alteration of an entity's program.

(1) A public or governmental entity is not required to comply with this part 11 if doing so would require a fundamental alteration of the entity's program.

(2) (a) The following factors must be considered for purposes of evaluating a fundamental alteration defense to not complying with this part 11:

(I) The amount of money the public or governmental entity allots, spends, receives, or could receive if the entity applied for available federal funding to provide services to qualified individuals with disabilities;

(II) All relevant costs, not just those funded by the single agency that operates or funds the segregated or integrated setting for qualified individuals with disabilities;

(III) Changes in the costs of the segregated setting compared with changes in costs of community-based services;

(IV) Any possible transitional costs of converting from segregated to integrated settings for qualified individuals with disabilities. Transitional costs may be considered, but are not determinative.

(V) Whether the proposed modification results in the reduction or delay of the receipt of community-based services for other individuals with disabilities.

(b) If a public or governmental entity decides to serve new qualified individuals with disabilities in segregated settings after individuals with disabilities in a plaintiff class are moved to integrated settings, rather than to close or downsize the segregated settings, the costs associated with such a decision must not be included in the fundamental alteration analysis.

Source: L. 2025: Entire part added, (HB 25-1017), ch. 231, p. 1095, § 2, effective August 6.

25.5-1-1106. No private right of action - consistency with federal *Olmstead* standard.

(1) Nothing in this part 11 creates:

(a) A new right of action against the state of Colorado or other public entities; or

(b) A standard different than that delineated in *Olmstead*, subsequent cases interpreting *Olmstead*, and United States department of justice guidance interpreting *Olmstead*, as of April 20, 2025.

Source: L. 2025: Entire part added, (HB 25-1017), ch. 231, p. 1096, § 2, effective August 6.

ARTICLE 2

State-funded Health and Medical Care

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

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

25.5-2-103. Reproductive health-care program - report - rules - definitions.

25.5-2-104. State-funded health and medical care - rules.

25.5-2-105. State children's basic health plan. (Repealed)

25.5-2-106. State-funded abortion care.

25.5-2-107. State-only funding for certain entities - application - rules.

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

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

(2) Any money remaining in the state old age pension fund after full payment of basic minimum awards to qualified old age pension members, and after establishment and

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

(3) Repealed.

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

Source: L. 2006: Entire article amended with relocations, p. 1800, § 5, effective July 1. **L. 2007:** (4) added, p. 465, § 1, effective July 1. **L. 2009:** (3) amended, (SB 09-261), ch. 201, p. 905, § 1, effective May 1. **L. 2010:** (3)(b)(III) amended and (3)(b)(IV) and (3)(b)(V) added, (HB 10-1380), ch. 215, p. 932, § 1, effective May 6. **L. 2011:** (3)(b)(VI) added, (SB 11-164), ch. 33, p. 93, § 5, effective March 18; (3) amended, (SB 11-210), ch. 187, p. 718, § 1, effective July 1; (1) and (4) amended, (SB 11-210), ch. 187, p. 719, § 2, effective July 15, 2012. **L. 2017:** (2) amended, (SB 17-242), ch. 263, p. 1326, § 197, effective May 25. **L. 2024:** (2) amended, (SB 24-176), ch. 152, p. 620, § 15, effective August 7.

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

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

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

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

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

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

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

25.5-2-103. Reproductive health-care program - report - rules - definitions.

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

(a) Repealed.

(b) "Eligible individual" means an individual with reproductive capacity, regardless of gender, who would be eligible to enroll in the medical assistance program, as described in section 25.5-4-103 (13), but is not eligible due solely to the individual's immigration status, and who is not eligible for, or declines to enroll in, state medical assistance, as described in section 25.5-2-104.

(c) "FDA" means the federal food and drug administration.

(d) "Participant" means an eligible individual enrolled in the reproductive health-care program.

(e) "Pharmacist" means a licensed pharmacist who has entered into a collaborative pharmacy practice agreement pursuant to section 12-280-602 to prescribe and dispense hormonal contraceptive patches and oral hormonal contraceptives.

(f) "Provider" has the same meaning as set forth in section 25.5-4-103 (19)(a).

(g) "Reproductive health-care services" means family planning services, as defined in section 25.5-4-412 (2)(b), and family-planning-related services, as defined in section 25.5-4-412 (2)(a).

(2) On and after July 1, 2022, the state department shall administer a reproductive health-care program, referred to in this section as the "program", that provides reproductive health-care services to participants.

(3) Upon the participant's initial and follow-up visits to the participant's provider, and unless the participant requests a shorter period of time, the program shall comply with the federal centers for disease control and prevention's selected practice recommendations for contraceptive use by ensuring the participant is offered at least a one-year supply of either:

(a) The requested contraceptive drug, device, or product or one or more therapeutic equivalents of the requested drug, device, or product, if the therapeutic equivalent is available and approved by the FDA; or

(b) An alternative contraceptive drug, device, or product, if a contraceptive drug, device, or product is deemed medically inadvisable by the participant's provider.

(4) A participant's choice of a contraceptive drug, device, or product must not be infringed upon and must not require prior authorization, step therapy, or other utilization control techniques for medically appropriate contraceptive drugs, devices, or products approved by the FDA.

(5) The state board shall adopt rules as necessary to implement this section, including rules specifying the manner in which eligible individuals will be notified about the program and the manner in which eligible individuals may enroll in the program.

(5.5) To the extent practicable, the state department shall ensure that eligible individuals seeking to participate in the program are able to apply for and enroll in the program through their local county office, a state medical assistance program site, an online application, or any other mechanism that is available to applicants for the state medical assistance program.

(6) The state department shall provide reproductive health-care services to participants without imposing any cost-sharing requirements.

(7) Beginning in state fiscal year 2023-24, the state department shall analyze and report the cost-effectiveness of the program to the public through the annual hearing, pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2. At a minimum, the report must include:

(a) The total number of eligible individuals;

(b) The total number of participants enrolled in the program, disaggregated by race, ethnicity, gender identity, and income level;

(c) The cost of providing reproductive health-care services to participants;

(d) The participants' preferred method of contraceptive methods; and

(e) The cost savings realized due to avoided unintended pregnancies, including avoided hospital costs.

Source: L. 2021: Entire section added, (SB 21-009), ch. 430, p. 2845, § 2, effective September 7. **L. 2022:** (2) amended, (HB 22-1191), ch. 9, p. 113, § 1, effective March 7; (1)(b) amended, (HB 22-1289), ch. 399, p. 2838, § 9, effective June 7. **L. 2023:** (1)(a) repealed, (1)(g) and (5.5) added, and (2), (6), and (7)(c) amended, (SB 23-189), ch. 69, p. 259, § 7, effective April 14.

Cross references: For the legislative declaration in SB 21-009, see section 1 of chapter 430, Session Laws of Colorado 2021. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-2-104. State-funded health and medical care - rules.

(1) (a) There is created the state medical assistance program, referred to in this section as "state medical assistance". Subject to the limitations detailed in subsection (1)(b) of this section, state medical assistance includes all benefits and services at the same cost to the beneficiary as benefits and services offered pursuant to the medical assistance program, defined in section 25.5-4-103 (13), such that, to the maximum extent possible, an eligible individual is not able to tell that they are enrolled in a different program from medical assistance, as defined in section 25.5-4-103 (13).

(b) Pregnant women who are not eligible for the medical assistance program solely due to their immigration status and children under nineteen years old whose family household income does not exceed two hundred sixty percent of the federal poverty line, adjusted for family size, and who do not meet the immigration requirements for eligibility are subject to the following limitations on benefits:

(I) Beginning July 1, 2026, they are subject to an annual cap on dental services in the amount of one thousand one hundred dollars;

(II) Beginning January 1, 2027, they must be offered behavioral health services on a fee-for-service basis only;

(III) Beginning January 1, 2027, they are not eligible for services offered through the accountable care collaborative pursuant to section 25.5-5-419; and

(IV) Beginning January 1, 2027, they shall not receive managed care services pursuant to part 4 of article 5 of this title 25.5.

(c) Beginning January 1, 2027, children under nineteen years old whose family household income does not exceed two hundred sixty percent of the federal poverty line, adjusted for family size, and who are not eligible for the medical assistance program due to their immigration status, shall not receive, pursuant to the state medical assistance program created in this section, long-term services and supports described in section 25.5-5-102 (1)(e); section 25.5-5-202 (1)(c), (1)(n), and (1)(p); home health services described in section 25.5-5-102 (1)(f) for members who require ongoing home health services following sixty days of acute home health services; and services described in part 19 of article 6 of this title 25.5 unless they already receive these services on or before December 31, 2026.

(2) A child who is less than nineteen years of age is eligible to receive state medical assistance if the child would be eligible for medical assistance as defined in section 25.5-4-103 (13) but is not eligible due solely to the child's immigration status.

(3) A child who is less than nineteen years of age is presumptively eligible for state medical assistance and will receive services specified by state law only if a parent or legal guardian of the child declares all pertinent information relating to the criteria of income and assets of the child's family.

(3.5) (a) For the 2026-27 state fiscal year, enrollment in state medical assistance of children under nineteen years old whose family household income does not exceed two hundred sixty percent of the federal poverty line, adjusted for family size, and who are not eligible for the medical assistance program due to their immigration status, is subject to an enrollment cap of twenty-five thousand if one of the following conditions is met:

(I) Enrollment of the children described in this subsection (3.5)(a) in state medical assistance exceeds twenty-five thousand children; or

(II) Expenditures for a fiscal quarter of the 2026-27 state fiscal year exceed one quarter of the appropriation for state medical assistance plus five percent to account for cost fluctuations due to seasonality.

(b) If a condition detailed in subsection (3.5)(a) of this section is met, the state department must cap the enrollment of the children described in subsection (3.5)(a) of this section at twenty-five thousand children beginning on the first day of the month following sixty days after the state department determines that a condition detailed in subsection (3.5)(a) of this section is met.

(c) The state department shall adopt rules necessary to implement the enrollment cap detailed in this subsection (3.5).

(d) On or before November 1, 2026, the state department shall submit a report to the joint budget committee detailing what is driving enrollment and utilization of state medical assistance by children who are under nineteen years old whose family household income does not exceed two hundred sixty percent of the federal poverty line, adjusted for family size, and who are not eligible for the medical assistance program due to their immigration status. The report must include strategies for reducing costs associated with enrolling these children in state medical assistance.

(4) State medical assistance must be funded by state funds only, except to the extent federal funds are made available through express written authorization through a federal waiver, state plan amendment, or otherwise, by the federal centers for medicare and medicaid services.

(5) The state department shall seek any necessary federal approvals to maximize any available federal financial participation in implementing this section.

(6) To the maximum extent allowable under federal law, the state department shall, using appropriate funding, use the same infrastructure and provider network to deliver state medical assistance as it does to deliver medical assistance as defined in section 25.5-4-103 (13).

(7) This section constitutes state authority within the meaning of 8 U.S.C. sec. 1621 (d), as that law existed on January 1, 2022.

(8) (a) During its 2024 presentation to the joint budget committee of the general assembly and in its presentation to the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees, at the hearing held pursuant to section 2-7-203 (2)(a) of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", the state department shall report on its plans and progress in implementing state medical assistance.

(b) Beginning January 1, 2026, and continuing every January thereafter, the state department, in its presentation to the joint budget committee of the general assembly and in its presentation to the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees, at the hearing held pursuant to section 2-7-203 (2)(a) of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", shall report on the cost savings and health improvements associated with state medical assistance.

Source: L. 2022: Entire section added, (HB 22-1289), ch. 399, p. 2838, § 10, effective June 7. **L. 2023:** (4) amended, (HB 23-1301), ch. 303, p. 1829, § 44, effective August 7. **L. 2026:** (1) amended and (3.5) added, (HB 26-1411), ch. 398, p. 2490, § 1, effective June 4.

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-2-105. State children's basic health plan. (Repealed)

Source: L. 2022: Entire section added, (HB 22-1289), ch. 399, p. 2838, § 10, effective June 7. **L. 2024:** (4) amended, (HB 24-1450), ch. 490, p. 3420, § 60, effective August 7. **L. 2026:** Entire section repealed, (HB 26-1411), ch. 398, p. 2493, § 4, effective June 4.

25.5-2-106. State-funded abortion care.

When abortion care services are provided in accordance with articles 4, 5, and 6 of this title 25.5, the services must be reimbursed by state funds only.

Source: L. 2025: Entire section added, (SB 25-183), ch. 97, p. 443, § 2, effective January 1, 2026.

25.5-2-107. State-only funding for certain entities - application - rules.

(1) The state department shall reimburse a prohibited entity, as defined in Pub.L. 119-21 sec. 71113, using only state funds for services covered under Title XIX of the federal "Social Security Act" and provided on or after July 1, 2025, except those services covered pursuant to section 25.5-2-106.

(2) This section does not apply if a prohibited entity is eligible for reimbursement from the federal centers for medicare and medicaid services at the time the services are provided.

(3) The state board may adopt rules as necessary to implement this section.

Source: L. 2025, 1st Ex. Sess.: Entire section added, (SB 25B-002), ch. 1, p. 1, § 1, effective August 26.

PRESCRIPTION DRUGS

ARTICLE 2.5

Prescription Drugs

PART 1
COLORADO CARES RX ACT

25.5-2.5-101. Short title.

25.5-2.5-102. Legislative declaration.

25.5-2.5-103. Lower-cost prescription drugs - information - research - reporting.

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

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

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

PART 2
CANADIAN PRESCRIPTION DRUG IMPORTATION PROGRAM

25.5-2.5-201. Short title.

25.5-2.5-202. Definitions.

25.5-2.5-203. Canadian prescription drug importation program - created - importation process - contract with vendor - vendor duties.

25.5-2.5-204. Eligible prescription drugs - eligible Canadian suppliers - eligible importers - distribution requirements.

25.5-2.5-205. Federal approval.

25.5-2.5-206. Reports.

25.5-2.5-207. Importation program authorized - rules.

25.5-2.5-208. Expansion of program to include additional foreign suppliers - federal action required - notice to general assembly.

PART 1

COLORADO CARES RX ACT

25.5-2.5-101. Short title.

The short title of this part 1 is the "Colorado Cares Rx Act".

Source: L. 2007: Entire article added, p. 1, § 1, effective February 5. **L. 2019:** Entire section amended, (SB 19-005), ch. 184, p. 2073, § 4, effective August 2.

Cross references: For the legislative declaration in SB 19-005, see section 1 of chapter 184, Session Laws of Colorado 2019.

25.5-2.5-102. Legislative declaration.

(1) The general assembly finds that:

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

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

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

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

(2) The general assembly, therefore, declares that it is important to make information available to the public concerning ways to purchase lower-cost generic and nonpatented prescription drugs through the "Colorado Cares Rx Act" in order to protect the health of uninsured, underinsured, and older Coloradans. The general assembly further declares that the state should continue to actively research cost-effective mechanisms or programs that may provide additional options to address this need in Colorado.

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

25.5-2.5-103. Lower-cost prescription drugs - information - research - reporting.

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

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

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

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

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

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

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

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

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

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

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

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

PART 2

CANADIAN PRESCRIPTION DRUG IMPORTATION PROGRAM

Cross references: For the legislative declaration in SB 19-005, see section 1 of chapter 184, Session Laws of Colorado 2019.

25.5-2.5-201. Short title.

The short title of this part 2 is the "Dr. Irene Aguilar Canadian Prescription Drug Importation Act".

Source: L. 2019: Entire part added, (SB 19-005), ch. 184, p. 2065, § 3, effective August 2.

25.5-2.5-202. Definitions.

As used in this part 2, unless the context otherwise requires:

(1) "Canadian supplier" means a manufacturer, wholesale distributor, or pharmacy that is appropriately licensed or permitted under Canadian federal and provincial laws and regulations to manufacture, distribute, or dispense prescription drugs.

(2) "Eligible importer" means an importer that is described in section 25.5-2.5-204 (3).

(3) "Federal act" means the "Federal Food, Drug, and Cosmetic Act", 21 U.S.C. sec. 301 et seq.

(4) "Medicaid pharmacy" means a pharmacy registered pursuant to section 12-280-119 that has a provider agreement in effect with the state department and is in good standing with the state department.

(5) "Pharmacist" means a person who holds an active and unencumbered license to practice pharmacy pursuant to section 12-280-114.

(6) "Prescription drug" has the same meaning set forth in section 12-280-103 (42); except that the term includes only drugs that are intended for human use.

(7) "Program" means the Canadian prescription drug importation program created in section 25.5-2.5-203.

(8) "Vendor" means a vendor with which the state department contracts for the provision of services under the program pursuant to section 25.5-2.5-203 (1).

Source: L. 2019: Entire part added, (SB 19-005), ch. 184, p. 2065, § 3, effective August 2.

25.5-2.5-203. Canadian prescription drug importation program - created - importation process - contract with vendor - vendor duties.

(1) The Canadian prescription drug importation program is created in the state department. Upon receiving approval of the program as described in section 25.5-2.5-205 (1), the state department shall contract with one or more vendors to provide services under the program. For three years following August 2, 2019, the selection of any vendor pursuant to this subsection (1) is exempt from the requirements of the procurement code, articles 101 to 112 of title 24.

(2) (a) Each vendor, in consultation with the state department and any other vendors, shall establish a wholesale prescription drug importation list that identifies the prescription drugs that have the highest potential for cost savings to the state. In developing the list, each vendor shall consider, at a minimum, which prescription drugs will provide the greatest cost savings to the state, including prescription drugs for which there are shortages, specialty prescription drugs, and high-volume prescription drugs. Each vendor shall revise the list at least annually and at the direction of the state department pursuant to subsection (2)(b) of this section.

(b) The state department shall review the wholesale prescription drug importation list at least every three months to ensure that it continues to meet the requirements of the program. The state department may direct a vendor to revise the list, as necessary.

(c) Each vendor, in consultation with the state department, shall identify Canadian suppliers that are in full compliance with relevant Canadian federal and provincial laws and regulations and that have agreed to export prescription drugs identified on the wholesale prescription drug importation list. Each vendor shall verify that such Canadian suppliers meet all of the requirements of the program and will export prescription drugs at prices that will provide cost savings to the state. Each vendor shall contract with such eligible Canadian suppliers, or facilitate contracts between eligible importers and Canadian suppliers, to import prescription drugs under the program.

(d) Each vendor shall assist the state department in developing and administering a distribution program within the program.

(e) Each vendor shall assist the state department with the annual report described in section 25.5-2.5-206 and provide any information requested by the state department for the report.

(f) Each vendor shall ensure the safety and quality of drugs imported under the program, as follows:

(I) (A) For an initial imported shipment, ensure that each batch of the drug in the shipment is statistically sampled and tested for authenticity and degradation in a manner consistent with the federal act; and

(B) For any subsequent imported shipment, ensure that a statistically valid sample of the shipment is tested for authenticity and degradation in a manner consistent with the federal act;

(II) Certify that each drug:

(A) Is approved for marketing in the United States and is not adulterated or misbranded; and

(B) Meets all of the labeling requirements under 21 U.S.C. sec. 352;

(III) Maintain qualified laboratory records, including complete data derived from all tests necessary to ensure that the drug is in compliance with the requirements of this section; and

(IV) Maintain documentation demonstrating that the testing required by this section was conducted at a qualified laboratory in accordance with the federal act and any other applicable federal and state laws and regulations governing laboratory qualifications.

(3) All testing required by this section must be conducted in a qualified laboratory that meets the standards under the federal act and any other applicable federal and state laws and regulations governing laboratory qualifications for drug testing.

(4) Each vendor shall maintain a list of all eligible importers that participate in the program.

(5) Each vendor shall ensure compliance with Title II of the federal "Drug Quality and Security Act", Pub.L. 113-54, by all Canadian suppliers, eligible importers, distributors, and other participants in the program.

(6) Each vendor shall provide an annual financial audit of its operations to the state department. Each vendor shall also provide quarterly financial reports specific to the program and shall include information concerning the performance of its subcontractors and vendors. The state department shall determine the format and contents of the reports.

(7) Each vendor shall submit evidence of a surety bond with any bid or initial contract negotiation documents and shall maintain documentation of evidence of such a bond with the state department throughout the contract term. The surety bond may be from this state or any other state in the United States and must be in an amount of at least twenty-five thousand dollars. The surety bond or comparable security arrangement must include the state of Colorado as a beneficiary. In lieu of the surety bond, a vendor may provide a comparable security agreement, such as an irrevocable letter of credit or a deposit into a trust account or financial institution that includes the state of Colorado as a beneficiary, payable to the state of Colorado. The purposes of the bond or other security arrangement are to:

(a) Ensure participation of the vendor in any civil or criminal legal action by the state department, any other state agency, or private individuals or entities against the vendor because of the vendor's failure to perform under the contract, including but not limited to causes of actions for personal injury, negligence, and wrongful death;

(b) Ensure payment by the vendor through the use of a bond or other comparable security arrangement of any legal judgments and claims that are awarded to the state, other entities acting on behalf of the state, individuals, or organizations if the vendor is assessed a final judgment or other monetary penalty in a court of law for a civil or criminal action under the program. The bond or comparable security arrangement may be accessed if the vendor fails to pay any judgment or claim within sixty days after final judgment.

(c) Allow for civil and criminal litigation claims to be made against the bond or other comparable security arrangements for up to one year after the vendor's contract under the program has ended with the state department, the vendor's license is no longer valid, or the program has ended, whichever occurs last.

(8) Each vendor shall maintain information and documentation submitted under this section for a period of at least seven years.

(9) The state department may require each vendor to collect any other information necessary to ensure the protection of the public health.

Source: L. 2019: Entire part added, (SB 19-005), ch. 184, p. 2066, § 3, effective August 2.

25.5-2.5-204. Eligible prescription drugs - eligible Canadian suppliers - eligible importers - distribution requirements.

(1) An eligible importer may import a prescription drug from a Canadian supplier if:

(a) The drug that is to be imported meets the federal food and drug administration's standards related to safety, effectiveness, misbranding, and adulteration;

(b) Importing the drug would not violate federal patent laws;

(c) Importing the drug is expected to generate cost savings; and

(d) The drug is not:

(I) A controlled substance as defined in 21 U.S.C. sec. 802 (6);

(II) A biological product as defined in 42 U.S.C. sec. 262 (i);

(III) An infused drug;

(IV) An intravenously injected drug;

(V) A drug that is inhaled during surgery; or

(VI) A drug that is a parenteral drug, the importation of which is determined by the federal secretary of health and human services to pose a threat to public health.

(2) A Canadian supplier may export prescription drugs into the state under the program if the supplier:

(a) Is in full compliance with relevant Canadian federal and provincial laws and regulations;

(b) Is identified by the vendor as eligible to participate in the program pursuant to section 25.5-2.5-203 (2)(c); and

(c) Submits an attestation that the supplier has a registered agent in the United States, which attestation includes the name and United States address of the registered agent.

(3) The following entities are eligible importers and may obtain imported prescription drugs:

(a) A pharmacist or wholesaler employed by or under contract with a medicaid pharmacy, for dispensing to the pharmacy's medicaid members;

(b) A pharmacist or wholesaler employed by or under contract with the department of corrections, for dispensing to inmates in the custody of the department of corrections;

(c) Commercial plans, as defined by rules promulgated by the state board and as approved by the federal government; and

(d) A licensed Colorado pharmacist or registered wholesaler approved by the state department.

(4) (a) The state department shall designate an office or division that must be a registered wholesaler or that shall contract with a wholesaler registered pursuant to part 3 of article 280 of title 12.

(b) The office or division designated by the state department pursuant to subsection (4)(a) of this section shall:

(I) Set a maximum profit margin so that a wholesaler, distributor, pharmacy, or other licensed provider participating in the program maintains a profit margin that is no greater than the profit margin that the wholesaler, distributor, pharmacy, or other licensed provider would have earned on the equivalent nonimported drug;

(II) Exclude generic products if the importation of the products would violate United States patent laws applicable to United States-branded products;

(III) Comply with the requirements of 21 U.S.C. sec. 360eee to 360eee-4 as enacted in Title II of the federal "Drug Quality and Security Act"; and

(IV) Determine a method for covering the administrative costs of the program, which method may include a fee imposed on each prescription pharmaceutical product sold through the program or any other appropriate method as determined by the state department, but the state department shall not require a fee in an amount the state department determines would significantly reduce consumer savings.

(5) Canadian suppliers and eligible importers participating under the program:

(a) Shall comply with the tracking and tracing requirements of 21 U.S.C. sec. 360eee et seq.; and

(b) Shall not distribute, dispense, or sell prescription drugs imported under the program outside of the state.

(6) A participating eligible importer shall submit to the vendor all of following information about each drug to be acquired by the importer under the program:

(a) The name and quantity of the active ingredient of the drug;

(b) A description of the dosage form of the drug;

(c) The date on which the drug is received;

(d) The quantity of the drug that is received;

(e) The point of origin and destination of the drug; and

(f) The price paid by the importer for the drug.

(7) A participating Canadian supplier shall submit to the vendor the following information about each drug to be supplied by the Canadian supplier under the program:

(a) The original source of the drug, including:

(I) The name of the manufacturer of the drug;

(II) The date on which the drug was manufactured; and

(III) The country, state or province, and city where the drug was manufactured;

(b) The date on which the drug is shipped;

(c) The quantity of the drug that is shipped;

(d) The quantity of each lot of the drug originally received and the source of the lot; and

(e) The lot or control number and the batch number assigned to the drug by the manufacturer.

(8) The state department shall immediately suspend the importation of a specific drug or the importation of drugs by a specific eligible importer if it discovers that any drug or activity is in violation of this section or any federal or state law or regulation. The state department may revoke the suspension if, after conducting an investigation, it determines that the public is adequately protected from counterfeit or unsafe drugs being imported into this state.

Source: L. 2019: Entire part added, (SB 19-005), ch. 184, p. 2068, § 3, effective August 2. **L. 2021:** (3)(d) and (4)(a) amended, (SB 21-094), ch. 314, p. 1945, § 35, effective September 1. **L. 2024:** (3)(a) amended, (SB 24-176), ch. 152, p. 620, § 16, effective August 7.

25.5-2.5-205. Federal approval.

(1) On or before September 1, 2020, the state department shall submit a request to the United States secretary of health and human services for approval of the program under 21 U.S.C. sec. 384. The state department shall begin operating the program not later than six months after receiving such approval. The request must, at a minimum:

(a) Describe the state department's plan for operating the program;

(b) Demonstrate how the prescription drugs imported into the state under the program will meet the applicable federal and state standards for safety, effectiveness, misbranding, and adulteration;

(c) Include a list of prescription drugs that have the highest potential for cost savings to the state through importation at the time that the request is submitted;

(d) Estimate the total cost savings attributable to the program; and

(e) Include a list of potential Canadian suppliers from which the state would import prescription drugs and demonstrate that the suppliers are in full compliance with relevant Canadian federal and provincial laws and regulations.

(2) Notwithstanding any provision of this part 2 to the contrary, the state department may expend money for the purpose of requesting approval of the program as described in subsection (1) of this section but the state department shall not spend any other money to implement the program until the state department receives approval of the program as described in said subsection (1).

(3) Upon receipt of federal approval of the program, the state department shall notify the president of the senate and the speaker of the house of representatives, as well as the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees. After approval is received and before the start of the next regular session of the general assembly in which the proposal could be funded, the state department shall submit to all parties specified in this subsection (3) a proposal for program implementation and program funding.

Source: L. 2019: Entire part added, (SB 19-005), ch. 184, p. 2071, § 3, effective August 2.

25.5-2.5-206. Reports.

(1) Notwithstanding section 24-1-136 (11)(a)(I), on or before December 1, 2021, and on or before December 1 each year thereafter, the state department shall submit a report to the governor, the president of the senate, and the speaker of the house of representatives concerning the operation of the program during the previous fiscal year. The report must include, at a minimum:

(a) A list of the prescription drugs that were imported under the program;

(b) The number of participating Canadian suppliers and eligible importers;

(c) The number of prescriptions dispensed through the program;

(d) The estimated cost savings during the previous fiscal year and to date;

(e) A description of the methodology used to determine which prescription drugs should be included on the wholesale prescription drug importation list established pursuant to section 25.5-2.5-203 (2)(a); and

(f) Documentation demonstrating how the program ensures that:

(I) The vendor verifies that Canadian suppliers participating in the program are in full compliance with relevant Canadian federal and provincial laws and regulations;

(II) Prescription drugs imported under the program are not shipped, sold, or dispensed outside of the state once in the possession of the eligible importer;

(III) Prescription drugs imported under the program are pure, unadulterated, potent, and safe;

(IV) The program does not put consumers at a higher health and safety risk than if the program did not exist; and

(V) The program provides cost savings to the state on imported prescription drugs.

Source: L. 2019: Entire part added, (SB 19-005), ch. 184, p. 2072, § 3, effective August 2.

25.5-2.5-207. Importation program authorized - rules.

(1) Upon approval by the United States secretary of health and human services, in accordance with section 25.5-2.5-205, the state department shall administer an importation program.

(2) The state department shall approve a method of financing the administrative costs of the importation program, which method may include imposing a fee on each prescription pharmaceutical product sold through the importation program or any other appropriate method determined by the state department to finance administrative costs. The state department shall not require a fee in an amount that the state department determines would significantly reduce consumer savings.

(3) The executive director shall promulgate rules, in accordance with article 4 of title 24 and section 25.5-1-108, as necessary for the administration of this part 2.

Source: L. 2019: Entire part added, (SB 19-005), ch. 184, p. 2073, § 3, effective August 2. **L. 2021:** (1) amended, (SB 21-266), ch. 423, p. 2802, § 20, effective July 2.

25.5-2.5-208. Expansion of program to include additional foreign suppliers - federal action required - notice to general assembly.

(1) Notwithstanding any provision of this part 2 to the contrary, the state department may expand the program to allow a manufacturer, wholesale distributor, or pharmacy from a nation other than Canada to export prescription drugs into the state under the program if:

(a) The United States congress enacts legislation to amend 21 U.S.C. sec. 384 or otherwise enacts legislation to permit states, including Colorado, to import prescription drugs from foreign countries other than Canada;

(b) A vendor, in consultation with the state department, has identified the manufacturer, wholesale distributor, or pharmacy as a supplier that satisfies the requirements of the program and that will export prescription drugs at prices that will provide cost savings to the state;

(c) The manufacturer, wholesale distributor, or pharmacy is appropriately licensed or permitted under that nation's laws and regulations pertaining to the manufacturing, distribution, or dispensing of prescription drugs;

(d) The manufacturer, wholesale distributor, or pharmacy is located in a nation that is approved to export prescription drugs into Colorado by the United States secretary of health and human services or by another authority that is designated for such purpose by federal law; and

(e) The state department submits evidence to the president of the senate, the speaker of the house of representatives, and the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees, which evidence compares the exporting nation's regulatory system for prescription drugs to the regulatory system for prescription drugs administered by the United States food and drug administration pursuant to the federal act and demonstrates that the exporting nation's regulatory system is as stringent as the system in the United States or otherwise ensures the safety, purity, and potency of the prescription drugs from the exporting nation. The evidence must compare the regulations for:

(I) Securing the supply chain for prescription drugs;

(II) Prescription drug manufacturing;

(III) Prescription drug labeling; and

(IV) Prescription drug tracking and tracing.

(2) If, upon the satisfaction of the conditions described in subsection (1) of this section, the state department decides to expand the program to allow a manufacturer, wholesale distributor, or pharmacy from a nation other than Canada to export prescription drugs into the state under the program, the executive director shall notify the president of the senate, the speaker of the house of representatives, and the health and human services committee of the senate and the health and

insurance committee of the house of representatives, or any successor committees, of the state department's intent to do so. The executive director shall provide the notice at least thirty days before the program is expanded, and the notice may include any recommendations of the state department for legislation to amend this part 2 to reflect the expansion of the program.

(3) If the state department expands the program in accordance with this section, an eligible importer may import a prescription drug from a foreign supplier pursuant to this section if the drug that is to be imported is a prescription drug, as defined in 21 U.S.C. sec. 384 (a)(3).

Source: L. 2021: Entire section added, (SB 21-123), ch. 57, p. 233, § 2, effective September 7.

Cross references: For the legislative declaration in SB 21-123, see section 1 of chapter 57, Session Laws of Colorado 2021.

INDIGENT CARE

ARTICLE 3

Indigent Care

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PART 1

COLORADO INDIGENT CARE PROGRAM

Editor's note: (1) Section 25.5-3-113 provided for the repeal of this part 1, effective July 1, 2025. (See L. 2024, p. 248.)

(2) This part 1 was added in 2005 and amended with relocations in 2006. For amendments to this part 1 prior to its repeal in 2025, consult the 2024 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(3) For the amendments in SB 25-264 in effect from April 25, 2025, to July 1, 2025, see chapter 129, Session Laws of Colorado 2025. (L. 2025, p. 506.)

(4) Section 25.5-3-106 was repealed in SB 25-183, effective January 1, 2026. However, that repeal was superseded by the repeal of this entire part, effective July 1, 2025.

25.5-3-101 to 25.5-3-113. (Repealed)

PART 2

COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM

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

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

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

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

25.5-3-203. Definitions. (Repealed)

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

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

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

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

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

25.5-3-206. Reports. (Repealed)

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

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

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

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

PART 3

COMPREHENSIVE PRIMARY CARE SERVICES

Editor's note: This part 3 was added in 2006. It was repealed in 2011 and was subsequently recreated and reenacted in 2012, resulting in the addition, relocation, or elimination of sections as well as subject matter. For amendments to this part 3 prior to 2011, consult the 2010 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

25.5-3-301. Definitions.

As used in this part 3, unless the context otherwise requires:

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

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

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

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

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

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

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

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

(a) Whose annual household income is at or below two hundred percent of the federal poverty guideline; and

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

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

Source: L. 2012: Entire part RC&RE, (HB 12-1203), ch. 5, p. 15, § 1, effective March 1. **L. 2024:** (3)(a) amended, (HB 24-1399), ch. 76, p. 248, § 2, effective July 1, 2025.

25.5-3-302. Annual allocation - primary care services - qualified provider - rules.

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

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

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

(2) (a) A qualified provider shall annually submit to the state department information sufficient to establish the provider's eligibility status as specified in rule by the state board. A qualified provider shall submit an annual application for money that includes the total number of patients served, the number of uninsured or medically indigent patients served who have an

annual household income at or below two hundred percent of the federal poverty guideline, and the number of patients served who are enrolled in the medical assistance program, articles 4, 5, and 6 of this title 25.5, or the children's basic health plan, article 8 of this title 25.5.

(b) Each qualified provider shall annually develop and submit to the state department documentation regarding the quality assurance program in place at the provider's facility to ensure that quality comprehensive primary care services are being provided. The state department may, through state board rule, exempt a community health center from the reporting requirements described in this subsection (2)(b).

(c) The data regarding the number of patients served must be verified by an outside entity. For purposes of this part 3, the number of patients served is the number of unduplicated users of health-care services and is not the number of visits by a patient.

(3) (a) The state department shall make annual direct allocations of the total amount of money annually appropriated by the general assembly to the primary care fund pursuant to section 24-22-117 (2)(b), minus three percent for the administrative costs of the program, to all qualified providers.

(b) A qualified provider's allocation is based on the number of uninsured or medically indigent patients served by the provider in proportion to the total number of uninsured or medically indigent patients served by all qualified providers in the previous calendar year.

(c) The state department shall establish a schedule for allocating the money in the primary care fund for qualified providers. The disbursement of money in the primary care fund to qualified providers pursuant to this part 3 is exempt from the provisions of the "Procurement Code", articles 101 to 112 of title 24.

(4) Beginning in the 2021-22 state fiscal year, and to the extent available and permitted by the federal government and section 21 of article X of the state constitution, the state department shall maximize federal funds for payment to qualified providers pursuant to this section by aligning payments with the "Colorado Medical Assistance Act", articles 4, 5, and 6 of this title 25.5.

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

Source: L. 2012: Entire part RC&RE, (HB 12-1203), ch. 5, p. 16, § 1, effective March 1. **L. 2021:** (4) amended and (5) added, (SB 21-212), ch. 87, p. 361, § 1, effective May 4. **L. 2024:** (2) and (3) amended, (HB 24-1399), ch. 76, p. 248, § 3, effective July 1, 2025.

25.5-3-303. Consultation.

At least annually, the state department shall consult with representatives of federally qualified health centers, school-based health centers, family residency directors, certified rural health clinics, other qualified providers, and consumer advocates regarding the implementation and administration of the allocation of moneys to qualified providers under this part 3.

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

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

25.5-3-304. Primary care fund report.

(1) Beginning February 1, 2026, and each February 1 thereafter, the executive director shall prepare and submit an annual report to the house of representatives health and human services committee and the senate health and human services committee, or their successor committees; the joint budget committee; the governor; and the state board concerning the status of the primary care fund, created in section 24-22-117 (2)(b). At a minimum, the report must include:

(a) The number of uninsured or medically indigent patients served who have an annual household income at or below two hundred percent of the federal poverty guideline;

(b) The allocation of money to qualified providers;

(c) The state department's recommendations concerning the primary care fund; and

(d) The information presented by the state department to the general assembly pursuant to section 25.5-3-505 (6).

Source: L. 2024: Entire section added, (HB 24-1399), ch. 76, p. 249, § 4, effective July 1, 2025.

PART 4

COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

25.5-3-401. Short title.

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

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

25.5-3-402. Legislative declaration.

(1) The general assembly hereby finds and declares that:

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

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

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

(I) The local area agencies on aging;

(II) Community health centers;

(III) Safety-net clinics;

(IV) Private practice dental providers; and

(V) Foundations; and

(d) The state department shall implement this part 4 as a grant program throughout all geographic regions of the state using best practices and experience from other grant programs

operated by the state department to provide maximum flexibility to safety-net and private-practice dental providers in order to promote the health and welfare of low-income seniors.

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

25.5-3-403. Definitions.

As used in this part 4, unless the context otherwise requires:

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

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

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

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

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

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

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

(b) A community-based organization or foundation;

(c) A federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4); safety-net clinic; or health district;

(d) A local public health agency; or

(e) A private dental practice.

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

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1359, § 1, effective May 31. **L. 2020:** (6)(c) amended, (SB 20-136), ch. 70, p. 289, § 27, effective September 14.

Cross references: For the legislative declaration in SB 20-136, see section 1 of chapter 70, Session Laws of Colorado 2020.

25.5-3-404. Colorado dental health care program for low-income seniors - rules.

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

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

(2) The state department shall:

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

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

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

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

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

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

(3) (a) Qualified grantees shall:

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

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

(III) Identify eligible seniors and qualified providers;

(IV) Demonstrate collaboration with community organizations;

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

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

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

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

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

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

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

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

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

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

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

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1360, § 1, effective May 31. **L. 2019:** (2)(a) amended, (HB 19-1326), ch. 172, p. 2000, § 1, effective May 14.

25.5-3-405. Program reporting.

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

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

(b) Repealed.

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1362, § 1, effective May 31. **L. 2017:** (2) amended, (HB 17-1060), ch. 6, p. 16, § 7, effective March 1. **L. 2019:** Entire section amended, (HB 19-1326), ch. 172, p. 2000, § 2, effective May 14.

Editor's note: Subsection (2)(b)(II) provided for the repeal of subsection (2)(b), effective January 1, 2020. (See L. 2019, p. 2000.)

25.5-3-406. Senior dental advisory committee - creation - duties - repeal.

(1) (a) There is created in the state department a senior dental advisory committee comprised of eleven members appointed by the executive director as follows:

(I) A member representing the state department;

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

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

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

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

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

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

(VIII) Two consumer advocates;

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

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

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

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

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

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

(d) Repealed.

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

(2) The advisory committee shall:

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

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

(I) Defining covered dental care services;

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

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

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

(V) A maximum amount per procedure that can be spent by qualified grantees and qualified providers that must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in articles 4, 5, and 6 of this title 25.5.

(3) (a) This section is repealed, effective September 1, 2029.

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

Source: L. 2014: Entire part added, (SB 14-180), ch. 314, p. 1362, § 1, effective May 31. **L. 2016:** IP(2)(b) amended, (SB 16-189), ch. 210, p. 773, § 66, effective June 6. **L. 2019:** (2)(b)(V) amended, (HB 19-1326), ch. 172, p. 2001, § 3, effective May 14. **L. 2024:** (3)(a) amended, (HB 24-1256), ch. 201, p. 1230, § 2, effective August 7.

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

PART 5

HEALTH-CARE BILLING FOR INDIGENT PATIENTS RECEIVING SERVICES NOT REIMBURSED THROUGH THE COLORADO INDIGENT CARE PROGRAM

25.5-3-501. Definitions.

As used in this part 5, unless the context otherwise requires:

(1) "Health-care facility" means:

(a) A hospital licensed as a general hospital pursuant to part 1 of article 3 of title 25;

(b) A hospital established pursuant to section 23-21-503 or 25-29-103;

(c) Any freestanding emergency department licensed pursuant to section 25-1.5-114;

(d) Any outpatient health-care facility that is licensed as an on-campus department or service of a hospital or that is listed as an off-campus location under a hospital's license, except:

(I) A federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4); or

(II) A student-learning medical and dental clinic that is established for the purpose of student learning and offering discounted patient care as part of a program of student learning and is physically situated within a health sciences school; or

(e) A critical access hospital as defined in section 25-1.5-114.5.

(2) "Health-care services" has the same meaning as set forth in section 10-16-102 (33).

(2.5) "Inpatient hospital service" has the same meaning as set forth in 42 CFR 440.10.

(3) "Licensed health-care professional" means any health-care professional who is registered, certified, or licensed pursuant to title 12 or who provides services under the supervision of a health-care professional who is registered, certified, or licensed pursuant to title 12, and who provides health-care services in a health-care facility.

(4) Repealed.

(4.5) "Outpatient hospital service" has the same meaning as set forth in 42 CFR 440.20.

(5) "Qualified patient" means an individual who attests to residing in Colorado whose household income is not more than two hundred fifty percent of the federal poverty level and who received an inpatient hospital service or outpatient hospital service at a health-care facility.

(6) "Screen" or "screening" means a process described in section 25.5-3-502 whereby health-care facilities assess a patient's circumstances related to eligibility criteria and determine whether the patient has qualified or is likely to qualify for public health-care coverage or discounted care and, at the option of the health-care facility, is eligible or is likely eligible for the health-care facility's financial assistance program; inform the patient of the health-care facility's determination; and provide information to the patient about how the patient can enroll in public health-care coverage or the health-care facility's financial assistance program.

(6.7) "Uniform application" or "application" means a uniform form that is developed by the state department to determine whether a patient is a qualified patient and is completed following a screening or when required by section 25.5-3-502.5.

(7) "Uninsured" means an uninsured individual, as defined in section 10-22-113 (5)(d).

Source: L. 2021: Entire part added, (HB 21-1198), ch. 435, p. 2874, § 1, effective September 7. **L. 2024:** (2.5) and (4.5) added, (4) repealed, and (5) amended, (SB 24-116), ch. 300, p. 2040, § 1, effective August 7; (4) repealed, (HB 24-1399), ch. 76, p. 257, § 24, effective July 1, 2025; (1)(c) and (1)(d)(II) amended and (1)(e) added, (SB 24-121), ch. 439, p. 3067, § 5, effective July 1, 2026. **L. 2026:** (6) amended and (6.7) added, (SB 26-138), ch. 308, p. 1764, § 6, effective August 12.

Editor's note: Subsection (4) was repealed in HB 24-1399, effective July 1, 2025. Those amendments were superseded by the repeal of subsection (4) in SB 24-116, effective August 7, 2024.

Cross references: For the legislative declaration in SB 26-138, see section 1 of chapter 308, Session Laws of Colorado 2026.

25.5-3-502. Requirement to screen patients for eligibility for financial assistance - questionnaire - definition - rules.

(1) Beginning September 1, 2022, a health-care facility shall screen, unless a patient declines, each uninsured patient for eligibility for:

(a) Public health insurance programs, including but not limited to medicare; the state medical assistance program described in articles 4, 5, and 6 of this title 25.5; emergency medicaid; and the children's basic health plan described in article 8 of this title 25.5;

(b) Discounted care, as described in section 25.5-3-503; and

(c) At the option of the health-care facility, the health-care facility's financial assistance program, which often offers broader eligibility than public health insurance programs.

(2) A health-care facility may conduct screenings pursuant to subsection (1) of this section through:

(a) Accessing eligibility information through an industry-standard third-party resource, such as a major credit bureau;

(b) Requesting the patient complete a uniform screening questionnaire developed by the state department; or

(c) A combination of information obtained through subsections (2)(a) and (2)(b) of this section.

(3) If a health-care facility determines it has obtained sufficient information through the screening conducted pursuant to subsection (1) of this section, the health-care facility may make a determination of whether the patient is a qualified patient or is likely eligible for public health-care coverage without requiring the patient to provide further information through a uniform application pursuant to section 25.5-3-502.5.

(3.5) Upon completion of the screening conducted pursuant to subsection (1) of this section, a health-care facility shall:

(a) If the health-care facility determines that a patient is a qualified patient, provide the patient notice of the determination, the patient's identified federal poverty guideline percentage, and the patient's monthly installment maximum payment, as described in section 25.5-3-503;

(b) If the health-care facility determines that a patient is likely not a qualified patient, inform the patient of the results of the screening, including the patient's identified federal poverty guideline percentage, and provide the patient with:

(I) Information on how to complete an application pursuant to section 25.5-3-502.5; and

(II) If applicable, at the option of the health-care facility, information regarding the patient's eligibility for the health-care facility's financial assistance program and the amount of any discount offered through the program;

(c) If the health-care facility is certified by the state department as a presumptive eligibility site and determines that the patient is presumptively eligible for medical assistance, inform the patient of the determination and provide the patient with information on how the patient can enroll in public health-care coverage;

(d) If the health-care facility determines that a patient is likely eligible for public health-care coverage, inform the patient of the determination and:

(I) Provide the patient with information explaining how to apply for public health-care coverage, including at least one available method for submitting an application;

(II) Offer reasonable assistance or referral for support to complete an application for public health-care coverage; and

(III) Treat completion of an application for public health-care coverage as the primary pathway for resolving the patient's financial responsibility for hospital services until the patient is denied public health-care coverage or forty-five days after the date of discharge, whichever occurs first; and

(e) If the health-care facility needs more information to make a determination of whether the patient has qualified or is likely to qualify for discounted care or a financial assistance program, inform the patient of the patient's identified federal poverty guideline percentage and notify the patient that the patient must provide additional information to complete an application pursuant to section 25.5-3-502.5.

(3.7) (a) (I) If a patient has not been determined eligible for public health-care coverage pursuant to subsection (3.5)(d) of this section within forty-five days after the date of discharge, a health-care facility shall proceed with a determination of whether the patient is a qualified patient.

(II) Upon notification of a determination that a patient is ineligible for public health-care coverage pursuant to subsection (3.5)(d) of this section, a health-care facility shall proceed with a determination of whether the patient is a qualified patient.

(b) Subsection (3.5)(d) of this section does not prohibit a patient or health-care facility from completing an application pursuant to section 25.5-3-502.5 while a determination of the patient's eligibility for public health-care coverage is pending.

(c) While a determination of a patient's eligibility for public health-care coverage is pending, a health-care facility may defer completion of a final determination for discounted care if the patient is afforded the protections from billing and collection activity required by section 25.5-3-506.

(d) If a patient is determined eligible for public health-care coverage pursuant to subsection (3.5)(d) of this section, reimbursement through public health-care coverage is the primary reimbursement before any discounts are provided pursuant to this section.

(e) Where a health-care facility determines, based on available information, that a patient is facially ineligible for public health-care coverage, the health-care facility may proceed directly with a determination of whether the patient is a qualified patient.

(f) A health-care facility shall not deny eligibility for discounted care solely because a patient did not apply for public health-care coverage.

(4) If the patient declines the screening described in this section, the health-care facility shall document the patient's decision in accordance with state department rules. A patient's decision to decline the screening that is documented and complies with state department rules is a complete defense to a claim brought by a patient under section 25.5-3-506 (2) for a violation of section 25.5-3-506 (1)(a) or (1)(b).

(5) If requested by an insured patient, a health-care facility shall perform the screening described in this section and, if applicable, complete the application pursuant to section 25.5-3-502.5 to determine if the insured patient is a qualified patient.

(6) As used in this section, "inform" means to convey required information, unless otherwise specified in this section, including through verbal, electronic, or other formats. The health-care facility shall document the manner in which the information was provided.

(7) A health-care facility may use the same communication to comply with both state and federal requirements.

Source: L. 2021: Entire part added, (HB 21-1198), ch. 435, p. 2875, §1, effective September 7. **L. 2022:** IP(1) amended, (HB 22-1403), ch. 203, p. 1362, § 1, effective May 20. **L. 2024:** (1)(a) amended, (HB 24-1399), ch. 76, p. 258, § 25, effective July 1, 2025; (1)(b)(II) added by

revision, (HB 24-1399), ch. 76, pp. 258, 260, §§ 25, 33. **L. 2026:** Entire section amended, (SB 26-138), ch. 308, p. 1765, § 7, effective August 12.

Editor's note: Subsection (1)(b)(II) provided for the repeal of subsection (1)(b), effective July 1, 2025. (See L. 2024, pp. 258, 260.)

Cross references: For the legislative declaration in SB 26-138, see section 1 of chapter 308, Session Laws of Colorado 2026.

25.5-3-502.5. Uniform application for discounted care.

(1) After completion of the screening conducted pursuant to section 25.5-3-502, a health-care facility shall request information from a patient to complete a uniform application for discounted care if:

(a) The health-care facility needs more information to make a determination of whether the patient has qualified or is likely to qualify for discounted care or the health-care facility's financial assistance program, including if the health-care facility's policy is to require an application prior to making a final determination; or

(b) The patient requests an application, unless the patient has no balance remaining after applying any discounts pursuant to section 25.5-3-503 or the health-care facility's financial assistance program.

(2) A health-care facility shall use the uniform application developed by the state department to complete the application required by this section.

(3) Upon completion and review of the application, a health-care facility shall:

(a) If the health-care facility determines that a patient is a qualified patient, provide the patient notice of the determination, the patient's identified federal poverty guideline percentage, and the patient's monthly installment maximum payment, as described in section 25.5-3-503;

(b) If the health-care facility determines that a patient is not a qualified patient, provide the patient notice of the determination, which, if applicable, may also include notice that the patient is eligible for the health-care facility's financial assistance program and the amount of any discount offered through that program, and shall provide either:

(I) An opportunity for the patient to appeal the determination in accordance with state department rules; or

(II) A statement that the patient has no balance due after applying any discounts from the health-care facility's financial assistance program; and

(c) If the health-care facility is certified by the state department as a presumptive eligibility site and determines that the patient is presumptively eligible for medical assistance, provide the patient notice of the determination and information on how the patient can enroll in public health-care coverage.

Source: L. 2026: Entire section added, (SB 26-138), ch. 308 p. 1768, § 8, effective August 12.

Cross references: For the legislative declaration in SB 26-138, see section 1 of chapter 308, Session Laws of Colorado 2026.

25.5-3-503. Health-care discounts on services not eligible for Colorado indigent care program reimbursement - definition.

(1) Beginning September 1, 2022, if a patient is screened pursuant to section 25.5-3-502 or has completed a uniform application pursuant to section 25.5-3-502.5 and is determined to be a qualified patient, a health-care facility and a licensed health-care professional shall, for emergency hospital and other health-care services:

(a) Limit the amounts charged to not more than the discounted rate established in state department rule pursuant to section 25.5-3-505 (2)(j);

(b) Collect amounts charged, not including amounts owed by third-party payers, in monthly installments such that the patient is not paying more than four percent of the patient's monthly household income on a bill from a health-care facility, not paying more than two percent of the patient's monthly household income on a bill from each licensed health-care professional, and not paying more than six percent of the patient's household income on a comprehensive bill containing all health-care facility and licensed health-care professional charges; and

(c) After a cumulative thirty-six months of payments, consider the patient's bill paid in full and permanently cease any and all collection activities on any balance that remains unpaid.

(2) A health-care facility shall not:

(a) Deny discounted care on the basis that the patient has not applied for any public benefits program, unless during the screening the patient is determined to be presumptively eligible for the state medical assistance program; or

(b) Adopt or maintain any policies that result in the denial of admission or treatment of a patient because the patient lacks health insurance coverage, may qualify for discounted care, requires extended or long-term treatment, or has an unpaid medical bill.

(3) The licensed health-care professional who provides services to a patient pursuant to this part 5 is responsible for billing the patient for those services, unless the services are billed on a comprehensive bill issued by a health-care facility.

(4) For the purposes of this part 5, "emergency hospital and other health-care services" does not include primary care provided in a clinic located in a designated rural or frontier county that offers a sliding-fee scale as approved by the state department.

Source: L. 2021: Entire part added, (HB 21-1198), ch. 435, p. 2876 § 1, effective September 7. **L. 2022:** IP(1) amended, (HB 22-1403), ch. 203, p. 1362, § 2, effective May 20. **L. 2024:** IP(1), (1)(b), and (2)(a) amended and (3) and (4) added, (SB 24-116), ch. 300, p. 2041, § 2, effective August 7. **L. 2026:** IP(1) and (2)(a) amended, (SB 26-138), ch. 308, p. 1769, § 9, effective August 12.

Cross references: For the legislative declaration in SB 26-138, see section 1 of chapter 308, Session Laws of Colorado 2026.

25.5-3-504. Notification of patients' rights - website link.

(1) A health-care facility shall make information developed by the state department about patients' rights under this part 5 and a link on the state department website to access the uniform application developed by the state department pursuant to section 25.5-3-505 (2)(i) available to the public and to each patient. At a minimum, the health-care facility shall:

(a) Post the information in all required languages pursuant to this subsection (1) conspicuously on the health-care facility's website, including a link to the information on the health-care facility's main landing page;

(b) Make the information available in patient waiting areas;

(c) Make the information available to each patient, or the patient's legal guardian, verbally, which may include using a professional interpretation service, or in writing in the patient's or legal guardian's primary language before the patient is discharged from the health-care facility; and

(d) Inform each patient on the patient's billing statement of the patient's rights pursuant to this part 5, including the right to apply for discounted care, and provide the website, email

address, and telephone number where the information may be obtained in the patient's primary language.

(2) The state department shall post the uniform application developed pursuant to section 25.5-3-505 (2)(i) in all required languages on a publicly accessible website.

Source: L. 2021: Entire part added, (HB 21-1198), ch. 435, p. 2877, § 1, effective September 7. **L. 2022:** IP(1) amended, (HB 22-1403), ch. 203, p. 1362, § 3, effective May 20. **L. 2026:** IP(1) amended and (2) added, (SB 26-138), ch. 308, p. 1769, § 10, effective August 12.

Cross references: For the legislative declaration in SB 26-138, see section 1 of chapter 308, Session Laws of Colorado 2026.

25.5-3-505. Health-care facility reporting requirements - agency enforcement - report - rules.

(1) Beginning September 1, 2023, and each September 1 thereafter, each health-care facility and licensed health-care professional shall report to the state department data that the state department determines is necessary to evaluate compliance across race, ethnicity, age, and primary-language-spoken patient groups with the screening, discounted care, payment plan, and collections practices required pursuant to this part 5. If a health-care facility or licensed health-care professional is not capable of disaggregating the data required pursuant to this subsection (1) by race, ethnicity, age, and primary language spoken, the health-care facility or licensed health-care professional shall report to the state department the steps the facility or licensed health-care professional is taking to improve race, ethnicity, age, and primary-language-spoken data collection and the date by which the facility or licensed health-care professional will be able to disaggregate the reported data.

(2) No later than July 1, 2027, the state board shall adopt rules necessary for the administration and implementation of this part 5. At a minimum, the rules must:

(a) Outline a process for an insured patient to request a screening pursuant to section 25.5-3-502 (5);

(b) Outline a process for documenting, pursuant to section 25.5-3-502 (4), that a patient has made an informed decision to decline the screening, including procedures for retaining such documentation;

(c) Establish the process for and the maximum number of days that a health-care facility has to:

(I) Initiate a screening after a patient receives services;

(II) Request information from a patient needed for the screening process if the health-care facility conducts a screening using the uniform screening questionnaire as described in section 25.5-3-502 (2); and

(III) Complete the screening process;

(d) Outline the requirements for notifying the patient of the results of the screening, including:

(I) An explanation of the basis for a denial of discounted care; and

(II) The process for completing an application to provide more information to determine whether the patient is a qualified patient;

(d.5) Establish a process for and the maximum number of days that a health-care facility has to:

(I) Request information from the patient to complete an application, if the application is required pursuant to section 25.5-3-502.5; and

(II) Complete the application process as described in section 25.5-3-502.5;

(e) Establish guidelines for patient appeals regarding eligibility for discounted care pursuant to section 25.5-3-502.5;

(f) Establish acceptable methodologies for health-care facilities to determine monthly household income. For purposes of the screening conducted pursuant to section 25.5-3-502, the use of an industry-standard third-party resource, including major credit bureaus, is an acceptable methodology. A health-care facility shall disclose to the department which industry-standard third-party resources they use to determine monthly household income. The methodologies must not consider a patient's assets.

(g) For purposes of the application, identify the documents that may be required to establish income eligibility for discounted care using the minimum amount of information needed to determine eligibility;

(h) Identify the steps a health-care facility and licensed health-care professional must take before sending patient debt to collections;

(i) Create a uniform application that a health-care facility must use when an application is required after screening a patient for eligibility for discounted care, as described in sections 25.5-3-502 and 25.5-3-502.5; and

(j) Annually establish rates for discounted care pursuant to section 25.5-3-503 (1)(a). The rates should approximate and not be less than one hundred percent of the medicare rate or one

hundred percent of the medicaid base rate, whichever is greater. The state department shall publicly post the established rates on the state department's website.

(3) In promulgating rules pursuant to this section, the state department shall consider potential limitations relating to the federal "Emergency Medical Treatment and Labor Act", 42 U.S.C. sec. 1395dd.

(4) Prior to promulgating rules pursuant to this section, the state department shall hold at least one stakeholder meeting with hospital representatives, health-care consumers, and health-care consumer advocates that is accessible to individuals whose primary language is not English, if requested.

(5) The state department:

(a) Using feedback from hospital health-care consumers and health-care consumer advocate stakeholders, develop a written explanation of a patient's rights under this section that is written in plain language at a sixth-grade reading level and translated into all languages spoken by ten percent or more of the population in each county of the state and post the written explanation in all required languages on the state department's website. Each health-care facility shall make the explanation available to the public and each patient as provided in section 25.5-3-504.

(b) (I) Shall establish a process for patients to submit a complaint relating to noncompliance with this part 5 to the state department by phone, by mail, or online. The state department shall conduct a review of a patient's complaint within thirty days after receiving the complaint.

(II) (A) Shall periodically review health-care facilities and licensed health-care professionals to ensure qualified patients are identified in compliance with this part 5, are not charged more than the discounted rate established in state board rules pursuant to subsection (2)(j) of this section, are offered installment payments as required by section 25.5-3-503, and do not have their debt assigned or sold before all requirements of section 25.5-3-506 are met. The review shall be conducted in accordance with state department rules, and the frequency, sample size, and timeline of the review must be reasonable considering the size and resources of the health-care facility.

(B) If the state department finds that a health-care facility or licensed health-care professional is not in compliance with this section and the noncompliance has resulted in a delay or denial of a discount owed to a patient as a result of the screening or application required pursuant to section 25.5-3-502 or 25.5-3-502.5, as a result of the health-care facility or the licensed health-care professional charging the patient more than the discounted rate established in state department rule pursuant to section 25.5-3-505 (2)(j), due to a failure to offer installment payments pursuant to section 25.5-3-503, or due to the assigning or selling of patient debt to a collection agency in violation of section 25.5-3-506, the state department shall notify the health-care facility or licensed health-care professional and the facility or professional has ninety days after notification to file a corrective action plan with the state department. If the noncompliance

resulted in excess charges to the patient, the corrective action plan must include measures to inform the patient about the noncompliance and provide a financial correction consistent with this part 5. A health-care facility or licensed health-care professional may request up to one hundred twenty days to submit a corrective action plan. The state department may require a health-care facility or licensed health-care professional that is not in compliance with this part 5 or any state board rules adopted pursuant to this part 5 to develop and operate under a corrective action plan until the state department determines the health-care facility or licensed health-care professional is in compliance.

(C) If a health-care facility's or licensed health-care professional's noncompliance with this part 5 did not result in a delay or denial of a discount owed to a patient, the state department may notify the health-care facility or licensed health-care professional of the noncompliance for purposes of quality improvement.

(III) If a health-care facility's or licensed health-care professional's noncompliance with this section is determined by the state department to be knowing or willful or there is a repeated pattern of noncompliance, the state department may fine the facility or professional no more than five thousand dollars. If the health-care facility or licensed health-care professional fails to take corrective action or fails to file a corrective action plan with the state department pursuant to subsection (5)(b)(II) of this section, the state department may fine the facility or professional no more than five thousand dollars a week until the facility or professional takes corrective action. The state department shall consider the size of the health-care facility and the seriousness of the violation in setting the fine amount.

(6) The state department shall make the information reported pursuant to subsection (1) of this section and any corrective action plans for which fines were imposed pursuant to subsection (5)(b) of this section available to the public and shall annually report the information as a part of its presentation to its committees of reference at a hearing held pursuant to section 2-7-203 (2)(a) of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act".

(7) (a) The state department shall comply with section 24-4-103 (1) when imposing changes to the uniform screening questionnaire, changes to the application, new requirements, new reporting obligations, new documentation standards, new data elements, or new program criteria. The state department shall ensure the changes or new requirements are:

(I) Adopted by rule pursuant to the "State Administrative Procedure Act", article 4 of title 24 , by September 1, 2026, for a rule that will go into effect during to the 2026-27 state fiscal year and every year thereafter by June 1 prior to the state fiscal year for which the rule will go into effect; and

(II) Subject to stakeholder engagement pursuant to subsection (4) of this section.

(b) Any change or new requirement described in subsection (7)(a) of this section that was not adopted through rule-making is advisory only and does not serve as the basis for enforcement.

(c) The state department shall maintain an updated public archive of all manuals and subregulatory issuances, including the rationale for changes and citations to statutory or regulatory authority for each change or new requirement.

(d) This subsection (7) does not apply to rules adopted by the state department or the state board to update annual federal poverty guidelines or in response to emergent and immediate trends that are identified by consumers or hospitals as limiting the program's effectiveness and are demonstrated by data submitted to the state department or the state board.

Source: L. 2021: Entire part added, (HB 21-1198), ch. 435, p. 2877, § 1, effective September 7. **L. 2022:** (1) amended, (HB 22-1403), ch. 203, p. 1363, § 4, effective May 20. **L. 2024:** (1) amended, (SB 24-116), ch. 300, p. 2041, § 3, effective August 7; (2)(i) and (3) amended, (HB 24-1399), ch. 76, p. 258, § 26, effective July 1, 2025. **L. 2026:** IP(2), (2)(c)(II), (2)(d), (2)(e), (2)(f), (2)(g), (2)(i), IP(5), (5)(b)(I), and (5)(b)(II) amended and (2)(d.5) and (7) added, (SB 26-138), ch. 308, p. 1769, § 11, effective August 12.

Cross references: For the legislative declaration in SB 26-138, see section 1 of chapter 308, Session Laws of Colorado 2026.

25.5-3-506. Limitations on collection actions - private enforcement.

(1) Beginning September 1, 2022, before assigning or selling patient debt to a collection agency, as defined in section 5-16-103 (3)(a), or a debt buyer, as defined in section 5-16-103 (8.5), or before pursuing, either directly or indirectly, any permissible extraordinary collection action, as defined in section 6-20-201 (7):

(a) A health-care facility shall meet the screening requirements in section 25.5-3-502;

(b) A health-care facility and licensed health-care professional shall provide discounted care to a patient pursuant to section 25.5-3-503;

(c) A health-care facility and licensed health-care professional shall provide a plain language explanation of the health-care services and fees being billed and notify the patient of potential collection actions; and

(d) A health-care facility and health-care professional shall bill any third-party payer that is responsible for providing health-care coverage to the patient. If a health-care professional is an out-of-network provider under a qualified patient's health insurance plan, the health-care

professional and health insurance carrier shall comply with the out-of-network billing requirements described in sections 10-16-704 (3) and 12-30-113.

(2) A health-care facility or licensed health-care professional that fails to comply with the requirements of this section is liable to the patient in an amount equal to the sum of:

(a) Any actual damages sustained by the patient as a result of such failure;

(b) In the case of such action brought by an individual, any additional damages that the court may allow, not to exceed one thousand dollars;

(c) In the case of a class action, such amount for each named plaintiff that may recover damages under subsection (2)(b) of this section, and such amount that the court may allow for all other class members without regard to a minimum individual recovery, not to exceed the lesser of five hundred thousand dollars or one percent of the net worth of the health-care facility or licensed health-care professional; and

(d) In the case of any successful action to enforce the foregoing liability, the costs of the action together with reasonable attorney fees as determined by the court. On a finding by the court that the action was brought in bad faith, the court may award reasonable attorney fees to the defendant that are related to the work expended and costs.

(3) In determining the amount of liability in any action pursuant to subsection (2) of this section, the court shall consider, among other relevant factors:

(a) In any individual action brought pursuant to subsection (2)(a) of this section, the frequency and persistence of noncompliance by the health-care facility or licensed health-care professional, the nature of such noncompliance, and the extent to which such noncompliance was intentional; or

(b) In any individual action brought pursuant to subsection (2)(b) of this section, the frequency and persistence of noncompliance by the health-care facility or licensed health-care professional, the nature of such noncompliance, the resources of the health-care facility or licensed health-care professional, the number of individuals adversely affected, and the extent to which the health-care facility's or licensed health-care professional's noncompliance was intentional.

Source: L. 2021: Entire part added, (HB 21-1198), ch. 435, p. 2880, § 1, effective September 7. **L. 2022:** IP(1) amended, (HB 22-1403), ch. 203, p. 1363, § 5, effective May 20.

25.5-3-507. Hospital discounted care advisory committee - repeal.

(1) The hospital discounted care advisory committee is created in the state department. The advisory committee consists of the following members, appointed by the executive director:

(a) Three members who are health-care consumers, of whom no more than two members may be employed by a health-care consumer advocacy organization;

(b) One member who is a representative of the state department;

(c) One member who is a representative of a safety net hospital for which the percent of medicaid-eligible inpatient days relative to the hospital's total inpatient days is equal to or greater than one standard deviation above the mean;

(d) One member who is a representative of a hospital in a rural area;

(e) One member who is a representative of a hospital in an urban area;

(f) One member who is a representative of a statewide organization of hospitals;

(g) One member who is a representative of licensed health-care professionals who provide services to patients in a hospital setting;

(h) One member who is a representative of an organization of Colorado community health centers or a representative of a Colorado community health center, as defined in 42 U.S.C. sec. 254b; and

(i) One member who is a representative of an organization of safety-net health providers or a safety-net health provider that is not a community health center.

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

(3) (a) The executive director shall designate a member to serve as chair of the advisory committee. The advisory committee shall meet at least twice each year and as necessary at the call of the chair.

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

(4) The advisory committee shall advise the state department on the operations and policies of this part 5 and make recommendations to the state board regarding promulgating rules pursuant to this part 5.

(5) This section is repealed, effective September 1, 2029. Prior to the repeal, the advisory committee is scheduled for review in accordance with section 2-3-1203.

Source: L. 2024: Entire section added, (HB 24-1399), ch. 76, p. 250, § 5, effective July 1, 2025.

PART 6

SAFETY NET PROVIDER STABILIZATION

Cross references: For the legislative declaration in SB 25-290, see section 1 of chapter 274, Session Laws of Colorado 2025.

25.5-3-601. Legislative declaration.

(1) The general assembly finds and declares that:

(a) Safety net providers in the state incur significant costs by providing services to a large portion of the state's low-income, uninsured populations and individuals and families enrolled in medicaid or the children's basic health plan; and

(b) This part 6 is enacted to leverage money loaned from the unclaimed property trust fund to the provider stabilization fund to obtain federal matching money to make provider stabilization payments to eligible safety net providers in order to:

(I) Reduce the underpayment to safety net providers participating in medicaid or the children's basic health plan and to provide compensation to safety net providers that provide services to low-income, uninsured individuals on a sliding-fee schedule or for free;

(II) Ensure access to high-quality, affordable health care for low-income and uninsured populations; and

(III) Maintain the quality and continuity of services delivered by safety net providers to low-income, uninsured individuals and individuals and families enrolled in medicaid or the children's basic health plan.

Source: L. 2025: Entire part added, (SB 25-290), ch. 274, p. 1422, § 2, effective May 28.

25.5-3-602. Definitions.

As used in this part 6, unless the context otherwise requires:

(1) "Children's basic health plan" has the same meaning as set forth in section 25.5-8-103 (2).

(2) "Eligible safety net provider" means a safety net provider determined, pursuant to section 25.5-3-604 (2), to be eligible for a provider stabilization payment.

(3) "Low-income, uninsured individual" means an individual:

(a) Receiving services from a safety net provider;

(b) Whose annual household income is at or below two hundred percent of the federal poverty guideline;

(c) Who is not enrolled in medicaid, medicare, or the children's basic health plan; and

(d) For whom a third party is not paying or reimbursing the safety net provider for all or a portion of the amount charged for the services provided to the individual.

(4) "Medicaid" means a medical assistance program under articles 4 to 6 of this title 25.5.

(5) "Medicare" means the "Health Insurance for the Aged Act", title XVIII of the federal "Social Security Act", as amended.

(6) "Provider stabilization fund" or "fund" means the provider stabilization fund created in section 25.5-3-603.

(7) "Provider stabilization fund advisory board" or "advisory board" means the provider stabilization fund advisory board created in section 25.5-3-605.

(8) "Safety net provider" means:

(a) A comprehensive community behavioral health provider, as defined in section 27-50-101 (11);

(b) A rural health clinic, as defined in 42 U.S.C. sec. 1395x (aa)(2);

(c) A federally qualified health center, as defined in 42 U.S.C. sec. 1395x (aa)(4); or

(d) A health-care provider that is delivering primary care services and at least fifty percent of whose client caseload is individuals who are enrolled in medicaid, medicare, or the children's basic health plan or who are low-income, uninsured individuals, or any combination of such enrollees or low-income, uninsured individuals.

(9) "Unclaimed property trust fund" means the unclaimed property trust fund created in section 38-13-801 (1).

Source: L. 2025: Entire part added, (SB 25-290), ch. 274, p. 1423, § 2, effective May 28.

25.5-3-603. Provider stabilization fund - creation - use.

(1) (a) The provider stabilization fund is created in the state treasury. The provider stabilization fund consists of:

(I) Money credited to the fund as a loan from the unclaimed property trust fund pursuant to section 38-13-801 (6);

(II) Any other money the general assembly may appropriate, transfer, or credit to the fund; and

(III) Any gifts, grants, or donations the state department may receive from public or private sources for the fund.

(b) (I) (A) Money credited to the fund pursuant to section 38-13-801 (6) is an interest-free loan from the unclaimed property trust fund to the fund. The state department may accept and expend the money so credited and shall repay the loan received pursuant to section 38-13-801 (6) no later than January 1, 2045.

(B) If, in any state fiscal year that begins on or after July 1, 2026, state revenues from sources not excluded from state fiscal year spending, as defined in section 24-77-102 (17), do not exceed the limit on state fiscal year spending calculated pursuant to section 24-77-103, the state department shall present to the joint budget committee a proposal to repay all or a portion of the loan earlier than the loan repayment deadline specified in subsection (1)(b)(I)(A) of this section.

(C) To the extent possible and for purposes of repaying the loan from the unclaimed property trust fund, the general assembly shall prioritize making annual transfers from the general fund to the unclaimed property trust fund beginning in the 2030-31 state fiscal year, or sooner, if funds are available.

(II) A loan made from the unclaimed property trust fund to a separate fund associated with a state department:

(A) Is an interfund loan according to governmental accounting standards board codification 1800.102, meaning that the loan is not classified as revenue and is booked as an interfund receivable or payable; and

(B) Is not state fiscal year spending, as defined in section 24-77-102 (17), or state revenues, as defined in section 24-77-103.6 (6)(c), and does not count against either the state fiscal year spending limit imposed by section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I)(G).

(III) Loan liabilities that are recorded in the fund but that are not required to be paid in the current fiscal year shall not be considered when calculating sufficient statutory fund balance for purposes of section 24-75-109.

(2) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the provider stabilization fund to the general fund. The state treasurer shall invest, as provided by law, any money in the fund not expended for the purposes specified in section 25.5-3-604. Money in the fund, other than interest, shall not be transferred to any other fund and shall not be used for any purpose other than the purposes specified in section 25.5-3-604.

(3) Subject to annual appropriation by the general assembly, the state department shall expend the money in the fund and any federal matching money, in accordance with section 25.5-3-604 (1), to distribute provider stabilization payments to safety net providers determined eligible for payments in accordance with section 25.5-3-604 (2).

(4) The state department, in collaboration with the provider stabilization fund advisory board, may seek, accept, and expend gifts, grants, or donations from private or public sources for the purposes of section 25.5-3-604. The state department shall transmit all money received through gifts, grants, or donations to the state treasurer, who shall credit the money to the provider stabilization fund.

(5) The state department, in consultation with the provider stabilization fund advisory board, shall leverage money in the fund to obtain federal matching money, working with or through the state board to the extent required by federal law or otherwise necessary.

Source: L. 2025: Entire part added, (SB 25-290), ch. 274, p. 1424, § 2, effective May 28.

25.5-3-604. Provider stabilization payments - eligibility.

(1) (a) The state department, in collaboration with the provider stabilization fund advisory board, shall annually allocate money appropriated by the general assembly from the provider stabilization fund as provider stabilization payments to safety net providers in the state that comply with the requirements of subsection (2) of this section and are determined to be eligible for a provider stabilization payment. The state department shall allocate the provider stabilization payments in amounts proportionate to the number of low-income, uninsured individuals served by an eligible safety net provider relative to the total number of low-income, uninsured individuals served by all eligible safety net providers.

(b) The state department, in consultation with the advisory board, shall establish a schedule for allocating the money appropriated from the provider stabilization fund for eligible safety net

providers. The disbursement of money in the provider stabilization fund to eligible safety net providers pursuant to this section is exempt from the provisions of the "Procurement Code", articles 101 to 112 of title 24.

(c) Provider stabilization payments from the provider stabilization fund pursuant to this subsection (1) are made to supplement, not supplant, general fund appropriations to support safety net provider reimbursements.

(2) (a) For a safety net provider to be eligible for a provider stabilization payment pursuant to subsection (1)(a) of this section, the safety net provider shall provide sufficient information to the state department, as specified in subsection (2)(b) of this section, to establish that the provider provides services to low-income, uninsured individuals:

(I) At no cost; or

(II) On a sliding-fee schedule.

(b) A safety net provider applying for a provider stabilization payment shall annually submit to the state department information that the state department, in consultation with the advisory board, determines necessary to establish the provider's eligibility for a provider stabilization payment pursuant to subsection (1)(a) of this section. The safety net provider shall provide the following:

(I) Information demonstrating that the provider is a safety net provider as described in section 25.5-3-602 (8)(a), (8)(b), or (8)(c) or has a client caseload that satisfies the requirements of section 25.5-3-602 (8)(d);

(II) For a safety net provider described in section 25.5-3-602 (8)(d), the total number of patients served, the number of low-income, uninsured individuals that the provider served, and the number of enrollees in medicaid, medicare, or the children's basic health plan that the provider served; and

(III) Information to demonstrate that the provider provides services in compliance with subsection (2)(a)(I) or (2)(a)(II) of this section, as applicable.

(c) For purposes of this subsection (2), the number of patients served is the number of unduplicated users of health-care services and is not the number of visits by a patient.

Source: L. 2025: Entire part added, (SB 25-290), ch. 274, p. 1425, § 2, effective May 28.

25.5-3-605. Provider stabilization fund advisory board - creation - membership - duties - repeal.

(1) (a) The provider stabilization fund advisory board is created to support the state department with the implementation of this part 6. The advisory board consists of nine members appointed by the governor as follows:

(I) Five members who are eligible safety net providers or who represent associations of eligible safety net providers, at least two of whom must be from a rural area of the state;

(II) Three members who are low-income, uninsured individuals who are Colorado residents and who rely on safety net providers for health care or who are representatives from Colorado-based consumer advocacy organizations that work on safety net health-care matters; and

(III) One member who is an employee of the state department.

(b) (I) The governor shall make the initial appointments to the advisory board as soon as possible after May 28, 2025, but no later than August 1, 2025.

(II) Members of the advisory board serve at the pleasure of the governor. The term of appointment is three years.

(c) Members of the advisory board serve without compensation and without reimbursement for expenses.

(d) The advisory board shall elect a chair and vice-chair from among its provider and consumer members and shall meet as necessary at the call of the chair to perform its functions as specified in this part 6.

(2) The advisory board shall consult with the state department, as well as the state board as necessary, in implementing this part 6, including assisting the state department in administering and providing oversight of the provider stabilization fund and in leveraging the fund to obtain federal matching money.

(3) This section is repealed, effective September 1, 2031. Before the repeal, the committee is scheduled for review in accordance with section 2-3-1203.

Source: L. 2025: Entire part added, (SB 25-290), ch. 274, p. 1427, § 2, effective May 28.

25.5-3-606. Provider stabilization fund report.

(1) Beginning September 1, 2026, and by each September 1 thereafter, the state department, with assistance from the advisory board, shall prepare and submit an annual report concerning the provider stabilization fund to:

(a) The health and human services committee of the house of representatives and the health and human services committee of the senate, or their successor committees;

(b) The joint budget committee;

(c) The governor; and

(d) The state board.

(2) At a minimum, the report must include:

(a) The number of low-income, uninsured individuals and the number of medicaid, medicare, and children's basic health plan enrollees served by eligible safety net providers that received provider stabilization payments in the immediately preceding fiscal year;

(b) The allocation of money to eligible safety net providers, including an itemization of the total amount of provider stabilization payments allocated to each eligible safety net provider; and

(c) Any other information that the state department, in consultation with the advisory board, deems necessary or appropriate.

(3) Notwithstanding the requirement in section 24-1-136 (11)(a)(I), the requirement to submit the report required in this section continues indefinitely.

Source: L. 2025: Entire part added, (SB 25-290), ch. 274, p. 1427, § 2, effective May 28.

COLORADO MEDICAL ASSISTANCE ACT

ARTICLE 4

Colorado Medical Assistance Act - General Medical Assistance

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PART 1

GENERAL PROVISIONS

25.5-4-101. Short title.

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

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

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

ANNOTATION

Applied in Sherman v. District Court, 637 P.2d 378 (Colo. 1981) (decided prior to the 2006 amendments relocating article 4 of title 26 to title 25.5).

25.5-4-102. Legislative declaration.

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

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

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

ANNOTATION

Annotator's note. Since § 25.5-4-102 is similar to § 26-4-102 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5, relevant cases construing that provision have been included in the annotations to this section.

Program not limited to services and procedures available under Medicaid. While this statute furnishes a limiting guide for administration of Colorado's medical assistance program, it does not limit the scope of that program to medical services and procedures for reimbursement under the federal Medicaid program. Dodge v. State Dept. of Soc. Servs., 657 P.2d 969 (Colo. App. 1982).

Applied in City of Colo. Springs v. State, 640 P.2d 870 (Colo. App. 1982).

25.5-4-103. Definitions.

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

(1) Repealed.

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

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

(2.5) "Case management agency" has the same meaning as set forth in section 25.5-6-1702 (2).

(3) "Case management services" means services provided by case management agencies and comprehensive community behavioral health providers, as defined in section 27-50-101, to assist persons in gaining access to needed medical, social, educational, and other services.

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

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

(5.5) "Dementia diseases and related disabilities" has the same meaning set forth in section 25-1-502 (2.5).

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

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

(a) Nursing services;

(b) Home health aide services;

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

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

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

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

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

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

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

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

(12) "Managed care system" means a health-care system organized to manage costs, utilization, and quality. The statewide managed care system provides for the delivery of health benefits and additional services through contracted arrangements between state medicaid agencies and MCEs.

(13) "Medical assistance" means payment on behalf of members eligible for and enrolled in the state medical assistance program established pursuant to this article 4 and articles 5 and 6 of this title 25.5, which is funded through Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396u-1, to providers enrolled in the state medical assistance program who render or provide medical care, services, goods, and devices to members pursuant to this article 4 and articles 5 and 6 of this title 25.5, and other related payments, pursuant to this article 4 and articles 5 and 6 of this title 25.5 and the rules of the state department.

(13.2) "Member" means a person who has been determined eligible to receive benefits under this article 4 and articles 5 and 6 of this title 25.5.

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

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

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

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

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

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

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

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

(19.5) "Psychiatric residential treatment facility" means a facility that is licensed as a residential child care facility, as defined in section 26-6-903, that is not a hospital, and that provides inpatient psychiatric services for individuals who are less than twenty-one years of age under the direction of a physician licensed pursuant to article 240 of title 12, and that meets any other requirement established in rule by the state board. "Psychiatric residential treatment facility" includes a state-owned psychiatric residential treatment facility as defined in section 26-6-903.

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

(21) Repealed.

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

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

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

(24.5) "Serious mental illness" means the following psychiatric illnesses, as defined by the American Psychiatric Association in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders:

(a) Bipolar disorders (hypomanic, manic, depressive, and mixed);

(b) Depression in childhood and adolescence;

(c) Major depressive disorders (single episode or recurrent);

(d) Obsessive-compulsive disorders;

(e) Paranoid and other psychotic disorders;

(f) Schizoaffective disorders (bipolar or depressive); and

(g) Schizophrenia.

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

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

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

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

(25.7) "Telemedicine" means the delivery of medical and health-care services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication.

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

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

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

Source: L. 2006: (19.5) added, p. 1202, § 1, effective May 26; entire article added with relocations, p. 1815, § 7, effective July 1; (3) amended, p. 1389, § 18, effective August 7. **L. 2007:** (19.5) amended, p. 2043, § 74, effective June 1. **L. 2008:** (25.5) added, p. 1184, § 2, effective May 22. **L. 2010:** (3) amended, (SB 10-175), ch. 188, p. 800, § 65, effective April 29. **L. 2011:** (10) amended, (HB 11-1303), ch. 264, p. 1168, § 65, effective August 10. **L. 2013:** (3), IP(9), and (9)(a) amended, (HB 13-1314), ch. 323, p. 1808, § 44, effective March 1. **L. 2014:** (1) repealed, (2) amended, and (13.5) added, (SB 14-067), ch. 12, p. 109, § 1, effective February 27. **L. 2016:** (19.5) amended, (SB 16-189), ch. 210, p. 773, § 67, effective June 6. **L. 2017:** IP(1) and (14) amended, (HB 17-1046), ch. 50, p. 159, § 13, effective March 16; IP amended and (1.5) added, (HB 17-1353), ch. 231, p. 895, § 1, effective May 23; IP and (3) amended, (SB 17-242), ch. 263, p. 1327, § 198, effective May 25; IP and IP(7) amended, (SB 17-091), ch. 321, p. 1731, § 1, effective June 5. **L. 2018:** (5.5) added, (HB 18-1091), ch. 74, p. 642, § 2, effective August 8; (12) amended, (HB 18-1431), ch. 313, p. 1892, § 9, effective August 8. **L. 2019:** (19.5) amended, (HB 19-1172), ch. 136, p. 1707, § 177, effective October 1. **L. 2021:** (2.5) added and (3) amended, (HB 21-1187), ch. 83, p. 331, § 23, effective July 1, 2024; (25.7) added, (HB 21-1190), ch. 152, p. 875, § 3, effective May 18. **L. 2022:** (10) amended, (HB 22-1289), ch. 399, p. 2841, § 11, effective June 7; (3) amended, (HB 22-1278), ch. 222, p. 1511, § 66, effective July 1; (19.5) amended, (HB 22-1295), ch. 123, p. 848, § 75, effective July 1; (3) amended, (HB 22-1256), ch. 451, p. 3239, § 53, effective August 10; (3) amended, (HB 22-1278), ch. 222, p. 1593, § 232, effective July 1, 2024. **L. 2023:** (24.5) added, (HB 23-1130), ch. 394, p. 2356, § 2, effective August 7. **L. 2024:** (11), (13), (22), (26), and (28) amended, (13.2) added, and (21) repealed, (SB 24-176), ch. 152, p. 621, § 18, effective August 7. **L. 2025:** (19.5) amended, (HB 25-1172), ch. 155, p. 627, § 3, effective August 6. **L. 2026:** (20) amended, (HB 26-1235), ch. 361, p. 2169, § 2, effective August 12.

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

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

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

(4) Amendments to subsection (3) by HB 22-1256 and HB 22-1278 were harmonized.

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-4-104. State medical assistance program - single state agency.

(1) The state department, by rules, shall establish a program of medical assistance to provide necessary medical care for the categorically needy. The state department is designated as the single state agency to administer the medical assistance program in accordance with Title XIX of the federal "Social Security Act" and this article 4 and articles 5 and 6 of this title 25.5. The program is not required to furnish to members under sixty-five years of age the benefits that are provided to members sixty-five years of age and over under Title XVIII of the federal "Social Security Act", but the medical assistance program must otherwise be uniform to the extent required by Title XIX of the federal "Social Security Act".

(2) The state department may review any decision of a county department and may consider any application upon which a decision has not been made by the county department within a reasonable time to determine the propriety of the action or failure to take timely action on an application for medical assistance. The state department shall conduct any additional investigation the state department deems necessary. After giving the county department an opportunity to rebut the state department's findings or conclusions that the action or delay in taking action was a violation of or contrary to state department rules, the state department shall make a decision whether to grant medical benefits and the amount of medical benefits pursuant to this article 4 and articles 5 and 6 of this title 25.5 and the rules of the state department. Applicants or members affected by the state department's decisions, upon request, must be given reasonable notice and opportunity for a fair hearing by the state department.

Source: L. 2006: Entire article added with relocations, p. 1819, § 7, effective July 1. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 622, § 19, effective August 7.

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

ANNOTATION

Annotator's note. Since § 25.5-4-104 is similar to § 26-4-104 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5, relevant cases construing that provision have been included in the annotations to this section.

Program for "medically needy" not required. The superimposition of a program for the medically needy could create much administrative difficulty and uncertainty and encourage excessive medical expenses and resultant waste. Fullington v. Shea, 320 F. Supp. 500 (D. Colo. 1970), aff'd mem., 404 U.S. 963 (1971).

Since the federal laws relative to the "medically indigent" are optional, the failure of Colorado to extend medicaid to the "medically indigent" while at the same time extending it to the "categorical" recipients does not constitute an invalid discrimination violative of the equal protection clause of the fourteenth amendment to the constitution of the United States. Fullington v. Shea, 320 F. Supp. 500 (D. Colo. 1970), aff'd mem., 404 U.S. 963 (1971).

Applied in Dodge v. State Dept. of Soc. Servs., 657 P.2d 969 (Colo. App. 1982).

25.5-4-105. Federal requirements under Title XIX.

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

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

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

25.5-4-106. Cooperation with federal government - grants-in-aid - cooperation with the state department of human services in delivery of services.

(1) The state department shall be the sole state agency for administering the state plans for health and medical assistance pursuant to this title, and any other state plan relating to medical assistance that requires state action which is not specifically the responsibility of some other state department, division, section, board, commission, or committee under the provisions of federal or state law.

(2) (a) The state department may accept on behalf of the state of Colorado the provisions and benefits of acts of congress designed to provide funds or other property for particular medical assistance within the state, which funds or other property are designated for such purposes within

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

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

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

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

(4) The rules of the state department may include provisions to accommodate requirements of contracts entered into between the state department and the federal department of health and human services, or any successor agency, for studies of guaranteed annual income or other forms of income maintenance research projects; and for such purpose, the requirements of this title as to eligibility for medical assistance shall not apply for the term of and in accordance with the contract for such purpose.

(5) The state department is responsible for administering the delivery of medical assistance by county departments of human or social services or any other public or private entities participating in the delivery of medical assistance pursuant to this article 4 and articles 5 and 6 of this title 25.5.

Source: L. 2006: Entire article added with relocations, p. 1820, § 7, effective July 1. **L. 2018:** (5) amended, (SB 18-092), ch. 38, p. 444, § 109, effective August 8.

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

Cross references: For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018.

25.5-4-107. Retaliation definition.

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

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

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

(II) An adverse action must not be taken against a member after a complaint has been filed until the member is notified of the proposed action, informed of the reason for the proposed action, and provided an opportunity to appeal the proposed action.

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

Source: L. 2006: Entire section added, p. 1019, § 1, effective May 25. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 622, § 20, effective August 7.

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

PART 2

ADMINISTRATION

25.5-4-201. Cash system of accounting - financial administration of medical services premiums - medical programs administered by department of human services - federal contributions - rules.

(1) The state department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the state department relating to the financial administration of any nonadministrative expenditure that qualifies for federal financial participation under Title XIX of the federal "Social Security Act", and for the administration of the state-funded health and medical care program, created pursuant to section 25.5-2-104, except for expenditures under the program for the medically indigent, article 3 of this title 25.5.

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

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

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

Source: L. 2006: Entire section amended, p. 917, § 1, effective May 11; entire article added with relocations, p. 1821, § 7, effective July 1. **L. 2007:** (1.5) added, p. 465, § 2, effective July 1. **L. 2009:** (1.5) amended, (SB 09-265), ch. 205, p. 935, § 1, effective May 1. **L. 2022:** (1) amended, (HB 22-1289), ch. 399, p. 2841, § 12, effective June 7. **L. 2026:** (1) amended, (HB 26-1411), ch. 398, p. 2493, § 6, effective June 4.

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

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

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

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

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

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

25.5-4-203. Advisory council established. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1822, § 7, effective July 1. **L. 2022:** Entire section amended, (SB 22-013), ch. 2, p. 64, § 87, effective February 25. **L. 2023:** (1)(a) amended, (HB 23-1301), ch. 303, p. 1829, § 45, effective August 7. **L. 2024:** (2) amended, (SB 24-176), ch. 152, p. 623, § 21, effective August 7. **L. 2026:** Entire section repealed, (HB 26-1235), ch. 361, p. 2175, § 10, effective August 12.

Editor's note: Prior to its repeal, this section was similar to former § 26-4-108 as it existed prior to 2006.

25.5-4-204. Automated medical assistance administration.

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

(a) Electronic claim submittals;

(b) Online eligibility determinations;

(c) Electronic remittance statements;

(d) Electronic fund transfers; and

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

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

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

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

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

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

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

(4) County-level fraud functions must be administered using the centralized member integrity service, established in section 25.5-1-210, or shared services, as defined in section 26-1-802.

Source: L. 2006: Entire article added with relocations, p. 1822, § 7, effective July 1. **L. 2026:** (4) added, (HB 26-1429), ch. 374, p. 2313, § 12, effective June 4.

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

Cross references: For the legislative declaration in HB 26-1429, see section 1 of chapter 374, Session Laws of Colorado 2026.

25.5-4-205. Application - verification of eligibility - demonstration project - rules.

(1) (a) Determination of eligibility for medical benefits shall be made by the county department in which the applicant resides, except as otherwise specified in this section. Local social security offices also determine eligibility for medicaid benefits at the same time the local social security office determines eligibility for supplemental security income. The state department may accept medical assistance applications and determine medical assistance eligibility and may designate the private service contractor that administers the children's basic health plan, Denver health and hospital authority, created in section 25-29-103, a hospital that is designated as a regional pediatric trauma center, as defined in section 25-3.5-703 (4)(f), and other medical assistance sites determined necessary by the state department to accept medical assistance applications, to determine medical assistance eligibility, and to determine presumptive eligibility. A hospital licensed pursuant to part 1 of article 3 of title 25 or certified pursuant to section 25-1.5-103 (1)(a)(II) is authorized to determine presumptive eligibility for medical assistance pursuant to 42 U.S.C. sec. 1396a (a)(47)(B). When the state department determines that it is necessary to designate an additional medical assistance site, the state department shall notify the county in which the medical assistance site is located that an additional medical assistance site has been designated. A person who is determined to be eligible pursuant to the requirements of this article 4 and articles 5 and 6 of this title 25.5 is eligible for benefits until the person is determined to be ineligible. Upon determination that a person is ineligible for medical benefits, the county department, the state department, or other entity designated by the state department shall notify the applicant in writing of its decision and the reason. When an applicant is found ineligible for medical assistance eligibility programs, the applicant's application data and verifications must be automatically shared with the state insurance marketplace through a system interface. Separate determination of eligibility and formal application for benefits pursuant to this article 4 and articles 5 and 6 of this title 25.5 for persons eligible pursuant to sections 25.5-5-101 and 25.5-5-201 must be made in accordance with the rules of the state department.

(a.5) Repealed.

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Notwithstanding any other provision in this subsection (3)(b), for applications that contain self-employment income, the state department shall not implement this subsection (3)(b) until the state department can verify self-employment income through federally approved electronic data sources as authorized by rules of the state department and federal law.

(C) The state department may seek federal authorization to not require additional verification during a member's eligibility reenrollment process if information about the member's income is not verified through a federally approved electronic data source. The state department may use the information on file or the information that was originally collected during the application process to determine whether the member is eligible for reenrollment. Notwithstanding this subsection (3)(b)(I.5)(C) to the contrary, the state department shall require additional income verification if information about a member's income is not verified through a federally approved electronic data source for two or more consecutive years or as specified through federal authorization.

(D) The state department may seek federal authorization to not require additional verification during a member's eligibility reenrollment process if information about the member's assets is not verified through a federally approved electronic data source in a reasonable time, as determined by the state department. The state department may complete the member's eligibility reenrollment process without any additional verification of the member's assets if there has been no change in the member's assets since the initial verification during the application process or as specified through federal authorization.

(E) The state department may seek federal authorization to delay a member's procedural termination during the reenrollment process to allow the member to continue receiving necessary services during the reenrollment process. The state department may apply this delay in procedural termination to a specific population or as specified through federal authorization.

(F) The state department may seek federal authorization to allow an applicant's or member's eligibility for reenrollment to be based on financial findings from the supplemental nutrition assistance program established pursuant to part 3 of article 2 of title 26, the temporary assistance for needy families program established pursuant to part 7 of article 2 of title 26, and other means-tested benefit programs administered through the Colorado benefits management system. The state department may apply financial eligibility for medicaid to individuals whose gross income program and assets for applicable means-tested benefit programs are below applicable medicaid limits, regardless of differences in household composition and income-counting rules between programs or as specified through federal authorization.

(G) Subject to available appropriations and upon receiving necessary federal authorization, the state department may implement subsections (3)(b)(I.5)(C), (3)(b)(I.5)(D), (3)(b)(I.5)(E), and (3)(b)(I.5)(F) of this section.

(H) On or before July 1, 2028, the state department shall seek any necessary federal authorization to allow the state department to determine a member's eligibility for reenrollment without checking federally approved electronic data sources or requesting additional verification, if the member's income consists solely of social security income or other source of stable income or assets. The department, in consultation with medicaid members and advocacy groups, shall make a reasonable determination of what types of income and assets are considered stable or expected to decrease in value and assume no change in those income sources or assets without checking federally approved electronic data sources or requesting additional verification. On or before July 1, 2028, the state department shall seek any necessary federal authorization to allow the state department to determine a member's eligibility for reenrollment without requiring additional verification of the member's income or assets, if the member's income or assets has not changed since the initial verification that took place during the application process or as specified through federal authorization.

(II) Repealed.

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

(d) (I) In addition, an applicant who is eighteen years of age or older shall be required to supply a form of personal photographic identification either by providing a valid Colorado driver's license or a valid identification card issued by the department of revenue pursuant to section 42-2-302, C.R.S. The state department may adopt rules that exempt applicants from the requirement of supplying a form of personal photographic identification if the requirement causes an unreasonable hardship or if the requirement is in conflict with federal law.

(II) The state department shall also adopt rules that allow for assistance to be provided until the applicant is able to obtain or qualify for a driver's license or identification card; however, a county department or an entity designated by the state department pursuant to subsection (1) of this section is not required to pursue recovery of assistance from an applicant who fails, upon recertification, to meet the photographic identification requirement.

(e) (I) In collaboration with and to augment the state department's efforts to simplify eligibility determinations for benefits under the state medical assistance program and the children's basic health plan, the state department shall establish a process so that a member, or the parent or guardian of a member, may apply for reenrollment either over the telephone or through the internet.

(II) (A) Subject to receipt of federal authorization and spending authority, the state department may implement a pilot program that allows a limited number of members to apply for reenrollment either over the telephone or through the internet during a transition to a process that will serve members statewide. The pilot program is not a replacement for a statewide process.

(B) Notwithstanding any other provision in this subsection (3)(e), the state department shall not implement this subsection (3)(e) until the state department can verify the eligibility of a member over the telephone or through the internet as authorized by rules of the state department and federal law.

(C) Notwithstanding any other provision in this paragraph (e), the state department shall not implement or administer any portion of this paragraph (e) until spending authority has been received in the general appropriation act or any supplemental appropriation and shall only implement and administer this paragraph (e) to the extent of such spending authority.

(III) The state department may solicit and accept gifts, grants, and donations from public or private sources for the development or implementation of reenrollment either over the telephone or through the internet process described in this paragraph (e); except that the state department may not accept a gift, grant, or donation that is subject to conditions that are inconsistent with this paragraph (e) or any other law. Any gifts, grants, or donations received by the state department shall be transmitted to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund created pursuant to section 25.5-1-109.

(f) Repealed.

(4) (a) By signing an application for medical assistance, a person assigns to the state department, by operation of law, all rights the applicant may have to medical support or payments for medical expenses from any other person on the applicant's own behalf or on behalf of any other member of the applicant's family for whom application is made. For purposes of this subsection (4), an assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant meets the requirements of subsection (3) of this section and shall remain in effect so long as an individual is eligible for and receives medical assistance benefits. The application shall contain a statement explaining this assignment.

(b) An applicant for medical benefits upon initial application and each redetermination shall disclose any third party who may be responsible for the payment of medical expenses on behalf of the applicant or any other member of the applicant's family for whom application is made. As part of its medicaid eligibility modernization, the state department shall require the county department or other entity designated to accept applications for medical benefits to enter the third-party information into the automated system developed pursuant to section 25.5-4-204.

(5) (a) The state department shall not pursue recovery from a county for the cost of medical services provided to a person who has been incorrectly determined eligible for medical assistance by that county or any other entity.

(b) (Deleted by amendment, L. 2008, p. 2024, § 1, effective June 3, 2008.)

Source: L. 2006: (1)(a.5) added, p. 1592, § 2, effective June 2; entire article added with relocations, p. 1823, § 7, effective July 1. **L. 2008:** (3) and (5)(b) amended, p. 2024, § 1, effective June 3. **L. 2009:** (3)(e) added, (HB09-1020), ch. 298, p. 1595, § 1, effective May 21; (3)(b)(I)(C) and (3)(B)(I)(D) amended and (3)(b)(I.5) added, (SB 09-292), ch. 369, p. 1974, § 96, effective August 5. **L. 2010:** (4) amended, (SB 10-002), ch. 366, p. 1727, § 3, effective June 7; (1)(a.7) added, (HB 10-1041), ch. 25, p. 100, § 1, effective August 11. **L. 2012:** (3)(b)(I)(A), (3)(b)(I)(B), and (3)(b)(I.5)(A) amended, (HB 12-1120), ch. 27, p. 108, § 25, effective June 1. **L. 2014:** (1)(a), (3)(b)(I)(A), (3)(b)(I)(B), (3)(b)(I.5), and (3)(d)(II) amended, (SB 14-067), ch. 12, p. 109, § 2, effective February 27. **L. 2021:** (1)(a.7) amended, (HB 21-1187), ch. 83, p. 332, § 24, effective July 1, 2024. **L. 2023:** (3)(f) added, (SB 23-182), ch. 118, p. 431, § 3, effective April 27. **L. 2024:** (3)(b)(I.5) and (3)(f) amended, (HB 24-1400), ch. 77, p. 262, § 3, effective April 18; (1)(a) amended, (SB 24-116), ch. 300, p. 2042, § 4, effective August 7; IP(3)(a), (3)(b)(I)(B), (3)(b)(I.5)(A), (3)(e)(I), (3)(e)(II)(A), and (3)(e)(II)(B) amended, (SB 24-176), ch. 152, p. 623, § 22, effective August 7. **L. 2025:** (3)(b)(I.5)(H) added, (HB 25-1162), ch. 335, p. 1768, § 1, effective August 6.

Editor's note: (1) This section is similar to former § 26-4-106 as it existed prior to 2006.

(2) Subsection (1)(a.5) was enacted as § 26-4-106 (1)(b.5) in House Bill 06-1270 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

(3) Subsection (3)(b)(II)(B) provided for the repeal of subsection (3)(b)(II), effective July 1, 2009. (See L. 2008, p. 2024.)

(4) Subsection (1)(a.5)(VIII) provided for the repeal of subsection (1)(a.5), effective July 1, 2010. (See L. 2006, p. 1592.)

(5) The effective date for amendments to subsections (3)(b)(I)(A), (3)(b)(I)(B), and (3)(b)(I.5)(A) of this section by House Bill 12-1120 (chapter 27, Session Laws of Colorado 2012) was changed from August 8, 2012, to June 1, 2012, by House Bill 12S-1002 (First Extraordinary Session, chapter 2, p. 2432, Session Laws of Colorado 2012.)

(6) Subsection (3)(f)(III) provided for the repeal of subsection (3)(f), effective January 1, 2025. (See L. 2024, p. 262.)

Cross references: For the legislative declaration contained in the 2006 act enacting subsection (1)(a.5), see section 1 of chapter 320, Session Laws of Colorado 2006. For the legislative declaration in the 2010 act amending subsection (4), see section 1 of chapter 366, Session Laws of Colorado 2010.

ANNOTATION

Law reviews. For article, "The Game of Liens: Untangling the Statutory Lien Scheme in Colorado Workers' Compensation Cases", see 50 Colo. Law. 48 (Apr. 2021).

Plaintiff's income subject to trusts is not "available" within the meaning of federal law and Colorado regulations defining eligibility for medicaid since the court had removed all vested property interests the plaintiff had in his income. Miller v. Ibarra, 746 F. Supp. 19 (D. Colo. 1990) (decided under former § 26-4-107 as it existed prior to the 1991 repeal and reenactment of article 4 of title 26).

25.5-4-205.5. Confined persons - suspension of benefits.

(1) For purposes of this section, unless the context otherwise requires, "confined person" means a person who is:

(a) An inmate confined to a correctional institution operated by or under contract with the department of corrections;

(b) Confined in a jail;

(c) Committed to a juvenile commitment facility;

(d) Committed to a department of human services facility pursuant to part 1 of article 8 of title 16, C.R.S.; or

(e) A patient placed in a department of human services facility pursuant to court order or certification.

(2) Notwithstanding any other provision of law, a person who, immediately prior to becoming a confined person, was a member of medical assistance pursuant to this article 4 or article 5 or 6 of this title 25.5, remains eligible for medical assistance while a confined person; except that medical assistance may not be furnished pursuant to this article 4 or article 5 or 6 of this title 25.5 while the person is a confined person unless federal financial participation is available for the cost of the assistance, including, but not limited to, juveniles held in a facility operated by or under contract to the division of youth services established pursuant to section 19-2.5-1501 or the department of human services. Once a person is no longer a confined person, the person is eligible for receipt of medical assistance pursuant to this article 4 or article 5 or 6 of this title 25.5 until the person is determined to be ineligible for the receipt of the assistance. To the extent permitted by federal law, the time during which a person is a confined person is not included in any calculation of when the person must renew the person's eligibility for medical assistance pursuant to this article 4 or article 5 or 6 of this title 25.5.

Source: L. 2008: Entire section added, p. 903, § 1, effective May 20. **L. 2017:** (2) amended, (HB 17-1329), ch. 381, p. 1983, § 59, effective June 6. **L. 2021:** (2) amended, (SB 21-059), ch. 136, p. 746, § 122, effective October 1. **L. 2024:** (2) amended, (SB 24-176), ch. 152, p. 624, § 23, effective August 7.

25.5-4-206. Reimbursement to counties - costs of administration.

The state department shall reimburse the county departments for costs of administration incurred by the counties under this article and articles 5 and 6 of this title in accordance with the provisions of section 26-1-122 (5), C.R.S.

Source: L. 2006: Entire article added with relocations, p. 1825, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-411 as it existed prior to 2006.

25.5-4-207. Appeals - rules - applicability.

(1) (a) (I) If an application for medical assistance is not acted upon within a reasonable time after filing the application, or if an application is denied in whole or in part, or if medical assistance benefits are suspended, terminated, or modified, the applicant or member may appeal to the state department in the manner and form prescribed by the rules of the state department. Except as permitted under federal law, state department rules must provide for at least a ten-day advance notice before the effective date of any suspension, termination, or modification of medical assistance. The county department or designated service agency shall notify the applicant or member in writing of the basis for the decision or action and shall inform the applicant or member of the right to a county department or service agency conference under the dispute resolution process described in subsection (1)(b) of this section and of the right to a state-level appeal and the process for appeal.

(II) The applicant or member has sixty days after the date of the notice to file an appeal. If the member files an appeal prior to the effective date of the intended action, existing medical assistance benefits must automatically continue unchanged until the appeal process is completed, unless the member requests in writing that medical assistance benefits not continue during the appeal process; except that, to the extent authorized by federal law, state department rules may permit existing medical assistance benefits to continue until the appeal process is completed even if the member's appeal is filed after the effective date of the intended action. The state department shall promulgate rules consistent with federal law that prescribe the circumstances under which the county department or designated service agency may continue benefits if an

appeal is filed after the effective date of the intended action. At a minimum, the rules must allow for continuing benefits when the member's health or safety is impacted, the member was not able to timely respond due to the member's disability or employment, the member's caregiver was unavailable due to the caregiver's health or employment, or the member did not receive the county department's or designated service agency's notice prior to the effective date of the intended action.

(III) Either prior to appeal or as part of the filing of an appeal, the applicant or member may request the dispute resolution process described in subsection (1)(b) of this section through the county department or service delivery agency.

(b) Every county department or service delivery agency shall adopt procedures for the resolution of disputes arising between the county department or the service delivery agency and any applicant for or member of medical assistance. The procedures are referred to in this section as the "dispute resolution process". Two or more counties may jointly establish the dispute resolution process. The dispute resolution process must be consistent with rules promulgated by the state board pursuant to article 4 of title 24. The dispute resolution process must include an opportunity for all members to have a county department conference, upon the member's request, and the requirement may be met through a telephonic conference upon the agreement of the member and the county department. The dispute resolution process does not need to conform to the requirements of section 24-4-105 as long as the rules adopted by the state board include provisions specifically setting forth expeditious time frames, notice, and an opportunity to be heard and to present information. If the dispute is resolved through the county department or service delivery agency's dispute resolution process and the applicant or member has already filed an appeal, the county department shall inform the applicant or member of the process for dismissing the appeal.

(c) The state board shall adopt rules setting forth what other issues, if any, may be appealed by an applicant or member to the state department. The state department is not required to grant a hearing when either state or federal law requires or results in a reduction or deletion of a medical assistance benefit unless the applicant or member is arguing that the applicant's or member's case does not fit within the parameters set forth by the change in the law. In notifying the applicant or member that an appeal is being denied because of a change in state or federal law, the state department's notice must inform the applicant or member that further appeal should be directed to the appropriate state or federal court.

(d) Upon receipt of an appeal, the office of administrative courts shall give the appellant at least ten days' notice of the hearing date and an opportunity for a fair hearing in accordance with the rules of the state department. The fair hearing must comply with section 24-4-105, C.R.S., and the state department's administrative law judge shall preside.

(d.5) (I) At the commencement of a hearing that concerns the termination or reduction of an existing benefit, the state department's administrative law judge shall review the legal sufficiency

of the notice of action from which the member is appealing. If the administrative law judge determines that the notice is legally insufficient, the administrative law judge shall inform the appellant that the termination or reduction may be set aside on the basis of insufficient notice without proceeding to a hearing on the merits. The appellant may affirmatively waive the defense of insufficient notice and agree to proceed with a hearing on the merits or may ask the administrative law judge to decide the appeal on the basis of the judge's finding that the notice is legally insufficient. The administrative law judge shall also inform the appellant that the state department may issue legally sufficient notice in the future and that the state department may seek recoupment of benefits if a basis for denial or reduction of benefits is subsequently determined.

(II) This subsection (1)(d.5) applies to hearings conducted on and after January 1, 2018.

(e) The appellant shall have an opportunity to examine all applications and pertinent records concerning the appellant that constitute a basis for the denial, suspension, termination, or modification of medical assistance benefits. The person or persons involved in the decision denying, suspending, terminating, or modifying medical assistance benefits or, if the person or persons are not reasonably available, a person familiar with the facts underlying the basis for the decision, shall be available for cross-examination if requested by the appellant.

(2) All decisions of the state department shall be binding upon the county department involved and shall be complied with by such county department.

Source: L. 2006: Entire article added with relocations, p. 1825, § 7, effective July 1. **L. 2016:** (1) amended, (HB 16-1277), ch. 198, p. 698, § 1, effective September 1. **L. 2017:** (1)(d.5) added, (HB 17-1126), ch. 123, p. 427, § 1, effective April 6. **L. 2024:** (1)(a), (1)(b), (1)(c), and (1)(d.5)(I) amended, (SB 24-176), ch. 152, p. 624, § 24, effective August 7.

Editor's note: This section is similar to former § 26-4-402 as it existed prior to 2006.

25.5-4-208. County duties - transitional medicaid.

County departments shall assist families in completing the reporting requirements for transitional medicaid. This shall include informing families of the transitional medicaid eligibility requirements and the required reporting calendar.

Source: L. 2006: Entire article added with relocations, p. 1826, § 7, effective July 1. **L. 2014:** Entire section amended, (SB 14-067), ch. 12, p. 116, § 11, effective February 27.

Editor's note: This section is similar to former § 26-4-106.5 as it existed prior to 2006.

25.5-4-209. Payments by third parties - copayments by members - review - appeal - children's waiting list reduction fund - rules.

(1) (a) Any member receiving benefits pursuant to this article 4 or article 5 or 6 of this title 25.5 who receives any supplemental income, available for medical purposes under rules of the state department, or who receives proceeds from sickness, accident, health, or casualty insurance, must apply the supplemental income or insurance proceeds to the cost of the benefits rendered, and the state department rules may require reports from providers of other payments received from or on behalf of members.

(b) Subject to any limitations imposed by Title XIX of the federal "Social Security Act", a member shall pay at the time of service a portion of the cost of any medical benefit rendered to the member or to the member's dependents pursuant to this article 4 or article 5 or 6 of this title 25.5, as determined by rules of the state department.

(c) to (e) Repealed.

(2) (a) Notwithstanding the provisions of section 26-1-114, C.R.S., the state department is authorized to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available, including the collection of sufficient information from individuals who are eligible for medical assistance to pursue claims against the third parties. The state department shall collect the information at the time of any determination or redetermination of eligibility for medical assistance. A knowing or willful failure of an individual to provide the information may result in the termination of the individual's eligibility for medical assistance.

(b) A third party, as a condition of doing business in the state, shall:

(I) (A) Provide on a monthly basis to the state department or its business associate eligibility records identifying all persons covered by the third party in a manner prescribed by rule to allow the state department or its business associate to perform an analysis and determine which persons are eligible for medical assistance;

(B) The eligibility record data elements provided by the third party shall be the minimum necessary to achieve a satisfactory data match. The third party shall provide, upon request of the state department or its business associate, additional data elements as needed to confirm eligibility matches as determined by the initial analysis, including, but not limited to, the name, address, and identifying number of the third party's plan.

(II) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the third party for an item or service for which

payment has been made under the medical assistance plan to the extent that such service is covered by the third party;

(III) No later than sixty days following the receipt of an inquiry by the state department regarding a claim for payment for any health-care item or service that is submitted no later than three years after the date of the provision of the health-care item or service, respond by either paying the claim or issuing a written denial to the state department;

(IV) Agree not to deny a claim submitted by the state department solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if:

(A) The claim is submitted by the state within the three-year period beginning on the date that the item or service is furnished; and

(B) Any action by the state department to enforce its rights with respect to the claim is commenced within six years after the state department's submission of the claim; and

(V) Accept the state department's payment of a claim for a health-care item or service to be the equivalent of the health-care provider or the member having obtained prior authorization for the item or service from the third party.

(c) The cost to a third party of providing data, including eligibility records, shall be borne by the state department.

(d) A third party that provides data required by the state department, whether confidential or not, shall not be held liable for the provision of such data to the state department or for any use made thereof.

(e) (I) The state department's business associate shall not use, transfer, extract, copy, revise, or store any data required to be provided to the state department and its business associate, including the eligibility records, social security numbers, coverage, nature of coverage, period provided, or any other data elements, for purposes other than:

(A) The identification of persons eligible to receive medical assistance, as defined by section 25.5-1-103 (5);

(B) Cost avoidance;

(C) The remuneration of the state department for services provided or paid for;

(D) Any record retention requirements;

(E) Audit requirements; and

(F) Purposes related to litigation and testimony.

(II) The state department's business associate shall destroy all data once the functions specified in subparagraph (I) of this paragraph (e) have been accomplished.

(f) (I) A Colorado resident shall have a private right of action against the state department's business associate if the business associate negligently uses the data specified in paragraph (e) of this subsection (2) for purposes other than those stated in paragraph (e) of this subsection (2). The right of action shall be enforceable in the courts of Colorado and limited to the actual damages incurred by the individual bringing the action.

(II) A third party may bring an action on behalf of a Colorado resident for injunctive relief against the state department's business associate to prevent the business associate from intentionally using the data for purposes other than those specified in paragraph (e) of this subsection (2).

(g) As used in this section:

(I) "Business associate" shall have the same meaning as provided in 45 CFR 160.103.

(II) "Third party" means a health insurer, self-insured plan, group health plan as defined in 29 U.S.C. sec. 1167 (1), service benefit plan, managed care organization, pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health-care item or service.

(3) (a) The rights assigned by a member of medical assistance to the state department pursuant to section 25.5-4-205 (4) must include the right to appeal an adverse coverage decision by a third party for which the medical assistance program may be responsible for payment, including but not limited to the internal and external reviews described in sections 10-16-113 and 10-16-113.5 and a third party's reasonable appeal procedure under state and federal law. The state department or the independent contractor retained pursuant to subsection (3)(b) of this section shall review and, if necessary, may appeal at any level an adverse coverage decision, except an adverse coverage decision relating to medicare, Title XVIII of the federal "Social Security Act", as amended.

(b) The state department shall enter into one or more agreements with an independent contractor to pursue recoveries from third parties pursuant to paragraph (a) of this subsection (3). Any such agreement shall provide that the independent contractor's only compensation shall be a prudent and reasonable percentage of the amount recovered on behalf of the state department as determined by the state department.

(c) (I) An independent contractor retained pursuant to paragraph (b) of this subsection (3) shall maintain a contemporaneous record of the hours of services provided and any costs incurred. When the matter is resolved, the independent contractor shall provide to the state department a statement of the hours of services provided, the amount of costs incurred, the total amount of the contingent fee, and the hourly rate for the services provided. The hourly rate for

the services provided shall be determined by dividing the amount of the contingent fee, less the amount of costs incurred, by the number of hours of services provided by the independent contractor. The statement required by this subparagraph (I) shall be available for inspection and copying at reasonable times at the state department.

(II) Compliance with this paragraph (c) does not relieve a contracting attorney of any obligation or legal responsibility imposed by the Colorado rules of professional conduct or any provision of law.

(d) Nothing in this subsection (3) authorizes the denial of or delay of payment to a provider by the state department or the delay or interference with the provision of services to a medical assistance member.

(e) Repealed.

(4) With respect to programs administered by the state department, the state department shall access available data from the public assistance reporting information system for the purpose of identifying persons who are receiving certain public benefits from other states. The state department shall ensure that duplicate benefits are not being paid improperly to persons identified pursuant to the public assistance reporting information system.

Source: L. 2006: Entire article added with relocations, p. 1826, § 7, effective July 1. **L. 2008:** (1)(a), (2), and (3)(a) amended, p. 1768, § 1, effective June 2. **L. 2010:** (4) added, (SB 10-167), ch. 296, p. 1378, § 5, effective May 26; (3)(a) amended and (3)(e) added, (SB 10-002), ch. 366, p. 1727, § 4, effective June 7. **L. 2017:** (1)(b) amended and (1)(c) and (1)(d) added, (SB 17-267), ch. 267, p. 1447, § 14, effective May 30. **L. 2023:** (1)(b) amended and (1)(c) and (1)(d) repealed, (SB 23-222), ch. 90, p. 342, § 1, effective April 20; (1)(e) added, (SB 23-182), ch. 118, p. 432, § 6, effective April 27. **L. 2024:** (1)(a), (1)(b), (3)(a), and (3)(d) amended, (SB 24-176), ch. 152, p. 626, § 25, effective August 7. **L. 2025:** (2)(b)(III), IP (2)(b)(IV), and (2)(b)(IV)(B) amended and (2)(b)(V) added, (HB 25-1033), ch. 6, p. 13, § 1, effective March 7.

Editor's note: (1) This section is similar to former § 26-4-518 as it existed prior to 2006.

(2) Subsection (3)(e)(IV) provided for the repeal of subsection (3)(e), effective July 1, 2013. (See L. 2010, p. 1727.)

(3) Subsection (1)(e)(III) provided for the repeal of subsection (1)(e), effective September 30, 2024. (See L. 2023, p. 432.)

Cross references: For the legislative declaration in SB 10-002, see section 1 of chapter 366, Session Laws of Colorado 2010. For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010. For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

ANNOTATION

Annotator's note. Since § 25.5-4-209 is similar to § 26-4-518 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-518 is similar to § 26-4-110 (4) as it existed prior to the 1991 repeal and reenactment of article 4 of title 26, relevant cases construing that provision have been included in the annotations to this section.

Suspension of optional incentive allowance under medicaid program does not violate state or federal law so long as the state meets federal requirements concerning the level of care provided to patients. Colo. Health Care Ass'n v. State Dept. of Soc. Servs., 598 F. Supp. 1400 (D. Colo. 1984).

Suspensions and elimination of incentive allowance component of daily rate paid to nursing home providers did not violate federal requirement for reasonable and adequate payment. Colo. Health Care v. State Dept. of Soc. Servs., 842 F.2d 1158 (10th Cir. 1988).

Emergency rulemaking suspending incentive allowance payments was within department's authority and in accordance with the State Administrative Procedure Act and the Medicaid Act. Colo. Health Care v. State Dept. of Soc. Servs., 842 F.2d 1158 (10th Cir. 1988).

Elimination of incentive allowance in medicaid reimbursement does not violate contracts between state and nursing home providers. Colo. Health Care v. State Dept. of Soc. Servs., 842 F.2d 1158 (10th Cir. 1988).

Where the nursing home informs the county that a patient has not paid any amounts due under this section and the county fails to take remedial action, the department of social services is responsible to the nursing home for any uncollected amounts. Colo. Dept. of Soc. Servs. v. Health Care Management Consultants, Inc., 813 P.2d 829 (Colo. App. 1991).

Applied in Country View Care v. State Dept. of Soc. Servs., 703 P.2d 1334 (Colo. App. 1985).

25.5-4-210. Purchase of health insurance for members.

(1) (a) The state department shall purchase group health insurance for a medical assistance member who is eligible to enroll for coverage if enrollment of the member in the group plan would be cost-effective. In addition, the state department may purchase individual health

insurance for a medical assistance member who is eligible to enroll in a health insurance plan if enrollment of the member would be cost-effective to this state. A determination of cost-effectiveness must be in accordance with federal guidelines established by the secretary of the federal department of health and human services.

(b) Notwithstanding any provision of subsection (1)(a) of this section to the contrary, the state department, in purchasing health insurance for medical assistance members who are eligible to enroll for private coverage, shall not purchase health insurance for more than two thousand individuals.

(2) Enrollment in a group health insurance plan is required of members for whom enrollment has been determined to be cost-effective as a condition of obtaining or retaining medical assistance. A parent is required to enroll a dependent child member, but medical assistance for the child is not discontinued if a parent fails to enroll the child.

(3) The state department shall pay any premium, deductible, coinsurance, or other cost-sharing obligation required under the group plan for services covered under the state medical assistance plan. In addition, the state department shall pay any premium, deductible, coinsurance, or other cost-sharing obligation required under an individual plan purchased by the state department for a medical assistance member pursuant to subsection (1) of this section. Payment of the services is treated as payment for medical assistance. Coverage provided by the purchased health insurance plan is considered third-party liability for the purposes of section 25.5-4-209.

(4) Services not available to a member under the purchased plan are provided to the member if the services would otherwise be provided as medical assistance services pursuant to this article 4 or article 5 or 6 of this title 25.5. Nothing in this section requires services provided under a group health insurance plan for medical assistance to be made available to members not enrolled in the plan. Enrollment in a group health insurance plan pursuant to this section does not affect the eligibility of a member who otherwise qualifies for medical assistance pursuant to this article 4 or article 5 or 6 of this title 25.5.

Source: L. 2006: Entire article added with relocations, p. 1828, § 7, effective July 1. **L. 2010:** (1) amended, (SB 10-167), ch. 296, p. 1378, § 6, effective May 26. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 627, § 26, effective August 7.

Editor's note: This section is similar to former § 26-4-518.5 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

25.5-4-211. Medicaid management information system - appropriation in annual general appropriation act - expenditure in next fiscal year.

(1) Subject to the limitation in subsection (2) of this section, unexpended and unencumbered moneys from an appropriation in the annual general appropriation act to the state department for the medicaid management information system remain available for expenditure by the state department in the next fiscal year without further appropriation. This section applies to appropriations made by the general assembly for fiscal years beginning on and after July 1, 2013.

(2) On or before June 30, 2014, and on or before June 30 of each year thereafter, the state department shall notify the state controller of the amount of the appropriation from the annual general appropriation act for the medicaid management information system for the current fiscal year that the state department needs to remain available for expenditure in the next fiscal year. The state department may not expend more than the amount notified under the authority granted in this section.

(3) Repealed.

Source: L. 2013: Entire section added, (HB 13-1281), ch. 205, p. 851, § 1, effective May 11. **L. 2017:** (3) amended, (HB 17-1060), ch. 6, p. 16, § 8, effective March 1.

Editor's note: Subsection (3)(b) provided for the repeal of subsection (3), effective January 3, 2018. (See L. 2017, p. 16.)

25.5-4-212. Medicaid member correspondence improvement process - legislative declaration - definition.

(1) (a) The general assembly finds and declares that:

(I) Accurate, understandable, timely, informative, and clear correspondence from the state department is critical to the life and health of medicaid members and applicants and, in some cases, is a matter of life and death for our most vulnerable populations;

(II) Unclear, confusing, and late correspondence from the state department causes an increased workload for the state, counties administering the medicaid program, and nonprofit advocacy groups assisting applicants and members; and

(III) Government should be a good steward of taxpayers' money, ensuring that it is spent in the most cost-effective manner.

(b) Therefore, the general assembly finds that improving medicaid member correspondence is critical to the health and safety of medicaid members and will reduce unnecessary confusion that requires members to call counties and the state department or file appeals.

(2) As used in this section, unless the context otherwise requires, "member correspondence" means any communication to provide notice of an approval, denial, termination, or change to an individual's medicaid eligibility; to provide notice of the approval, denial, reduction, suspension, or termination of a medicaid benefit; or to request additional information that is relevant to determining an individual's medicaid eligibility or benefits. "Member correspondence" does not include communications regarding the state department's review of trusts or review of documents or records relating to trusts.

(3) The state department shall improve medicaid member correspondence by ensuring that member correspondence revised or created after January 1, 2018:

(a) Is written using person-first, plain language;

(b) Is written in a format that includes the date of the correspondence and a member greeting;

(c) Is consistent, using the same terms throughout to the extent practicable, including commonly used program names;

(d) Is accurately translated into the second most commonly spoken language in the state if a member indicates that the language is the member's written language of preference or as required by law;

(e) Includes a statement translated into the top fifteen languages most commonly spoken by individuals in Colorado with limited English proficiency informing an applicant or member how to seek further assistance in understanding the content of the correspondence;

(f) Clearly conveys the purpose of the applicant or member correspondence, the action or actions being taken by the state department or the state department's designated entity, if any, and the specific action or actions that the applicant or member shall or may take in response to the correspondence;

(g) Includes a specific description of any necessary information or documents requested from the applicant or member;

(h) Includes contact information for applicant or member questions; and

(i) Includes a specific and plain language explanation of the basis for the denial, reduction, suspension, or termination of the benefit, if applicable.

(4) Subject to the availability of sufficient appropriations and receipt of federal financial participation, on and after July 1, 2018, the state department shall make electronically available

to a member specific and detailed information concerning the member's household composition, assets, income sources, and income amounts, if relevant to a determination for which member correspondence was issued. If implemented, the state department shall notify members in the written correspondence of the option to access this information.

(5) The state department is encouraged to promote the receipt of member correspondence electronically or through mobile applications for members who choose those methods of delivery as allowed by law.

(6) As part of its ongoing process to create and improve member correspondence, the state department may engage with experts in written communication and plain language to test member correspondence against the criteria set forth in subsection (3) of this section with a geographically diverse and representative sample of medicaid members relevant to the member correspondence being revised. The state department shall also develop a process to review and consider feedback from stakeholders, including consumer advocates and counties, prior to implementing significant changes to correspondence.

(7) The state department shall ensure that applicant or member correspondence that may only affect a small number of applicants or members, but may, nonetheless, have a significant impact on the lives of those applicants or members, is appropriately prioritized for revision.

(8) As part of its annual presentation made to its legislative committee of reference pursuant to section 2-7-203, the state department shall present information concerning:

(a) The state department's process for ongoing improvement of member correspondence;

(b) Member correspondence revised pursuant to criteria set forth in subsection (3) of this section during the prior year and member correspondence improvements that are planned for the upcoming year; and

(c) A description of the results of testing of new or significantly revised member correspondence pursuant to subsection (6) of this section, including a description of the stakeholder feedback.

Source: L. 2017: Entire section added, (SB 17-121), ch. 303, p. 1651, § 1, effective August 9. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 628, § 27, effective August 7.

25.5-4-213. Audit of medicaid member correspondence - definition.

(1) As used in this section, unless the context otherwise requires, "member correspondence" has the same meaning as defined in section 25.5-4-212.

(2) During the 2020 calendar year and the 2023 calendar year, the office of the state auditor shall conduct or cause to be conducted a performance audit of member correspondence. Thereafter, the state auditor, in the exercise of the state auditor's discretion, may conduct or cause to be conducted additional performance audits of member correspondence pursuant to this section. The audit must include correspondence generated through the Colorado benefits management system, as well as correspondence that is not generated through the Colorado benefits management system.

(3) The performance audit conducted pursuant to this section must include:

(a) A review of available data from counties, from the state department's customer service contract center, and from assistors within the health benefit exchange, created in article 22 of title 10, regarding customer service contacts that are related to member or applicant confusion regarding correspondence received by medicaid members or applicants;

(b) A review of the accuracy of member correspondence at the time the correspondence is generated;

(c) A review of whether member correspondence satisfies the requirements of any state or federal law, rule, or regulation relating to the sufficiency of any notice;

(d) A review of any member correspondence testing process conducted by the state department and whether testing is done prior to implementing new or significantly revised member correspondence;

(e) A review of the results of any member correspondence testing, including member comprehension of the intended purpose or purposes of the correspondence; and

(f) A review of the accuracy of member income and household composition information that is communicated electronically, if applicable.

(4) If audit findings include findings that information contained in member correspondence is inaccurate at the time the correspondence was generated, the audit must identify, if possible, the source of the inaccurate information, which may include but is not limited to computer system or interface issues, county input error, or applicant error.

(5) Based on the findings and conclusions identified during the performance audit conducted pursuant to this section, the office of the state auditor shall make recommendations to the state department for improving member correspondence. On or before December 30, 2020, December 30, 2023, and December 30 in any calendar year in which an audit is conducted pursuant to this section, the office of the state auditor shall submit the findings, conclusions, and recommendations from the performance audit in the form of a written report to the legislative audit committee, which shall hold a public hearing for the purposes of reviewing the report. The report must also be submitted to the joint budget committee, the public health care and human

services committee of the house of representatives, the health and human services committee of the senate, and the joint technology committee, or any successor committees.

Source: L. 2017: Entire section added, (HB 17-1143), ch. 67, p. 211, § 1, effective August 9; (1) amended, (SB 17-121), ch. 303, p. 1653, § 2, effective August 9. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 630, § 28, effective August 7.

25.5-4-214. Feasibility study - residential and inpatient substance use disorder treatment - report - repeal. (Repealed)

Source: L. 2017: Entire section added, (HB 17-1351), ch. 288, p. 1600, § 2, effective June 2.

Editor's note: Subsection (5) provided for the repeal of this section, effective July 1, 2019. (See L. 2017, p. 1600.)

25.5-4-215. Study - benefits for persons on work release - repeal. (Repealed)

Source: L. 2022: Entire section added, (SB 22-196), ch. 193, p. 1293, § 8, effective May 19.

Editor's note: Subsection (2) provided for the repeal of this section, effective June 30, 2024. (See L. 2022, p. 1293.)

Cross references: For the legislative declaration in SB 22-196, see section 1 of chapter 193, Session Laws of Colorado 2022.

25.5-4-216. Report on impact of hospital facility fees in Colorado - definitions - steering committee - repeal. (Repealed)

Source: L. 2023: Entire section added, (HB 23-1215), ch. 277, p. 1636, § 4, effective May 30.

Editor's note: Subsection (11) provided for the repeal of this section, effective January 1, 2025. (See L. 2023, p. 1636.)

25.5-4-217. Federal reimbursement for public expenditures - excess to general fund - notice to revisor of statutes - repeal.

(1) Notwithstanding any other provision of law, for the state fiscal year starting July 1, 2021, and any subsequent fiscal years, if a provider submits a certification of public expenditures pursuant to 42 CFR 433.51 (b), the state department shall retain any federal money payable as reimbursement for the expenditure in excess of fifty percent of the expenditure amount; except that the state department shall only retain the federal money based on the date of service as long as the increased reimbursements and payments made pursuant to the federal "Families First Coronavirus Response Act", Pub.L. 116-127, and the federal "Consolidated Appropriations Act, 2023", Pub.L. 117-328, are still available. The state treasurer shall transfer the money to the general fund created in section 24-75-201 for appropriation to the state medical assistance program.

(2) This section will be repealed if the reconciliation of all reimbursements and payments for services delivered during the period of increased reimbursement and payment described in subsection (1) of this section is completed. The executive director of the state department shall notify the revisor of statutes in writing of the date when the condition specified in this subsection (2) has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. This section is repealed, effective upon the date identified in the notice that the completion of the applicable reconciliations occurred or, if the notice does not specify that date, upon the date of the notice to the revisor of statutes.

Source: L. 2026: Entire section added, (HB 26-1367), ch. 240, p. 1377, § 1, effective May 29.

25.5-4-218. Multiple procedure payment reductions for outpatient therapy - prohibition - definitions.

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

(a) "Multiple procedure payment reduction" means a reimbursement methodology that reduces payment for one or more different services furnished to a member during the same date of service, encounter, or episode of care based solely on the number, sequencing, or combination of different services performed.

(b) "Outpatient therapy services" means professional services provided by an occupational therapist, physical therapist, or speech language pathologist in a setting other than a hospital.

(2) If the state department plans to implement, apply, or enforce a new multiple procedure payment reduction for outpatient therapy services provided under the medical assistance program, the state department must provide notice to the impacted providers of the forthcoming change at least six months prior to implementing the change to ensure adequate time for providers to prepare and hold at least one stakeholder meeting to discuss the implementation, application, and enforcement of the new multiple procedure payment reduction for outpatient therapy services. The stakeholder process must include a discussion regarding the metrics the state department plans to use in implementing the changes.

Source: L. 2026: Entire section added, (HB 26-1235), ch. 361, p. 2169, § 3, effective August 12.

25.5-4-219. Community engagement requirements for medicaid eligibility - notice to revisor of statutes - rules - reporting - repeal.

(1) On or before January 1, 2027, the state board shall adopt rules that are necessary to implement the community engagement requirements of Title XIX of the federal "Social Security Act of 1965", 42 U.S.C. sec. 1396a (xx), as amended or relocated, in a manner that ensures all applicants and members can obtain or maintain coverage with the least amount of administrative burdens.

(2) The state board's authority to adopt rules pursuant to subsection (1) of this section is repealed if the community engagement requirements of Title XIX of the federal "Social Security Act of 1965", 42 U.S.C. sec. 1396a (xx), as amended or relocated, are repealed.

(3) The state board shall notify the revisor of statutes in writing of the date when the condition specified in subsection (2) of this section has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. This section is repealed, effective upon the date identified in the notice, or if the notice does not specify that date, upon the date of the notice to the revisor of statutes.

(4) (a) Beginning March 1, 2027, and each month thereafter, the state department shall make the following data concerning enrollment in the medical assistance program available on the state department's website:

(I) The number of applications for medical assistance that were approved and denied;

(II) The number of renewal applications for medical assistance that were approved and denied;

(III) The number of members whose medical assistance eligibility was renewed using existing data and records without requiring the member to submit additional information;

(IV) The rate of reenrollment in the medical assistance program within ninety days after a member's renewal application for medical assistance was denied; and

(V) Other data the state department determines is necessary to share with the public and any other data that may be federally required to comply with the community engagement requirements of Title XIX of the federal "Social Security Act of 1965", 42 U.S.C. sec. 1396a (xx), as amended or relocated.

(b) The purpose of the reporting requirement set forth in this subsection (4) is to demonstrate the impacts of the community engagement requirements of Title XIX of the federal "Social Security Act of 1965", 42 U.S.C. sec. 1396a (xx), as amended or relocated, on eligibility and enrollment in the medical assistance program.

(c) The state department's duty to post data on the state department's website pursuant to this subsection (4) is repealed if the community engagement requirements of Title XIX of the federal "Social Security Act of 1965", 42 U.S.C. sec. 1396a (xx), as amended or relocated, are repealed.

(d) The executive director of the state department shall notify the revisor of statutes in writing of the date when the condition specified in subsection (4)(c) of this section has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. This subsection (4) is repealed effective upon the date identified in the notice, or if the notice does not specify that date, upon the date of the notice to the revisor of statutes.

Source: L. 2026: Entire section added, (HB 26-1235), ch. 361, p. 2170, § 4, effective August 12.

PART 3

RECOVERY

25.5-4-300.4. Last resort for payment - legislative intent.

It is the intent of the general assembly that medicaid is the last resort for payment for medically necessary goods and services furnished to members and that all other sources of payment are primary to medical assistance provided by medicaid.

Source: L. 2008: Entire section added, p. 1771, § 2, effective June 2. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 631, § 29, effective August 7.

25.5-4-300.7. Prevention of coding errors - prepayment review of claims.

(1) The state department shall implement and maintain a system for reducing medical services coding errors in medicaid claims submitted to the state department for reimbursement. The system shall include automatic, prepayment review of medicaid claims through the use of nationally recognized correct coding methods in the medicaid management information system, in accordance with 42 U.S.C. sec. 1396b (r) and regulations thereunder, as amended by Pub.L. 111-148, and any other subsequent acts of congress. The state department shall acquire and maintain any information technology necessary to implement the automated, prepayment review of medicaid claims.

(2) Repealed.

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1379, § 8, effective May 26. **L. 2016:** (2) repealed, (HB 16-1081), ch. 22, p. 50, § 2, effective August 10.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

25.5-4-300.9. Explanation of benefits - medicaid members - legislative declaration.

(1) (a) The general assembly finds and declares that:

(I) Colorado's medicaid program provides critical medical services to the state's poorest and most vulnerable residents;

(II) Funding for these services is provided through a financial partnership between Colorado and the federal government;

(III) For the 2015-16 state budget year, the general assembly appropriated $8,891,000,000 for Colorado's medicaid program, of which $2,508,000,000 is from the general fund and $677,000,000 is from the hospital provider fee, with the remainder from federal money;

(IV) It is in the best interest of Colorado to do everything possible to minimize error, inefficiency, and fraud in providing medicaid services to ensure the long-term viability of this safety net program;

(V) In the private sector, as well as the medicare program, insurers routinely provide an explanation of benefits to their clients, listing claims submitted by providers for services

rendered to the client even when the insurer is not seeking a co-payment for the service and the provider is not claiming an amount due from the client;

(VI) While creating an explanation of benefits is not without cost to the health-care system, only the member receiving medical services or the member's authorized representative is in the position to verify whether the claimed medical services were actually provided and for whom they were provided, which is a necessary first step in containing health-care costs;

(VII) While medicaid members may not appear to be affected financially by billing errors or fraudulent claims, medicaid members who rely on these services for survival and independence are most severely affected by the inappropriate use of scarce resources; and

(VIII) Further, medicaid members and consumer advocates for low-income and vulnerable Coloradans want the opportunity to partner with the state department and providers to ensure a well-run and fraud-free medicaid program in Colorado.

(b) Therefore, the general assembly declares that creating an explanation of benefits for members of medicaid-funded services is a necessary step in managing the state's medicaid program and in safeguarding the significant public investment, both state and federal, in meeting the health-care needs of low-income and vulnerable Coloradans.

(2) On or before July 1, 2017, the state department shall develop and implement an explanation of benefits for members of medical services pursuant to this article 4 and article 5 or 6 of this title 25.5. The purpose of the explanation of benefits is to inform a medicaid member of a claim for reimbursement made for services provided to the member or on the member's behalf, so that the member may discover and report administrative or provider errors or fraudulent claims for reimbursement.

(3) The explanation of benefits is required for all acute and long-term care services for which a provider is seeking reimbursement under a fee-for-service model.

(4) The explanation of benefits must include, at a minimum:

(a) The name of the medicaid member receiving the service;

(b) The name of the service provider;

(c) A description of the service provided;

(d) The billing code for the service;

(e) The date of service, or range of dates for services, if multiple services are provided in a set period of time, such as personal care services;

(f) A clear statement to the medicaid member that the explanation of benefits is not a bill, but is only provided for the member's information and to make sure that a provider is being reimbursed only for services actually provided;

(g) Information regarding at least one verbal and one written method for the medicaid member to report errors in the explanation of benefits that are relevant to provider reimbursement; and

(h) Any other information that the state department determines is useful to the medicaid member or for purposes of discovering administrative or provider error or fraud.

(5) The state department shall develop the form and content of the explanation of benefits in conjunction with medicaid members and consumer advocates to ensure that medicaid members understand the information provided and the purpose of the explanation of benefits. The state department shall also work with medicaid members and consumer advocates to develop educational materials for the state department's website and for distribution by advocacy and nonprofit organizations that explain the process for reporting errors and encourage members to take responsibility for reporting errors.

(6) The state department shall provide the explanation of benefits to a medicaid member not less frequently than once every two months, if services have been provided to or on behalf of the member during that time period. The state department shall determine the most cost-effective means for producing and distributing the explanation of benefits to medicaid members, which may include email or web-based distribution, with mailed copies by request only. Further, the state department may include the explanation of benefits with an existing mailing or existing electronic or web-based communication to medicaid members.

(7) Nothing in this section requires the state department to produce an explanation of benefits form if the information required to be included in the explanation of benefits pursuant to subsection (4) of this section is already included in another format that is understandable to the medicaid member.

Source: L. 2016: Entire section added, (SB 16-120), ch. 254, p. 1044, § 1, effective August 10. **L. 2024:** (1)(a)(VI), (1)(a)(VII), (1)(a)(VIII), (1)(b), (2), (4)(a), (4)(f), (4)(g), (4)(h), (5), (6), and (7) amended, (SB 24-176), ch. 152, p. 631, § 30, effective August 7.

25.5-4-301. Recoveries - overpayments - penalties - interest - adjustments - liens - review or audit procedures - cash fund - rules - definitions - repeal.

(1) (a) (I) Except as provided in section 25.5-4-302 and subsection (1)(a)(III) of this section, a member or estate of the member is not liable for the cost or the cost remaining after payment by medicaid, medicare, or a private insurer of medical benefits authorized by Title XIX of the federal "Social Security Act", by this title 25.5, or by rules promulgated by the state board, which benefits are rendered to the member by a provider of medical services authorized to render the service in the state of Colorado, except those contributions required pursuant to section 25.5-4-

209 (1). However, a member may enter into a documented agreement with a provider under which the member agrees to pay for items or services that are nonreimbursable under the medical assistance program. Under these circumstances, a member is liable for the cost of the services and items.

(II) The provisions of subsection (1)(a)(I) of this section apply regardless of whether medicaid has actually reimbursed the provider and regardless of whether the provider is enrolled in the Colorado medical assistance program.

(II.5) (A) A provider of medical services who bills or seeks collection through a third party from a member or the estate of a member for medical services authorized by Title XIX of the federal "Social Security Act" in an amount in violation of subsection (1)(a)(I) of this section is liable for and subject to the following: A refund to the member of any amount unlawfully received from the member, plus statutory interest from the date of the receipt until the date of repayment; a civil monetary penalty of one hundred dollars for each violation of subsection (1)(a)(I) of this section; and all amounts submitted to a collection agency in the name of the medicaid member. When determining income or resources for purposes of determining eligibility or benefit amounts for any state-funded program under this title 25.5, the state department shall exclude from consideration any money received by a member pursuant to this subsection (1)(a)(II.5). The imposition of a civil monetary penalty by the state department may be appealed administratively.

(A.5) A provider of medical services who, within thirty days of notification by the state department, or longer if approved by the state department, voids the bill, returns any amount unlawfully received, and makes every reasonable effort to resolve any collection actions so that the member or the estate of the member has no adverse financial consequences is not subject to the provisions of subsection (1)(a)(II.5)(A) of this section.

(B) In order to establish a claim for the civil monetary penalty established by subsection (1)(a)(II.5)(A) of this section, a member or the estate of a member, or a person acting on behalf of a member or the estate of a member, shall notify the state department.

(C) The provisions of this subsection (1)(a)(II.5) do not apply to a long-term care facility licensed pursuant to section 25-3-101.

(D) The provisions of subsection (1)(a)(II.5)(A) of this section do not apply if a member knowingly misrepresents the member's medicaid coverage status to a provider of medical services and the provider submits documentation to the state department that the member knowingly misrepresented the member's medicaid coverage status and the documentation clearly establishes a good cause basis for granting an exception to the provider.

(III) (A) When a third party is primarily liable for the payment of the costs of a member's medical benefits, prior to receiving nonemergency medical care, the member shall comply with the protocols of the third party, including using providers within the third party's network or

receiving a referral from the member's primary care physician. Any member failing to follow the third party's protocols is liable for the payment or cost of any care or services that the third party would have been liable to pay; except that, if the third party or the service provider substantively fails to communicate the protocols to the member, the items or services are nonreimbursable under this article 4 and articles 5 and 6 of this title 25.5 and the member is not liable to the provider.

(B) A member may enter into a written agreement with a third party or provider under which the member agrees to pay for items provided or services rendered that are outside of the network or plan protocols. The member's agreement to be personally liable for nonemergency, nonreimbursable items must be recorded on forms approved by the state board and signed and dated by both the member and the provider in advance of the services being rendered.

(b) Member income applied pursuant to section 25.5-4-209 (1) does not disqualify any recipient, as defined in section 26-2-103 (8), from receiving benefits pursuant to this article 4, article 5 or 6 of this title 25.5, or public assistance pursuant to article 2 of title 26, and does not disqualify an individual from receiving child care assistance pursuant to part 1 of article 4 of title 26.5. If, at any time during the continuance of medical benefits, the member gains possession of property having a value in excess of that amount set by law or by the rules of the state department or receives any increase in income, the member shall notify the county department and the county department may, after investigation, either revoke the medical benefits or alter the amount of medical benefits, as the circumstances may require.

(c) Any medical assistance paid to which a member was not lawfully entitled is recoverable from the member or the estate of the member by the county as a debt due the state pursuant to section 25.5-1-115, but no lien may be imposed against the property of a member on account of medical assistance paid or to be paid on the member's behalf under this article 4 or article 5 or 6 of this title 25.5, except pursuant to the judgment of a court of competent jurisdiction or as provided by section 25.5-4-302.

(d) If any medical assistance was obtained fraudulently, interest must be charged and paid to the county department on the amount of the medical assistance calculated at the legal rate and calculated from the date that payment for medical services rendered on behalf of the member is made to the date the amount is recovered.

(2) Any overpayment to a provider, including those of personal needs funds made pursuant to section 25.5-6-206, are recoverable regardless of whether the overpayment is the result of an error by the state department, a county department of human or social services, an entity acting on behalf of either department, or by the provider or any agent of the provider as follows:

(a) (I) If the state department makes a determination that such overpayment has been made as a result of the provider's false representation, the state department may collect the overpayment, plus a civil monetary penalty equal to one-half the amount of the overpayment,

and interest on the sum of the two amounts accruing at the statutory rate from the date the overpayment is identified, by the means specified in this subsection (2). Such sum may be collected for up to the amount of time prescribed in section 13-80-103.5, C.R.S., after the overpayment is identified. Amounts remaining uncollected for more than the time period prescribed in section 13-80-103.5, C.R.S., after the last repayment was made may be considered uncollectible. For the purposes of this subparagraph (I), "false representation" means an inaccurate statement that is relevant to a claim for reimbursement and is made by a provider who has actual knowledge of the truth of false nature of the statement or by a provider acting in deliberate ignorance of or with reckless disregard for the truth of the statement. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the department, board, or the department's fiscal agent.

(II) If the state department makes a determination that the overpayment has been made for some other reason than a false representation by the provider specified in subsection (2)(a)(I) of this section, the state department may collect the amount of overpayment, plus interest accruing at the statutory rate from the date the provider is notified of the overpayment, by the means specified in this subsection (2). Pursuant to the criteria established in rules promulgated by the state board, the state department may waive the recovery or adjustment of all or part of the overpayment and accrued interest specified in this subsection (2)(a)(II) if it would be inequitable, uncollectible, or administratively impracticable; except that no action shall be taken against a member of medical services initially determined to be eligible pursuant to section 25.5-4-205 if the overpayment occurred through no fault of the member. Amounts remaining uncollected for more than five years after the last repayment was made may be considered uncollectible.

(b) In order to collect the amounts specified in paragraph (a) of this subsection (2), the state department may withhold subsequent payments to which the provider is or becomes entitled and apply the amount withheld as an offset. The state board shall establish in rules the rate at which an overpayment may be offset, with provision for a reduction of such rate upon a good cause shown by the provider that the rate at which payment will be withheld will result in an undue hardship for the provider. In determining whether to grant a good cause reduction, the state department shall consider the impact of collecting the amount provided by state board rules on the quality of patient care and the financial viability of the provider. The state department may also take such other steps administratively as are available for the collection of the amounts specified in paragraph (a) of this subsection (2).

(c) If a provider defaults on repayment of the amounts specified in paragraph (a) of this subsection (2), the state department may bring a suit against the provider in the appropriate court. Court costs shall not be assessed against the state department but shall be assessed against the provider if the court finds in favor of the state department. Any costs collected by the state department shall be paid into the registry of the court. Once the amount has been reduced to judgment, the state department may proceed with all available postjudgment remedies.

(d) Repealed.

(e) Any provider adversely affected by actions taken pursuant to this subsection (2), except when a suit is filed against the provider pursuant to paragraph (c) of this subsection (2), may appeal the determination of the state department pursuant to the provisions in section 24-4-105, C.R.S.

(f) If the state department, either directly or through a contracting agent, undertakes a review or an audit of a provider to determine whether an overpayment has been made to that provider, the review or audit shall be subject to the procedures required in subsection (3) of this section.

(3) (a) A review or audit of a provider is subject to the following procedures:

(I) The reviewer or auditor shall conduct a review or audit in accordance with applicable state and federal law.

(II) The reviewer or auditor shall apply uniform standards and procedures to each class of providers subject to a review or an audit to determine an overpayment.

(III) The reviewer or auditor shall prepare findings for the entire period under review or audit, and a provider shall be subject to only one demand for repayment in connection with the review or audit.

(IV) Prior to a review or audit requiring an inspection of a provider's records, the reviewer or auditor, or a qualified agent contracted with the state department pursuant to subsection (3)(b) of this section, shall confirm the provider's contact information with the provider. After confirming the provider's contact information, the reviewer or auditor, or qualified agent, shall notify the provider of additional information concerning the review or audit, including instructions, correspondence timelines, and a state department contact for the provider to notify if the provider does not receive the written request for records. The reviewer or auditor shall initiate each review or audit requiring an inspection of the provider's records by delivering to the provider not less than ten business days prior to the commencement of the audit a written request through both email and certified mail describing in detail such records and offering the provider the option of providing either a reproduction of such records or inspection by the reviewer or auditor at the provider's site. The request must also clearly define milestone dates pertaining to records' requested due dates, permissible extensions of dates, the timelines for informal reconsideration, and deadlines for requesting a formal appeal. The records subject to the request must be limited to records directly related to claims for reimbursement submitted by the provider. Prior to a qualified agent commencing any review or audit, the state department shall ensure providers understand the relationship between the state department and the qualified agent and how to contact the qualified agent. In the event such records are available from a county department of human or social services or another agency, subdivision, or contractor of the state, the reviewer or auditor shall request such records from such other agencies as may be appropriate prior to making a request to the provider. The reviewer or auditor shall conduct on-site inspections at

reasonable times during regular business hours, and the reviewer or auditor shall make arrangements necessary for the reproduction of such records on site. If the provider chooses to provide a reproduction of the records requested by the reviewer or auditor instead of on-site inspection, the reviewer or auditor shall give the provider a reasonable period of time, not less than forty-five days, to provide such records, taking into account the scope of the request, the time frame covered, and the reproduction arrangements available to the provider.

(IV.5) At the request of the provider, the reviewer or auditor shall conduct an in-person or telephonic interview with the provider prior to the preparation of a preliminary draft of the report of the reviewer or auditor at which the reviewer or auditor and the provider shall discuss:

(A) The findings of the reviewer or auditor;

(B) Any documentation useful for the provider to refute the findings of the reviewer or auditor; and

(C) The next steps in the review or audit process.

(V) A physician's record or other order for health-care services, drugs, or medicinal supplies in a form transmitted electronically shall be sufficient to validate the provider's records regarding the ordering of the health-care services, drugs, or medicinal supplies.

(VI) Whenever possible, the reviewer or auditor shall base a determination of an overpayment to a provider upon a review of actual records of the department, its agents, or the provider. In the event sufficient records are not available to the reviewer or auditor, an overpayment determination may be based upon a sampling of records so long as the sampling and any extrapolation therefrom is reasonably valid from a statistical standpoint and is in accordance with generally accepted auditing standards.

(VI.5) (A) If an audit of a provider who provides nonemergency medical transportation services or pediatric behavioral therapy, including applied behavioral analysis, is initiated after July 1, 2026, for services provided from January 1, 2022, through December 31, 2023, the state department is authorized to determine and recover an overpayment to a provider using a sampling of records and extrapolation of the records so long as the sampling and extrapolation methods employed utilize a statistically valid sample and are designed and implemented in accordance with nationally recognized, generally accepted statistical principles, standards, and methods.

(B) If an audit conducted pursuant to subsection (3)(a)(VI.5)(A) of this section identifies a statistically significant pattern of alleged overpayments to a provider of nonemergency medical transportation services or pediatric behavioral therapy, the auditor is authorized to use the same statistical sampling and extrapolation methods to audit services provided by the provider from January 1, 2024, through December 31, 2025. For the purposes of this subsection

(3)(a)(VI.5)(B), "statistically significant pattern" means a claims error rate identified through the audit that exceeds ten percent.

(C) If an audit identifies an alleged overpayment, the state department shall issue a notice to the provider of the alleged overpayment within sixty days after the alleged overpayment is identified. The notice of the alleged overpayment must include the basis of the alleged overpayment, the rationale for the alleged overpayment, the methodology used to calculate the alleged overpayment, and information on how the state department identified the alleged overpayment, including claims samples used, claim-level findings, and other documentation to enable the provider to fully evaluate and replicate the auditor's analysis. Prior to the state department implementing recovery of an overpayment, the provider has the right to an informal reconsideration in accordance with subsection (3)(a)(VII) of this section or the right to a formal appeal in accordance with subsection (3)(a)(VIII) of this section.

(D) If the state department enters into a contract for the purpose of conducting an audit pursuant to this subsection (3)(a)(VI.5), the contract must not be a contingency-based contract based on a percentage of the amount of recovery collected from the provider.

(E) After the state department completes an audit of a provider pursuant to this subsection (3)(a)(VI.5), the state auditor or a person authorized by the state auditor shall conduct an examination in accordance with section 2-3-103 to determine whether the state department used proper statistical sampling and extrapolation methods when determining whether overpayments were made to a provider. The state auditor shall annually present a report of the findings made pursuant to this subsection (3)(a)(VI.5)(E) to the legislative audit committee and the joint budget committee until the audits are complete.

(VII) If a reviewer or auditor determines that there has been an overpayment to the provider, then, at the time demand for repayment is made, the state department shall offer the provider an informal reconsideration of the review or audit findings. The state department shall notify the provider in writing of the right to an informal reconsideration prior to implementing any recovery of an overpayment and give the provider an opportunity to request an informal reconsideration. In the event informal reconsideration is requested or a formal appeal is filed pursuant to subparagraph (VIII) of this paragraph (a), the state department shall not implement recovery of the overpayment until such informal reconsideration or formal appeal has been completed. Within forty-five days after the request for an informal reconsideration, the state department shall render a decision on the request and notify the provider of the decision. The notification shall include information concerning requesting a formal appeal, including informing the provider that the request must be filed within thirty days after the date of the state department's decision on the request for an informal reconsideration. If the state department is unable to render a decision on the request for informal reconsideration within forty-five days after the request, within forty-five days after the request, the state department shall notify the provider of its inability to complete the decision and shall include information concerning

requesting a formal appeal, including informing the provider that the request must be filed within thirty days after the receipt of the notification that the state department is unable to render a decision. For purposes of this subparagraph (VII), an informal reconsideration shall be considered final thirty days after the earlier of the date on which the provider withdraws its request or the date on which the state department issues a written decision on the request.

(VIII) In accordance with paragraph (e) of subsection (2) of this section, any provider adversely affected by the actions of the state department or its contracting agent in connection with a review or an audit, including whether the state department or its contracting agent adhered to the provisions of this subsection (3) in making an overpayment determination, may appeal such actions pursuant to the provisions of section 24-4-105, C.R.S.

(IX) Repealed.

(a.5) Any additional review or audit procedures shall be adopted by rule of the state board and shall be specifically referenced in any contract with a provider.

(b) The state department is authorized to engage the services of a qualified agent through a competitive contract issued pursuant to the state's procurement code for the purpose of conducting a review or audit of a provider to assist in determining whether there has been an overpayment to a provider and the amount of that overpayment. In addition to such terms and conditions as the state department may deem necessary, any contract shall be subject to the requirements for conducting a review or an audit in accordance with paragraph (a) of this subsection (3). The state department is further authorized to enter into a contract with a qualified agent for the purpose of conducting a review or an audit of a provider that provides that the compensation of the contracting agent shall be contingent and based upon a percentage of the amount of the recovery collected from the provider. A contract issued by the state department for the purpose of conducting a review or an audit of a provider to determine whether the provider has received an overpayment shall also be subject to the following conditions:

(I) The compensation paid to the contracting agent under a contingency-based contract shall not exceed eighteen percent of the amount finally collected from the provider overpayment, and the state department may establish a limit on the amount of annual compensation that may be paid to a contracting agent under a contingency-based contract and may further establish a limit on the amount that may be paid to a contracting agent under a contingency-based contract for recovery from any one provider.

(II) Reimbursement of the contracting agent's costs in performing the review or audit under a contingency-based contract shall be deemed included in the percentage compensation due the agent under the contract.

(III) No employee or agent of the contracting agent involved in the performance of a contingency-based contract shall be compensated by the contracting agent based upon the amount recovered under the contract.

(IV) The state department shall retain all authority for providing notice and otherwise making demand upon a provider for recovery of an overpayment, and the state department shall review and approve any written demand, request, or determination by the contracting agent regarding a review or an audit of a provider under this subsection (3).

(V) In any contingency-based contract authorized pursuant to this paragraph (b), the state of Colorado shall not be obligated to pay the contracting agent for amounts not actually collected from the provider.

(3.3) (a) As used in this subsection (3.3), unless the context otherwise requires:

(I) "Automated audit" means a RAC audit that reviews a provider's application of coding rules and does not require a provider to submit medical records to be audited.

(II) "Complex audit" means a RAC audit that requires a provider to submit medical records to be audited, which are individually reviewed by a representative of the state department or the state department's RAC vendor.

(III) "Denial rate" means the percentage of reviewed claims ultimately determined to involve improper payments after all administrative processes are complete, including the resolution of an appeal.

(IV) "RAC audit" means a recovery audit contractor audit conducted pursuant to the federal "Social Security Act", 42 U.S.C. sec. 1396a (a)(42)(B).

(V) "RAC vendor" means a vendor who meets the requirements of 42 CFR 455.508 and contracts with the state department to perform recovery audit contractor audits of providers on behalf of the state department.

(b) The state department may solicit the services of a RAC vendor through a contract issued pursuant to the "Procurement Code", articles 101 to 112 of title 24, and pursuant to the federal requirements detailed in 42 CFR 455.508, for the purpose of conducting RAC audits of providers to identify possible medicaid overpayments and underpayments.

(c) (I) The contract described in subsection (3.3)(b) of this section must state that the RAC vendor's compensation is contingent upon the amount of overpayments the state recovers from a provider. At the expiration of the current contract between the state department and the RAC vendor, the state department shall establish contingency fee rates based on market rates determined by the results of a competitive procurement process and may negotiate lower rates as the market provides, with contingency rates not to exceed sixteen percent of recovered payments. The state department shall ensure that the contingency fee requirements are adhered to through effective monitoring and enforcement of the RAC vendor's performance. For contracts entered into after the expiration of the contract that established contingency fee rates for RAC vendor payments, the state department shall structure the RAC vendor compensation based on a tiered payment system that corresponds to the required work unless doing so conflicts with federal

directives in medicaid guidance pursuant to 42 CFR 455, subpart F, or results in an unfavorable impact to the state's general fund.

(II) When the state department enters into a contract pursuant to subsection (3.3)(b) of this section, the state department must publish on its website a copy of the contract, scope of the work, and information regarding supervision of contractor deliverables.

(III) The contract described in subsection (3.3)(b) of this section must require the RAC vendor to:

(A) Conduct informal conferences or phone calls with providers or provider associations to discuss the RAC program, processes, and findings;

(B) Conduct provider outreach and education activities, including notifying providers of audit policies, protocols, and common billing errors;

(C) Respond to provider questions and requests for information within two business days after receiving the question or request for information;

(D) Return, within thirty days, the contingency fee associated with inaccurate audit scenarios that resulted in provider refunds as prescribed by the state department; and

(E) Provide preliminary RAC audit findings to a provider within a reasonable period following receipt of any requested medical records, as determined by the state department in collaboration with the provider advisory group, created in subsection (3.5)(c)(I) of this section.

(d) The RAC contract described in subsection (3.3)(b) of this section may include an option to pay the RAC vendor to identify underpayments for consideration in future state department budget requests.

(e) (I) The state department shall implement a process to verify that the RAC vendor's staff who make clinical RAC audit findings are appropriately licensed pursuant to industry standards and federal requirements, including that the RAC vendor hire qualified coders and that the RAC vendor's staff who make billing RAC audit findings have knowledge of medicaid billing and coding rules and guidance adopted by the state department.

(II) The state department must ensure that qualified coders have relevant credentials for the type of medical services being reviewed, in accordance with industry standards.

(III) Any complex audit that requires a review of medical records must be conducted by licensed clinical staff with training and competency in the specific type of complex audit being conducted, in accordance with industry standards. Providers must make all relevant medical records and information related to claims reviewed during the complex audit available to the RAC vendor within the time limits specified in the initial medical records request.

(IV) The state department shall fully inform the RAC vendor of any changes to the state billing standards and ensure that the vendor only applies billing standards that were in effect at the specified date of service. The state department is responsible for monitoring compliance with this requirement and taking appropriate action to ensure the RAC vendor's compliance.

(V) The state department shall ensure that the RAC vendor complies with the contract requirements described in subsection (3.3)(b) of this section and conducts RAC audits in a fair and consistent manner.

(VI) The state department shall ensure that the RAC vendor incorporates into each audit scenario, whether an automated audit or a complex audit, the following information:

(A) Federal statutes and billing rules and standards that are applicable to the specific provider during the specified dates of service for each audit;

(B) State statutes, billing rules and standards, and policies as documented in the state department's provider billing manuals and provider bulletins, as well as in program guidance and directives effective for the specific provider during the specified dates of service for each audit; and

(C) Input from the state department's RAC staff and medical director, as well as any other necessary state department staff based on the staff's or medical director's review of the audit scenario.

(VII) When auditing claims to make RAC audit findings, the state department must ensure that the RAC vendor follows all relevant and appropriate federal billing guidelines, requirements set by the medicaid billing manual, standard clinical guidelines, and any other applicable state or federal rules and regulations.

(f) The state department shall comprehensively review all audit types proposed by the RAC vendor and must approve, adjust, or reject each audit type before the RAC vendor conducts the RAC audit. Within eighteen months of the rollout of a new audit, if the state department, in collaboration with providers and the provider advisory group created in subsection (3.5) of this section, determines that the audit is inaccurate, the state department must refund providers who submitted repayments based on inaccurate audit findings and require the RAC vendor to return the contingency fee associated with the payments within thirty days.

(g) The state department shall regularly review active RAC audits to ensure compliance with federal and state regulation changes and policy updates and discontinue a RAC audit if and when appropriate due to a change in federal or state regulation or policy updates.

(h) Consistent with 42 CFR 455.508 (f), RAC audits and reviews conducted pursuant to this section must not review claims more than three years after the expiration of the timely filing period. The state department may conduct a RAC audit for a claim filed more than three years after the expiration of the timely filing period if required by a federal audit that would otherwise

result in costs to the general fund or, if directed by the federal centers for medicare and medicaid services, the United States department of health and human services, or any other federal agency. If a RAC audit is initiated in response to a federal directive, the state department must provide notice to an impacted provider and include the reason for the RAC audit and any relevant information about the federal requirement in the notice.

(i) (I) The RAC vendor shall not require a provider to undergo more than three complex audits per calendar year. Hospitals must be grouped for complex audits based on their total medicaid reimbursement in the previous fiscal year, and groupings must be determined using state data and published annually by the state department.

(II) The maximum number of medical record requests a provider may receive each month must be clearly communicated to providers and reviewed annually by the state department. The RAC vendor shall not request more than the following number of medical records per hospital per month:

(A) Six hundred for hospitals with over two hundred fifty million dollars in medicaid revenue;

(B) Four hundred for hospitals with between seventy million dollars and two hundred forty-nine million nine hundred ninety-nine thousand nine hundred ninety-nine dollars in medicaid revenue;

(C) Two hundred for hospitals with between forty million dollars and sixty-nine million nine hundred ninety-nine thousand nine hundred ninety-nine dollars in medicaid revenue;

(D) One hundred for hospitals with between twenty million dollars and thirty-nine million nine hundred ninety-nine thousand nine hundred ninety-nine dollars in medicaid revenue;

(E) Fifty for hospitals with between ten million dollars and nineteen million nine hundred ninety-nine thousand nine hundred ninety-nine dollars in medicaid revenue;

(F) Twenty-five for hospitals with between one million dollars and nine million nine hundred ninety-nine thousand nine hundred ninety-nine dollars in medicaid revenue;

(G) Twenty for hospitals with under one million dollars in medicaid revenue; and

(H) Ten for out-of-state facilities.

(III) The requirements of this subsection (3.3)(i) do not apply if:

(A) Federal medicaid directives required pursuant to 42 CFR 455, subpart F, require a higher level of claim audits;

(B) An agency of the federal government requires, in writing, the state department to initiate additional audit activity; or

(C) A federal audit identifies additional provider findings that impact the state general fund and that should be appropriately recovered from that provider through an additional RAC audit and its recoupments.

(j) (I) The RAC vendor shall not require a provider to undergo more than four automated audits per calendar year. Providers must be grouped for automated audits based on their total medicaid reimbursement in the previous fiscal year, and groupings must be determined using state data and published annually.

(II) The maximum number of provider claims across all of a provider's locations for a given calendar year that undergo automated audits must not exceed:

(A) 2.92 percent for providers with over ten million dollars in medicaid revenue;

(B) 2.50 percent for providers with between four million dollars and ten million dollars in medicaid revenue;

(C) 2.08 percent for providers with between one million dollars and three million nine hundred ninety-nine thousand nine hundred ninety-nine dollars in medicaid revenue; and

(D) 1.67 percent for providers with less than one million dollars in medicaid revenue.

(III) After the administrative process is exhausted, if the state department identifies a denial rate of forty percent or higher for a specific provider on a specific audit type, the state department shall audit no more than an additional twenty-five percent of the claim percentages stated in subsection (3.3)(j)(II) of this section associated with that audit type.

(IV) The requirements of this subsection (3.3)(j) do not apply if:

(A) Federal medicaid directives required pursuant to 42 CFR 455, subpart F, require a higher level of claim audits;

(B) An agency of the federal government requires, in writing, the state department to initiate additional audit activity; or

(C) A federal audit identifies additional provider findings that impact the state general fund and that should be appropriately recovered from that provider through an additional RAC audit and its recoupments.

(k) When conducting audits, the RAC vendor must:

(I) Request provider records that are relevant to the claims being audited and that do not duplicate information already provided;

(II) Not audit the validity of a provider's prior authorization received from the state department; and

(III) For a complex audit, not audit claims that are on the federal centers for medicare and medicaid services inpatient-only list at the date of service for a level-of-care determination.

(l) (I) If the RAC vendor identifies preliminary findings during the RAC audit, the RAC vendor must send the provider a notice of preliminary audit findings detailing the preliminary findings, the rationale for the preliminary findings, and the methodology for how the dollar amounts associated with the preliminary findings were calculated and determined.

(II) For a complex audit, a provider may request an exit conference to discuss the preliminary findings with the RAC vendor and the state department medical director, or the state department medical director's designee, prior to participating in an informal reconsideration. The provider may provide additional information supporting the provider's claims at the exit conference. A provider must request an exit conference no later than thirty days after the provider receives a notice of preliminary audit findings from the RAC vendor, and if an exit conference is requested, the state department or the RAC vendor must schedule the exit conference within sixty days of receiving the request and on a mutually agreed upon date and time.

(III) Within thirty days of the exit conference, the state department must notify the provider on whether the state department will dismiss the preliminary findings or will issue a notice of informal reconsideration. The notice of informal reconsideration must include details on the preliminary findings, the rationale for the preliminary findings, and the methodology for how the dollar amount associated with the preliminary findings were calculated and determined. If an exit conference occurred, the notice must include information on why the state department did not agree with the provider's approach.

(IV) Unless the preliminary findings are accepted by the provider, dismissed by the state department following an exit conference, or the period for a provider to request an exit conference has expired, a provider who receives a notice of preliminary findings, the state department, and the RAC vendor must participate in an informal reconsideration before the provider may formally appeal the state department's determination. To participate in an informal consideration, the following requirements must be satisfied:

(A) Within sixty days of receiving the notice of informal reconsideration, the provider must submit all medical records relevant to the claims and the reasoning for the provider's disagreement concerning the preliminary audit findings. The medical records must substantiate the provider's argument to dispute any preliminary findings to allow the state department and the RAC vendor to reconsider the findings, and the department and the RAC vendor must review medical records prior to the informal reconsideration meeting;

(B) The state department must schedule an informal reconsideration meeting between mutually agreed upon participants from the state department, RAC vendor, and provider representatives at a mutually agreed upon date and time within ninety days of issuing the notice of informal reconsideration, although either party may request a sixty-day extension; and

(C) All agreed upon attendees must participate in the informal reconsideration meeting in good faith in an effort to resolve the dispute.

(V) If a claim remains in dispute after the informal reconsideration meeting, the state department must issue a notice of adverse action within sixty days of the informal reconsideration meeting. The notice of adverse action must include the basis of the alleged overpayment, the rationale for the alleged overpayment, the methodology used to calculate the alleged overpayment, and information on why the state department did not agree with the provider's approach.

(VI) Within thirty days of receiving a notice of adverse action, the provider may request a formal appeal, which must include an explanation of the basis of the appeal in accordance with rules adopted by the state department.

(VII) The state department must not recover an overpayment identified in the preliminary findings from a provider until the informal reconsideration process, and subsequent formal appeal, if filed, are complete.

(VIII) If the state department has not issued a notice of adverse action one hundred twenty days following the informal reconsideration meeting, the state department waives its right to recover the state share of the overpayment.

(m) Providers are subject to all state and federal medicaid fraud, waste, and abuse laws and must comply with all applicable program integrity requirements. Failure to comply may result in removal from the state medical assistance program, financial penalties, civil lawsuits, or criminal prosecution pursuant to 42 U.S.C. sec. 1320a-7k(d), 42 U.S.C. sec. 1320a-7, 31 U.S.C. secs. 3729-3733, sections 24-31-808, 25.5-4-301, 25.5-4-303.5 to 25.5-4-310, and 10 CCR 2505-10, sec. 8.076. By participating in the medical assistance program, providers acknowledge and accept their obligation to adhere to all state and federal laws governing medicaid fraud, waste, and abuse, and program integrity.

(n) (I) The state department shall publish and maintain on its website a RAC audit activity report for each RAC audit and review completed in the preceding year summarizing the findings of those RAC audits and reviews. The information posted on the state department's website concerning each RAC audit must include the following information:

(A) A summary of the audit scenario, the state department's billing practices, and policy guidelines being reviewed by the RAC vendor;

(B) The error rates identified during the RAC vendor's review;

(C) The number and amounts of overpayments and underpayments identified by the RAC vendor;

(D) The recoveries collected by the state department on identified overpayments;

(E) The number of claims appealed as a result of the audit; and

(F) Details on the audit scenarios and billing standards used by the RAC vendor and policy guidance on proper billing practices.

(II) In addition to the information required by subsection (3.3)(n)(I) of this section, the state department shall publish and maintain on its website information on the number of informal reconsideration meetings the state department participated in and the associated percentage of findings that were upheld, the number of appeals, and corresponding determinations.

(o) On or before January 1, 2026, the state department shall publish on its website provider education information; resources to assist providers in understanding the state department's medicaid billing manual and rules; and procedures related to RAC audits, including documentation requirements and the process for resolving disputes.

(p) At least quarterly, the state department shall:

(I) Conduct medicaid billing training for providers and hold meetings with providers to gather feedback on the RAC audit process. The state department shall publish meeting dates and times on the state department's website at least two weeks prior to the meetings.

(II) Conduct trainings for providers and hold stakeholder meetings regarding audits and reviews, during which the state department and RAC vendor must identify common billing errors identified by the RAC vendor in the previous quarter and provide clarification on the billing errors.

(q) The state department shall work with small or rural providers in order to identify and implement opportunities to reduce administrative burdens and better support compliance with medicaid billing practices, as adopted in the state department's medicaid billing manual, and experience with RAC audits.

(r) The state department must submit an annual report to the joint budget committee that includes a description of the following:

(I) The divisions of the state department that are included in the review and approval of RAC audit scenarios and the roles and responsibilities of each division;

(II) The RAC vendor's compliance with the response requirement described in subsection (3.3)(c)(III)(C) of this section;

(III) The state department's oversight and enforcement of the contractual requirement that the RAC vendor conduct informal conferences or phone calls with providers or provider associations to discuss the RAC program, appeal processes, and findings;

(IV) The training materials prepared by the RAC vendor after each RAC audit that identify and address the common errors and issues identified during the audit and the content and materials the RAC vendor used to educate providers to prevent errors in the future;

(V) A summary of the RAC vendor's outreach and education activities;

(VI) A summary of the state department's written policies, procedures, and guidance that establish processes for the state department to log provider communications, provide direction on how state department staff must respond to communications in a timely and relevant manner, and how the state department instituted routine analysis of provider communications to inform decisions on program improvements; and

(VII) The total amount of alleged overpayments identified by the RAC vendor, the proportion of those overpayments that were recovered, and the total amount paid to the RAC vendor.

(s) All recoveries collected by the state department on identified overpayments pursuant to this subsection (3.3) must be transmitted to the state treasurer, who shall credit the same to the recovery audit contractor recoveries cash fund, which fund is created in the state treasury and referred to in this subsection (3.3)(s) as the "cash fund". The cash fund consists of money credited to the cash fund pursuant to this subsection (3.3) and any other money that the general assembly may appropriate or transfer to the cash fund. Subject to annual appropriation by the general assembly, the state department may expend money from the cash fund to offset the need for appropriations for medical services and to pay the RAC vendor. The state treasurer shall credit all interest and income derived from the deposit and investment of money in the recovery audit contractor recoveries cash fund to the cash fund.

(t) The state department may adopt rules, as necessary, to implement the requirements of this subsection (3.3).

(3.5) (a) Prior to the start of a contract to review or audit providers, the state department is encouraged to meet with organizations or associations of providers to educate providers on the review or audit process and the responsibilities of both the providers and the state department throughout the review or audit process. The state department is also encouraged to prepare an annual report on common findings following a contract to review or audit providers and distribute the report to organizations or associations of providers. The annual report should include information to prevent similar findings in future reviews or audits and should direct providers to resource information.

(b) Repealed.

(c) (I) The state department shall create a provider advisory group for recovery audits consisting of employees of the state department and members from different provider types, including physicians, hospitals, and any other provider types directly impacted by audits

conducted pursuant to this section, appointed by the executive director. The provider advisory group shall meet at least quarterly to review quarterly activity reports required by subsection (3.3)(n) of this section and advise the state department on issues providers experience with audits of the recovery audit contractors program.

(II) The state department and the RAC vendor shall provide the provider advisory group with the opportunity to review RAC audit scenarios during the provider advisory group's quarterly meetings.

(III) The state department shall give providers the opportunity to anonymously describe RAC audit scenarios they are experiencing and ask questions about billing practices. The state department shall include RAC vendor staff and the relevant state department division staff in these discussions. If the discussions lead the state department to determine that an audit scenario was inaccurate, the state department must work with the RAC vendor to rescind the RAC audit.

(3.7) Repealed.

(4) If medical assistance is furnished to or on behalf of a member pursuant to the provisions of this article 4 and articles 5 and 6 of this title 25.5 for which a third party is liable, the state department has an enforceable right against the third party for the amount of medical assistance, including the lien right specified in subsection (5) of this section. Whenever the member has brought or may bring an action in court to determine the liability of the third party, the state department, without any other name, title, or authority to enforce the state department's right, may enter into appropriate agreements and assignments of rights with the member and the member's attorney, if any. Any agreement must be filed with the court in which the action is pending. The attorney named in the agreement upon designation as a special assistant attorney general by the attorney general shall prove both the member's claim and the state department's claim. The state department, without any other name, title, or authority, may take any necessary action to determine the existence and amount of the state department's claims under this section, whether the claims are founded on judgment, contract, lien, or otherwise, and take any other action that is appropriate to recover from third parties. To enforce the right, the attorney general, pursuant to section 24-31-101, on behalf of the state department, may institute and prosecute, or intervene of right in legal proceedings against the third party having legal liability, either in the name of the state department or in the name of the member or the member's assignee, guardian, personal representative, estate, or survivors. When the state department intervenes in legal proceedings against the third party, the state department is not liable for any portion of the attorney fees or costs of the member.

(5) (a) When the state department has furnished medical assistance to or on behalf of a member pursuant to the provisions of this article 4 or articles 5 and 6 of this title 25.5 for which a third party is liable, the state department has an automatic statutory lien for all medical assistance. The state department's lien is against any judgment, award, or settlement in a suit or

claim against the third party and is in an amount that is the fullest extent allowed by federal law as applicable in this state, but not to exceed the amount of the medical assistance provided.

(b) No judgment, award, or settlement in any action or claim by a member to recover damages for injuries in which the state department has a lien is satisfied without first satisfying the state department's lien. Failure by any party to the judgment, award, or settlement to comply with this section makes each party liable for the full amount of medical assistance furnished to or on behalf of the member for the injuries that are the subject of the judgment, award, or settlement.

(c) Except as otherwise provided in this article 4, the entire amount of any judgment, award, or settlement of the member's action or claim, with or without suit, regardless of how characterized by the parties, is subject to the state department's lien.

(d) When the action or claim is brought by the member alone and the member incurs a personal liability to pay attorney fees, the state department shall pay the state department's reasonable share of attorney fees not to exceed twenty-five percent of the state department's lien. The state department is not liable for costs.

(e) The state department's right to recover under this section is independent of the member's right.

(6) When the applicant or member, or the applicant's or member's guardian, executor, administrator, or other appropriate representative, brings an action or asserts a claim against any third party, the person shall give the state department written notice of the action or claim by personal service or certified mail within fifteen days after filing the action or asserting the claim. Failure to comply with this subsection (6) makes the member, legal guardian, executor, administrator, attorney, or other representative liable for the entire amount of medical assistance furnished to or on behalf of the member for the injuries that gave rise to the action or claim. The state department may, after thirty days' written notice to the person, enforce the state department's rights under subsection (5) of this section and this subsection (6) in the district court of the city and county of Denver; except that liability of a person other than the member exists only if the person had knowledge that the member had received medical assistance or if excusable neglect is found by the court. The court shall award the state department its costs and attorney fees incurred in the prosecution of any such action.

(7) When a legally responsible relative of the member agrees or is ordered to provide medical support or health insurance coverage for the member's dependents or other persons, and the dependents are applicants for, members of, or otherwise entitled to receive medical assistance pursuant to this article 4 and articles 5 and 6 of this title 25.5, the state department is subrogated to any rights that the responsible persons may have to obtain reimbursement from a third party or insurance carrier for the cost of medical assistance provided for such dependents or persons. When the state department gives written notice of subrogation, any third party or insurance

carrier liable for reimbursement for the cost of medical care shall accord to the state department all rights and benefits available to the responsible relative that pertain to the provision of medical care to any persons entitled to medical assistance pursuant to this article 4 and articles 5 and 6 of this title 25.5 for whom the relative is legally responsible.

(8) All members of medical assistance under the medicaid program are deemed to have authorized the member's attorneys, all third parties, including but not limited to insurance companies, and providers of medical care to release to the state department all information needed by the state department to secure and enforce its rights under subsections (4) and (5) of this section.

(9) Nothing in part 6 of article 4 of title 10 limits the right of the state department to recover the medical assistance furnished to or on behalf of a member as the result of the negligence of a third party.

(10) No action taken by the state department pursuant to subsection (4) of this section or any judgment rendered in the action bars any action upon the claim or cause of action of the applicant or member or the member's guardian, personal representative, estate, dependent, or survivors against the third party having legal liability, nor shall any action or judgment operate to deny the applicant or member the recovery for that portion of the member's medical costs or other damages not provided as medical assistance under this article 4 or article 5 or 6 of this title 25.5.

(11) (a) The state department may recover any amount of medical assistance paid on behalf of a member because:

(I) The trustee of a trust for the benefit of the member has used the trust property in a manner contrary to the terms of the trust; or

(II) A person holding the member's power of attorney has used the power for purposes other than the benefit of the member.

(b) To enforce the right under this subsection (11), the county or state department may institute or intervene in legal proceedings against the trustee or person holding the power of attorney. Any amount of medical assistance recovered pursuant to this subsection (11) shall be distributed between the state and county in proportion to the amount of medical assistance paid by each respectively, if any.

(c) No action taken by the county or state department pursuant to this subsection (11) or any judgment rendered in an action or proceeding bars any action upon the claim or cause of action of the member or the member's guardian, personal representative, estate, dependent, or survivors against the trustee or person holding the power of attorney.

(12) (a) An entity that provides managed care, as defined in section 25.5-5-403, that has entered into a risk contract with the state department shall have the same rights of the department

set forth in this section except with respect to the rights described in subsections (5) and (6) of this section. In addition, the attorney general may not enforce the rights set forth in this subsection (12). Venue for an action brought by or on behalf of an entity pursuant to this subsection (12) shall be governed by the Colorado rules of civil procedure.

(b) Within fifteen days after filing an action or asserting a claim against a third party, a member under a managed care plan or a guardian, executor, administrator, or other appropriate representative of the member shall provide to the entity that administers the managed care plan written notice of the action or claim. Notice must be by personal service or certified mail.

(c) In cases where the state department has recovery rights against a third party pursuant to subsections (4) and (5) of this section and an entity that provides managed care has subrogation rights against the same party pursuant to paragraph (a) of this subsection (12), the recovery rights of the state department shall take precedence over the rights of the managed care plan.

(13) To the extent allowable under federal law, the state department shall recover from the sponsor of a lawfully residing individual all medical assistance paid on behalf of the sponsored lawfully residing individual who is enrolled in the medical assistance program.

(14) Notwithstanding any provision of this section to the contrary:

(a) (I) The state department, or the state department's designated agent, shall conduct pre-enrollment and post-enrollment site visits of providers who are designated as moderate or high categorical risks to the medicaid program. The purpose of the site visit is to verify that the information submitted to the state department is accurate and to determine compliance with federal and state enrollment requirements.

(II) As established in rules promulgated by the state board, the state department may waive pre-enrollment and post-enrollment site visits of providers if the site visits are conducted by medicare or other federally designated entities.

(III) A provider is designated as a limited, moderate, or high categorical risk pursuant to the medicare program and federal regulations. If a provider is not designated in a risk category pursuant to the medicare program and federal regulations, the provider's risk category shall be established pursuant to rules promulgated by the state board.

(b) A provider enrolled in the medicaid program shall permit the federal centers for medicare and medicaid services or its agent or designated contractors and the state department or its agent to conduct unannounced, on-site inspections of any and all provider locations. Payment for any agent designated by the state department to perform on-site inspections shall not be based on any recoveries paid to the state department by a provider for violations discovered as a result of the on-site inspection.

(15) (a) The state department may request a written response from any provider who fails to comply with the rules, manuals, or bulletins issued by the state department, state board, or the

state department's fiscal agent, or from any provider whose activities endanger the health, safety, or welfare of medicaid members. The written response must describe how the provider will come into and ensure future compliance. If a written response is requested, a provider has thirty days, or longer if approved by the state department, to submit the written response.

(b) If the provider does not agree with the state department's findings that resulted in the request issued pursuant to subsection (15)(a) of this section, then the provider's written response must include an explanation and specific reasons for the provider's disagreement.

(16) (a) The state department may suspend the enrollment of a provider, including a children's basic health plan provider, only if:

(I) The state department identifies that the provider is participating in an alleged and ongoing organized crime or organized fraud scheme that impacts the state medical assistance program, this article 4 and articles 5 and 6 of this title 25.5, or the children's basic health plan, article 8 of this title 25.5; and

(II) The state department documents in writing that at least three of the following factors are met:

(A) The provider has been enrolled in the state medical assistance program or children's basic health plan for less than three years;

(B) At least three providers are involved in the organized crime or organized fraud scheme;

(C) The collective billing amount identified in the organized crime or organized fraud scheme exceeds one million dollars;

(D) The provider's billing indicates a pattern of abuse or noncompliance;

(E) The volume of claims or billing amount has increased at a significant rate and there is no other reasonable explanation for the increase;

(F) The federal centers for medicare and medicaid services has approved a provider enrollment moratorium for the provider type involved in the organized crime or organized fraud scheme; or

(G) The state department has notified law enforcement of the organized crime or organized fraud scheme.

(b) The state department shall notify the provider of the suspension in writing and include the reasons for the suspension.

(c) The state department may suspend a provider's enrollment pursuant to subsection (16)(a) of this section for an initial period of six months while the state department conducts a review of the organized crime or organized fraud scheme. After the state department's review is complete, regardless of whether the six-month period has ended, the state department must reinstate the

provider's enrollment if the state department determines the provider did not engage in an organized crime or organized fraud scheme. If the state department's review cannot be completed during the initial six-month period, the state department may extend the review period in additional six-month increments if the state department documents in writing the necessity for extending the review.

(d) As used in this subsection (16):

(I) "Organized crime or organized fraud scheme" means a provider is allegedly participating in a coercive, fraudulent, extortionary, criminal, or otherwise illegal coordinated scheme or operation that repeatedly or consistently defrauds the state medical assistance program or children's basic health plan that may put members' health, safety, or welfare at immediate risk.

(II) "Suspend" means temporarily prohibiting a provider from participating in the state medical assistance program or children's basic health plan, from rendering services or supplies to a member, and from submitting claims to the state department for any services or supplies rendered to a member.

(e) This section does not apply to a provider that has been enrolled in the state medical assistance program, including the children's basic health plan, for three years or more and that has consistently rendered services and received payment for those services during the provider's enrollment.

Source: L. 2006: Entire article added with relocations, p. 1829, § 7, effective July 1; (1)(a)(II.5) added, p. 107, § 1, effective January 1, 2007. **L. 2007:** (3)(a)(IV) and (3)(a)(VII) amended and (3)(a)(IV.5), (3)(a.5), and (3.5) added, pp. 1467, 1469, 1468, §§ 1, 3, 2, effective May 30. **L. 2009:** (5)(a) and (5)(c) amended, (HB 09-1191), ch. 100, p. 372, § 1, effective August 5. **L. 2010:** (2)(a)(II) amended, (SB 10-167), ch. 296, p. 1378, § 7, effective May 26. **L. 2013:** (14) added, (HB 13-1068), ch. 119, p. 405, § 1, effective April 8. **L. 2017:** (1)(a)(II.5)(A) and (1)(a)(II.5)(B) amended and (1)(a)(II.5)(A.5), (1)(a)(II.5)(D), and (15) added, (HB 17-1139), ch. 376, p. 1942, § 2, effective June 6. **L. 2018:** IP(2), IP(3)(a), and (3)(a)(IV) amended, (SB 18-092), ch. 38, p. 444, § 110, effective August 8. **L. 2021:** (2)(d) repealed, (SB 21-055), ch. 12, p. 78, § 14, effective March 21; (3)(a)(IV) amended, (SB 21-022), ch. 167, p. 931, § 1, effective September 7. **L. 2022:** (13) amended, (HB 2-1289), ch. 399, p. 2841, § 13, effective June 7; (1)(b) amended, (HB 22-1295), ch. 123, p. 848, § 76, effective July 1. **L. 2023:** (3)(a)(IX), (3.5)(c), and (3.7) added, (HB 23-1295), ch. 299, p. 1801, § 2, effective June 1; (14)(b) amended, (HB 23-1301), ch. 303, p. 1829, § 46, effective August 7. **L. 2024:** (16) added, (HB 24-1146), ch. 5, p. 10, § 1, effective February 20; (1), (2)(a)(II), (4), (5), (6), (7), (8), (9), (10), (11)(a), (11)(c), (12)(b), and (15)(a) amended, (SB 24-176), ch. 152, p. 633, § 31, effective August 7. **L. 2025:** (3)(a)(IX) repealed, (3.3) added, and (3.5)(c) amended, (SB 25-314), ch. 384, p. 2128, § 1,

effective August 6. **L. 2026:** (3)(a)(VI.5) added, (HB 26-1412), ch. 399, p. 2504, § 2, effective June 4; (1)(b) amended, (SB 26-169), ch. 311, p. 1809, § 44, effective August 12.

Editor's note: (1) This section is similar to former § 26-4-403 as it existed prior to 2006.

(2) Subsection (1)(a)(II.5) was enacted as § 26-4-403 (1)(a)(II.5) in House Bill 06-1079 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

(3) Subsection (3.5)(b)(II) provided for the repeal of subsection (3.5)(b), effective July 1, 2011. (See L. 2007, p. 1468.)

(4) Subsection (3.7)(c) provided for the repeal of subsection (3.7), effective July 1, 2025. (See L. 2023, p. 1801.)

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010. For the legislative declaration in HB 17-1139, see section 1 of chapter 376, Session Laws of Colorado 2017. For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022. For the legislative declaration in HB 23-1295, see section 1 of chapter 299, Session Laws of Colorado 2023. For the legislative declaration in HB 26-1412, see section 1 of chapter 399, Session Laws of Colorado 2026.

ANNOTATION

Law reviews. For article, "Collecting Pre- and Post-Judgment Interest in Colorado: A Primer", see 15 Colo. Law. 753 (1986). For article, "An Update of Appendices from Collecting Pre- and Post-Judgment Interest in Colorado", see 15 Colo. Law. 990 (1986). For article, "Trust Protection of Personal Injury Recoveries from Public Creditors", see 19 Colo. Law. 2187 (1990). For article, "Health Care Bankruptcy Issues: Provider Agreements as Executory Contracts", see 24 Colo. Law. 765 (1995). For article, "Medicaid Estate Recovery: The Role of the Advocate", see 28 Colo. Law. 51 (Apr. 1999).

Annotator's note. Since § 25.5-4-301 is similar to § 26-4-403 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-403 is similar to § 26-4-112 as it existed prior to the 1991 repeal and reenactment of article 4 of title 26, relevant cases construing those provisions have been included in the annotations to this section.

Colorado's medicaid lien statute is not inconsistent with the anti-lien provisions

of the federal Medicaid Act. It is consistent with the federal medicaid statute's anti-lien provisions as interpreted by the U.S. supreme court in Arkansas Dept. of Health & Human Servs. v. Ahlborn, 547 U.S. 268 (2006). I.P. ex rel. Cardenas v. Henneberry, 795 F. Supp. 2d 1189 (D. Colo. 2011).

Department of health care policy and financing's lien on settlement proceeds from medicaid recipient's malpractice suit is tantamount to a forced assignment of the right to recover that portion of the settlement that represents payments for medical care, which, under Ahlborn, is consistent with both the third-party liability provisions and the anti-lien provisions in the federal medicaid statute. I.P. ex rel. Cardenas v. Henneberry, 795 F. Supp. 2d 1189 (D. Colo. 2011).

The department can seek reimbursement from that portion of medicaid recipient's settlement proceeds that represents medical expenses — past and future — up to the total amount it spent on medicaid recipient's behalf as of the date of the settlement. I.P. ex rel. Cardenas v. Henneberry, 795 F. Supp. 2d 1189 (D. Colo. 2011).

Actions necessary for recovery of expenses by department of social services. The Colorado department of social services has a right and duty to recover expenses its beneficiaries incur by reason of personal injuries they sustain in accidents, but to do so, it must either join in the action against the wrongdoer, assign its right to the recipient, or file its own action. Gomez v. Black, 32 Colo. App. 332, 511 P.2d 531 (1973).

A county department is not precluded from recovering medicaid benefits to which a medicaid recipient is not entitled and which were paid erroneously before adequate notice of termination. Nededog v. Colo. Dept. of Health Care Policy & Fin., 98 P.3d 960 (Colo. App. 2004).

Department of social services may set off from payments to providers of services the amounts of past overpayments. Smith, Harst & Assoc. v. D.S.S., 780 P.2d 20 (Colo. App. 1989).

This section allows the state to assign its rights to a claim for medical expenses paid by the state's medicaid program only to the recipient of medicaid or the recipient's attorney. Therefore a deceased recipient's family members were not proper assignees. Kildahl v. Tagge, 942 P.2d 1283 (Colo. App. 1996).

The state has an independent right of action that cannot be denied because of any negligence of a recipient. Tucker v. Gorman, 944 P.2d 653 (Colo. App. 1997), aff'd, 961 P.2d 1126 (Colo. 1998).

However, so long as the recipient's negligence is not imputed to the state so as to deny the state's claim, the recipient's negligence may be considered in determining the extent of a party's liability for the state's expenditures. Tucker v. Gorman, 944 P.2d 653 (Colo. App. 1997), aff'd on other grounds, 961 P.2d 1126 (Colo. 1998).

This section does not provide for waiver of claims to recover medicaid benefits paid erroneously to a recipient, nor does it cross-reference any waiver

regulation of the department of human services. Nededog v. Colo. Dept. of Health Care Policy & Fin., 98 P.3d 960 (Colo. App. 2004).

The method used to calculate apportionment of a third-party settlement for purposes of Medicaid reimbursement for medical expenses must not be arbitrary or one-size-fits-all and must employ reasonable means. Dept. of Health Care Policy & Fin. v. S.P., 2015 COA 81, 356 P.3d 1033.

It was not clearly erroneous for the court, in applying a proportionate allocation method, to rely on the amount paid to medical providers by the state for medical expenses rather than the amount billed by the providers. Colo. Dept. of Health Care Policy & Fin. v. S.P., 2015 COA 81, 356 P.3d 1033.

The trial court did not err in applying its formula for apportioning medical expenses to the gross amount of the settlement, rather than the amount of the settlement net attorney fees. Dept. of Health Care Policy & Fin. v. S.P., 2015 COA 81, 356 P.3d 1033.

25.5-4-302. Recovery of assets.

(1) The general assembly finds, determines, and declares that the cost of providing medical assistance to qualified members throughout the state has increased significantly in recent years; that such increasing costs have created an increased burden on state revenues while reducing the amount of revenues available for other state programs; that recovering some of the medical assistance from the estates of medical assistance members would be a viable mechanism for members to share in the cost of assistance; and that an estate recovery program would be a cost-efficient method of offsetting medical assistance costs in an equitable manner. The general assembly also declares that, in order to ensure that medicaid is available for low-income individuals, reasonable restrictions consistent with federal law should be placed on the ability of persons to become eligible for medicaid by means of making transfers of property without fair and valuable consideration.

(2) (a) Medical assistance paid on behalf of any individual who was fifty-five years of age or older when the individual received such assistance may be recovered by the state department from the estate of such individual in accordance with paragraph (c) of this subsection (2).

(b) Medical assistance paid on behalf of any individual who is institutionalized may be recovered by the state department from the estate of such individual in accordance with paragraph (c) of this subsection (2).

(c) The state department shall establish an estate recovery program only insofar as such program is in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended, and shall not take any action to recover medical assistance when the amount of assistance to be recovered is economically inappropriate in relation to expenses of recovery.

(3) The state department is authorized to file liens against any property of an individual who is institutionalized and from whom the state department may recover medical assistance pursuant to paragraph (b) of subsection (2) of this section.

(4) The state department may compromise, settle, or waive any recovery of medical assistance authorized pursuant to subsection (2) of this section upon good cause shown.

(5) Subject to any limitation concerning estate recovery in Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended, the amount of any medical assistance paid pursuant to the provisions of this article and articles 5 and 6 of this title is a claim against the estate pursuant to the provisions of section 15-12-805 (1), C.R.S.

(6) The state board shall promulgate rules to implement the provisions of this section, including rules limiting the eligibility for medical assistance if the person made a voluntary assignment or transfer of property without fair and valuable consideration prior to applying for medical assistance. A contract for an exempt burial fund for an individual shall include a provision restricting the full amount to the cost of the burial and stating that any portion not expended for the burial costs shall be refunded to the state department by the mortuary as reimbursement for the cost of medical assistance provided to the individual. Said rules shall be in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p, as amended.

(7) Effective upon the implementation of a private-public partnership program for financing long-term care pursuant to section 25.5-6-110, this section shall apply to participants of such program only after excluding from the amount that may otherwise be recovered from such person's estate an amount allowed by rules adopted by the state board in accordance with section 25.5-6-110.

Source: L. 2006: Entire article added with relocations, p. 1836, § 7, effective July 1. **L. 2024:** (1) amended, (SB 24-176), ch. 152, p. 638, § 32, effective August 7.

Editor's note: This section is similar to former § 26-4-403.3 as it existed prior to 2006.

ANNOTATION

Law reviews. For article, "The Impacts of Trusts on Public Benefits for Disabled Persons", see 46 Colo. Law. 43 (Nov. 2017).

Annotator's note. Since § 25.5-4-302 is similar to § 26-4-403.3 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5, relevant cases

construing that provision have been included in the annotations to this section.

Where section requires the department to establish an estate recovery program consistent with federal law and federal standards require the state to adopt procedures under which individuals who will be affected by recovery will have the right to apply for an undue hardship waiver, the department's rule allowing for service of notice on the personal representative of the decedent's estate is reasonably calculated to give notice to the affected individuals. However, department's notice was fatally defective since it did not instruct the personal representative to forward the notice to affected individuals nor did it identify who should receive the notice. Estate of Schiola v. Colo. Dept. of Health Care Policy & Fin., 51 P.3d 1080 (Colo. App. 2002).

The corrected notice of estate claim sent to the estate remedied the deficiencies in the original notice and provided the information required under Estate of Schiola v. Colo. Dept. of Health Care Policy & Fin. annotated above and the department rules. In re Estate of Kochevar, 94 P.3d 1253 (Colo. App. 2004).

Waiver of recovery of medicaid expenses should only benefit those individuals who qualify for and are granted a waiver to prevent financial burdens upon the state. Cobeneficiaries of a beneficiary granted a waiver may not benefit from the waiver. In re Estate of Ligon, 160 P.3d 361 (Colo. App. 2007).

25.5-4-303. State income tax refund intercept - garnishment of earning - failure to provide medical support for child.

(1) (a) At any time prescribed by the department of revenue, but not less frequently than annually, the state department may certify to the department of revenue information regarding any person who:

(I) Is obligated to the state agency responsible for administering medical assistance in this state for medical support based on medical assistance provided to the obligor's dependent child; and

(II) Has received payment from a third party to cover the health-care costs of the child but has neither applied such payment to cover the child's health-care costs nor to reimburse the state department, the custodial parent of the child, or the provider of medical care.

(b) The information provided to the department of revenue shall include the name and the social security number of the person described in paragraph (a) of this subsection (1), the amount of medical assistance provided to the child during the period for which medical support was ordered but not provided as described in subparagraph (II) of paragraph (a) of this subsection (1), and any other identifying information required by the department of revenue.

(2) Prior to a final certification of the information described in subsection (1) of this section to the department of revenue, the state department shall notify the obligated person, in writing, that the state intends to refer the person's name to the department of revenue in an attempt to offset the person's medical support obligation against the person's state income tax refund. Such notification shall include information on the parent's right to object to the offset.

(3) Upon notification by the department of revenue of amounts deposited with the state treasurer pursuant to section 39-21-108 (3), C.R.S., the state department may recover the amount of the medical assistance described in paragraph (b) of subsection (1) of this section.

(4) The state department may garnish the wages and other earnings of a person described in paragraph (a) of subsection (1) of this section. The garnishment of wages and earning shall be in accordance with articles 54 and 54.5 of title 13, C.R.S.

(5) The state board shall adopt rules as are necessary for the implementation of this section.

Source: L. 2006: Entire article added with relocations, p. 1838, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-403.4 as it existed prior to 2006.

25.5-4-303.3. Provider fraud - attorney general report.

(1) No later than October 1, 2017, and no later than October 1 each year thereafter, the attorney general shall submit a written report to the state department for inclusion in a single, comprehensive report to the general assembly concerning medicaid fraud pursuant to section 25.5-1-115.5. The attorney general shall provide information relating to medicaid provider fraud including, at a minimum:

(a) Investigations of provider fraud during the year;

(b) Criminal complaints requested, cases dismissed, cases acquitted, convictions, and confessions of judgment;

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

(d) Civil claims;

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

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

Source: L. 2012: Entire section added, (SB 12-060), ch. 166, p. 578, § 2, effective August 8. **L. 2017:** IP(1), (1)(d), and (1)(e) amended and (1)(f) added, (SB 17-295), ch. 298, p. 1637, § 2, effective August 9.

25.5-4-303.5. Short title.

This section and sections 25.5-4-304 to 25.5-4-310 shall be known and may be cited as the "Colorado Medicaid False Claims Act".

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1379, § 10, effective May 26.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

ANNOTATION

Law reviews. For article, "Overview of the New Colorado Medicaid False Claims Act", see 39 Colo. Law. 27 (Oct. 2010).

25.5-4-304. Definitions.

As used in sections 25.5-4-303.5 to 25.5-4-309, unless the context otherwise requires:

(1) (a) "Claim" means a request or demand for money or property, whether under a contract or otherwise, and regardless of whether the state has title to the money or property, under the "Colorado Medical Assistance Act" that is:

(I) Presented to an officer, employee, or agent of the state; or

(II) Made to a contractor, grantee, or other recipient if the money or property is to be spent or used on the state's behalf or to advance a program or interest of the state and if the state:

(A) Provides or has provided any portion of the money or property requested or demanded; or

(B) Will reimburse the contractor, grantee, or other recipient for any portion of the money or property that is requested or demanded.

(b) "Claim" does not include a request or demand for money or property that the state has paid to an individual as compensation for employment by the state or as an income subsidy with no restriction on that individual's use of the money or property.

(2) "Colorado Medical Assistance Act" means this article and articles 5 and 6 of this title.

(3) (a) "Knowing" or "knowingly" means that a person, with respect to information:

(I) Has actual knowledge of the information;

(II) Acts in deliberate ignorance of the truth or falsity of the information; or

(III) Acts in reckless disregard of the truth or falsity of the information.

(b) "Knowing" or "knowingly" does not require proof of specific intent to defraud.

(4) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(5) "Obligation" means a fixed or contingent duty arising from an express or implied contractual, quasi-contractual, grantor-grantee, licensor-licensee, statutory, fee-based, or similar relationship, or the retention of overpayment.

Source: L. 2006: Entire article added with relocations, p. 1838, § 7, effective July 1. **L. 2010:** Entire section R&RE, (SB 10-167), ch. 296, p. 1379, § 11, effective May 26. **L. 2013:** (5) amended, (SB 13-205), ch. 276, p. 1441, § 3, effective August 7.

Editor's note: This section is similar to former §§ 26-4-1102 and 26-4-1103 (3) as they existed prior to 2006.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

25.5-4-305. False medicaid claims - liability for certain acts - false medicaid claims recovery fund.

(1) Except as otherwise provided in subsection (2) of this section, a person is liable to the state for a civil penalty of not less than five thousand five hundred dollars and not more than eleven thousand dollars; except that these upper and lower limits on liability shall automatically increase to equal the civil penalty allowed under the federal "False Claims Act", 31 U.S.C. sec. 3729, et seq., if and as the penalties in such federal act may be adjusted for inflation as described

in said act in accordance with the federal "Civil Penalties Inflation Adjustment Act of 1990", Pub. L. No. 101-410, plus three times the amount of damages that the state sustains because of the act of that person, if the person:

(a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(b) Knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;

(c) Has possession, custody, or control of property or money used, or to be used, by the state in connection with the "Colorado Medical Assistance Act"and knowingly delivers, or causes to be delivered, less than all of the money or property;

(d) Authorizes the making or delivery of a document certifying receipt of property used, or to be used, by the state in connection with the "Colorado Medical Assistance Act" and, intending to defraud the state, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(e) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the state in connection with the "Colorado Medical Assistance Act" who lawfully may not sell or pledge the property;

(f) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act", or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state in connection with the "Colorado Medical Assistance Act";

(g) Conspires to commit a violation of paragraphs (a) to (f) of this subsection (1).

(2) Notwithstanding the amount of damages authorized in subsection (1) of this section, for a person who violates subsection (1) of this section, the court may assess not less than twice the amount of damages that the state sustains because of the act of the person if the court finds that:

(a) The person who committed the violation of subsection (1) of this section furnished to the officials of the state responsible for investigating false claims violations all information about the violation known to the person and furnished said information within thirty days after the date on which the person first obtained the information;

(b) At the time the person furnished the information about the violation to the state, a criminal prosecution, civil action, or administrative action had not commenced with respect to the violation and the person did not have actual knowledge of the existence of an investigation into the violation; and

(c) The person fully cooperated with any investigation of the violation by the state.

(3) (a) In addition to any other liability, a person violating this section is liable to the federal government, state government, and affected agencies and political subdivisions thereof, including the department of law, for full reasonable expenses incurred in a civil action brought to recover penalties or remedies under the "Colorado Medicaid False Claims Act", sections 25.5-4-303.5 to 25.5-4-310, including the costs of investigation and litigation, attorney fees, court costs, witness fees, and deposition costs. Recovered costs and fees shall be transferred to the state treasurer for deposit in the false medicaid claims recovery fund, which fund is created in subsection (3)(b) of this section.

(b) (I) The false medicaid claims recovery fund is created in the state treasury. The fund consists of money credited to the fund pursuant to subsection (3)(a) of this section and any other money that the general assembly may appropriate or transfer to the fund.

(II) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the false medicaid claims recovery fund to the fund.

(III) Any money remaining in the fund at the end of a state fiscal year remains in the fund.

(IV) Subject to annual appropriation by the general assembly, the attorney general may expend money from the fund for the purpose of hiring necessary staff to implement the medicaid fraud control unit in the department of law and to defray the costs of investigating and litigating ongoing false claims cases by the unit.

(c) Proceeds recovered as a result of an action filed pursuant to the "Colorado Medicaid False Claims Act", sections 25.5-4-303.5 to 25.5-4-310, shall be distributed in the following order:

(I) To refund money falsely obtained from the federal government or state government or a political subdivision thereof; and

(II) To the state treasurer for deposit in the general fund, except as described in subsection (3)(e) of this section.

(d) A portion of the recovery equal to the amount of money falsely obtained from the federal government, the state government, an affected political subdivision thereof, or state agencies, or a combination thereof, shall be remitted to the entity shown to be defrauded, subject to any further requirements established by federal or state law.

(e) Upon receipt of a distribution described in subsection (3)(c)(II) of this section, the state treasurer shall deposit the entire amount in the general fund; except that, subject to relevant guidelines of the federal department of health and human services' office of inspector general regarding repayment of fees or recoveries, the state treasurer shall credit twenty percent of such a distribution to the false medicaid claims recovery fund created in subsection (3)(b) of this section.

(4) Any information furnished pursuant to subsection (2) of this section shall be exempt from disclosure under part 2 of article 72 of this title.

Source: L. 2006: Entire article added with relocations, p. 1839, § 7, effective July 1. **L. 2010:** Entire section R&RE, (SB 10-167), ch. 296, p. 1380, § 12, effective May 26. **L. 2011:** IP(1) amended, (HB 11-1303), ch. 264, p. 1168, § 66, effective August 10. **L. 2013:** IP(1) and (1)(a) amended, (SB 13-205), ch. 276, p. 1441, § 4, effective August 7. **L. 2026:** (3) amended, (HB 26-1426), ch. 334, p. 2027, § 103, effective August 12.

Editor's note: This section is similar to former § 26-4-1103 (1) and (2) as they existed prior to 2006.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

ANNOTATION

Law reviews. For article, "Colorado's Medicaid Compliance Statutes: False Statements and Claims, Kickbacks, and Physician Referrals", see 36 Colo. Law. 31 (Mar. 2007).

25.5-4-306. Civil actions for false medicaid claims.

(1) **Responsibility of attorney general.** The attorney general shall diligently investigate a violation under section 25.5-4-305. If the attorney general finds that a person has violated or is violating section 25.5-4-305, the attorney general may bring a civil action under this section against the person.

(2) **Actions by private persons.**

(a) A relator may bring a civil action for a violation of section 25.5-4-305 on behalf of the relator and the state. The action shall be brought in the name of the state. The action may be dismissed only if the court and the attorney general give written consent to the dismissal and their reasons for consenting.

(b) A copy of the complaint and written disclosure of substantially all material evidence and information the relator possesses shall be served on the state pursuant to rule 4 of the Colorado rules of civil procedure. The complaint shall be filed in camera, shall remain under seal for at

least sixty days, and shall not be served on the defendant until the court so orders. The state may elect to intervene and proceed with the action within sixty days after it receives both the complaint and the material evidence and information.

(c) The state may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (b) of this subsection (2). Any such motion may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to a complaint filed under this section until twenty days after the complaint is unsealed and served upon the defendant pursuant to rule 4 of the Colorado rules of civil procedure.

(d) Before the expiration of the sixty-day period pursuant to paragraph (b) of this subsection (2) or any extensions obtained under paragraph (c) of this subsection (2), the state shall:

(I) Proceed with the action, in which case the state shall conduct the action; or

(II) Notify the court that it declines to take over the action, in which case the relator shall have the right to conduct the action.

(e) When a relator brings an action under this subsection (2), no person other than the state may intervene or bring a related action based on the facts underlying the pending action.

(3) **Rights of parties to private actions.**

(a) If the state proceeds with an action brought under subsection (2) of this section, it shall have the primary responsibility for prosecuting the action and shall not be bound by an act of the relator. The relator shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (b) of this subsection (3).

(b) (I) The state may dismiss the action notwithstanding the objections of the relator if the relator has been notified by the state of the filing of the motion and the court has provided the relator with an opportunity for a hearing on the motion.

(II) The state may settle the action with the defendant notwithstanding the objections of the relator if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, the hearing may be held in camera.

(III) Upon a showing by the state that unrestricted participation during the course of the litigation by the relator would interfere with or unduly delay the state's prosecution of the case, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the relator's participation, including but not limited to:

(A) Limiting the number of witnesses the relator may call;

(B) Limiting the length of the testimony of the witnesses;

(C) Limiting the relator's cross-examination of witnesses; or

(D) Otherwise limiting the participation by the relator in the litigation.

(IV) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the relator would be for purposes of harassment or would cause the defendant undue burden or unnecessary expense, the court may limit the participation by the relator in the litigation.

(c) If the state elects not to proceed with the action, the relator who initiated the action shall have the right to conduct the action. If the state so requests, it shall be served with copies of all pleadings filed in the action and, at the state's expense, shall be supplied with copies of all deposition transcripts. When a relator proceeds with the action, the court, without limiting the status and rights of the relator, may nevertheless permit the state to intervene at a later date upon a showing of good cause.

(d) Regardless of whether the state proceeds with the action, upon a showing by the state that certain actions of discovery by the relator would interfere with the state's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay the discovery for a period of not more than sixty days. The showing shall be conducted in camera. The court may extend the sixty-day period upon a further showing in camera that the state has pursued the criminal or civil investigation or proceedings with reasonable diligence and that any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(e) Notwithstanding the provisions of subsection (2) of this section, the state may elect to pursue its claim through any alternate remedy available to the state, including any administrative proceeding to determine a civil money penalty. If an alternate remedy is pursued in another proceeding, the relator shall have the same rights in the proceeding as the relator would have had if the action had continued under this section. Any finding of fact or conclusion of law made in another proceeding that has become final shall be conclusive on all parties to an action under this section. For purposes of this paragraph (e), a finding or conclusion is final if it has been finally determined on appeal to the appropriate court of the state, if all time for filing such an appeal with respect to the finding or conclusion has expired, or if the finding or conclusion is not subject to judicial review.

(4) **Award to private persons.**

(a) (I) If the state proceeds with an action brought by a relator under subsection (2) of this section, the relator shall, subject to subparagraph (II) of this paragraph (a), receive at least fifteen percent but not more than twenty-five percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the relator substantially contributed to the prosecution of the action.

(II) If the court finds the action to be based primarily on disclosures of specific information, other than information provided by the relator, relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative, administrative, or state auditor's report, hearing, audit, or investigation, or from the news media, the court may award to the relator such sums as it considers appropriate, but in no case more than ten percent of the proceeds, taking into account the significance of the information and the role of the relator in advancing the case to litigation.

(III) Any payment to a relator under subparagraph (I) or (II) of this paragraph (a) shall be made from the proceeds. The relator shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred plus reasonable attorney fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(b) If the state does not proceed with an action brought under subsection (2) of this section, the relator bringing the action or settling the claim shall receive an amount that the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than twenty-five percent and not more than thirty percent of the proceeds of the action or settlement and shall be paid out of the proceeds. The relator shall also receive an amount for reasonable expenses that the court finds to have been necessarily incurred, plus reasonable attorney fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(c) Regardless of whether the state proceeds with an action brought under subsection (2) of this section, if the court finds that the action was brought by a relator who planned and initiated the violation of section 25.5-4-305 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action that the relator would otherwise receive under paragraph (a) or (b) of this subsection (4), taking into account the role of the relator in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the relator is convicted of criminal conduct arising from his or her role in the violation of section 25.5-4-305, the relator shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the state to continue the action.

(d) If the state does not proceed with an action brought under subsection (2) of this section and the relator bringing the action conducts the action, the court may award to the defendant its reasonable attorney fees and expenses if the defendant prevails in the action and the court finds that the claim of the relator was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(5) **Certain actions barred.**

(a) A court shall not have jurisdiction over an action brought under this section against a member of the general assembly, a member of the state judiciary, or an elected official in the

executive branch of the state of Colorado if the action is based on evidence or information known to the state when the action was brought.

(b) A relator shall not bring an action under subsection (2) of this section that is based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the state is already a party.

(c) (I) A court shall dismiss an action or claim brought under subsection (2) of this section unless opposed by the state, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed in a state criminal, civil, or administrative hearing in which the state or its agent is a party, in a legislative, administrative, or state auditor's report, hearing, audit, or investigation, or by the news media, unless the action is brought by the state or the relator is an original source of the information.

(II) For purposes of this paragraph (c), "original source" means an individual who, prior to a public disclosure under subparagraph (I) of this paragraph (c), has voluntarily disclosed to the state the information on which the allegations or transactions in a claim are based, or who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and has voluntarily provided the information to the state before filing an action under subsection (2) of this section.

(6) **State not liable for certain expenses.** The state is not liable for expenses that a relator incurs in bringing an action under this section.

(7) **Private action for retaliation.**

(a) An employee, contractor, or agent shall be entitled to all relief necessary to make the employee, contractor, or agent whole, if the employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by the defendant or by any other person because of lawful acts done by the employee, contractor, or agent, or associated others in furtherance of an action under this section or in furtherance of an effort to stop any violations of section 25.5-4-305.

(b) (I) An employee, contractor, or agent who seeks relief pursuant to this subsection (7) shall be entitled to all relief necessary to make the employee, contractor, or agent whole. Such relief shall include:

(A) Reinstatement with the same seniority status the employee, contractor, or agent would have had but for the discrimination, twice the amount of back pay, and interest on the back pay; and

(B) Compensation for any special damages sustained as a result of the discrimination or retaliation, including litigation costs and reasonable attorney fees.

(II) An employee, contractor, or agent may bring an action in the appropriate court of the state for the relief provided in this subsection (7).

Source: L. 2006: Entire article added with relocations, p. 1840, § 7, effective July 1. **L. 2009:** IP(1)(b), IP(1)(c), and (4) amended, (SB 09-292), ch. 369, p. 1974, § 97, effective August 5. **L. 2010:** Entire section R&RE, (SB 10-167), ch. 296, p. 1382, § 13, effective May 26. **L. 2013:** (2)(e), (5), and (7) amended, (SB 13-205), ch. 276, p. 1441, § 5, effective August 7.

Editor's note: This section is similar to former § 26-4-1104 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

ANNOTATION

Law reviews. For article, "Colorado's Medicaid Compliance Statutes: False Statements and Claims, Kickbacks, and Physician Referrals", see 36 Colo. Law. 31 (Mar. 2007).

25.5-4-307. False medicaid claims procedures - statute of limitations.

(1) A civil action under section 25.5-4-306 (1) or (2) may not be brought after the later of:

(a) More than six years after the date on which the violation of section 25.5-4-305 is committed; or

(b) More than three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the state charged with responsibility to act in the circumstances, but in no event more than ten years after the date on which the violation of section 25.5-4-305 is committed.

(2) If the state elects to intervene and proceed with an action brought under section 25.5-4-306, the state may file its own complaint or amend the relator's complaint to clarify or add detail to the claims in which the state is intervening and to add any additional claims with respect to which the state contends it is entitled to relief. For statute of limitations purposes, any such pleadings by the state shall relate back to the filing date of the relator's complaint, to the extent that the state's claim arises out of the conduct, transactions, or occurrences set forth, or attempted to be set forth, in the prior complaint of the relator.

(3) In an action brought under section 25.5-4-306, the state or relator must prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(4) Notwithstanding any other provision of law, the Colorado rules of criminal procedure, or the Colorado rules of evidence, a final judgment rendered in favor of the state in a criminal proceeding charging fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action that involves the same transaction as in the criminal proceeding and that is brought under section 25.5-4-306.

(5) A private action for retaliation under section 25.5-4-306 (7) may not be brought more than three years after the date when the retaliation occurred.

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1386, § 14, effective May 26. **L. 2013:** (5) added, (SB 13-205), ch. 276, p. 1442, § 6, effective August 7.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

25.5-4-308. False medicaid claims jurisdiction.

An action under section 25.5-4-306 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, or transacts business or in which an act proscribed by section 25.5-4-305 occurred. A summons as required by the Colorado rules of civil procedure shall be issued by the appropriate district court and served at any place.

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1387, § 14, effective May 26.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

25.5-4-309. False medicaid claims civil investigation demands.

(1) **General.**

(a) (I) Whenever the attorney general has reason to believe that a person may be in possession, custody, or control of documentary material or information relevant to a false medicaid claims law investigation, the attorney general may, before commencing a civil proceeding under section 25.5-4-306 or other false medicaid claims law or making an election under section 25.5-4-306 (2)(d), issue in writing and cause to be served upon the person a civil investigative demand requiring the person to:

(A) Produce the documentary material for inspection and copying;

(B) Answer in writing written interrogatories with respect to the documentary material or information;

(C) Give oral testimony concerning the documentary material or information; or

(D) Furnish any combination of such material, answers, or testimony.

(II) The attorney general may not delegate the authority to issue civil investigative demands under this subsection (1). Whenever a civil investigative demand is an express demand for any product of discovery, the attorney general, the deputy attorney general, or an assistant attorney general shall cause to be served, in any manner authorized by this section, a copy of the demand upon the person from whom the discovery was obtained and shall notify the person to whom the demand is issued of the date on which the copy was served.

(b) (I) Each civil investigative demand issued under this subsection (1) shall state the nature of the conduct constituting the alleged violation of a false medicaid claims law that is under investigation and the applicable provision of law alleged to be violated.

(II) If the demand is for the production of documentary material, the demand shall:

(A) Describe each class of documentary material to be produced with such definiteness and certainty as to permit the material to be fairly identified;

(B) Prescribe a return date for each such class that will provide a reasonable period of time within which the material so demanded may be assembled and made available for inspection and copying; and

(C) Identify the false medicaid claims law investigator to whom the material shall be made available.

(III) If the demand is for answers to written interrogatories, the demand shall:

(A) Specify the written interrogatories to be answered;

(B) Prescribe dates on which answers to written interrogatories shall be submitted; and

(C) Identify the false medicaid claims law investigator to whom the answers shall be submitted.

(IV) If the demand is for the giving of oral testimony, the demand shall:

(A) Prescribe a date, time, and place at which oral testimony shall be commenced and notify the deponent if the oral testimony is to be video or audio recorded;

(B) Identify a false medicaid claims law investigator who shall conduct the examination and the custodian to whom the transcript of the examination shall be submitted;

(C) Specify that such attendance and testimony are necessary to the conduct of the investigation;

(D) Notify the person receiving the demand of the right to be accompanied by an attorney and any other representative; and

(E) Describe the general purpose for which the demand is being issued and the general nature of the testimony, including the primary areas of inquiry, that will be taken pursuant to the demand.

(V) A civil investigative demand issued under this section that is an express demand for any product of discovery shall not be returned or returnable until twenty days after a copy of the demand has been served upon the person from whom the discovery was obtained.

(VI) The date prescribed for the commencement of oral testimony pursuant to a civil investigative demand issued under this section shall be a date that is not less than seven days after the date on which the demand is received, unless the attorney general or an assistant attorney general designated by the attorney general determines that exceptional circumstances are present that warrant the commencement of the testimony within a lesser period of time.

(VII) The attorney general shall not authorize the issuance under this section of more than one civil investigative demand for oral testimony by the same person unless the person requests otherwise or unless the attorney general, after investigation, notifies that person in writing that an additional demand for oral testimony is necessary. Notwithstanding section 24-31-103, C.R.S., the attorney general shall not authorize the performance, by any other officer, employee, or agency, of any function vested in the attorney general under this subparagraph (VII).

(2) **Protected material or information.**

(a) A civil investigative demand issued under subsection (1) of this section shall not require the production of documentary material, the submission of answers to written interrogatories, or the giving of oral testimony if the material, answers, or testimony would be protected from disclosure under:

(I) The standards applicable to subpoenas or subpoenas duces tecum issued by a court of this state to aid in a grand jury investigation; or

(II) The standards applicable to discovery requests under the Colorado rules of civil procedure, to the extent that the application of the standards to any such demand is appropriate and consistent with the provisions and purposes of this section.

(b) A demand that is an express demand for a product of discovery supersedes any inconsistent order, rule, or provision of law, other than this section, preventing or restraining disclosure of the product of discovery to a person. Disclosure of a product of discovery pursuant to an express demand does not constitute a waiver of any right or privilege that the person making the disclosure may be entitled to invoke to resist discovery of trial preparation materials.

(3) **Service and jurisdiction.**

(a) A civil investigative demand issued under subsection (1) of this section or a petition brought pursuant to subsection (10) of this section may be served by a false medicaid claims law investigator, a sheriff, or a deputy sheriff at any place within the state.

(b) A civil investigative demand issued under subsection (1) of this section or a petition filed under subsection (10) of this section may be served upon a person who is not found within the state in the manner prescribed by the Colorado rules of civil procedure for service in another state or a foreign country. To the extent that the courts of this state can assert jurisdiction over any such person consistent with due process, the district court for the city and county of Denver shall have the same jurisdiction to take an action respecting compliance with this section by any such person that the court would have if the person were personally within the jurisdiction of the court.

(4) **Service on legal entities and natural persons.**

(a) Service of a civil investigative demand issued under subsection (1) of this section or of a petition filed under subsection (10) of this section may be made upon a partnership, corporation, association, or other legal entity by:

(I) Delivering an executed copy of the demand or petition to a partner, executive officer, managing agent, or general agent of the partnership, corporation, association, or entity, or to an agent authorized by appointment or by law to receive service of process on behalf of the partnership, corporation, association, or entity;

(II) Delivering an executed copy of the demand or petition to the principal office or place of business of the partnership, corporation, association, or entity; or

(III) Depositing an executed copy of the demand or petition in the United States mail by registered or certified mail, with a return receipt requested, addressed to the partnership, corporation, association, or entity at its principal office or place of business.

(b) Service of a civil investigative demand issued under subsection (1) of this section or of a petition filed under subsection (10) of this section may be made upon a natural person by:

(I) Delivering an executed copy of the demand or petition to the person; or

(II) Depositing an executed copy of the demand or petition in the United States mail by registered or certified mail, with a return receipt requested, addressed to the person at the person's residence, principal office, or place of business.

(5) **Proof of service.** A verified return by the individual serving a civil investigative demand issued under subsection (1) of this section or a petition filed under subsection (10) of this section setting forth the manner of the service shall be proof of the service. In the case of service by registered or certified mail, the return shall be accompanied by the return post office receipt of delivery of the demand.

(6) **Documentary material.**

(a) (I) The production of documentary material in response to a civil investigative demand issued under subsection (1) of this section shall be made under a sworn certificate, in the form as the demand designates, by:

(A) In the case of a natural person, the person to whom the demand is directed; or

(B) In the case of a person other than a natural person, a person having knowledge of the facts and circumstances relating to the production and authorized to act on behalf of the person.

(II) The certificate shall state that all of the documentary material required by the demand and in the possession, custody, or control of the person to whom the demand is directed has been produced and made available to the false medicaid claims law investigator identified in the demand.

(b) A person upon whom a civil investigative demand for the production of documentary material has been served under this section shall make the material available for inspection and copying to the false medicaid claims law investigator identified in the demand at the principal place of business of the person, or at such other place as the false medicaid claims law investigator and the person thereafter may agree and prescribe in writing, or as the court may direct under subsection (10) of this section. The material shall be made so available on the return date specified in the demand, or on such later date as the false medicaid claims law investigator may prescribe in writing. The person may, upon written agreement between the person and the false medicaid claims law investigator, substitute copies for originals of all or any part of the material.

(7) **Interrogatories.**

(a) Each interrogatory in a civil investigative demand issued under subsection (1) of this section shall be answered separately and fully in writing under oath and shall be submitted under a sworn certificate, in the form the demand designates, by:

(I) In the case of a natural person, the person to whom the demand is directed; or

(II) In the case of a person other than a natural person, the person or persons responsible for answering each interrogatory.

(b) If an interrogatory is objected to, the reasons for the objection shall be stated in the certificate instead of an answer. The certificate shall state that all information required by the demand and in the possession, custody, control, or knowledge of the person to whom the demand is directed has been submitted. To the extent that any information is not furnished, the information shall be identified and reasons set forth with particularity regarding the reasons why the information was not furnished.

(8) **Oral examinations.**

(a) The examination of a person pursuant to a civil investigative demand for oral testimony issued under subsection (1) of this section shall be taken before an officer authorized to administer oaths and affirmations by the laws of the United States, the state of Colorado, or the place where the examination is held. The officer before whom the testimony is to be taken shall put the witness on oath or affirmation and shall, personally or with the assistance of someone acting under the direction of the officer and in the officer's presence, record the testimony of the witness. The testimony shall be taken stenographically and shall be transcribed. When the testimony is fully transcribed, the officer before whom the testimony is taken shall promptly transmit a copy of the transcript of the testimony to the custodian. This subsection (8) shall not preclude the taking of testimony by any means authorized by, and in a manner consistent with, the Colorado rules of civil procedure.

(b) The false medicaid claims law investigator conducting the examination shall exclude from the place where the examination is held all persons except the person giving the testimony, the attorney for and any other representative of the person giving the testimony, the attorney for the state, any person who may be agreed upon by the attorney for the state and the person giving the testimony, the officer before whom the testimony is to be taken, and the stenographer who is recording the testimony.

(c) The oral testimony of a person taken pursuant to a civil investigative demand served under this section shall be taken in the judicial district of the state within which the person resides, is found, or transacts business, or in another place as may be agreed upon by the false medicaid claims law investigator conducting the examination and the person.

(d) When the testimony is fully transcribed, the false medicaid claims law investigator or the officer before whom the testimony is taken shall afford the witness, who may be accompanied by counsel, a reasonable opportunity to examine and read the transcript, unless the witness waives the examination and reading. Any changes in form or substance that the witness desires to make shall be entered and identified upon the transcript by the officer or the false medicaid claims law investigator, with a statement of the reasons given by the witness for making the changes. The transcript shall then be signed by the witness, unless the witness in writing waives the signing, is

ill, cannot be found, or refuses to sign. If the witness does not sign the transcript within thirty days after being afforded a reasonable opportunity to examine it, the officer or the false medicaid claims law investigator shall sign it and state on the record the fact of the waiver, illness, absence of the witness, or refusal to sign, together with the reasons, if any, given therefor.

(e) The officer before whom the testimony is taken shall certify on the transcript that the witness was sworn by the officer and that the transcript is a true record of the testimony given by the witness, and the officer or false medicaid claims law investigator shall promptly deliver the transcript, or send the transcript by registered or certified mail, to the custodian.

(f) Upon payment of reasonable charges therefor, the false medicaid claims law investigator shall furnish a copy of the transcript to the witness only; except that the attorney general, the deputy attorney general, or an assistant attorney general may, for good cause, limit the witness to inspection of the official transcript of the testimony of the witness.

(g) (I) A person compelled to appear for oral testimony under a civil investigative demand issued under subsection (1) of this section may be accompanied, represented, and advised by counsel. Counsel may advise the person, in confidence, with respect to any question asked of the person. The person or counsel may object on the record to any question, in whole or in part, and shall briefly state for the record the reason for the objection. An objection may be made, received, and entered upon the record when it is claimed that the person is entitled to refuse to answer the question on the grounds of any constitutional or other legal right or privilege, including the privilege against self-incrimination. The person may not otherwise object to or refuse to answer any question and may not directly or through counsel otherwise interrupt the oral examination. If the person refuses to answer a question, the false medicaid claims law investigator may file a petition in a district court under paragraph (a) of subsection (10) of this section for an order compelling the person to answer the question.

(II) If the person refuses to answer a question on the grounds of the privilege against self-incrimination, the false medicaid claims law investigator may compel the testimony of the person in accordance with the provisions of section 13-90-118, C.R.S.

(III) A person appearing for oral testimony under a civil investigative demand issued under subsection (1) of this section shall be entitled to the same fees and allowances that are paid to witnesses in the district courts of this state.

(9) **Custodian of documents, answers, and transcripts.**

(a) The attorney general shall designate a false medicaid claims law investigator to serve as custodian of documentary material, answers to interrogatories, and transcripts of oral testimony received under this section and shall designate such additional false medicaid claims law investigators as the attorney general determines from time to time to be necessary to serve as deputies to the custodian.

(b) (I) A false medicaid claims law investigator who receives any documentary material, answers to interrogatories, or transcripts of oral testimony under this section shall transmit them to the custodian. The custodian shall take physical possession of the material, answers, or transcripts and shall be responsible for the use made of them and for the return of documentary material under paragraph (d) of this subsection (9).

(II) The custodian may cause the preparation of copies of the documentary material, answers to interrogatories, or transcripts of oral testimony as may be required for official use by a false medicaid claims law investigator or other officer or employee of the department of law who is authorized for such use under regulations that the attorney general shall issue. The material, answers, and transcripts may be used by any such authorized false medicaid claims law investigator or other officer or employee in connection with the taking of oral testimony under this section.

(III) (A) Except as otherwise provided in this subsection (9), documentary material, answers to interrogatories, or transcripts of oral testimony, or copies thereof, while in the possession of the custodian, shall not be available for examination by an individual other than a false medicaid claims law investigator or other officer or employee of the department of law authorized under subparagraph (II) of this paragraph (b).

(B) Sub-subparagraph (A) of this subparagraph (III) shall not apply if consent is given by the person who produced the material, answers, or transcripts or, in the case of any product of discovery produced pursuant to an express demand for the material, if consent is given by the person from whom the discovery was obtained.

(C) Nothing in this subparagraph (III) is intended to prevent disclosure to the general assembly, including any committee of the general assembly, or to any other agency of the state for use by the agency in furtherance of its statutory responsibilities. Disclosure of information to any such other agency shall be allowed only upon application, made by the attorney general to a district court, showing substantial need for the use of the information by the agency in furtherance of its statutory responsibilities.

(IV) While in the possession of the custodian and under such reasonable terms and conditions as the attorney general shall prescribe:

(A) Documentary material and answers to interrogatories shall be available for examination by the person who produced the material or answers, or by a representative of that person authorized by that person to examine the material and answers; and

(B) Transcripts of oral testimony shall be available for examination by the person who produced the testimony or by a representative of that person authorized by that person to examine the transcripts.

(c) Whenever an attorney of the department of law has been designated to appear before a court, grand jury, or state agency in a case or proceeding, the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony received under this section may deliver to the attorney such material, answers, or transcripts for official use in connection with the case or proceeding as the attorney determines to be required. Upon the completion of the case or proceeding, the attorney shall return to the custodian the material, answers, or transcripts so delivered that are not in the control of the court, grand jury, or agency through introduction into the record of the case or proceeding.

(d) The custodian shall, upon written request of a person who produced any documentary material in the course of any false medicaid claims law investigation pursuant to a civil investigative demand under this section, return to the person any such material, other than copies furnished to the false medicaid claims law investigator under paragraph (b) of subsection (6) of this section or made for the department of law under subparagraph (II) of paragraph (b) of this subsection (9), that is not in the control of a court, grand jury, or agency through introduction into the record of the case or proceeding, if:

(I) A case or proceeding before a court or grand jury arising out of the investigation or any proceeding before a state agency involving the material has been completed; or

(II) A case or proceeding in which the material may be used has not been commenced within a reasonable time after completion of the examination and analysis of all documentary material and other information assembled in the course of the investigation.

(e) (I) In the event of the death, disability, or separation from service in the department of law of the custodian of any documentary material, answers to interrogatories, or transcripts of oral testimony produced pursuant to a civil investigative demand under this section, or in the event of the official relief of the custodian from responsibility for the custody and control of the material, answers, or transcripts, the attorney general shall promptly:

(A) Designate another false medicaid claims law investigator to serve as custodian of the material, answers, or transcripts; and

(B) Transmit in writing to the person who produced the material, answers, or testimony notice of the identity and address of the successor so designated.

(II) A person who is designated to be a successor under this paragraph (e) shall have, with regard to the material, answers, or transcripts, the same duties and responsibilities as were imposed by this section upon that person's predecessor in office; except that the successor shall not be held responsible for any default or dereliction that occurred before that designation.

(10) **Judicial proceedings.**

(a) Whenever a person fails to comply with a civil investigative demand issued under subsection (1) of this section, or whenever satisfactory copying or reproduction of the material

requested in a demand cannot be done and the person refuses to surrender the material, the attorney general may file, in a district court for the judicial district in which the person resides, is found, or transacts business, and serve upon the person a petition for an order of the court for the enforcement of the civil investigative demand.

(b) (I) A person who has received a civil investigative demand issued under subsection (1) of this section may file a petition for an order of the court to modify or set aside the demand. The person shall file the petition in a district court for the judicial district within which the person resides, is found, or transacts business and shall serve a copy of the petition upon the false medicaid claims law investigator identified in the demand. In the case of a petition addressed to an express demand for a product of discovery, the person may file a petition to modify or set aside the demand only in the district court for the judicial district in which the proceeding in which the discovery was obtained is or was last pending. The person shall file a petition under this subparagraph (I):

(A) Within twenty days after the date of service of the civil investigative demand or at any time before the return date specified in the demand, whichever date is earlier; or

(B) Within such longer period as may be prescribed in writing by a false medicaid claims law investigator identified in the demand.

(II) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (I) of this paragraph (b) and may be based upon any failure of the demand to comply with the provisions of this section or upon any constitutional or other legal right or privilege of the person. During the pendency of the petition in the court, the court may stay, as it deems proper, the running of the time allowed for compliance with the demand, in whole or in part; except that the person filing the petition shall comply with any portions of the demand not sought to be modified or set aside.

(c) (I) In the case of a civil investigative demand issued under subsection (1) of this section that is an express demand for a product of discovery, the person from whom the discovery was obtained may file a petition for an order of the court to modify or set aside those portions of the demand requiring production of any product of discovery. The person shall file the petition in the district court for the judicial district in which the proceeding in which the discovery was obtained is or was last pending and shall serve a copy of the petition upon the false medicaid claims law investigator identified in the demand and upon the recipient of the demand. The person shall file a petition under this subparagraph (I):

(A) Within twenty days after the date of service of the civil investigative demand or at any time before the return date specified in the demand, whichever date is earlier; or

(B) Within such longer period as may be prescribed in writing by the false medicaid claims law investigator identified in the demand.

(II) The petition shall specify each ground upon which the petitioner relies in seeking relief under subparagraph (I) of this paragraph (c), and may be based upon any failure of the portions of the demand from which relief is sought to comply with the provisions of this section or upon any constitutional or other legal right or privilege of the petitioner. During the pendency of the petition, the court may stay, as it deems proper, compliance with the demand and the running of the time allowed for compliance with the demand.

(d) At any time during which a custodian is in custody or control of any documentary material or answers to interrogatories produced, or transcripts of oral testimony given, by a person in compliance with a civil investigative demand issued under subsection (1) of this section, the person, and in the case of an express demand for any product of discovery, the person from whom the discovery was obtained, may file a petition for an order of the court to require the performance by the custodian of any duty imposed upon the custodian by this section. The person shall file the petition in the district court for the judicial district within which the office of the custodian is situated and shall serve a copy of the petition upon the custodian.

(e) Whenever a petition is filed in a district court under this subsection (10), the court shall have jurisdiction to hear and determine the matter so presented and to enter such order or orders as may be required to carry out the provisions of this section. A final order so entered shall be subject to appeal under section 13-4-102, C.R.S. Any disobedience of a final order entered by a court under this section shall be punished as a contempt of the court.

(f) The Colorado rules of civil procedure shall apply to a petition under this subsection (10) to the extent that the rules are consistent with the provisions of this section.

(11) **Disclosure exemption.** Any documentary material, answers to written interrogatories, or oral testimony provided under a civil investigative demand issued under subsection (1) of this section shall be exempt from disclosure under section 24-72-203, C.R.S.

(12) **Definitions.** As used in this section, unless the context otherwise requires:

(a) "Custodian" means the custodian, or any deputy custodian, designated by the attorney general under paragraph (a) of subsection (9) of this section.

(b) "Documentary material" means the original or a copy of a book, record, report, memorandum, paper, communication, tabulation, chart, or other document, or data compilations stored in or accessible through computer or other information retrieval systems, together with instructions and all other materials necessary to use or interpret the data compilations, and any product of discovery.

(c) "False medicaid claims law" means:

(I) This section and sections 25.5-4-303.5 to 25.5-4-308; and

(II) Any law enacted before, on, or after May 26, 2010, that prohibits or makes available to the state in a court of the state a civil remedy with respect to a false medicaid claim against, bribery of, or corruption of an officer or employee of the state.

(d) "False medicaid claims law investigation" means an inquiry conducted by a false medicaid claims law investigator for the purpose of ascertaining whether a person is or has been engaged in a violation of a false medicaid claims law.

(e) "False medicaid claims law investigator" means an attorney or investigator employed by the department of law who is charged with the duty of enforcing or carrying into effect a false medicaid claims law or an officer or employee of the state acting under the direction and supervision of the attorney or investigator in connection with a false medicaid claims law investigation.

(f) "Person" means a natural person, partnership, corporation, association, or other legal entity.

(g) "Product of discovery" means:

(I) The original or duplicate of a deposition, interrogatory, document, thing, result of the inspection of land or other property, examination, or admission, any one of which is obtained by a method of discovery in a judicial or administrative proceeding of an adversarial nature;

(II) A digest, analysis, selection, compilation, or derivation of an item listed in subparagraph (I) of this paragraph (g); and

(III) An index or other manner of access to an item listed in subparagraph (I) of this paragraph (g).

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1387, § 14, effective May 26.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

25.5-4-310. Medicaid false claims report.

(1) Notwithstanding section 24-1-136 (11)(a)(I), on or before January 15, 2012, and on or before each January 15 thereafter, the attorney general shall submit a written report to the health and human services committees of the senate and the house of representatives, or any successor committees, and to the joint budget committee of the general assembly concerning claims

brought under the "Colorado Medicaid False Claims Act" during the previous fiscal year. The report shall include, but not be limited to:

(a) The number of actions filed by the attorney general;

(b) The number of actions filed by the attorney general that were completed;

(c) The amount that was recovered in actions filed by the attorney general through settlement or through a judgment and, if known, the amount recovered for damages, penalties, and litigation costs;

(d) The number of actions filed by a person other than the attorney general;

(e) The number of actions filed by a person other than the attorney general that were completed;

(f) The amount that was recovered in actions filed by a person other than the attorney general through settlement or through a judgment and, if known, the amount recovered for damages, penalties, and litigation costs, and the amount recovered by the state and the person; and

(g) The amount expended by the state for investigation, litigation, and all other costs for claims related to the "Colorado Medicaid False Claims Act".

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1399, § 14, effective May 26. **L. 2017:** IP(1) amended, (SB 17-233), ch. 175, p. 637, § 3, effective August 9.

Cross references: (1) For the "Colorado Medicaid False Claims Act", see section 25.5-4-303.5.

(2) For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

PART 4

PROVIDERS - REIMBURSEMENT

25.5-4-401. Providers - payments - rules.

(1) (a) The state department shall establish rules for the payment of providers under this article 4 and articles 5 and 6 of this title 25.5. Within the limits of available funds, the rules must provide reasonable compensation to providers, but no provider, by this section or any other provision of this article 4 or article 5 or 6 of this title 25.5, has any vested right to act as a

provider under this article 4 and articles 5 and 6 of this title 25.5 or to receive any payment in addition to or different from that which is currently payable on behalf of a member at the time the medical benefits are provided by the provider.

(b) (I) On and after July 1, 1992, the state department rules established for the payment of providers under this article and articles 5 and 6 of this title shall provide that services that are compensable under both Title XIX and Title XVIII of the social security act shall be paid at either the rate established under Title XIX or the rate established under Title XVIII, whichever is lower.

(II) If any provision of this paragraph (b) is found to be in conflict with any federal law or regulation, such conflicting portion of this paragraph (b) is declared to be inoperative to the extent of the conflict.

(c) The state department shall exercise its overexpenditure authority under section 24-75-109, C.R.S., and shall not intentionally interrupt the normal provider payment schedule unless notified jointly by the director of the office of state planning and budgeting and the state controller that there is the possibility that adequate cash will not be available to make payments to providers and for other state expenses. If it is determined that adequate cash is not available and the state department does interrupt the normal payment cycle, the state department shall notify the joint budget committee of the general assembly and any affected providers in writing of its decision to interrupt the normal payment schedule. Nothing in this paragraph (c) shall be interpreted to establish a right for any provider to be paid during any specific billing cycle.

(d) Repealed.

(2) As to all payments made pursuant to this article and articles 5 and 6 of this title, the state department rules for the payment of providers may include provisions that encourage the highest quality of medical benefits and the provision thereof at the least expense possible.

(3) (a) As used in this subsection (3), "capitated" means a method of payment by which a provider directly delivers or arranges for delivery of medical care benefits for a term established by contract with the state department based on a fixed rate of reimbursement per member.

(b) (I) In order to provide medical benefits under this article and articles 5 and 6 of this title on a capitated basis and subject to the condition imposed in subparagraph (II) of this paragraph (b), the state department is authorized to solicit negotiated contracts with providers based upon the requirements of this subsection (3). The state department may contract with one or more providers concerning the same medical services in a single geographic area.

(II) The state department may award a contract to one or more providers pursuant to subparagraph (I) of this paragraph (b) when the executive director determines that such contract will reduce the costs of providing medical benefits under this article and articles 5 and 6 of this title.

(III) The state department may define groups of members by geographic area or other categories and may require that all members of the defined group obtain medical services through one or more provider contracts entered into pursuant to this subsection (3).

(4) (a) The general assembly finds, determines, and declares that access to health-care services would be improved and costs of health care would be restrained if the members of the medicaid program would choose a primary care physician through a managed care provider. For purposes of this subsection (4), "managed care provider" means either a primary care physician program, a health maintenance organization, or a prepaid health plan.

(b) Subject to the provisions of subsection (4)(c) of this section, the executive director of the state department has the authority to require a member of the medicaid program to select a managed care provider and to assign a member to a managed care provider if the member has failed to make a selection within a reasonable time. To the extent possible, this requirement must be implemented on a statewide basis.

(c) The state department shall ensure the following:

(I) A managed care provider shall establish and implement member-friendly procedures and instructions for disenrollment and shall have adequate staff to explain issues concerning service delivery and disenrollment procedures to members, including staff to address the communications needs and requirements of members with disabilities.

(II) All members shall be adequately informed about available service delivery options consistent with the provisions of this subsection (4)(c)(II). If a member does not respond to a state department request for selection of a delivery option after forty-five calendar days, the state department shall send a second notification to the member. If the member does not respond after twenty days of the date of the second notification, the state department shall ensure that the member remains with the member's primary care physician, regardless of whether the primary care physician is enrolled in a health maintenance organization.

(5) The state board may promulgate rules to provide for the implementation and administration of subsections (3) and (4) of this section.

(6) The state department shall make good faith efforts to obtain a waiver or waivers from any requirements of Title XIX of the social security act which would prohibit the implementation of subsections (3) and (4) of this section. Such waiver or waivers shall be obtained from the federal department of health and human services, or any successor agency. If such waivers are not granted, the state department shall not act to implement or administer subsections (3) and (4) of this section to the extent that Title XIX prohibits it.

Source: L. 2006: Entire article added with relocations, p. 1841, § 7, effective July 1. **L. 2009:** (1)(d) added, (SB 09-265), ch. 205, p. 935, § 2, effective May 1. **L. 2010:** (1)(d) repealed, (HB

10-1382), ch. 217, p. 939, § 1, effective May 6. **L. 2024:** (1)(a), (3)(a), (3)(b)(III), and (4) amended, (SB 24-176), ch. 152, p. 638, § 33, effective August 7.

Editor's note: This section is similar to former § 26-4-404 as it existed prior to 2006.

ANNOTATION

Annotator's note. Since § 25.5-4-401 is similar to § 26-4-404 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-404 is similar to § 26-4-110 (1) as it existed prior to the 1991 repeal and reenactment of article 4 of title 26, relevant cases construing those provisions have been included in the annotations to this section.

Where a recipient's chosen provider would no longer exist as an independent primary care physician program and, therefore, the recipient's selection could no longer be honored, Colorado acted reasonably and did not violate subsection (4) when it automatically enrolled thousands of recipients into a health maintenance organization. RX Pharmacies Plus, Inc. v. Weil, 883 F. Supp. 549 (D. Colo. 1995).

The medical provider's right to payment is limited to that amount payable by the department of social services when the medical benefit is provided, and the medical provider has no vested right under the Colorado Medical Assistance Act to any greater amount. Colo. Dept. of Soc. Servs. v. Health Care Management Consultants, Inc., 813 P.2d 829 (Colo. App. 1991).

25.5-4-401.2. Performance-based payments - reporting.

(1) To improve health outcomes and lower health-care costs, the state department may develop payments to providers that are based on quantifiable performance or measures of quality of care. These performance-based payments may include, but are not limited to, payments to:

(a) Primary care providers;

(b) Federally qualified health centers;

(c) Providers of long-term care services and supports; and

(d) Behavioral health providers, including, but not limited to:

(I) Repealed.

(II) Behavioral health safety net providers, as defined in section 27-50-101; and

(III) Entities contracted with the state department to administer the statewide system of community behavioral health care established in section 25.5-5-402.

(2) (a) Prior to implementing performance-based payments in the medicaid program pursuant to this article 4 and articles 5 and 6 of this title 25.5, including performance-based payments set forth in this section, the state department shall submit to the joint budget committee:

(I) (A) Evidence that the performance-based payments are designed to achieve budget savings; or

(B) A budget request for costs associated with the performance-based payments;

(II) The estimated performance-based payments compared to total reimbursements for the affected service; and

(III) A description of the stakeholder engagement process for developing the performance-based payments, including the participants in the process and a summary of the stakeholder feedback, and the state department's response to stakeholder feedback.

(b) The information required pursuant to subsection (2)(a) of this section must be provided on or before November 1 for performance-based payments that will take effect in the following fiscal year unless the state department includes with its submission an explanation of the need for faster implementation of the payment. If faster implementation is requested, the state department shall provide the information at least three months prior to the implementation of the performance-based payments unless compliance with federal law necessitates shorter notice.

(3) On or before November 1, 2017, and on or before November 1 each year thereafter, the state department shall submit a report to the joint budget committee, the public health care and human services committee of the house of representatives, and the health and human services committee of the senate, or any successor committees, describing rules adopted by the state board and contract provisions approved by the federal centers for medicare and medicaid services in the preceding calendar year that authorize payments to providers based on performance. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), the report required pursuant to this subsection (3) continues indefinitely. The report must include, at a minimum:

(a) A description of performance-based payments included in state board rules, including which performance standards are targeted with each performance-based payment;

(b) A description of the goals and objectives of the performance-based payments, and how those goals and objectives align with other quality improvement initiatives;

(c) A summary of the research-based evidence for the performance-based payments, to the extent such evidence is available;

(d) A summary of the anticipated impact and clinical and nonclinical outcomes of implementing the performance-based payments;

(e) A description of how the impact or outcomes will be evaluated;

(f) An explanation of steps taken by the state department to limit the administrative burden on providers;

(g) A summary of the stakeholder engagement process with respect to each performance-based payment, including major concerns raised through the stakeholder process and how those concerns were remediated;

(h) When available, evaluation results for performance-based payments that were implemented in prior years; and

(i) A description of proposed modifications to current performance-based payments.

Source: L. 2017: Entire section added, (HB 17-1353), ch. 231, p. 898, § 3, effective May 23. **L. 2018:** (1)(d)(II) amended, (HB 18-1431), ch. 313, p. 1892, § 10, effective August 8. **L. 2022:** (1)(d) amended, (HB 22-1278), ch. 222, p. 1512, § 67, effective July 1. **L. 2023:** IP(3) amended, (HB 23-1301), ch. 303, p. 1830, § 47, effective August 7.

Editor's note: Subsection (1)(d)(I)(B) provided for the repeal of subsection (1)(d)(I), effective July 1, 2024. (See L. 2022, p. 1512.)

25.5-4-401.5. Review of provider rates - advisory committee - recommendations - repeal.

(1) (a) On or before September 1, 2023, the state department shall establish a schedule for an annual review of provider rates paid under the "Colorado Medical Assistance Act" so that each provider rate is reviewed at least every three years and shall provide the schedule to the advisory committee established pursuant to subsection (3) of this section and the joint budget committee. If the state department receives any petitions or proposals for provider rates to be reviewed or adjusted, the state department shall forward a copy of the petition or proposal to the advisory committee and the joint budget committee.

(b) The state department shall review each of the provider rates scheduled for review pursuant to the process described in this section. The advisory committee or the joint budget committee may, by a majority vote, direct that the state department conduct a review of a provider rate that is not scheduled for review during that year. The advisory committee or the joint budget committee shall notify the state department of the request for an out-of-cycle review by December 1 of the year prior to the year in which the out-of-cycle review will take place. If the state department determines that the request for an out-of-cycle review cannot be conducted,

the state department shall provide written notification to the advisory committee and the joint budget committee within thirty days after the request for an out-of-cycle review. The notification must include a description of the reasons the out-of-cycle review cannot be conducted.

(c) (I) The state department may propose to exclude rates from the schedule established pursuant to subsection (1)(a) of this section if those rates are adjusted or reviewed on a periodic basis as a result of other state statute or federal law or regulation. The state department shall include the proposed list of exclusions with the schedule established pursuant to subsection (1)(a) of this section.

(II) The advisory committee or the joint budget committee may, by a majority vote, direct the state department to include any rate that the state department has proposed to exclude from the schedule.

(2) (a) In the first phase of the review process, the state department shall conduct an analysis of the access, service, quality, and utilization of each service subject to a provider rate review. The state department shall compare the rates paid with available benchmarks, including medicare rates and usual and customary rates paid by private pay parties, and use qualitative tools to assess whether payments are sufficient to allow for provider retention and medicaid member access and to support appropriate reimbursement of high-value services.

(b) Following the analysis required by subsection (2)(a) of this section, the state department shall work with the advisory committee and any stakeholders identified by the state department or the advisory committee to review the analysis and develop strategies for responding to the findings, including any nonfiscal approaches or rebalancing of rates and strategies to address capacity issues that may exist in certain regions of the state.

(c) Following the review required by subsection (2)(b) of this section, the state department shall work with the office of state planning and budgeting to determine achievable goals and executive branch priorities within the statewide budget.

(d) (I) Notwithstanding section 24-1-136 (11)(a)(I), on or before November 1, 2023, and each November 1 thereafter, the state department shall submit a written report to the joint budget committee and the advisory committee on the analysis required pursuant to subsection (2)(a) of this section, a description of the information discussed during the quarterly public meeting conducted pursuant to subsection (2)(e) of this section, and the state department's recommendations on all of the provider rates reviewed pursuant to this section and all of the data relied upon by the state department in making the recommendations. The joint budget committee shall consider the recommendations in formulating the state department's budget.

(II) The state department shall submit, as part of the report required pursuant to this subsection (2)(d), a description of the information discussed during the quarterly public meeting; the state department's response to the public comments received from providers, members, and

other interested parties; and an explanation of how the public comments informed the provider rate review process and the recommendations concerning provider rates.

(e) The state department shall conduct a public meeting at least quarterly to inform the state department's review of provider rates paid under the "Colorado Medical Assistance Act". The state department shall invite to the public meeting providers, members, and other interested parties directly affected by the services scheduled to be reviewed at the public meeting. At a minimum, each public meeting must consist of, but is not limited to:

(I) A discussion of the analysis and review performed pursuant to subsection (2)(a) of this section; and

(II) Public comments from providers, members, and other interested parties concerning:

(A) The analysis and review performed pursuant to subsection (2)(a) of this section; and

(B) Recommended changes to the provider rate review process that may enhance or improve the process.

(3) (a) There is created in the state department the medicaid provider rate review advisory committee, referred to in this section as the "advisory committee", to assist the state department in the review of the provider rate reimbursements under the "Colorado Medical Assistance Act". The advisory committee shall:

(I) Review the schedule for annual review of provider rates established by the state department pursuant to subsection (1)(a) of this section and recommend any changes to the schedule;

(II) Review the analysis performed pursuant to subsection (2)(a) of this section and the reports prepared by the state department on its analysis of provider rates pursuant to subsection (2)(d) of this section and provide comments and feedback to the state department and the joint budget committee on the reports;

(III) Review the comments received from providers, members, and other interested parties and the state department's response to the comments required pursuant to subsection (2)(d)(II) of this section;

(IV) Review proposals or petitions received by the advisory committee for provider rates to be reviewed or adjusted;

(V) Determine whether any provider rates not scheduled for review during the next calendar year should be reviewed during that calendar year;

(VI) Recommend to the state department and to the joint budget committee any changes to the process of reviewing provider rates, including measures to increase access to the process, such as by providing for electronic comments by providers and the public; and

(VII) Provide other assistance to the state department and the joint budget committee as requested by the state department or the joint budget committee.

(b) (I) The advisory committee consists of the following seven members:

(A) Three members appointed by the governor;

(B) Two members appointed by the president of the senate, or the president's designee; and

(C) Two members appointed by the speaker of the house of representatives, or the speaker's designee.

(II) Each member appointed to the advisory committee must have proven expertise related to the medical assistance program in one or more of the following areas:

(A) Service delivery or case management services provided to one or more eligible populations;

(B) Provider finance or budget;

(C) Service capacity analysis;

(D) Business processes;

(E) Claims filing or processing; or

(F) Implementation of state and federal medicaid rules, regulations, and guidance.

(III) The state department may make recommendations to the governor, the president of the senate, and the speaker of the house of representatives concerning the qualifications of members appointed to the advisory committee.

(c) The appointing authorities shall make initial appointments to the advisory committee no later than January 1, 2023. In making appointments to the advisory committee, the appointing authorities shall make a concerted effort to include members of diverse political, racial, cultural, income, and ability groups and members from urban and rural areas.

(d) Each member of the advisory committee serves at the pleasure of the official who appointed the member. Each member of the advisory committee serves a four-year term and may be reappointed.

(e) The members of the advisory committee serve without compensation and without reimbursement for expenses.

(f) At the first meeting of the advisory committee, to be held on or after March 1, 2023, the members shall elect a chair and vice-chair from among the members.

(g) The advisory committee shall meet at least once every quarter. The chair may call additional meetings as may be necessary for the advisory committee to complete its duties.

(h) The advisory committee shall develop bylaws and procedures to govern its operations.

(i) On or before December 1, 2023, and each December 1 thereafter, the advisory committee shall present to the joint budget committee an overview of the provider rate review process, a summary of the provider rates that were reviewed, and the strategies for responding to the findings of the provider rate review, including any fiscal or nonfiscal approaches or rebalancing of rates, any advisory committee recommendations for rate adjustments made to the state department, and any recommendations for improving capacity and access to services in regions of the state where reduced capacity results in limited access to services.

(j) (I) This subsection (3) is repealed, effective September 1, 2034.

(II) Prior to repeal, the department of regulatory agencies shall conduct a sunset review of the advisory committee pursuant to the provisions of section 2-3-1203.

Source: L. 2015: Entire section added, (SB 15-228), ch. 288, p. 1177, § 1, effective June 5. **L. 2017:** (2)(a) and (2)(d) amended, (HB 17-1060), ch. 6, p. 17, § 9, effective March 1. **L. 2021:** (3)(b)(III)(D) amended, (HB 21-1187), ch. 83, p. 332, § 25, effective July 1, 2024. **L. 2022:** Entire section amended, (SB 22-236), ch. 410, p. 2897, § 1, effective July 1, 2023 (see editor's note). **L. 2023:** (2)(d)(I) amended, (SB 23-223), ch. 74, p. 273, § 1, effective April 17. **L. 2024:** (2)(a), (2)(d)(II), IP(2)(e), IP(2)(e)(II), and (3)(a)(III) amended, (SB 24-176), ch. 152, p. 640, § 34, effective August 7. **L. 2026:** (1)(c)(I) amended, (HB 26-1235), ch. 361, p. 2171, § 5, effective August 12.

Editor's note: (1) Section 3 of chapter 410, (SB 22-236), Session Laws of Colorado 2022, provides that subsection (3) takes effect December 1, 2022, subsection (2)(d) takes effect May 1, 2025, and the remainder of the section takes effect July 1, 2023.

(2) Section 2 of chapter 74, (SB 23-223), Session Laws of Colorado 2023, amended section 3 of chapter 410, (SB 22-236), Session Laws of Colorado 2022, to change the effective date for amendments to subsection (2)(a) by SB 22-236 from July 1, 2023, to April 30, 2023, and to change the effective date for amendments to subsection (2)(d) by SB 22-236 from May 1, 2025, to July 1, 2023.

25.5-4-402. Providers - hospital reimbursement - hospital review program - rules.

(1) For all licensed or certified hospitals contracting for services under this article and articles 5 and 6 of this title, except those hospitals operated by the department of human services or those hospitals deemed exempt by the state board, the state department shall pay for inpatient hospital services pursuant to a system of prospective payment, generally based on the elements

of a diagnosis-related group system. The state department shall develop and administer a system for ensuring appropriate utilization and quality of care provided by those providers who are reimbursed under this section. Subject to available appropriations, the state department may also make supplemental medicaid payments to certain hospitals. The state board shall promulgate rules to provide for the implementation of this section.

(2) (a) A hospital that receives payment under this article and articles 5 and 6 of this title for telemedicine services shall employ its existing quality-of-care protocols and patient confidentiality guidelines to ensure that such services meet the requirements of this article and articles 5 and 6 of this title.

(b) The executive director of the state department shall adopt rules in furtherance of this subsection (2), including, without limitation, rules to:

(I) Ensure the provision of appropriate care to patients;

(II) Prevent fraud and abuse; and

(III) Establish methods and procedures to avoid overuse of telemedicine services.

(3) (a) (I) In addition to the reimbursement rate process described in subsection (1) of this section and subject to federal approval and adequate funding being made available pursuant to section 25.5-4-402.4, the Colorado healthcare affordability and sustainability enterprise created in section 25.5-4-402.4 (3) shall pay an additional amount based upon performance in the hospital quality incentive program to those hospitals that deliver safer, more effective care that improves patient outcomes and reduces preventable utilization to reduce health-care costs. The hospital quality incentive program must include a performance metric related to workplace violence.

(II) (A) Prior to implementation of the program, the Colorado healthcare affordability and sustainability enterprise board shall approve the percentage of hospitals' reimbursement in the hospital quality incentive program, program structure, performance measures, and scoring methodology.

(B) When approving a program pursuant to this subsection (3)(a), the board shall require that new measures remain in place for a defined period of time not to exceed three years prior to modification or replacement of the new measures; except that the board may approve modifications or replacements prior to the end of the defined period of time if the board is presented with evidence that the approved measures are not meeting the goals of the program or require technical adjustments. Nothing in this subsection (3)(a) precludes the board from renewing measures that meet the goals of the program after the defined period of time not to exceed three years has expired.

(C) Any modifications to the hospital quality incentive program must be approved by the board prior to implementation; except that changes necessary to comply with federal law may be implemented immediately.

(III) Performance measures and methodologies must be based on factors that are reasonably within hospitals' control, aligned with nationally recognized standards to the maximum extent practicable, and designed to minimize administrative burden, including by avoiding duplicative reporting and leveraging existing data sources when possible. The hospital quality incentive program should align with federal quality standards.

(b) (I) For each state fiscal year, the total amount of the payments must be no more than seven percent of the total reimbursements made to hospitals in the previous state fiscal year.

(II) Notwithstanding subsection (3)(b)(I) of this section, the maximum percentage of payments must not exceed seven percent of the total reimbursements made to hospitals in the previous state fiscal year unless and until the Colorado healthcare affordability and sustainability enterprise board formally approves a hospital quality incentive program pursuant to subsection (3)(a) of this section, developed with input from hospital representatives with clinical expertise, after which the maximum percentage of payments must not exceed nine percent of the total reimbursements made to hospitals.

(c) (I) No later than September 1, 2025, the state department and the quality incentives payments subcommittee of the Colorado healthcare affordability and sustainability enterprise board created in section 25.5-4-402.4 (7) shall consult with the department of public health and environment, an association representing nurses working in Colorado hospitals, a representative of the health-care industry who participates in the Colorado medicaid program and does not represent a hospital, a representative from a statewide association of hospitals, a representative from an association representing rural hospitals, a representative from a hospital, the chairs of the house of representatives health and human services committee and the senate health and human services committee, and any other relevant state agencies to:

(A) Develop recommended workplace violence metrics after evaluating available national standards, considering innovative approaches, and accounting for variations across hospitals;

(B) Determine whether any federal or private funds are available to assist hospitals in lowering the number of incidents of workplace violence; and

(C) Develop legislative recommendations.

(II) During the state department's 2026 "SMART Act" hearing, the state department shall include a progress report on developing recommended workplace violence metrics, determining whether any federal or private funds are available to assist hospitals in lowering the number of incidents of workplace violence, and developing legislative recommendations pursuant to subsection (3)(c)(I) of this section.

(III) The Colorado healthcare affordability and sustainability enterprise board shall include the legislative recommendations developed pursuant to subsection (3)(c)(I)(C) of this section as part of its January 2027 report submitted pursuant to section 25.5-4-402.4 (7)(e).

(4) (a) Subject to federal approval, and notwithstanding any other provision of the "Colorado Medical Assistance Act", the state department shall design and implement an evidence-based hospital review program to ensure appropriate utilization of hospital services.

(b) Consistent with federal regulations set forth in 42 CFR 456, the hospital review program may include the following:

(I) Preadmission review;

(II) Continued stay review;

(III) Transfer planning;

(IV) Discharge planning;

(V) Care coordination; and

(VI) Retrospective claims review.

(c) The following factors must be considered in any coverage determinations made pursuant to the hospital review programs:

(I) Information provided, diagnosis determined, and treatment recommended by the treating provider or providers;

(II) Evidence-based clinical coverage criteria and member coverage guidelines as established by the state department;

(III) Nationally recognized utilization and technology assessment guidelines; and

(IV) Industry standard criteria, as appropriate.

(d) (I) The state department shall consult with affected stakeholders prior to implementation of the hospital review program. At a minimum, the state department shall solicit feedback from members, hospitals within Colorado that participate in medicaid, providers participating in the accountable care collaborative pursuant to section 25.5-5-419, and the Colorado healthcare affordability and sustainability enterprise board established in section 25.5-4-402.4 (7). If the state department contracts with a third-party vendor to implement the hospital review program, the state department shall require the vendor to participate in the stakeholder outreach with hospitals required pursuant to this subsection (4)(d)(I).

(II) Prior to implementation of the hospital review program, the state department shall provide an opportunity for hospitals to test connectivity to and workability of any new electronic

interface created or implemented as part of this section. The state department shall select a limited group of hospitals to test any new requirements prior to full implementation.

(III) The state department shall provide a report to the joint budget committee by November 1, 2018, on the status of the implementation of the hospital review program. The report must include the comments received as part of the stakeholder process described in subsection (4)(d)(I) of this section and a description of, and any available results from, the testing process described in subsection (4)(d)(II) of this section.

(IV) and (V) Repealed.

(e) The state board shall adopt any rules necessary for the administration and implementation of this section.

Source: L. 2006: Entire article added with relocations, p. 1844, § 7, effective July 1; entire section amended, p. 1546, § 3, effective July 1. **L. 2009:** (1) amended and (3) added, (HB 09-1293), ch. 152, p. 645, § 4, effective July 1. **L. 2017:** (3)(a) amended, (SB 17-267), ch. 267, p. 1448, § 15, effective July 1. **L. 2018:** (4) added, (SB 18-266), ch. 264, p. 1624, § 2, effective May 29. **L. 2023:** (3)(a) amended, (HB 23-1301), ch. 303, p. 1830, § 48, effective August 7. **L. 2024:** (4)(c)(II) and (4)(d)(I) amended and (4)(d)(IV) and (4)(d)(V) repealed, (SB 24-176), ch. 152, p. 640, § 35, effective August 7. **L. 2025:** (3) amended, (SB 25-166), ch. 169, p. 686, § 1, effective August 6. **L. 2026:** (3)(a) and (3)(b) amended, (HB 26-1432), ch. 408, p. 2558, § 1, effective June 4.

Editor's note: (1) This section is similar to former § 26-4-405 as it existed prior to 2006.

(2) Amendments to section 26-4-405 by Senate Bill 06-165 were harmonized with this section as it appeared in Senate Bill 06-219.

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

Cross references: For the legislative declaration contained in the 2006 act amending this section, see section 1 of chapter 312, Session Laws of Colorado 2006. For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal. (Repealed)

Source: L. 2009: Entire section added, (HB 09-1293), ch. 152, p. 633, § 1, effective July 1. **L. 2010:** (4)(b)(VIII) added, (SB 10-169), ch. 307, p. 1445, § 1, effective May 27; (4)(b)(IV) amended, (HB 10-1422), ch. 419, p. 2110, § 141, effective August 11. **L. 2011:** (3)(a)(II) and (3)(a)(III) amended and (3)(a)(IV), (4)(b)(IX), and (5)(b.5) added, (SB 11-212), ch. 146, pp. 508, 509, §§ 1, 2, 3, effective May 5. **L. 2013:** (4)(b)(IV)(A) and (4)(b)(IV)(C) amended, (SB 13-200), ch. 216, p. 897, § 1, effective May 13. **L. 2017:** (5)(b.3) added, (SB 17-256), ch. 198, p. 720, § 1, effective May 8; entire section repealed, (SB 17-267), ch. 267, p. 1448, § 16, effective July 1.

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

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-4-402.4. Hospitals - healthcare affordability and sustainability hospital provider fee - healthcare affordability and sustainability nursing facility provider fee - healthcare affordability and sustainability intermediate care facility fee - receipt of public funds - Colorado healthcare affordability and sustainability enterprise - federal waiver - funds created - reports - rules - legislative declaration - definitions - repeal.

(1) **Short title.** The short title of this section is the "Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017".

(2) **Legislative declaration.** The general assembly finds and declares that:

(a) The state and the providers of publicly funded medical services, and hospitals, nursing facility providers, and intermediate care facilities for individuals with intellectual disabilities in particular, share a common commitment to comprehensive health-care reform;

(b) Hospitals within the state incur significant costs by providing uncompensated emergency department care and other uncompensated medical services to low-income and uninsured populations;

(c) This section is enacted as part of a comprehensive health-care reform and is intended to provide the following services and benefits to hospitals, nursing facility providers, intermediate care facilities for individuals with intellectual disabilities, and individuals:

(I) Providing a payer source for some low-income and uninsured populations who may otherwise be cared for in emergency departments and other settings in which uncompensated care is provided;

(II) Reducing the underpayment to Colorado hospitals participating in publicly funded health insurance programs;

(III) Reducing the number of persons in Colorado who are without health-care benefits;

(IV) Reducing the need of hospitals and other health-care providers to shift the cost of providing uncompensated care to other payers;

(V) Expanding access to high-quality, affordable health care for low-income and uninsured populations;

(V.5) Sustaining or increasing the reimbursement for providing medical care under the state's medical assistance program for nursing facility providers and making supplemental medicaid payments to nursing facility providers;

(V.7) Maintaining the quality and continuity of services provided by intermediate care facilities for individuals with intellectual disabilities; and

(VI) Providing the additional business services specified in subsection (4)(a)(IV) of this section to hospitals that pay the healthcare affordability and sustainability hospital provider fee charged and collected as authorized by subsection (4) of this section by the Colorado healthcare affordability and sustainability enterprise created in subsection (3)(a) of this section;

(d) The Colorado healthcare affordability and sustainability enterprise provides business services to hospitals when, in exchange for payment of healthcare affordability and sustainability hospital provider fees by hospitals, it:

(I) Obtains federal matching money and returns both the hospital provider fee and the federal matching money to hospitals to increase reimbursement rates to hospitals for providing medical care under the state medical assistance program, including disproportionate share hospital payments pursuant to 42 U.S.C. sec. 1396r-4, and to increase the number of individuals covered by public medical assistance; and

(II) Provides additional business services to hospitals as specified in subsection (4)(a)(IV) of this section;

(d.5) The Colorado healthcare affordability and sustainability enterprise provides business services to nursing facility providers when, in exchange for payment of nursing facility provider fees, it obtains federal matching money and returns both the nursing facility provider fee and the federal matching money to nursing facility providers to sustain or increase reimbursement rates and make supplemental medicaid payments to nursing facility providers;

(d.7) The Colorado healthcare affordability and sustainability enterprise provides business services to intermediate care facilities for individuals with intellectual disabilities when, in exchange for payment of intermediate care facility fees, it obtains federal matching money and returns both the intermediate care facility fee and the federal matching money to intermediate care facilities for individuals with intellectual disabilities to sustain or increase reimbursement rates and make supplemental medicaid payments to such intermediate care facilities;

(e) It is necessary, appropriate, and in the best interest of the state to acknowledge that by providing the business services specified in subsections (2)(d) to (2)(d.7) of this section, the Colorado healthcare affordability and sustainability enterprise engages in an activity conducted in the pursuit of a benefit, gain, or livelihood and therefore operates as a business;

(f) Consistent with the determination of the Colorado supreme court in *Nicholl v. E-470 Public Highway Authority*, 896 P.2d 859 (Colo. 1995), that the power to impose taxes is inconsistent with enterprise status under section 20 of article X of the state constitution, it is the conclusion of the general assembly that the healthcare affordability and sustainability hospital provider fee, the healthcare affordability and sustainability nursing facility provider fee, the healthcare affordability and sustainability intermediate care facility fee, and the medicaid buy-in premiums charged and collected by the Colorado healthcare affordability and sustainability enterprise are fees, not taxes, because the fees are imposed for the specific purposes of allowing the enterprise to defray the costs of providing the business services specified in subsections (2)(d) to (2)(d.7) and (2)(c) of this section to hospitals and individuals, nursing facility providers, and intermediate care facilities for individuals with intellectual disabilities that pay the fees and are collected at rates that are reasonably calculated based on the benefits received by those hospitals and individuals, nursing facility providers, and intermediate care facilities;

(f.5) Transfers from governmental health-care providers to the enterprise through a mutually executed agreement, and as authorized by 42 CFR 433.51, are not "grants" under section 20 of article X of the state constitution because:

(I) Participating providers receive federal funds and other business services as described in this section; and

(II) Such transfers must be repaid if they are not utilized or approved, and thus do not meet the definition of "grant" set forth in section 24-77-102; and

(g) So long as the Colorado healthcare affordability and sustainability enterprise qualifies as an enterprise for purposes of section 20 of article X of the state constitution, the revenues from the fees charged and collected by the enterprise are not state fiscal year spending, as defined in section 24-77-102 (17), or state revenues, as defined in section 24-77-103.6 (6)(c), and do not count against either the state fiscal year spending limit imposed by section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I).

(3) **Colorado healthcare affordability and sustainability enterprise.**

(a) The Colorado healthcare affordability and sustainability enterprise is created. The enterprise is and operates as a government-owned business within the state department for the purpose of:

(I) Charging and collecting:

(A) The hospital provider fee;

(B) The nursing facility provider fee;

(C) The intermediate care facility fee; and

(D) Medicaid buy-in premiums;

(II) Leveraging revenue from the hospital provider fee, the nursing facility provider fee, and the intermediate care facility fee to obtain federal matching money; and

(III) Utilizing and deploying:

(A) The hospital provider fee revenue and federal matching money to provide the business services specified in subsections (2)(d)(I) and (2)(d)(II) of this section to hospitals that pay the healthcare affordability and sustainability fee;

(B) The nursing facility provider fee revenue and any federal matching money to provide the business services specified in subsection (2)(d.5) of this section to nursing facility providers that pay the nursing facility provider fee;

(C) The intermediate care facility fee revenue and any federal matching money to provide the business services specified in subsection (2)(d.7) of this section to intermediate care facilities for individuals with intellectual disabilities that pay the intermediate care facility fee; and

(D) The medicaid buy-in premium revenue to provide the medicaid buy-in programs created pursuant to part 14 of article 6 of this title 25.5 and section 25.5-5-206, which are services and benefits specified in subsection (2)(c) of this section.

(b) The enterprise constitutes an enterprise for purposes of section 20 of article X of the state constitution so long as it retains the authority to issue revenue bonds and receives less than ten percent of its total revenues in grants from all Colorado state and local governments combined.

So long as it constitutes an enterprise pursuant to this subsection (3)(b), the enterprise is not subject to any provisions of section 20 of article X of the state constitution.

(c) (I) The repeal of the hospital provider fee program, as it existed pursuant to section 25.5-4-402.3 before its repeal, effective July 1, 2017, by Senate Bill 17-267, enacted in 2017, and the creation of the Colorado healthcare affordability and sustainability enterprise as a new enterprise to charge and collect a new healthcare affordability and sustainability hospital provider fee as authorized by subsection (4) of this section and provide fee-funded business services to hospitals that replace and supplement services previously funded by the repealed hospital provider fees is the creation of a new government-owned business that provides business services to hospitals as a new enterprise for purposes of section 20 of article X of the state constitution, does not constitute the qualification of an existing government-owned business as an enterprise for purposes of section 20 of article X of the state constitution or section 24-77-103.6 (6)(b)(II), and, therefore, does not require or authorize adjustment of the state fiscal year spending limit calculated pursuant to section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I).

(II) Notwithstanding subsection (3)(c)(I) of this section, because the repeal of the hospital provider fee program, as it existed pursuant to section 25.5-4-402.3 before its repeal by Senate Bill 17-267, enacted in 2017, will allow the state to spend more general fund money for general governmental purposes than it would otherwise be able to spend below the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I), it is appropriate to restrain the growth of government by lowering the base amount used to calculate the excess state revenues cap for the 2017-18 state fiscal year by two hundred million dollars.

(III) The repeal of the medicaid buy-in cash fund, as it existed in section 25.5-6-1404 (3)(b) before its repeal, effective May 1, 2025, by Senate Bill 25-228, enacted in 2025, and the enterprise's ability to charge and collect the medicaid buy-in premiums and provide premium-funded business services to individuals and hospitals that replace and supplement services previously funded both by the medicaid buy-in premiums and the healthcare affordability and sustainability fee do not constitute creation of a new enterprise or the qualification of an existing government-owned business as an enterprise for purposes of section 20 of article X of the state constitution, section 24-77-103.6 (6)(b)(II), or section 24-77-108, and, therefore, do not require or authorize adjustment of the state fiscal year spending limit calculated pursuant to section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I), and do not require voter approval.

(IV) The repeal of the nursing facility provider fee program, as it existed in section 25.5-6-203 (1) before its repeal, effective May 1, 2025, by Senate Bill 25-270, enacted in 2025, and the enterprise's ability to charge and collect a new healthcare affordability and sustainability nursing facility provider fee as authorized by subsection (4.5) of this section and provide fee-funded business services to nursing facility providers that replace and supplement services previously

funded by the nursing facility provider fee does not constitute creation of a new enterprise or the qualification of an existing government-owned business as an enterprise for purposes of section 20 of article X of the state constitution, section 24-77-103.6 (6)(b)(II), or section 24-77-108, and, therefore, does not require or authorize adjustment of the state fiscal year spending limit calculated pursuant to section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I), and does not require voter approval.

(V) The repeal of the intermediate care facility service fee program, as it existed in section 25.5-6-204 (1)(c)(I) before its repeal, effective May 1, 2025, by Senate Bill 25-270, enacted in 2025, and the enterprise's ability to charge and collect a new healthcare affordability and sustainability intermediate care facility fee as authorized by subsection (4.7) of this section and provide fee-funded business services to intermediate care facilities for individuals with intellectual disabilities that replace and supplement services previously funded by the intermediate care facility service fee does not constitute creation of a new enterprise or the qualification of an existing government-owned business as an enterprise for purposes of section 20 of article X of the state constitution, section 24-77-103.6 (6)(b)(II), or section 24-77-108, and, therefore, does not require or authorize adjustment of the state fiscal year spending limit calculated pursuant to section 20 of article X of the state constitution or the excess state revenues cap, as defined in section 24-77-103.6 (6)(b)(I), and does not require voter approval.

(d) The enterprise's primary powers and duties are:

(I) To charge and collect:

(A) The hospital provider fee as specified in subsection (4) of this section;

(B) The nursing facility provider fee as specified in subsection (4.5) of this section;

(C) The intermediate care facility fee as specified in subsection (4.7) of this section; and

(D) The medicaid buy-in premiums described in subsection (5.1) of this section and sections 25.5-5-206 and 25.5-6-1404;

(II) To leverage revenue from the hospital provider fee, the nursing facility provider fee, and the intermediate care facility fee to obtain federal matching money, working with or through the state department and the state board to the extent required by federal law or otherwise necessary;

(III) To expend:

(A) Hospital provider fee revenue, matching federal money, and any other money from the hospital provider fee cash fund as specified in subsections (4) and (5) of this section;

(B) Nursing facility provider fee revenue, matching federal money, and any other money from the nursing facility provider fee cash fund as specified in subsection (5.5) of this section;

(C) Intermediate care facility fee revenue, matching federal money, and any other money from the intermediate care facility fee cash fund as specified in subsection (5.7) of this section; and

(D) Medicaid buy-in premium revenue from the buy-in fund as specified in subsection (5.1) of this section;

(IV) To issue revenue bonds payable from the revenues of the enterprise;

(V) To enter into agreements with the state department to the extent necessary to collect and expend revenue from the hospital provider fee, the nursing facility provider fee, and the intermediate care facility fee;

(V.5) To enter into agreements with the state department to the extent necessary to expend money from the hospital provider fee cash fund;

(VI) To engage the services of private persons or entities serving as contractors, consultants, and legal counsel for professional and technical assistance and advice and to supply other services related to the conduct of the affairs of the enterprise, including the provision of additional business services to hospitals as specified in subsection (4)(a)(IV) of this section;

(VII) To adopt and amend or repeal policies for the regulation of its affairs and the conduct of its business consistent with the provisions of this section; and

(VIII) To receive public funds as described in subsection (4) of this section.

(e) The enterprise is a **type 2** entity, as defined in section 24-1-105, and exercises its powers and performs its duties and functions under the department.

(4) **Healthcare affordability and sustainability hospital provider fee.**

(a) For the fiscal year commencing July 1, 2017, and for each fiscal year thereafter, the enterprise is authorized to charge and collect a healthcare affordability and sustainability hospital provider fee, as described in 42 CFR 433.68 (b), or as otherwise in compliance with 42 CFR 433, on outpatient and inpatient services provided by all licensed or certified hospitals, and receive public funds as described in 42 CFR 433.51, for the purpose of obtaining federal financial participation under the state medical assistance program as described in this article 4 and articles 5 and 6 of this title 25.5, including disproportionate share hospital payments pursuant to 42 U.S.C. sec. 1396r-4. If the amount of hospital provider fee revenue collected exceeds the federal net patient revenue-based limit on the amount of such fee revenue that may be collected, requiring repayment to the federal government of excess federal matching money received, hospitals that received such excess federal matching money are responsible for repaying the excess federal money and any associated federal penalties to the federal government. The enterprise shall use the hospital provider fee revenue to:

(I) Provide a business service to hospitals by increasing reimbursement to hospitals for providing:

(A) Medical care under the state medical assistance program; and

(B) Hospital financial assistance programs for care provided to uninsured patients;

(II) Provide a business service to hospitals by increasing the number of individuals covered by public medical assistance and thereby reducing the amount of uncompensated care that the hospitals must provide;

(II.3) and (II.5) Repealed.

(III) Pay the administrative costs to the enterprise in implementing and administering this section subject to the limitation that administrative costs of the enterprise are limited to three percent of the enterprise's expenditures based on a methodology approved by the office of state planning and budgeting and the staff of the joint budget committee of the general assembly; and

(IV) Provide or contract for or arrange the provision of additional business services to hospitals by:

(A) Consulting with hospitals to help them improve both cost efficiency and patient safety in providing medical services and the clinical effectiveness of those services;

(B) Advising hospitals regarding potential changes to federal and state laws and regulations that govern the provision of and reimbursement paid for medical services under the programs administered pursuant to this article 4 and articles 5 and 6 of this title 25.5;

(C) Providing coordinated services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the programs administered pursuant to this article 4 and articles 5 and 6 of this title 25.5, which may include data sharing, telehealth coordination and support, establishment of performance metrics, benchmarking to such metrics, and clinical and administrative process consulting and other appropriate services;

(D) Providing any other services to hospitals that aid them in efficiently and effectively participating in the programs administered pursuant to this article 4 and articles 5 and 6 of this title 25.5; and

(E) Providing funding for, and in cooperation with, the state department and hospitals supporting the implementation of the hospital quality incentive program created in section 25.5-4-402 (3)(a).

(b) The enterprise shall recommend for approval and establishment by the state board the amount of the hospital provider fee that it intends to charge and collect and the amount of public funds that it intends to receive. The state board must establish the final amount of the fee by rules promulgated in accordance with article 4 of title 24. The state board shall not establish any

amount that exceeds the federal limit for such fees or public funds. The state board may deviate from the recommendations of the enterprise, but shall express in writing the reasons for any deviations. In establishing the amount of the fee and in promulgating the rules governing the fee, the state board shall:

(I) Consider recommendations of the enterprise;

(II) Establish the amount of the hospital provider fee and public funds so that the amount collected from the fee, the amount received from public funds, and federal matching funds associated with the fee and public funds are sufficient to pay for the items described in subsection (4)(a) of this section, but nothing in this subsection (4)(b)(II) requires the state board to increase the fee or the amount of public funds to be received above the amounts recommended by the enterprise; and

(III) For the 2017-18 fiscal year, establish the amount of the hospital provider fee so that the amount collected from the fee is approximately equal to the sum of the amounts of the appropriations specified for the fee in the general appropriation act, Senate Bill 17-254, enacted in 2017, and any other supplemental appropriation act.

(c) (I) In accordance with the redistributive method set forth in 42 CFR 433.68 (e)(1) and (e)(2), the enterprise, acting in concert with or through an agreement with the state department if required by federal law, may seek a waiver from the broad-based hospital provider fee requirement or the uniform hospital provider fee requirement, or both. Subject to federal approval and to minimize the financial impact on certain hospitals, the enterprise may exempt from payment of the hospital 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 and certified by the department of public health and environment under 42 CFR 485, subpart F;

(D) Inpatient rehabilitation facilities; or

(E) Hospitals specified for exemption under 42 CFR 433.68 (e).

(II) In determining whether a hospital may be excluded, the enterprise shall use one or more of the following criteria:

(A) A hospital that is located in a rural area;

(B) A hospital with which the state department does not contract to provide services under the state medical assistance program;

(C) A hospital whose inclusion or exclusion would not significantly affect the net benefit to hospitals paying the hospital provider fee; or

(D) A hospital that must be included to receive federal approval.

(III) The enterprise may reduce the amount of the hospital provider fee for certain hospitals to obtain federal approval and to minimize the financial impact on certain hospitals. In determining for which hospitals the enterprise may reduce the amount of the hospital provider fee, the enterprise shall use one or more of the following criteria:

(A) The hospital is a type of hospital described in subsection (4)(c)(I) of this section;

(B) The hospital is located in a rural area;

(C) The hospital serves a higher percentage than the average hospital of persons covered by the state medical assistance program, medicare, or commercial insurance or persons enrolled in a managed care organization;

(D) The hospital does not contract with the state department to provide services under the state medical assistance program;

(E) If the hospital paid a reduced hospital provider fee, the reduced fee would not significantly affect the net benefit to hospitals paying the fee; or

(F) The hospital is required not to pay a reduced hospital provider fee as a condition of federal approval.

(IV) The enterprise may change how it pays hospital reimbursement or quality incentive payments, or both, in whole or in part, under the authority of a federal waiver if the total reimbursement to hospitals is equal to or above the federal upper payment limit calculation under the waiver.

(d) The enterprise may alter the process prescribed in this subsection (4) to the extent necessary to meet the federal requirements and to obtain federal approval.

(e) (I) The enterprise shall establish policies on the calculation, assessment, and timing of the hospital provider fee. The enterprise shall assess the hospital provider fee on a schedule to be set by the enterprise board as provided in subsection (7)(d) of this section. The periodic hospital provider fee payments from a hospital and the enterprise's reimbursement to the hospital under subsections (5)(b)(I) and (5)(b)(II) of this section are due as nearly simultaneously as feasible; except that the enterprise's reimbursement to the hospital is due no more than two days after the periodic hospital provider fee payment is received from the hospital. The hospital provider fee must be imposed on each hospital even if more than one hospital is owned by the same entity. The fee must be prorated and adjusted for the expected volume of service for any year in which a hospital opens or closes.

(II) The enterprise is authorized to refund any unused portion of the hospital provider fee. For any portion of the hospital provider fee that has been collected by the enterprise but for which the enterprise has not received federal matching funds, the enterprise shall refund back to the hospital that paid the fee the amount of that portion of the fee within five business days after the fee is collected.

(III) The enterprise shall establish requirements for the reports that hospitals must submit to the enterprise to allow the enterprise to calculate the amount of the hospital provider fee. Notwithstanding the provisions of part 2 of article 72 of title 24 or subsection (7)(f) of this section, information provided to the enterprise pursuant to this section is confidential and is not a public record. Nonetheless, the enterprise may prepare and release summaries of the reports to the public.

(f) A hospital shall not include any amount of the hospital provider fee as a separate line item in its billing statements.

(g) (I) The state board shall promulgate any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, necessary for the administration and implementation of this section. Prior to submitting any proposed rules concerning the administration or implementation of the hospital provider fee to the state board, the enterprise shall consult with the state board on the proposed rules as specified in subsection (7)(d) of this section.

(II) No later than July 1, 2025, the state board, in consultation with the enterprise, shall promulgate rules concerning the policy for qualification for disproportionate share hospital payments. Subject to the requirements under federal law, the disproportionate share hospital payment policy must direct funding to hospitals serving a greater proportion of medicaid and uninsured patients compared to other hospitals and offering financial assistance to lower-income Coloradans.

(4.5) **Healthcare affordability and sustainability nursing facility provider fee.**

(a) Beginning on May 1, 2025, the enterprise is authorized to charge and collect a healthcare affordability and sustainability nursing facility provider fee on health-care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state medical assistance program as described in this article 4 and articles 5 and 6 of this title 25.5. The enterprise shall use the nursing facility provider fee revenue to provide a business service to nursing facility providers by sustaining or increasing reimbursement for providing medical care under the state medical assistance program for nursing facility providers and making supplemental medicaid payments to nursing facility providers, as specified by the priority of the uses of the nursing facility provider fee revenue set forth in subsection (5.5)(b) of this section.

(b) The enterprise shall recommend for approval and establishment by the state board the amount of the nursing facility provider fee that it intends to charge and collect. The state board

must establish the final amount of the fee by rule. The state board shall not establish any amount that exceeds the federal limit for such fees. The state board may deviate from the recommendations of the enterprise, but shall express in writing the reasons for any deviations. In establishing the amount of the fee and in promulgating the rules governing the fee, the state board shall:

(I) Consider recommendations of the enterprise; and

(II) Establish the amount of the nursing facility 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 subsection (4.5)(a) of this section, but nothing in this subsection (4.5)(b)(II) requires the state board to increase the fee above the amount recommended by the enterprise.

(c) The enterprise shall not charge or collect the nursing facility provider fee in the absence of the federal government's approval of a state medicaid plan amendment authorizing federal financial participation for the nursing facility provider fee. The enterprise may alter the process prescribed in this subsection (4.5) to the extent necessary to meet federal requirements and to obtain federal approval. The enterprise may lower the amount of the nursing facility provider fee charged to certain nursing facility providers to meet the requirements of 42 CFR 433.68 (e) and to obtain federal approval.

(d) (I) In accordance with the redistributive method set forth in 42 CFR 433.68 (e)(1) and (e)(2), the enterprise, acting in concert with or through an agreement with the state department if required by federal law, may seek a waiver from the broad-based nursing facility provider fee requirement or the uniform nursing facility provider fee requirement, or both.

(II) Subject to federal approval and to minimize the financial impact on certain nursing facility providers, the enterprise may exempt from payment of the nursing facility provider fee certain types of nursing provider facilities, including but not limited to:

(A) A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services, and skilled nursing care on a single, contiguous campus. Assisted living services include an assisted living residence as defined in section 25-27-102 or a facility that provides assisted living services on-site, twenty-four hours per day, seven days per week.

(B) A skilled nursing facility owned and operated by the state;

(C) A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and

(D) A facility that has forty-five or fewer licensed beds.

(e) (I) The enterprise shall establish policies on the calculation, assessment, and timing of the nursing facility provider fee. The enterprise shall assess the nursing facility provider fee on a

monthly basis. The nursing facility provider fee payments from a nursing facility provider and the enterprise's reimbursement and supplemental payments to the nursing facility provider under subsection (5.5)(b) of this section are due as nearly simultaneously as feasible; except that the enterprise's reimbursement and supplemental payments to the nursing facility provider are due no more than fifteen days after the nursing facility provider fee payment is received from the nursing facility provider.

(II) The enterprise shall establish requirements for the reports that nursing facility providers must submit to the enterprise to allow the enterprise to calculate the amount of the nursing facility provider fee, including a requirement that each nursing facility provider report annually its total number of days of care provided to nonmedicare residents. Notwithstanding part 2 of article 72 of title 24 or subsection (7)(f) of this section, information provided to the enterprise pursuant to this subsection (4.5)(e)(II) is confidential and is not a public record. Nonetheless, the enterprise may prepare and release summaries of the reports to the public.

(f) A nursing facility provider shall not include any amount of the nursing facility provider fee as a separate line item in its billing statements.

(g) The state board shall adopt any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, necessary for the administration and implementation of this section. Prior to submitting any proposed rules concerning the administration or implementation of the nursing facility provider fee to the state board, the enterprise shall consult with the state board on the proposed rules as specified in subsection (7)(h) of this section.

(4.7) **Healthcare affordability and sustainability intermediate care facility fee.**

(a) Beginning on May 1, 2025, the enterprise is authorized to charge and collect a healthcare affordability and sustainability intermediate care facility fee on both privately owned and state-operated intermediate care facilities for individuals with intellectual disabilities for the purpose of maintaining the quality and continuity of services provided by intermediate care facilities for individuals with intellectual disabilities. The enterprise shall use the intermediate care facility fee revenue to provide a business service to such intermediate care facilities by sustaining or increasing reimbursement to such facilities, as specified in subsection (5.7)(b) of this section.

(b) The enterprise shall recommend for approval and establishment by the state board the amount of the intermediate care facility fee that it intends to charge and collect, which must not exceed five percent of the total costs incurred by all intermediate care facilities for the fiscal year in which the fee is charged. The state board must establish the final amount of the fee by rule. The state board shall not establish any amount that exceeds the federal limit for such fees. The state board may deviate from the recommendations of the enterprise, but shall express in writing the reasons for any deviations.

(c) The enterprise may alter the process prescribed in this subsection (4.7) to the extent necessary to meet federal requirements.

(d) (I) The enterprise shall establish policies on the calculation, assessment, and timing of the intermediate care facility fee.

(II) The enterprise shall establish requirements for the reports that intermediate care facilities must submit to the enterprise to allow the enterprise to calculate the amount of the intermediate care facility fee. Notwithstanding part 2 of article 72 of title 24 or subsection (7)(f) of this section, information provided to the enterprise pursuant to this subsection (4.7)(d)(II) is confidential and is not a public record. Nonetheless, the enterprise may prepare and release summaries of the reports to the public.

(e) The state board shall adopt any rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, necessary for the administration and implementation of this section. Prior to submitting any proposed rules concerning the administration or implementation of the intermediate care facility fee to the state board, the enterprise shall consult with the state board on the proposed rules as specified in subsection (7)(h) of this section.

(5) **Healthcare affordability and sustainability hospital provider fee cash fund.**

(a) (I) Any healthcare affordability and sustainability hospital provider fee collected or public funds received pursuant to this section by the enterprise must be transmitted to the state treasurer, who shall credit the fee or public funds to the healthcare affordability and sustainability hospital provider fee cash fund, which fund is created. The state treasurer shall credit all interest and income derived from the deposit and investment of money in the hospital provider fee cash fund to the fund. The state treasurer shall invest any money in the hospital provider fee cash fund not expended for the purposes specified in subsection (5)(b) of this section as provided by law. Money in the hospital provider fee cash fund shall not be transferred to any other fund and shall not be used for any purpose other than the purposes specified in this subsection (5) and in subsection (4) of this section.

(II) (A) The fund created in this subsection (5)(a) was renamed as the healthcare affordability and sustainability hospital provider fee cash fund in Senate Bill 25-270, enacted in 2025. For purposes of the annual general appropriation acts for the 2024-25 and 2025-26 state fiscal years, the cash funds appropriations made to the department of health care policy and financing from the healthcare affordability and sustainability fee cash fund, as the fund was named prior to the enactment of Senate Bill 25-270, enacted in 2025, are from the healthcare affordability and sustainability hospital provider fee cash fund, as renamed by Senate Bill 25-270, enacted in 2025.

(B) This subsection (5)(a)(II) is repealed, effective July 1, 2027.

(b) All money in the hospital provider fee cash fund is subject to federal matching as authorized under federal law and, subject to annual appropriation by the general assembly, shall be expended by the enterprise for the following purposes:

(I) To maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limits as defined in 42 CFR 447.272 and 42 CFR 447.321;

(I.5) To maximize the inpatient and outpatient hospital reimbursements, as permitted in 42 CFR 438.6(c);

(I.7) To maximize reimbursement for physician services at Denver health and hospital authority through a state-directed payment program, as permitted in 42 CFR 438.6(c).

(II) To increase hospital reimbursements through disproportionate share hospital payments to up to one hundred percent of the hospital's hospital-specific disproportionate share hospital limit;

(III) To pay the quality incentive payments provided in section 25.5-4-402 (3);

(IV) Subject to available revenue from the hospital provider fee and federal matching funds, to expand eligibility for public medical assistance by:

(A) Increasing the eligibility level for parents and caretaker relatives of children who are eligible for medical assistance, pursuant to section 25.5-5-201 (1)(m), from sixty-one percent to one hundred thirty-three percent of the federal poverty line;

(B) Increasing the eligibility level for children and pregnant women under the children's basic health plan to up to two hundred sixty percent of the federal poverty line;

(C) Providing eligibility under the state medical assistance program for a childless adult or an adult without a dependent child in the home, pursuant to section 25.5-5-201 (1)(p), who earns up to one hundred thirty-three percent of the federal poverty line; and

(D) Providing a buy-in program in the state medical assistance program for disabled adults and children whose families have income of up to four hundred fifty percent of the federal poverty line;

(V) To provide continuous eligibility for twelve months for children enrolled in the state medical assistance program;

(VI) To pay the enterprise's actual administrative costs of implementing and administering this section, including but not limited to the following costs:

(A) Administrative expenses of the enterprise;

(B) The enterprise's actual costs related to implementing and maintaining the hospital provider fee and receipt of public funds, including personal services, operating, and consulting expenses;

(C) The enterprise's actual costs for the changes and updates to the medicaid management information system for the implementation of subsections (5)(b)(I) to (5)(b)(III) of this section;

(D) The enterprise's personal services and operating costs related to personnel, consulting services, and for review of hospital costs necessary to implement and administer the increases in inpatient and outpatient hospital payments made pursuant to subsections (5)(b)(I) and (5)(b)(I.5) of this section, disproportionate share hospital payments made pursuant to subsection (5)(b)(II) of this section, and quality incentive payments made pursuant to subsection (5)(b)(III) of this section;

(E) The enterprise's actual costs for the changes and updates to the Colorado benefits management system and medicaid management information system to implement and maintain the expanded eligibility provided for in subsections (5)(b)(IV) and (5)(b)(V) of this section;

(F) The enterprise's personal services and operating costs related to personnel necessary to implement and administer the expanded eligibility for public medical assistance provided for in subsections (5)(b)(IV) and (5)(b)(V) of this section, including but not limited to administrative costs associated with the determination of eligibility for public medical assistance by county departments; and

(G) The enterprise's personal services, operating, and systems costs related to expanding the opportunity for individuals to apply for public medical assistance directly at hospitals or through another entity outside the county departments, in connection with section 25.5-4-205, that would increase access to public medical assistance and reduce the number of uninsured served by hospitals;

(VII) To offset the loss of any federal matching money due to a decrease in the certification of the public expenditure process for outpatient hospital services for medical services premiums that were in effect as of July 1, 2008;

(VIII) Subject to federal approval, for the hospital quality incentive program described in section 25.5-4-402 (3);

(VIII.3) to (VIII.7) Repealed.

(IX) To provide additional business services to hospitals as specified in subsection (4)(a)(IV) of this section.

(c) Repealed.

(5.1) **Healthcare affordability and sustainability medicaid buy-in cash fund.**

(a) The healthcare affordability and sustainability medicaid buy-in cash fund, referred to in this section as the "buy-in fund", is created in the state treasury. The buy-in fund consists of the premiums credited to the buy-in fund pursuant to sections 25.5-5-206 and 25.5-6-1404 and any other money that the general assembly may appropriate or transfer to the buy-in fund. Money in the buy-in fund shall not be transferred to any other fund and shall not be used for any purpose other than the purposes specified in this subsection (5.1).

(b) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the buy-in fund to the buy-in fund.

(c) Subject to annual appropriation by the general assembly, the enterprise may expend money from the buy-in fund for the purpose of providing the medicaid buy-in programs created pursuant to part 14 of article 6 of this title 25.5 and section 25.5-5-206.

(5.5) **Healthcare affordability and sustainability nursing facility provider fee cash fund.**

(a) All healthcare affordability and sustainability nursing provider fees collected pursuant to this section by the enterprise must be transmitted to the state treasurer, who shall credit the fee to the healthcare affordability and sustainability nursing facility provider fee cash fund, which fund is created. The state treasurer shall credit all interest and income derived from the deposit and investment of money in the nursing facility provider fee cash fund to the nursing facility provider fee cash fund. The state treasurer shall invest any money in the nursing facility provider fee cash fund not expended for the purposes specified in subsections (4.5)(a) and (5.5)(b) of this section as provided by law. Money in the nursing facility provider fee cash fund shall not be transferred to any other fund and shall not be used for any purpose other than the purposes specified in this subsection (5.5) and in subsection (4.5)(a) of this section.

(b) All money in the nursing facility provider fee cash fund is subject to federal matching as authorized under federal law and, subject to annual appropriation by the general assembly, must be expended by the enterprise for the following purposes:

(I) (A) To pay the administrative costs of implementing this subsection (5.5) and subsection (4.5) of this section;

(B) To satisfy settlements or judgments resulting from nursing facility provider reimbursement appeals; and

(C) To pay a nursing facility provider a supplemental medicaid payment for care and services rendered to medicaid residents to offset payment of the nursing facility provider fee. The enterprise, in consultation with the state department, shall compute this payment annually, beginning on May 1, 2025, and each July 1 thereafter.

(II) After the payment of the amounts described in subsection (5.5)(b)(I) of this section, to pay the supplemental medicaid payments for acuity or case-mix of residents established under section 25.5-6-202 (2), prior to its repeal on July 1, 2026, or as provided in the rules adopted by the state board pursuant to section 25.5-6-202 (10) and (14)(a), in consultation with the enterprise as provided in subsection (7)(h)(IV) of this section;

(III) After the payment of the amounts described in subsections (5.5)(b)(I) and (5.5)(b)(II) of this section, to pay supplemental medicaid payments based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents. The enterprise, in consultation with the state board, shall determine the payment

amount based upon performance measures established in rules adopted by the state board in the domains of quality of life, quality of care, and facility management. During each state fiscal year, the enterprise may discontinue the supplemental medicaid payment established pursuant to this subsection (5.5)(b)(III) to any nursing facility provider that fails to comply with the established performance measures during the state fiscal year, and the enterprise may initiate the supplemental medicaid payment established pursuant to this subsection (5.5)(b)(III) to any nursing facility provider that comes into compliance with the established performance measures during the state fiscal year.

(IV) (A) After the payment of the amounts described in subsections (5.5)(b)(I) to (5.5)(b)(III) of this section, to pay the supplemental medicaid payments to nursing facility providers that serve residents who have moderate to very severe mental health conditions, dementia diseases and related disabilities, or acquired brain injury. The enterprise, in consultation with the state department, shall compute this payment annually, beginning on May 1, 2025, and each July 1 thereafter.

(B) If the enterprise determines, in consultation with the state department, that the case-mix reimbursement described in subsection (5.5)(b)(II) of this section includes a factor for nursing facility providers that serve residents with severe dementia diseases and related disabilities or acquired brain injury, the enterprise may eliminate this supplemental medicaid payment to those nursing facility providers that serve residents with severe dementia diseases and related disabilities or acquired brain injury.

(V) After the payment of the amounts described in subsections (5.5)(b)(I) to (5.5)(b)(IV) of this section, to pay the supplemental medicaid payments for the amount of the aggregate statewide average per diem rate of patient payment established under section 25.5-6-202 (9), prior to its repeal on July 1, 2026, or as provided in the rules adopted by the state board pursuant to section 25.5-6-202 (10) and (14)(a), in consultation with the enterprise as provided in subsection (7)(h)(IV) of this section.

(5.7) **Healthcare affordability and sustainability intermediate care facility fee cash fund.**

(a) All healthcare affordability and sustainability intermediate care facility fees collected pursuant to this section by the enterprise must be transmitted to the state treasurer, who shall credit the fee to the healthcare affordability and sustainability intermediate care facility fee cash fund, which fund is created. The state treasurer shall credit all interest and income derived from the deposit and investment of money in the intermediate care facility fee cash fund to the intermediate care facility cash fund. The state treasurer shall invest any money in the intermediate care facility fee cash fund not expended for the purposes specified in subsections (4.7)(a) and (5.7)(b) of this section as provided by law. Money in the intermediate care facility fee cash fund shall not be transferred to any other fund and shall not be used for any purpose

other than the purposes specified in this subsection (5.7) and in subsection (4.7)(a) of this section.

(b) All money in the intermediate care facility fee cash fund is subject to federal matching as authorized under federal law and, subject to annual appropriation by the general assembly, must be expended by the enterprise for the following purposes:

(I) To pay the administrative costs of implementing this subsection (5.7) and subsection (4.7) of this section; and

(II) To supplement reimbursements to intermediate care facilities for individuals with intellectual disabilities as provided in section 25.5-6-204. The enterprise, in consultation with the state department, shall compute this payment annually, beginning on May 1, 2025, and each July 1 thereafter.

(6) **Appropriations.**

(a) (I) Except as otherwise provided in subsection (6)(b)(I.5) or (6)(b)(I.7) of this section, the hospital provider fee and public funds are to supplement, not supplant, general fund appropriations to support hospital reimbursements. General fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008; except that general fund appropriations for hospital reimbursements may be reduced if an index of appropriations to other providers shows that general fund appropriations are reduced for other providers. If the index shows that general fund appropriations are reduced for other providers, the general fund appropriations for hospital reimbursements shall not be reduced by a greater percentage than the reductions of appropriations for the other providers as shown by the index.

(II) If general fund appropriations for hospital reimbursements are reduced below the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008, the general fund appropriations will be increased back to the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008, at the same percentage as the appropriations for other providers as shown by the index. The general assembly is not obligated to increase the general fund appropriations back to the level of appropriations in the medical services premium line item in a single fiscal year, and such increases may occur over nonconsecutive fiscal years.

(III) For purposes of this subsection (6)(a), the "index of appropriations to other providers" or "index" means the average percent change in reimbursement rates through appropriations or legislation enacted by the general assembly to home health providers, physician services, and outpatient pharmacies, excluding dispensing fees. The state board, after consultation with the enterprise board, is authorized to clarify this definition as necessary by rule.

(IV) Except as otherwise provided in subsection (5.5)(b)(V) of this section, the nursing facility provider fee is to supplement, not supplant, general fund appropriations to support nursing facility provider reimbursements.

(V) Except as otherwise provided in subsection (5.7)(b)(II) of this section, the intermediate care facility fee is to supplement, not supplant, general fund appropriations to support intermediate care facility reimbursements.

(b) If the revenue from the hospital provider fee is insufficient to fully fund all of the purposes described in subsection (5)(b) of this section:

(I) The general assembly is not obligated to appropriate general fund revenues to fund such purposes;

(I.3) to (I.7) Repealed.

(II) The hospital provider reimbursement and quality incentive payment increases described in subsections (5)(b)(I), (5)(b)(II), and (5)(b)(III) of this section and the costs described in subsection (5)(b)(VI) of this section shall be fully funded using revenue from the hospital 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 subsection (5)(b)(IV) of this section, and the state department thereafter notifies the enterprise board that the revenue available from the hospital provider fee and the federal matching funds will not be sufficient to pay for all or part of the expanded eligibility, the enterprise board shall recommend to the state board reductions in medical benefits or eligibility so that the revenue will be sufficient to pay for all of the reduced benefits or eligibility. After receiving the recommendations of the enterprise board, the state board shall adopt rules providing for reduced benefits or reduced eligibility for which the revenue will be sufficient and shall forward any adopted rules to the joint budget committee. Notwithstanding the provisions of section 24-4-103 (8) and (12), following the adoption of rules pursuant to this subsection (6)(b)(III)(A), the state board shall not submit the rules to the attorney general and shall not file the rules with the secretary of state until the joint budget committee approves the rules pursuant to subsection (6)(b)(III)(B) of this section.

(B) The joint budget committee shall promptly consider any rules adopted by the state board pursuant to subsection (6)(b)(III)(A) of this section. The joint budget committee shall promptly notify the state department, the state board, and the enterprise board of any action on the rules. If the joint budget committee does not approve the rules, the joint budget committee shall recommend a reduction in benefits or eligibility so that the revenue from the hospital 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 subsection (6)(b)(III)(B), the joint budget committee shall request that the committee on legal services, created pursuant to section 2-3-501, extend the

rules as provided for in section 24-4-103 (8) unless the committee on legal services finds after review that the rules do not conform with section 24-4-103 (8)(a).

(C) After the state board has received notification of the approval of rules adopted pursuant to subsection (6)(b)(III)(A) of this section, the state board shall submit the rules to the attorney general pursuant to section 24-4-103 (8)(b) and shall file the rules and the opinion of the attorney general with the secretary of state pursuant to section 24-4-103 (12) and with the office of legislative legal services. Pursuant to section 24-4-103 (5), the rules are effective twenty days after publication of the rules and are only effective until the following May 15 unless the rules are extended pursuant to a bill enacted pursuant to section 24-4-103 (8).

(b.5) If the revenue from the nursing facility provider fee is insufficient to fully fund all of the purposes described in subsection (5.5)(b) of this section:

(I) The general assembly is not obligated to appropriate general fund revenues to fund such purposes; and

(II) Subject to the priority of the uses for the nursing facility provider fee as provided in subsection (5.5)(b) of this section, the enterprise, in consultation with the state department, may suspend or reduce any supplemental medicaid payment.

(c) Notwithstanding any other provision of this section, if, after receipt of authorization to receive federal matching funds for money in the hospital provider fee cash fund, the authorization is withdrawn or changed so that federal matching funds are no longer available, the enterprise shall cease collecting the hospital provider fee and receiving public funds and shall repay to the hospitals any money received by the hospital provider fee cash fund that is not subject to federal matching funds.

(c.5) Notwithstanding any other provision of this section, if, after receipt of authorization to receive federal matching funds for money in the nursing facility provider fee cash fund, the authorization is withdrawn or changed so that federal matching funds are no longer available, the enterprise shall cease collecting the nursing facility provider fee and shall repay to the nursing facility providers any money received in the nursing facility provider fee cash fund that is not subject to federal matching funds.

(c.7) Notwithstanding any other provision of this section, if, after receipt of authorization to receive federal matching funds for money in the intermediate care facility fee cash fund, the authorization is withdrawn or changed so that federal matching funds are no longer available, the enterprise shall cease collecting the intermediate care facility fee and shall repay to the intermediate care facilities any money received in the intermediate care facility fee cash fund that is not subject to federal matching funds.

(7) **Colorado healthcare affordability and sustainability enterprise board.**

(a) (I) Except as otherwise provided in subsection (7)(a)(II) of this section, the enterprise board consists of thirteen members appointed by the governor, with the advice and consent of the senate, as follows:

(A) Five members who are employed by hospitals in Colorado, including at least one person who is employed by a hospital in a rural area, one person who is employed by a safety-net hospital for which the percent of medicaid-eligible inpatient days relative to its total inpatient days is equal to or greater than one standard deviation above the mean, and one person who is employed by a hospital in an urban area;

(B) One member who is a representative of a statewide organization of hospitals;

(C) One member who represents a statewide organization of health insurance carriers or a health insurance carrier licensed pursuant to title 10 and who is not a representative of a hospital;

(D) One member of the health-care industry who does not represent a hospital or a health insurance carrier;

(E) One member who is a consumer of health care and who is not a representative or an employee of a hospital, health insurance carrier, or other health-care industry entity;

(F) One member who is a representative of persons with disabilities, who is living with a disability, and who is not a representative or an employee of a hospital, health insurance carrier, or other health-care industry entity;

(G) One member who is a representative of a business that purchases or otherwise provides health insurance for its employees; and

(H) Two employees of the state department.

(II) The initial members of the enterprise board are the members of the hospital provider fee oversight and advisory board that was created and existed pursuant to section 25.5-4-402.3 (6), prior to July 1, 2017, and such members shall serve on and after July 1, 2017, for the remainder of the terms for which they were appointed as members of the advisory board. The powers, duties, and functions of the enterprise board include the powers, duties, and functions of the former hospital provider fee oversight and advisory board, and the hospital provider fee oversight and advisory board is abolished.

(III) The governor shall consult with representatives of a statewide organization of hospitals in making the appointments pursuant to subsections (7)(a)(I)(A) and (7)(a)(I)(B) of this section. No more than six members of the enterprise board may be members of the same political party.

(IV) Members of the enterprise board serve at the pleasure of the governor. All terms are for four years. A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the former member.

(V) The governor shall designate a chair from among the members of the enterprise board appointed pursuant to subsections (7)(a)(I)(A) to (7)(a)(I)(G) of this section. The enterprise board shall elect a vice-chair from among its members.

(b) Members of the enterprise board serve without compensation but must be reimbursed from money in the hospital provider fee cash fund for actual and necessary expenses incurred in the performance of their duties pursuant to this section.

(c) The enterprise board may contract for a group facilitator to assist the members of the enterprise board in performing their required duties.

(d) The enterprise board has, at a minimum, the following duties:

(I) To determine the timing and method by which the enterprise assesses the hospital provider fee and the amount of the fee;

(II) If requested by the health and human services committee of the senate or the health and human services committee of the house of representatives, or any successor committees, to consult with the committees on any legislation that may impact the fees, payments, or reimbursements established pursuant to this section;

(III) To determine changes in the hospital provider fee that increase the number of hospitals benefitting from the uses of the fee described in subsections (5)(b)(I) to (5)(b)(IV) of this section or that minimize the number of hospitals that suffer losses as a result of paying the hospital 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 direct and oversee the enterprise in seeking, in concert with or through an agreement with the state department if required by federal law, any federal waiver necessary to fund and, in cooperation with the state department and hospitals, support the implementation of the hospital quality incentive program created in section 25.5-4-402 (3)(a);

(VI) To recommend to the state department the schedule and approach to the implementation of subsections (5)(b)(IV) and (5)(b)(V) of this section;

(VII) If money in the fund is insufficient to fully fund all of the purposes specified in subsection (5)(b) of this section, to recommend to the state board changes to the expanded eligibility provisions described in subsection (5)(b)(IV) of this section;

(VIII) To prepare the reports specified in subsection (7)(e) of this section;

(IX) To monitor the impact of the hospital provider fee, the nursing facility provider fee, and the intermediate care facility fee on the broader health-care marketplace;

(X) To establish requirements for the reports that hospitals must submit to the enterprise to allow the enterprise to calculate the amount of the hospital provider fee; and

(XI) To perform any other duties required to fulfill the enterprise board's charge or those assigned to it by the state board or the executive director.

(e) On or before January 15, 2018, and on or before January 15 each year thereafter, the enterprise board shall submit a written report to the health and human services committee of the senate and the health and human services committee of the house of representatives, or any successor committees, the joint budget committee of the general assembly, the governor, and the state board. The report shall include, but need not be limited to:

(I) The recommendations made to the state board pursuant to this section;

(II) A description of the formula for how the hospital provider fee is calculated and the process by which the fee is assessed and collected;

(II.5) A description of the formula for how the nursing facility provider fee is calculated and the process by which the fee is assessed and collected;

(II.7) A description of the formula for how the intermediate care facility fee is calculated and the process by which the fee is assessed and collected;

(III) An itemization of the total amount of the hospital 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 subsections (5)(b)(I) and (5)(b)(II) of this section and the quality incentive payments made pursuant to subsection (5)(b)(III) of this section; and

(B) The increased eligibility described in subsections (5)(b)(IV) and (5)(b)(V) of this section;

(III.5) An itemization of the total amount of the nursing facility provider fee paid by each nursing facility provider and any projected revenue that each nursing facility provider is expected to receive due to increased reimbursements and supplemental payments made pursuant to subsection (5.5)(b) of this section;

(III.7) An itemization of the total amount of the intermediate care facility fee paid by each intermediate care facility for individuals with intellectual disabilities and any projected revenue that each intermediate care facility is expected to receive due to increased reimbursements made pursuant to subsection (5.7)(b) of this section;

(IV) An itemization of the costs incurred by the enterprise in implementing and administering the hospital provider fee, the nursing facility provider fee, and the intermediate care facility fee;

(V) Estimates of the differences between the cost of care provided and the payment received by hospitals on a per-patient basis, aggregated for all hospitals, for patients covered by each of the following:

(A) Medicaid;

(B) Medicare; and

(C) All other payers; and

(VI) A summary of:

(A) The efforts made by the enterprise to implement the hospital quality incentive program required pursuant to section 25.5-4-402 (3), including information about the structure of the hospital quality incentive program and any results achieved as a result of the hospital quality incentive program; and

(B) The progress actually made by the enterprise, in cooperation with the state department and hospitals, toward the goal of implementing such a program and the enterprise board's legislative recommendations for changes to the hospital quality incentive program.

(e.5) The enterprise board shall calculate the estimates described in subsection (7)(e)(V) of this section by using appropriate information provided to the state department by hospitals and any state department analysis of that information.

(f) (I) The enterprise is subject to the open meetings provisions of the "Colorado Sunshine Act of 1972", contained in part 4 of article 6 of title 24, and the "Colorado Open Records Act", part 2 of article 72 of title 24.

(II) For purposes of the "Colorado Open Records Act", part 2 of article 72 of title 24, and except as may otherwise be provided by federal law or regulation or state law, the records of the enterprise are public records, as defined in section 24-72-202 (6), regardless of whether the enterprise receives less than ten percent of its total annual revenues in grants, as defined in section 24-77-102 (7), from all Colorado state and local governments combined.

(III) The enterprise is a public entity for purposes of part 2 of article 57 of title 11.

(g) (I) The medicaid buy-in enterprise support board is created within the enterprise for the purpose of supporting the enterprise board with the implementation of the medicaid buy-in programs. The medicaid buy-in enterprise support board consists of five members appointed by the governor, with the advice and consent of the senate, as follows:

(A) One member who is a representative of persons with disabilities, who is living with a disability;

(B) Two members who are representatives of a disability rights organization or a disabled persons consumer advocacy organization;

(C) One employee of the state department; and

(D) One employee of the department of labor and employment created in section 24-1-121.

(II) (A) Members of the medicaid buy-in enterprise support board serve at the pleasure of the governor. All terms are for four years. A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the former member.

(B) The governor shall make the initial appointments to the medicaid buy-in enterprise support board as soon as practical following May 1, 2025.

(III) The medicaid buy-in enterprise support board shall elect a chair and a vice-chair from among its members.

(IV) On behalf of the enterprise, the medicaid buy-in enterprise support board shall consult with the state department and the state board on the amount of the premiums for and other components of the medicaid buy-in programs created pursuant to part 14 of article 6 of this title 25.5 and section 25.5-5-206.

(V) Members of the medicaid buy-in enterprise support board serve without compensation but must be reimbursed from money in the buy-in fund for actual and necessary expenses incurred in the performance of their duties pursuant to this section.

(h) (I) The facility provider fee enterprise support board is created within the enterprise for the purpose of supporting the enterprise board with the implementation of the nursing facility provider fee and the intermediate care facility fee. The facility provider fee enterprise support board consists of eight members appointed by the governor, with the advice and consent of the senate, as follows:

(A) Two members who are representatives of nursing facility associations;

(B) Two members who are representatives of nursing facilities, with one member representing a rural nursing facility;

(C) One member who is a resident of a long-term care facility or a consumer of long-term care services, or a family member or guardian representing such resident or consumer;

(D) One employee of the state department;

(E) One employee of the department of human services created in section 24-1-120; and

(F) One employee of the department of public health and environment created in section 25-1-102.

(II) (A) Members of the facility provider fee enterprise support board serve at the pleasure of the governor. All terms are for four years. A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the former member.

(B) The governor shall make the initial appointments to the facility provider fee enterprise support board as soon as practical following May 1, 2025.

(III) The facility provider fee enterprise support board shall elect a chair and a vice-chair from among its members.

(IV) The facility provider fee enterprise support board shall fulfill, at a minimum, the following duties on behalf of the enterprise:

(A) To determine the timing and method by which the enterprise assesses the nursing facility provider fee and the intermediate care facility fee and the amounts of the fees;

(B) To determine changes in the nursing facility provider fee that increase the number of nursing facility providers benefitting from the uses of the fee described in subsection (5.5)(b) of this section or that minimize the number of nursing facility providers that suffer losses as a result of paying the nursing facility provider fee;

(C) To determine changes in the intermediate care facility fee that increase the number of intermediate care facilities for individuals with intellectual disabilities that benefit from the uses of the fee described in subsection (5.7)(b) of this section or that minimize the number of intermediate care facilities for individuals with intellectual disabilities that suffer losses as a result of paying the nursing facility provider fee;

(D) To consult with the state board on the rules regarding payments to nursing facility providers that it adopts pursuant to section 25.5-6-202 (10) and (14)(a);

(E) To consult with the state board and the state department on the rules, price schedules, and allowances regarding reimbursement and payments to intermediate care facilities that they adopt pursuant to section 25.5-6-204;

(F) To establish requirements for the reports that nursing facility providers must submit to the enterprise to allow the enterprise to calculate the amount of the nursing facility provider fee; and

(G) To establish requirements for the reports that intermediate care facilities must submit to the enterprise to allow the enterprise to calculate the amount of the intermediate care facility fee.

(V) Members of the facility provider fee enterprise support board serve without compensation but must be reimbursed from money in the nursing facility provider fee cash fund or the intermediate care facility fee cash fund for actual and necessary expenses incurred in the performance of their duties pursuant to this section.

(7.5) **Enterprise transparency and reporting.** To ensure transparency and accountability, and in addition to the report required by subsection (7)(e) of this section, the enterprise shall:

(a) No later than November 1, 2025, and by November 1 of each three-year period thereafter, publish and post on its website a three-year plan that details how the enterprise will execute its business purposes during the current state fiscal year and the two subsequent state fiscal years and that estimates the amount of funding needed to implement the plan; and

(b) Create, maintain, and regularly update on its website a public accountability dashboard that provides, at a minimum, accessible and transparent summary information regarding the implementation of its three-year plan, the funding status and progress toward completion of each project that it wholly or partly funds, and its per-project and total funding and expenditures.

(8) Repealed.

(9) **Definitions.** As used in this section, unless the context otherwise requires:

(a) "Case-mix" has the same meaning as set forth in section 25.5-6-201 (8).

(b) "Case-mix reimbursement" has the same meaning as set forth in section 25.5-6-201 (12).

(c) "Colorado healthcare affordability and sustainability enterprise" or "enterprise" means the enterprise created in subsection (3) of this section.

(d) "Facility provider fee enterprise support board" means the facility provider fee enterprise support board created in subsection (7)(h) of this section.

(e) "Healthcare affordability and sustainability hospital provider fee" or "hospital provider fee" means the healthcare affordability and sustainability hospital provider fee charged and collected as authorized by subsection (4) of this section.

(f) "Healthcare affordability and sustainability hospital provider fee cash fund" or "hospital provider fee cash fund" means the healthcare affordability and sustainability hospital provider fee cash fund created in subsection (5) of this section.

(g) "Healthcare affordability and sustainability intermediate care facility fee" or "intermediate care facility fee" means the healthcare affordability and sustainability intermediate care facility fee for intermediate care facilities for individuals with intellectual disabilities charged and collected as authorized by subsection (4.7) of this section.

(h) "Healthcare affordability and sustainability intermediate care facility fee cash fund" or "intermediate care facility fee cash fund" means the healthcare affordability and sustainability intermediate care facility fee cash fund created in subsection (5.7) of this section.

(i) "Healthcare affordability and sustainability nursing facility provider fee" or "nursing facility provider fee" means the healthcare affordability and sustainability nursing facility provider fee charged and collected as authorized by subsection (4.5) of this section.

(j) "Healthcare affordability and sustainability nursing facility provider fee cash fund" or "nursing facility provider fee cash fund" means the healthcare affordability and sustainability nursing facility provider fee cash fund created in subsection (5.5) of this section.

(k) "Hospital" means a licensed or certified hospital.

(l) "Nursing facility provider" has the same meaning as set forth in section 25.5-6-201 (25).

(l.5) "Physician services" means medically necessary services that are rendered by a licensed physician or qualified medical professional and are billed separately from hospital facility fees.

(m) "State medical assistance program" means the program described in this article 4 and articles 5 and 6 of this title 25.5.

(n) "Statewide average per diem rate" has the same meaning as set forth in section 25.5-6-201 (35).

(o) "Supplemental medicaid payment" has the same meaning as set forth in section 25.5-6-201 (36).

(10) **State-directed payments program - funding and implementation.** The enterprise, acting in concert with, or through an agreement with, the state department, if required by federal law, shall seek a state plan amendment or any federal authorization necessary to fund and, in cooperation with the state department and hospitals, support the implementation of a state-directed payment program in compliance with 42 CFR 438.6(c) that complies with all federal requirements for financing of the non-federal share and shall support a total payment rate for each state-directed payment that does not exceed the average commercial rate and is distributed pursuant to the requirements of subsection (5) of this section.

Source: L. 2017: Entire section added, (SB 17-267), ch. 267, p. 1448, § 17, effective July 1. **L. 2018:** IP(5)(b) amended, (SB 18-195), ch. 173, p. 1205, § 1, effective July 1. **L. 2019:** (7)(e.5) added, (HB 19-1001), ch. 52, p. 177, § 1, effective August 2. **L. 2020:** (5)(b)(VIII) and (6)(a)(I) amended and (4)(a)(II.5), (5)(b)(VIII.5), and (6)(b)(I.3) added, (HB 20-1361), ch. 161, p. 756, § 2, effective June 29; (5)(b)(VIII) and (6)(a)(I) amended and (4)(a)(II.3), (5)(b)(VIII.3), and (6)(b)(I.5) added, (HB 20-1385), ch. 173, p. 795, § 2, effective June 29; IP(4)(a), (5)(b)(VIII), and (6)(a)(I) amended and (4)(a)(II.5), (5)(b)(VIII.7), and (6)(b)(I.7) added, (HB 20-1386), ch. 210, p. 1023, § 1, effective June 30. **L. 2021:** (4)(a)(II.3), (5)(b)(VIII.3), and (6)(b)(I.5)(B) amended, (SB 21-213), ch. 88, p. 363, § 2, effective May 4; (4)(a)(II.5), (5)(b)(VIII.5), and (6)(b)(I.3) repealed and (6)(a)(I) amended, (SB 21-211), ch. 86, p. 358, § 2, effective May 4; (5)(c) added, (SB 21-286), ch. 395, p. 2626, § 2, effective June 30. **L. 2022:** (5)(c)(I) amended, (HB 22-1188), ch. 14, p. 124, § 1, effective March 7; (5)(b)(IV)(B) amended, (SB 22-052), ch. 43, p. 216, § 1, effective March 24; (3)(e) and (7)(a)(II) amended, (SB 22-162), ch. 469, p. 3371, § 60; effective August 10. **L. 2024:** (2)(d)(I), IP(4)(a), (4)(a)(I), (4)(g), (5)(b)(II), and

(5)(b)(VI)(D) amended, (HB 24-1399), ch. 76, p. 251, § 7, effective July 1, 2025; (4)(c)(I)(C) amended, (SB 24-121), ch. 439, p. 3067, § 6, effective July 1, 2026. **L. 2025:** IP(2), (2)(f), (2)(g), (3)(a), (3)(d)(I), and (3)(d)(III) amended and (3)(c)(III), (5.1), and (7)(g) added, (SB 25-228), ch. 150, p. 571, § 1, effective May 1; IP(2), (2)(a), IP(2)(c), (2)(c)(V), (2)(c)(VI), IP(2)(d), (2)(d)(I), (2)(e), (2)(f), (2)(g), (3)(a), (3)(c)(I), (3)(d)(I), (3)(d)(II), (3)(d)(III), (3)(d)(V), IP(4)(a), IP(4)(b), (4)(b)(II), (4)(b)(III), IP(4)(c)(I), (4)(c)(II)(C), IP(4)(c)(III), (4)(c)(III)(E), (4)(c)(III)(F), (4)(e), (4)(f), (4)(g), (4)(g)(I), (5)(a), IP(5)(b), IP(5)(b)(IV), (5)(b)(VI)(B), (5)(c)(I)(A), (5)(c)(II)(C), (5)(c)(III), (5)(c)(V), (6)(a)(I), IP(6)(b), (6)(b)(II), (6)(b)(III)(A), (6)(b)(III)(B), (6)(c), (7)(b), (7)(d)(I), (7)(d)(II), (7)(d)(III), (7)(d)(IX), (7)(d)(X), IP(7)(e), (7)(e)(II), IP(7)(e)(III), and (7)(e)(IV) amended and (2)(c)(V.5), (2)(c)(V.7), (2)(d.5), (2)(d.7), (3)(c)(IV), (3)(c)(V), (4.5), (4.7), (5.5), (5.7), (6)(a)(IV), (6)(a)(V), (6)(b.5), (6)(c.5), (6)(c.7), (7)(e)(II.5), (7)(e)(II.7), (7)(e)(III.5), (7)(e)(III.7), (7)(h), (7.5), and (9) added, (SB 25-270), ch. 151, pp. 577, 597, §§ 1, 2, effective May 1; (2)(f), (3)(d)(V), (3)(d)(VI), (3)(d)(VII), IP(4)(a), IP(4)(b), (4)(b)(II), (5)(a), (5)(b)(VI)(B), (5)(b)(VI)(D), (6)(a)(I), (6)(b)(II), and (6)(c) amended and (2)(f.5), (3)(d)(VIII), (5)(b)(I.5), and (10) added, (HB 25-1213), ch. 276, p. 1435, § 4, effective August 6. **L. 2026:** (5)(b)(I.7) and (9)(l.5) added, (HB 26-1366), ch. 195, p. 1131, § 1, effective May 28; (4)(a)(IV)(E). IP(4)(c)(I), (5)(b)(VIII), (7)(d)(V), and (7)(e)(VI) amended and (8) repealed, (HB 26-1432), ch. 408, p. 2559, § 2, effective June 4.

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

(2) Amendments to subsection (6)(a)(I) by HB 20-1361, HB 20-1385, and HB 20-1386 were harmonized.

(3) Subsection (4)(a)(II.5) was added in HB 20-1361. It was superseded by the addition of subsection (4)(a)(II.5) in HB 20-1386.

(4) Subsection (5)(b)(VIII.7)(B) provided for the repeal of subsection (5)(b)(VIII.7), effective December 31, 2021. (See L. 2020, p. 1023.)

(5) Subsection (6)(b)(I.7)(B) provided for the repeal of subsection (6)(b)(I.7), effective December 31, 2021. (See L. 2020, p. 1023.)

(6) Amendments to subsection (2)(f) by SB 25-228, SB 25-270, and HB 25-1213 were harmonized.

(7) Amendments to subsections (3)(a), (3)(d)(I), and (3)(d)(III) by SB 25-270 and SB 25-228 were harmonized.

(8) Amendments to subsection (4)(b)(II) by HB 25-1213 were harmonized in part with and superseded in part by SB 25-270.

(9) Amendments to subsections (3)(d)(V), IP(4)(a), IP(4)(b), (5)(a), (5)(b)(VI)(B), (6)(a)(I), (6)(b)(II), and (6)(c) by SB 25-270 and HB 25-1213 were harmonized, and, as a result, amendments to subsection (3)(d)(V) by HB 25-1213 were relettered as (3)(d)(V.5).

(10) Subsections (4)(a)(II.3)(B), (5)(b)(VIII.3)(B), and (6)(b)(I.5)(B) provided for the repeal of subsections (4)(a)(II.3), (5)(b)(VIII.3), and (6)(b)(I.5), respectively, effective December 31, 2024. (See L. 2021, p. 363.)

(11) For the amendments to subsection (5)(c) in SB 25-270 in effect from May 1, 2025, to July 1, 2025, see chapter 151, Session Laws of Colorado 2025. (L. 2025, p. 577.)

(12) Subsection (5)(c)(VI) provided for the repeal of subsection (5)(c), effective July 1, 2025. (See L. 2021, p. 2626.)

(13) For the amendments to subsections (2)(d)(I), IP(4)(a), and (4)(g) in SB 25-270 in effect from May 1, 2025, to July 1, 2025, see chapter 151, Session Laws of Colorado 2025. (L. 2025, p. 577.)

Cross references: (1) For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

(2) For the short title (the "Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

ANNOTATION

Foundations and members of foundations lacked standing to contest the constitutionality of the healthcare affordability and sustainability fee program created in this section as violative of the Taxpayer's Bill of Rights (TABOR) and on other grounds. The members lacked taxpayer standing generally and under the citizen-suit provision of TABOR because hospitals, not taxpayers, made required payments to the program, and there was therefore no clear nexus between their taxpayer status and the fee. The members lacked individual standing because the program affected health care consumers only indirectly, and the members therefore suffered no direct and individualized injury. The foundations lacked associational

standing because the members did not otherwise have standing to sue in their own right. TABOR Found. v. Dept. of Health Care, 2020 COA 156, 487 P.3d 1277.

25.5-4-402.5. Providers - state university teaching hospitals.

Subject to appropriations by the general assembly, the state department shall make payments to state university teaching hospitals for providing care under the state's medical assistance program established pursuant to this article and articles 5 and 6 of this title.

Source: L. 2008: Entire section added, p. 1185, § 3, effective May 22.

25.5-4-402.7. Unexpended hospital provider fee cash fund - creation - transfer from hospital provider fee cash fund - use of fund - repeal. (Repealed)

Source: L. 2017: Entire section added, (SB 17-267), ch. 267, p. 1464, § 18, effective July 1.

Editor's note: Subsection (2) provided for the repeal of this section, effective November 1, 2018. (See L. 2017, p. 1464.)

25.5-4-402.8. Hospital transparency report and requirements - definitions.

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

(a) "Acquired" means the purchase by a hospital, or entity that is owned by or under common ownership and control with the hospital, of all or substantially all of an organization subject to subsection (1)(b)(I) or (1)(b)(II) of this section through an asset, equity, or similar purchase agreement that is a single transaction or series of transactions.

(b) "Affiliated" or "affiliate" means there is a contractual relationship between a hospital or an entity that is owned by or under common ownership and control with the hospital where the contractual relationship enables the hospital or an entity that is owned by or under common ownership and control with the hospital to exercise control over one of the following entities:

(I) Another hospital;

(II) An entity owned by or under common ownership and control with another hospital; or

(III) A physician group practice.

(c) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of management and policies of an affiliate, whether through the ownership of equity or membership, by contract or otherwise.

(d) "Major payer group" includes commercial insurers, medicare, medicaid, individuals who self-pay, and a financial assistance plan.

(2) (a) The state department shall annually prepare a written hospital transparency report detailing hospital costs, including uncompensated care costs, and the different categories of expenditures, by major payer group, made by hospitals in the state. The state department shall coordinate the analysis, review, and release of the hospital transparency report and the reports required pursuant to sections 25.5-1-703 (3) and 25.5-4-402.4 (7)(e), including the opportunity to review and consult on the reports made by the Colorado healthcare affordability and sustainability enterprise board, created pursuant to section 25.5-4-402.4 (7) and referred to in this section as the "enterprise board". The state department may share any information and analytics of information that it receives from hospitals with the enterprise board. The state department may include information it receives from hospitals in accordance with subsection (2)(b) of this section and that is not otherwise publicly available in the transparency report and share such information with the enterprise board; except that information the state department receives from hospitals in accordance with subsections (2)(b)(II)(D), (2)(b)(III)(N), (2)(b)(III)(O), (2)(b.5)(I), and (2)(b.5)(II) of this section is confidential, proprietary, contains trade secrets, and is not a public record pursuant to part 2 of article 72 of title 24. The state department shall not include in the transparency report, share with the enterprise board, or otherwise publish or distribute information derived from reports pursuant to subsections (2)(b)(II)(D), (2)(b)(III)(N), (2)(b)(III)(O), (2)(b.5)(I), and (2)(b.5)(II) of this section, although the state department may share this information if such information has been de-identified and aggregated in a manner to prevent identification of the transaction price of any individual acquisition or affiliation.

(b) Except as provided in subsection (2)(c) of this section, each hospital licensed pursuant to part 1 of article 3 of title 25, or certified pursuant to section 25-1.5-103 (1)(a)(II), shall make information available to the state department for purposes of preparing the annual hospital transparency report. The state board shall establish the content and format of the information provided by each hospital on an annual basis by rule, establishing the format for information for the 2026 annual report as the default format unless modified by rule. Each hospital shall provide the following information to the state department on an annual basis using the most recent content and format requirements that were adopted by the state board at least thirty days prior to the beginning of the hospital's fiscal year:

(I) The hospital cost report submitted to the federal centers for medicare and medicaid services (CMS) pursuant to 42 CFR 413.20, including a copy of the final forms and worksheets submitted to CMS as part of the hospital cost report;

(II) (A) Annual audited financial statements, prepared in accordance with generally accepted accounting principles. Each hospital shall submit the statements within one hundred fifty days after the end of its fiscal year unless the state department grants an extension in writing in advance of that date.

(B) Notwithstanding the provisions of subsection (2)(b)(II)(A) of this section, if a hospital is operating within a health system or other corporate structure and is normally included in that health system or other corporate structure's financial statement, the hospital may submit the health system or other corporate structure's financial statement if the statement separately identifies the financial information for each of the health system or other corporate structure's licensed hospitals operating in this state.

(C) In lieu of an audited financial statement, each hospital operating within a health system or other corporate structure that does not produce an annual audited financial statement specific to each individual hospital, but instead produces consolidated financial statements, shall submit a reconciliation of the consolidated financial statement and hospital-specific revenue and expenses reported on the medicare cost report pursuant to the federal centers for medicare and medicaid services provider reimbursement manual form 339.

(D) An annual summary of the hospital's transfers of cash, equity, investments, or other assets to and from related parties, including but not limited to the hospital's parent organization. The summary must include the purpose of the transfers and whether the transfers were made within or outside of Colorado. A hospital may aggregate the transfers for each entity receiving or making the transfer.

(E) A hospital-specific statement of cash flow within a time frame specified annually by the state department, but not less than one hundred twenty days after the hospital's fiscal year end.

(F) Changes to no more than twenty-five categories of specific major service lines, as requested by the state department.

(G) A narrative report of major planned and completed projects and capital investments greater than twenty-five million dollars; except that the information the state department receives from hospitals regarding planned activities is confidential, proprietary, contains trade secrets, and is not a public record pursuant to part 2 of article 72 of title 24.

(III) A report that contains the following information:

(A) The total number of available beds and licensed beds;

(B) Inpatient statistics in total and by major payer group and by care setting, including but not limited to inpatient discharges and patient days;

(C) Other inpatient statistics, including but not limited to the number of inpatient surgeries, number of births, number of newborn patient days, number of admissions from the hospital-

based emergency department, and number of admissions from free-standing emergency departments;

(D) Outpatient statistics in total and by type of visit, including but not limited to hospital-based emergency department visits, free-standing emergency department visits, ambulatory surgery visits, home health visits, and all other outpatient visits;

(E) Gross charges in total, by major payer group, and by care setting, including but not limited to inpatient care and outpatient care;

(F) Contractual allowances in total and by major payer group;

(G) Bad debt write-offs in total and by major payer group;

(H) Charity write-offs in total and by major payer group;

(I) Operating expenses in total and by expense classification, including but not limited to nonphysician payroll expenses and associated hours, physician payroll expenses and associated hours, total payroll expenses and associated hours, contract labor expenses and associated hours, employee benefits expenses, business development, marketing and advertising expenses, supply expenses, depreciation expenses, interest expenses, and all other operating expenses;

(J) Other operating revenue, operating margin, nonoperating gains and losses, gross revenue, net profit, and total margin;

(K) A balance sheet, including but not limited to details for current assets, restricted assets, long-term assets, other assets, current liabilities, long-term debt, other liabilities, and equity or net assets;

(L) Staffing information, including but not limited to full-time equivalents, staff turnover, and staff vacancy rates;

(M) A roll forward of property, plant, and equipment accounts by asset type from the beginning to the end of the reporting period by asset category, including but not limited to purchases, other acquisitions, sales, disposals, and other changes;

(N) The names and transaction price of acquired hospitals, affiliated hospitals, newly constructed hospitals, and rehabilitated hospitals; the names and transaction price of acquired or affiliated physician group practices; and the number and transaction price of individual physician practices acquired;

(O) Information on current affiliations and a report of physician practice acquisitions;

(P) Salary and total compensation data of the top five highest paid administrative positions of each nonprofit hospital, including the title, a brief description of duties, base compensation, incentive or bonus compensation, and other compensation. The compensation reported must indicate what performance measures were included in the chief executive officer's performance

evaluation generated by the hospital's governing board, including, at a minimum, quality of care outcomes performance, patient satisfaction performance, community benefit performance, consumer and employer affordability performance, market share performance, profits or margins, revenue growth, change in days cash on hand or cash reserves, and workforce. The state department may include information it receives from public hospitals pursuant to this subsection (2)(b)(III)(P) that is not otherwise publicly available in the hospital transparency report; except that information the state department receives from a nonprofit hospital is not a public record pursuant to part 2 of article 72 of title 24. The state department may only report information received pursuant to this subsection (2)(b)(III)(P) in an aggregated format that does not name individual hospitals or administrators.

(Q) In a form and manner specified by the state department, details of significant other revenue that would otherwise be reported in the medicare cost report; and

(IV) (A) A quarterly financial report that includes an income statement and balance sheet. If a hospital is owned or affiliated with a health system that is comprised of three or more hospitals or that has more than one billion dollars in reserves, the health system may submit a consolidated quarterly financial report.

(B) Any quarterly financial report made publicly available must clearly state that the quarterly financial report is unaudited, if applicable. The state department shall provide any analysis, report, or presentation based on the quarterly financial report to each hospital at least fifteen days prior to the public release of the analysis, report, or presentation.

(b.5) No later than July 1, 2024, each hospital shall provide the following information to the state department:

(I) For each fiscal year 2014-15 through 2019-20, a summary of the hospital's transfers of cash, equity, investments, or other assets to and from related parties, including but not limited to the hospital's parent organization. The summary must include the purpose of the transfers and whether the transfers were made within or outside of Colorado. A hospital may aggregate the transfers for each entity receiving or making the transfer.

(II) For each fiscal year from 2014-15 through 2019-20, information on affiliations and a report of physician practice acquisitions; and

(III) For each fiscal year from 2019-20 through 2022-23, in a form and manner specified by the state department, details of significant other revenue that would otherwise be reported in the medicare cost report.

(c) The state department may exempt from certain reporting requirements described in subsections (2)(b) and (2)(b.5) of this section certain types of hospitals, including but not limited to:

(I) Psychiatric hospitals, as licensed by the department of public health and environment;

(II) Hospitals that are licensed as general hospitals and certified as long-term care hospitals by the department of public health and environment;

(III) Critical access hospitals that are licensed and certified by the department of public health and environment pursuant to 42 CFR 485 subpart F;

(IV) Inpatient rehabilitation facilities; and

(V) Hospitals specified for exemption under 42 CFR 433.68 (e).

(d) Repealed.

(e) Prior to issuing the hospital transparency report, the state department shall provide any hospital referenced in the hospital transparency report a copy of the draft report by December 1 of each year. Each hospital and a statewide hospital association must have a minimum of fifteen business days to review the hospital transparency report and any underlying data and submit corrections or clarifications to the state department.

(f) The state department shall provide a statewide hospital association any information received pursuant to this section in a machine-readable format at no cost to the association.

(g) (I) If a hospital does not provide all of the information required pursuant to subsection (2)(b) of this section, the state department shall inform the hospital of its noncompliance within sixty days and identify the information that needs to be provided. If a hospital does not comply, the state department shall issue a corrective action plan with a timeline of sixty days required for compliance. If a hospital continues to not comply, the state department may create a mandatory pay-for-reporting compliance measure within the hospital transformation program that is tied to the healthcare affordability and sustainability hospital provider fee supplemental payment and is based on compliance with subsection (2)(b) of this section.

(II) If the state department determines a hospital's noncompliance with this section is knowing or willful or there is a repeated pattern of noncompliance, the state department shall consider the size of the hospital and the seriousness of the violation in setting a fine amount which, for hospitals owned or affiliated with a hospital system comprised of three or more hospitals, must not exceed twenty thousand dollars per violation per week until the hospital takes corrective action and, for all other hospitals, must not exceed five thousand dollars per week until the hospital takes corrective action.

(3) The hospital transparency report must include, but not be limited to:

(a) A description of the methods of analysis and definitions of report components;

(b) Uncompensated care costs by major payer group; and

(c) The percentage that each of the following categories contributes to overall expenses of hospitals:

(I) Delivery of inpatient health care and services by major payer group;

(II) Delivery of outpatient health care and services by major payer group and site location;

(III) Administrative costs;

(IV) Capital construction costs and associated bond liabilities;

(V) Maintenance;

(VI) Capital expenditures;

(VII) Personnel services;

(VIII) Uncompensated care by major payer group; and

(IX) Other expenditure categories, as determined by the state department.

(4) (a) On or before January 15, 2020, and on or before January 15 each year thereafter, the state department shall submit the annual hospital transparency report to:

(I) The house of representatives health and human services committee, or any successor committee;

(II) The health and human services committee of the senate, or any successor committee;

(III) The joint budget committee of the general assembly;

(IV) The governor; and

(V) The state board.

(b) The state department may request that the enterprise board combine the hospital transparency report described in this section with the report of the enterprise board specified in section 25.5-4-402.4 (7)(e), so long as the specific requirements of this section are fulfilled, and so long as the enterprise board agrees to the request. The state department shall post the annual report on its website by January 15 of each year.

(c) Notwithstanding section 24-1-136 (11)(a)(I), the report required in this section continues indefinitely.

(4.5) The state department shall report on the annual hospital transparency report during the state department's "SMART Act" hearing.

(5) The state department, in consultation with the department of public health and environment and the division of insurance, shall review the hospital report card, created pursuant to section 25-3-703, and the hospital charge report, created pursuant to section 25-3-705, and make recommendations to the general assembly by November 1, 2019. The recommendations must identify any structural or substantive changes that should be made to the hospital report

card or hospital charge report to increase the value of those reports, including a consideration of whether the hospital report card or hospital charge report still provides value to consumers and policymakers.

Source: L. 2019: Entire section added, (HB 19-1001), ch. 52, p. 177, § 2, effective August 2. **L. 2021:** (2)(c)(III) amended, (SB 21-266), ch. 423, p. 2802, § 21, effective July 2. **L. 2023:** (2)(a), IP(2)(b), (2)(b)(II)(A), (2)(b)(III)(J), (2)(b)(III)(M), IP(2)(c), (2)(e), IP(3), IP(4)(a), (4)(a)(I), and (4)(b) amended, (2)(b)(II)(D), (2)(b)(II)(E), (2)(b)(II)(F), (2)(b)(II)(G), (2)(b)(III)(O), (2)(b)(III)(P), (2)(b)(III)(Q), (2)(b)(IV), (2)(b.5), (2)(g), and (4.5) added, and (2)(d) repealed, (HB 23-1226), ch. 306, p. 1871, § 1, effective August 7. **L. 2024:** (2)(g)(II) amended, (HB 24-1450), ch. 490, p. 3420, § 61, effective August 7; (1)(d) amended, (HB 24-1399), ch. 76, p. 258, § 27, effective July 1, 2025; (2)(c)(III) amended, (SB 24-121), ch. 439, p. 3068, § 7, effective July 1, 2026. **L. 2025:** (2)(g)(I) amended, (SB 25-270), ch. 151, p. 604, § 12, effective May 1. **L. 2026:** IP(2)(b), (2)(b)(II)(A), and (2)(e) amended, (SB 26-138), ch. 308, p. 1772, § 12, effective August 12; (4)(a)(I) amended, (SB 26-169), ch. 311, p. 1810, § 45, effective August 12.

Cross references: For the legislative declaration in SB 26-138, see section 1 of chapter 308, Session Laws of Colorado 2026.

25.5-4-403. Providers - behavioral health safety net providers - reimbursement.

(1) For the purpose of reimbursing essential behavioral health safety net and comprehensive community behavioral health providers, as defined in section 27-50-101, except for those that are also federally qualified health centers, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x(aa)(4), which have payment methodology pursuant to section 25.5-5-408, the state department shall establish an appropriate cost accounting methodology annually with the behavioral health administration in the department of human services in order to support sustainable access to behavioral health safety net services, as defined in section 27-50-101. In establishing the payment methodology, the state department shall consider:

(a) Actual costs of services, including services to address language and cultural barriers necessary to serve communities of color and other underserved populations;

(b) Costs that are reasonable, as determined by the state department in collaboration with the behavioral health administration in the department of human services;

(c) Quality and accessibility of behavioral health safety net care provided, as determined by the state department, in collaboration with the behavioral health administration in the department of human services, by rule;

(d) Health equity;

(e) Access by priority populations as determined by the behavioral health administration in the department of human services; and

(f) Value-based payment approaches that incentivize providers to expand access to cost-effective behavioral health services to serve the behavioral health safety net.

(2) The standards and processes for determining the payment methodology will be determined by an auditing and accounting committee. The members of the committee are selected by the state department to include behavioral health administrative service organizations, managed care entities, behavioral health safety net providers as defined in section 27-50-101, independent auditors, actuaries, consumer and family advocates, local government representatives, other state agencies, and other relevant stakeholders.

Source: L. 2006: Entire article added with relocations, p. 1844, § 7, effective July 1. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1512, § 68, effective July 1.

Editor's note: This section is similar to former § 26-4-409 as it existed prior to 2006.

25.5-4-403.1. Providers - comprehensive community behavioral health providers - cost reporting.

(1) For the purposes of increased payment methodology transparency, no later than March 15, 2023, and each March 15 thereafter, the state department shall:

(a) Publish cost reports for comprehensive community behavioral health providers, as defined in section 27-50-101;

(b) Establish a cost-reporting template and cost-reporting schedule to assist providers in providing cost reports;

(c) Redact information to maintain compliance with state and federal law including, but not limited to, personally identifying information and protected health information as necessary to protect the privacy of patients;

(d) Create a publicly available website that provides insight to medicaid members, medicaid providers, and members of the public regarding behavioral health reimbursement rates. The website must include the following:

(I) All completed cost reports for each behavioral health safety net provider, as defined in section 27-50-101 (7);

(II) An overview of the purpose of the cost report described in this subsection (1);

(III) Information on how to interpret the cost reports and where to find information in the cost reports;

(IV) An overview of:

(A) How reimbursement rates are determined;

(B) What constitutes a reasonable and allowable cost; and

(C) How value-based payments impact reimbursement rates; and

(V) The state department's plan to improve behavioral health reimbursement rates and annual updates to the plan.

Source: L. 2022: Entire section added, (HB 22-1268), ch. 363, p. 2598, § 3, effective June 3. **L. 2025:** (1)(a) amended, (HB 25-1326), ch. 309, p. 1611, § 4, effective August 6.

Cross references: For the legislative declaration in HB 22-1268, see section 1 of chapter 363, Session Laws of Colorado 2022.

25.5-4-403.2. Certified community behavioral health clinic - application - repeal. (Repealed)

Source: L. 2024: Entire section added, (HB 24-1384), ch. 488, p. 3398, § 1, effective June 7.

Editor's note: Subsection (3) provided for the repeal of this section, effective January 1, 2026. (See L. 2024, p. 3398.)

25.5-4-404. Payments for clinic services - restrictions on use.

All payments received by county or district public health agencies or boards of health for clinic services, as defined in section 25.5-5-301 (3), furnished to patients shall be used only to offset costs incurred for provision of services by such county or district public health agencies or boards of health or to cash fund health-care services in the county where the services were provided.

Source: L. 2006: Entire article added with relocations, p. 1844, § 7, effective July 1. **L. 2010:** Entire section amended, (HB 10-1422), ch. 419, p. 2110, § 142, effective August 11.

Editor's note: This section is similar to former § 26-4-515 as it existed prior to 2006.

25.5-4-405. Mental health managed care service providers - requirements.

(1) Each contract between the state department and a managed care organization providing mental health services to a member under the medical assistance program must comply with all federal requirements, including but not limited to:

(a) Ensuring that a member with complex or multiple needs who requires mental health services has access to mental health professionals with appropriate training and credentials and providing the member with the services in collaboration with the member's other providers;

(b) Informing each member of the member's right to and the process for appeal upon notification of denial, termination, or reduction of a requested service; and

(c) Administering initial stabilization treatment for a member and transferring the member for appropriate continued services.

(1.5) Each contract between the state department and a managed care organization providing mental health services to a member under the medical assistance program must allow for the use of telemedicine pursuant to section 25.5-5-320.

(2) For mental health managed care members, the state department shall have a patient representative program for member grievances that complies with all federal requirements and that must:

(a) Be posted in a conspicuous place at each location at which mental health services are provided;

(b) Allow for a patient representative to serve as a liaison between the member and the provider;

(c) Describe the qualifications for a patient representative;

(d) Outline the responsibilities of a patient representative;

(e) Describe the authority of a patient representative; and

(f) Establish a method by which each member is informed of the patient representative program and how a patient representative may be contacted.

Source: L. 2006: Entire article added with relocations, p. 1844, § 7, effective July 1. **L. 2008:** (1.5) added, p. 111, § 1, effective August 5. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 641, § 36, effective August 7.

Editor's note: This section is similar to former § 26-4-409.5 as it existed prior to 2006.

25.5-4-406. Rate setting - medicaid residential treatment service providers - monitoring and auditing - report.

(1) The state department shall approve a rate-setting process consistent with medicaid requirements for providers of medicaid residential treatment services in the state of Colorado as developed by the department of human services. The rate-setting process developed pursuant to this section may include, but shall not be limited to:

(a) A range for reimbursement that represents a base-treatment rate for serving a child who is subject to out-of-home placement due to dependency and neglect, a child placed in a residential child care facility pursuant to the "Children and Youth Mental Health Treatment Act", article 67 of title 27, or a child who has been adjudicated a delinquent, which includes a defined service package to meet the needs of the child;

(b) A request for proposal to contract for specialized service needs of a child, including but not limited to: Substance-abuse treatment services; sex offender services; and services for the developmentally disabled; and

(c) Negotiated incentives for achieving outcomes for the child as defined by the state department, counties, and providers.

(2) The medicaid rate-setting process approved by the state department shall include a two- or three-year implementation timeline with implementation beginning in state fiscal year 2008-09.

(3) The state department and the department of human services, in consultation with the representatives of the counties and the provider community, shall review the rate-setting process

every two years and shall submit any changes to the joint budget committee of the general assembly.

Source: L. 2006: Entire article added with relocations, p. 1845, § 7, effective July 1. **L. 2007:** (1)(a), (2), and (3) amended, p. 618, § 2, effective August 3. **L. 2010:** (1)(a) amended, (SB 10-175), ch. 188, p. 800, § 66, effective April 29. **L. 2018:** (1)(a) amended, (HB 18-1094), ch. 343, p. 2044, § 10, effective June 30.

25.5-4-407. Services by licensed psychologists without a doctor's referral.

The executive director of the state department may authorize the providing of services of licensed psychologists without the requirement that the services be referred by a doctor of medicine or a doctor of osteopathy, but such services shall be subject to the cost containment program specified under section 25.5-4-408. The executive director may except from the authorization those services the director determines to be necessary for the purpose of promoting the primary care physician program.

Source: L. 2006: Entire article added with relocations, p. 1846, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-412 as it existed prior to 2006.

25.5-4-408. Services provided by licensed psychologists - cost containment program.

(1) Working in conjunction with licensed psychologists in the state, the state board shall promulgate rules to establish and implement mechanisms for containing the costs of services provided by licensed psychologists under the medical assistance programs established pursuant to this article and articles 5 and 6 of this title. The cost containment mechanism shall ensure that the costs to the medical assistance program will result in no increase in the total cost of the program solely as a result of the reimbursement for services of licensed psychologists pursuant to section 25.5-4-407. The cost containment mechanisms may include the following:

(a) Limiting the number of days a licensed psychologist may be reimbursed per patient for inpatient hospitalization, partial hospitalization, and outpatient visits without an order for continued treatment from a doctor of medicine or osteopathy;

(b) Limiting the number of hours a licensed psychologist may be reimbursed for diagnostic testing and evaluation per patient per year;

(c) Provision of group therapy when needed or appropriate;

(d) Provision of licensed psychologists' services from a pool of those licensed psychologists requesting to be included in such pool;

(e) Provision of a licensed psychologist's services through the use of telemedicine pursuant to the provisions of section 25.5-5-320.

Source: L. 2006: Entire article added with relocations, p. 1846, § 7, effective July 1. **L. 2008:** (1)(e) added, p. 111, § 2, effective August 5.

Editor's note: This section is similar to former § 26-4-516 as it existed prior to 2006.

25.5-4-409. Authorization of services - nurse anesthetists - advanced practice registered nurses.

(1) When services by a certified registered nurse anesthetist are provided pursuant to an order by a physician in accordance with this article 4, articles 5 and 6 of this title 25.5, and section 12-255-104 (10), the executive director of the state department shall authorize reimbursement for said services. Payment for such services shall be made directly to the nurse anesthetist, if requested by the nurse anesthetist; except that this section shall not apply to nurse anesthetists when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

(2) When services by an advanced practice registered nurse registered pursuant to section 12-255-111 are provided in accordance with this article 4 and articles 5 and 6 of this title 25.5, the executive director of the state department shall authorize reimbursement for said services. Payment for the services shall be made directly to the advanced practice registered nurse, if requested by the advanced practice registered nurse; except that this section shall not apply to advanced practice registered nurses when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

Source: L. 2006: Entire article added with relocations, p. 1846, § 7, effective July 1. **L. 2008:** (2) amended, p. 138, § 1, effective July 1. **L. 2019:** Entire section amended, (HB 19-1172), ch. 136, p. 1707, § 178, effective October 1.

Editor's note: This section is similar to former § 26-4-413 as it existed prior to 2006.

ANNOTATION

The governor's attestation under federal law that allows states to opt out of the requirement that certified nurse anesthetists receive physician supervision while administering anesthesia in order to receive Medicare reimbursement is not a binding interpretation of the supervision provisions of the state Nurse Practice Act. The attestation has the single effect of exempting certified nurse anesthetists from the federal supervision requirement without jeopardizing their Medicare reimbursements. Colo. Med. Soc'y v. Hickenlooper, 2015 CO 41, 349 P.3d 1133.

25.5-4-410. Services of audiologists and speech pathologists without supervision.

(1) When medical or diagnostic services by an audiologist or speech pathologist are provided pursuant to an order by a physician in accordance with this article and articles 5 and 6 of this title, the executive director of the state department shall authorize reimbursement for said services. For the purposes of this section, "audiologist" or "speech pathologist" means an individual who meets the requirements set forth in the federal "Social Security Act", as amended, or any federal regulations adopted pursuant thereto, for participating providers of audiology or speech pathology services.

(2) Nothing in this section shall be construed as expanding the provision of services available as a part of the medical assistance program established pursuant to this article and articles 5 and 6 of this title. For the purposes of making payments to audiologists or speech pathologists pursuant to this section, the state board shall establish rules implementing this section. The rules promulgated pursuant to this subsection (2) shall ensure that the costs to the medical assistance program will result in no increase in the total cost of the program solely as a result of the reimbursement for services of an audiologist or speech pathologist pursuant to this section.

(3) Payments for services included in this section shall be made directly to the audiologist or speech pathologist, if requested by the audiologist or speech pathologist; except that this section shall not apply to audiologists or speech pathologists when acting within the scope of their employment as salaried employees of public or private institutions or physicians.

Source: L. 2006: Entire article added with relocations, p. 1847, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-414 as it existed prior to 2006.

25.5-4-411. Authorization of services provided by dental hygienists.

(1) When dental hygiene services are provided to children by a licensed dental hygienist or dental therapist who is providing dental hygiene services pursuant to section 12-220-503 without the supervision of a licensed dentist, the executive director of the state department shall authorize reimbursement for said services, subject to the requirements of this section. Payment for the services shall be made directly to the licensed dental hygienist or dental therapist, if requested by the licensed dental hygienist or dental therapist; except that this section does not apply to licensed dental hygienists or dental therapists when acting within the scope of their employment as salaried employees of public or private institutions, physicians, or dentists.

(2) For each child provided dental hygiene services pursuant to this section, the dental hygienist or dental therapist shall attempt to identify a dentist participating in medicaid for the child.

Source: L. 2006: Entire article added with relocations, p. 1847, § 7, effective July 1. **L. 2019:** (1) amended, (HB 19-1172), ch. 136, p. 1707, § 179, effective October 1. **L. 2020:** (1) amended, (HB 20-1056), ch. 64, p. 263, § 9, effective September 14. **L. 2022:** Entire section amended, (SB 22-219), ch. 381, p. 2727, § 39, effective January 1, 2023.

Editor's note: This section is similar to former § 26-4-414.3 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 22-219, see section 1 of chapter 381, Session Laws of Colorado 2022.

25.5-4-412. Family planning services - family-planning-related services - rules - definitions.

(1) When family planning services or family-planning-related services are provided in accordance with this article 4 and articles 5 and 6 of this title 25.5, the executive director of the state department shall authorize reimbursement for the services. The state department, any intermediary, or any managed care organization shall reimburse the provider of those services. Family planning services and family-planning-related services are not subject to policy deductibles, copayments, or coinsurance.

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

(a) "Family-planning-related services" means services provided in a family planning setting as part of or as a follow-up to a family planning visit, including:

(I) Medically necessary evaluations or preventive services, such as tobacco utilization screening, counseling, testing, and cessation services;

(II) Cervical cancer screening and prevention;

(III) Diagnosis or treatment of a sexually transmitted infection or sexually transmitted disease, and medication and supplies to prevent a sexually transmitted infection or sexually transmitted disease; and

(IV) Any other medical diagnosis, treatment, or preventive service that is routinely provided pursuant to a family planning visit, including abortion care.

(b) "Family planning services" means all services covered by the federal Title X family planning program, regardless of an individual's age, sex, or gender identity, or the age, sex, or gender identity of the individual's partner, including but not limited to:

(I) All contraception, as defined in section 2-4-401 (1.5);

(II) Health-care and counseling services focused on preventing, delaying, or planning for a pregnancy;

(III) Follow-up visits to evaluate or manage problems associated with contraceptive methods;

(IV) Sterilization services, regardless of an individual's sex; and

(V) Basic fertility services.

(3) (Deleted by amendment, L. 2021.)

(4) For purposes of making payments to providers, the state board shall establish rules implementing this section.

(5) Any member may obtain family planning services or family-planning-related services from any licensed health-care provider, including a doctor of medicine, doctor of osteopathy, physician assistant, advanced practice registered nurse, or certified midwife who provides such services. The enrollment of a member in a managed care organization, or a similar entity, does not restrict a member's choice of the licensed provider from whom the member may receive those services.

(6) The state board shall promulgate rules establishing the specific family-planning-related services and family planning services identified in subsections (2)(a) and (2)(b) of this section. Prior to promulgating the rules, the state department shall engage in a stakeholder process that attempts to include individuals who have received family planning services through the state's

medical assistance program or the children's basic health plan, representatives of consumer advocacy organizations, and family planning providers. The stakeholders must be diverse with regard to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic region of the state.

Source: L. 2006: Entire article added with relocations, p. 1848, § 7, effective July 1. **L. 2016:** (2) amended, (SB 16-158), ch. 204, p. 729, § 21, effective August 10. **L. 2021:** Entire section amended, (SB 21-016), ch. 428, p. 2835, § 3, effective July 6. **L. 2023:** (5) amended, (SB 23-167), ch. 261, p. 1549, § 62, effective May 25. **L. 2024:** (5) amended, (SB 24-176), ch. 152, p. 642, § 37, effective August 7. **L. 2025:** (1) and (2)(a)(IV) amended, (SB 25-183), ch. 97, p. 443, § 3, effective January 1, 2026.

Editor's note: This section is similar to former § 26-4-414.5 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 16-158, see section 1 of chapter 204, Session Laws of Colorado 2016.

25.5-4-413. Certain providers to inform patients of rights concerning advance medical directives.

(1) On and after November 5, 1991, with regard to any service rendered on and after said date, each hospital, nursing care facility, home health agency, hospice program, and health maintenance organization participating in the state medical assistance program or providing medical assistance pursuant to parts 3 to 12 of article 6 of this title shall provide written information to all adult patients of such providers concerning patients' rights under state law to make medical treatment decisions, including the right to accept or refuse any medical or surgical treatment and the right to formulate advance directives regarding said decisions. As used in this section, "advance directives" includes any written or oral instructions recognized under state law concerning the making of medical treatment decisions on behalf of or the provision of medical care for the person who provided the instructions in the event such person becomes incapacitated. Advance directives include, but are not limited to, medical durable powers of attorney, durable powers of attorney, or living wills.

(2) Providers listed in subsection (1) of this section shall provide educational programs for staff and the community concerning advance directives and shall maintain written policies detailing methods for safeguarding patients' rights concerning medical treatment decisions, including documenting in the patient's medical or patient record whether the patient has

executed, amended, or revoked an advance directive. No provider shall condition the provision of services or otherwise discriminate against a patient on the basis of whether the patient has executed an advance directive.

Source: L. 2006: Entire article added with relocations, p. 1848, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-403.5 as it existed prior to 2006.

25.5-4-414. Providers - physicians - prohibition of certain referrals - definitions.

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

(a) "Designated health services" means any of the following services:

(I) Clinical laboratory services;

(II) Physical therapy services;

(III) Occupational therapy services;

(IV) Radiology and other diagnostic services;

(V) Radiation therapy services;

(VI) Durable medical equipment;

(VII) Parenteral or enteral nutrients, equipment, and supplies;

(VIII) Prosthetics, orthotics, and prosthetic devices;

(IX) Home health services;

(X) Outpatient prescription drugs; and

(XI) Inpatient and outpatient hospital services.

(b) "Financial relationship" means an ownership or investment interest in an entity furnishing designated health services or a compensation arrangement between a provider or an immediate family member of the provider and the entity. An ownership or investment interest may be reflected in equity, debt, or other instruments.

(c) "Immediate family member of the provider" means any spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, stepbrother, stepsister, in-law, grandparent, or grandchild of the provider.

(d) "Provider" means:

(I) A doctor of medicine or osteopathy who is licensed to practice medicine pursuant to article 240 of title 12;

(II) A doctor of dental surgery or of dental medicine who is licensed to practice dentistry pursuant to article 220 of title 12;

(III) A doctor of podiatric medicine who is licensed to practice podiatry pursuant to article 290 of title 12;

(IV) A doctor of optometry who is licensed to practice optometry pursuant to article 275 of title 12; or

(V) A chiropractor who is licensed to practice chiropractic pursuant to article 215 of title 12.

(2) (a) Except as otherwise provided in this subsection (2), a provider participating in the medical assistance program under this article and articles 5 and 6 of this title is prohibited from making a referral to an entity for designated health services for which payment may be made under the state's medical assistance program if the provider or an immediate family member of the provider has a financial relationship with the entity.

(b) Paragraph (a) of this subsection (2) shall not apply to any financial relationship that meets the requirements of an exception to the prohibitions established by 42 U.S.C. sec. 1395nn, as amended, or any regulations promulgated thereunder, as amended.

(c) Paragraph (a) of this subsection (2) shall not apply to a financial relationship or referral for designated health services if the financial relationship or referral for designated health services would not violate 42 U.S.C. sec. 1395nn, as amended, and any regulations promulgated thereunder, as amended, if the designated health services were eligible for payment under medicare rather than the "Colorado Medical Assistance Act".

(3) An entity that provides designated health services as a result of a prohibited referral shall not present a claim or bill to any individual, any third-party payor, the state department, or any other entity for the designated health services.

(4) An entity that provides designated health services shall provide to the state department, upon its request and in the form specified by the state department, information concerning the entity's ownership arrangements including:

(a) The items and services provided by the entity;

(b) The names and provider identification numbers of all providers with a financial interest in the entity or whose immediate family members have a financial interest in the entity.

(5) If a provider refers a patient for designated health services in violation of paragraph (a) of subsection (2) of this section or the entity refuses to provide the information required in subsection (4) of this section, the state department may:

(a) Deny any claims for payment from the provider or entity;

(b) Require the provider or entity to refund payments for services;

(c) Refer the matter to the appropriate agency for medical assistance fraud investigation; or

(d) Terminate the provider's or entity's participation in the medical assistance program.

Source: L. 2006: Entire article added with relocations, p. 1849, § 7, effective July 1. **L. 2019:** (1)(d) amended, (HB 19-1172), ch. 136, p. 1708, § 180, effective October 1.

Editor's note: This section is similar to former § 26-4-410.5 as it existed prior to 2006.

ANNOTATION

Law reviews. For article, "Interpreting and Applying the ‘Stark’ Statute: Colorado's Compliance Conundrum", see 30 Colo. Law. 65 (Nov. 2001). For article, "Colorado's Medicaid Compliance Statutes: False Statements and Claims, Kickbacks, and Physician Referrals", see 36 Colo. Law. 31 (Mar. 2007).

25.5-4-415. No public funds for abortion - exception - definitions - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1851, § 7, effective July 1. **L. 2021:** (3) amended, (SB 21-142), ch. 168, p. 934, § 3, effective May 21. **L. 2025:** Entire section repealed, (SB 25-183), ch. 97, p. 444, § 7, effective January 1, 2026.

Editor's note: Prior to its repeal, this section was similar to former § 26-4-512 as it existed prior to 2006.

25.5-4-416. Providers - medical equipment and supplies - requirements.

(1) As used in this section, unless the context otherwise requires, "provider" means a person or entity that delivers disposable medical supplies or durable medical equipment products or services directly to a member.

(2) On and after January 1, 2007, the state board rules for the payment for disposable medical supplies and durable medical equipment, including but not limited to prosthetic and orthotic devices, shall prohibit a provider from being reimbursed unless the provider:

(a) (I) Has one or more physical locations within the state of Colorado or within fifty miles of a border of Colorado with a street address, a local business telephone number, an inventory, and a sufficient staff to service or repair products; except that the requirements of this paragraph (a) shall not apply to durable medical equipment or disposable medical supplies that are medically necessary and cannot be purchased from a provider meeting the requirements of this paragraph (a);

(II) Complies with all state and local licensing, insurance, and regulatory requirements for operating the provider's business;

(III) Is responsible for the delivery of and instructing the member on the proper use of the equipment; and

(IV) Provides repairs, replacements, or adjustments to the provider's products pursuant to rules of the state board; or

(b) Contracts with a provider who meets the criteria established in paragraph (a) of this subsection (2).

(3) The provisions of this section shall apply to fee-for-service and primary care physician program recipients.

Source: L. 2006: Entire section added, p. 525, § 1, effective August 7. **L. 2024:** (1) and (2)(a)(III) amended, (SB 24-176), ch. 152, p. 642, § 38, effective August 7.

Editor's note: This section was originally numbered as § 26-4-410.7 in House Bill 06-1299. Section 2 of the act provided for the renumbering and relocation of § 26-4-410.7 to this section. (See L. 2006, p. 526.)

25.5-4-417. Provider fee - medicaid providers - state plan amendment - rules - definitions.

(1) For purposes of this section, unless the context otherwise requires:

(a) "Local government" means a county, home rule county, home rule or statutory city, town, territorial charter city, or city and county.

(b) "Provider fee" means a licensing fee, assessment, or other mandatory payment that is related to health-care items or services as specified under 42 CFR 433.55.

(c) "Qualified provider" means a hospital licensed pursuant to section 25-3-101, C.R.S., or a certified home health-care agency within the territorial boundaries of the local government.

(2) For the purpose of sustaining or increasing reimbursement for providing medical care under the state's medical assistance program and to low-income populations, the state department shall amend the state plan effective July 1, 2006. Implementation of the state plan amendment shall be subject to the approval of the federal government. The imposition and collection of a provider fee by a local government pursuant to article 28 of title 29, C.R.S., shall be prohibited without the federal government's approval of a state plan amendment authorizing federal financial participation for the provider fees.

(3) In accordance with the redistributive method set forth in 42 CFR 433.68 (e)(1) and (e)(2), the state department may seek a waiver from the broad-based provider fee requirement or the uniform provider fee requirement, or both, to exclude qualified providers from the provider fee.

(4) To the extent authorized by federal law, the state department may exclude a governmental qualified provider from payment of the provider fee, benefits from the provider fee, or any federal financial participation due to the fee.

(5) To the extent authorized by federal law, the state department shall distribute the provider fee and any associated federal financial participation either to a local government that has certified payment to qualified providers within the local government or directly to the qualified providers. The state department shall establish reimbursement methods to distribute the provider fee and associated federal financial participation to qualified providers. The state department may alter reimbursement methods to qualified providers participating under the state's medical assistance program to the extent necessary to meet the federal requirements and to obtain federal approval of the provider fee. The state department shall work with a statewide association of hospitals on changes to reimbursement methods or provider fees that impact hospital providers. The state department shall work with a statewide association of home health-care agencies on changes to reimbursement methods or provider fees that impact home health-care agencies.

(6) The state board shall adopt any rules necessary for the administration and implementation of this section.

Source: L. 2006: Entire section added, p. 887, § 2, effective May 5. **L. 2008:** Entire section amended, p. 927, § 1, effective May 20. **L. 2024:** (5) amended, (HB 24-1399), ch. 76, p. 258, § 28, effective July 1, 2025.

Editor's note: This section was enacted as § 26-4-427 in Senate Bill 06-145 but was relocated due to its harmonization with this article as it appeared in Senate Bill 06-219.

25.5-4-418. Integration of physical and behavioral health services - department review - report - repeal. (Repealed)

Source: L. 2011: Entire section added, (HB 11-1242), ch. 271, p. 1230, § 1, effective July 1.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2012. (See L. 2011, p. 1230.)

25.5-4-419. Supplemental state payment to qualified providers - office-administered drugs - no federal financial participation - definition - rules - repeal. (Repealed)

Source: L. 2018: Entire section added, (HB 18-1330), ch. 146, p. 932, § 1, effective April 23.

Editor's note: Subsection (6) provided for the repeal of this section, effective July 1, 2019. (See L. 2018, p. 932.)

25.5-4-420. Providers to obtain unique NPI - service site - provider type - definitions.

(1) As used in this section:

(a) "Health care clearinghouse" has the same meaning as set forth in 45 CFR 160.103.

(b) "NPI" or "national provider identifier" means the standard, unique health identifier for health-care providers that is issued by the national provider system in accordance with 45 CFR part 162.

(c) "Off-campus location" means a facility:

(I) Whose operations are directly or indirectly owned or controlled by, in whole or in part, or affiliated with a hospital, regardless of whether the operations are under the same governing body as the hospital;

(II) That is located more than two hundred fifty yards from the hospital's main campus;

(III) That provides services that are organizationally and functionally integrated with the hospital; and

(IV) That is an outpatient facility providing preventive, diagnostic, treatment, or emergency services.

(d) "Organization health-care provider" means a provider that is not an individual and includes a hospital.

(e) "Subpart" has the same meaning as that term is used in 45 CFR part 162 and means a component or separate physical location of an organization health-care provider that may be separately licensed or certified by the state.

(2) (a) Each organization health-care provider and each subpart that is required or eligible to obtain an NPI pursuant to 45 CFR 162.410 must apply for, obtain, and use, on all claims for payment for medical care, services, or goods authorized under this article 4 and articles 5 and 6 of this title 25.5, a unique NPI for each site at which the organization health-care provider or its subparts deliver medical care, services, or goods.

(b) Each organization health-care provider and each subpart that is required or eligible to obtain an NPI pursuant to 45 CFR 162.410 must apply for, obtain, and use, on all claims for payment for medical care, services, or goods authorized under this article 4 and articles 5 and 6 of this title 25.5, a unique NPI for each provider type, as specified by the state department, under which the organization health-care provider or its subparts deliver medical care, services, or goods.

(c) An organization health-care provider or subpart submitting a claim for payment for medical care, services, or goods rendered under this article 4 or article 5 or 6 of this title 25.5 shall include on the claim the unique NPI that identifies both the site where the medical care, services, or goods were provided and the provider type, as specified by the state department, regardless of whether the claim is filed or submitted by or through a central office of the organization health-care provider or a health care clearinghouse.

(3) (a) For an organization health-care provider that is a licensed or certified hospital contracting for services under this article 4 and articles 5 and 6 of this title 25.5, the hospital shall obtain and use a unique, separate, and distinct NPI for:

(I) Its main campus;

(II) Each off-campus location of the hospital; and

(III) Each provider type, if specified by the state department, when the hospital delivers medical care, services, or goods at either the hospital's main campus or at an off-campus location.

(b) A hospital submitting a claim for payment for medical care, services, or goods rendered under this article 4 or article 5 or 6 of this title 25.5 shall include on the claim the unique NPI that identifies both the site where the medical care, services, or goods were provided and the provider type, as specified by the state department, regardless of whether the claim is filed or submitted by or through a central office of the hospital or a health care clearinghouse.

(4) (a) Starting January 1, 2020, an organization health-care provider applying to enroll as a new provider under this article 4 and articles 5 and 6 of this title 25.5 shall demonstrate that it has obtained one or more NPIs as required by this section, and upon enrollment, shall use its unique NPI on every claim for payment in the manner required by this section.

(b) Starting January 1, 2021, an organization health-care provider enrolled and applying for revalidation as a provider under this article 4 and articles 5 and 6 of this title 25.5 shall demonstrate that it has obtained one or more NPIs as required by this section as a condition of receiving revalidation, and upon receiving revalidation as a provider, shall use its unique NPI on every claim for payment in the manner required by this section.

Source: L. 2018: Entire section added, (HB 18-1282), ch. 158, p. 1109, § 3, effective August 8.

Cross references: For the legislative declaration in HB 18-1282, see section 1 of chapter 158, Session Laws of Colorado 2018.

25.5-4-421. Supplemental state payment to qualified durable medical equipment providers - no federal financial participation - definition - rules - repeal. (Repealed)

Source: L. 2018: Entire section added, (HB 18-1329), ch. 206, p. 1323, § 1, effective May 4.

Editor's note: Subsection (6) provided for the repeal of this section, effective July 1, 2019. (See L. 2018, p. 1323.)

25.5-4-422. Cost control - legislative intent - use of technology - stakeholder feedback - reporting - rules.

(1) It is the intent of the general assembly that:

(a) The department of health care policy and financing pursue strategies to control costs in the medicaid program authorized in the "Colorado Medical Assistance Act";

(b) The state department dedicate permanent staff and resources to pursue cost-control strategies, value-based payments, and other approaches to reduce the rate of expenditure growth in the medicaid program; and

(c) This section not preclude the state department from pursuing other cost-containment activities that are not specifically described in this section.

(2) (a) The state department shall provide information regarding medicaid expenditures and the quality of medical services provided by providers participating in the medicaid program to providers participating in the accountable care collaborative pursuant to section 25.5-5-419.

(b) The state department shall provide information regarding medicaid expenditures and the quality of available pharmaceuticals prescribed by providers participating in the medicaid program to providers participating in the accountable care collaborative pursuant to section 25.5-5-419.

(c) The state department may provide the information described in subsections (2)(a) and (2)(b) of this section to other providers participating in the medicaid program.

(3) (a) The state department shall utilize the medicaid management information system to ensure that claims are automatically reviewed prior to payment to identify and correct improper coding that leads to inappropriate payment in medicaid claims.

(b) The state department may procure commercial technology to implement the requirements of subsection (3)(a) of this section.

(4) (a) The state department shall pursue cost-control strategies, value-based payments, and other approaches to reduce the rate of expenditure growth in the medicaid program.

(b) Prior to implementing and reporting on any new measures authorized by this section, the state department shall provide an opportunity for affected members, providers, and stakeholders to provide feedback and make recommendations on the state department's proposed implementation.

(5) By November 1, 2018, the state department shall provide a report to the joint budget committee concerning:

(a) The feedback received pursuant to subsection (4)(b) of this section; and

(b) The timelines for implementation of any cost-control measures enacted pursuant to this section.

(c) Repealed.

(6) (a) The state department shall contract with a third party to perform an independent evaluation of the cost-control measures authorized pursuant to this section.

(b) Repealed.

(7) The state board shall adopt any rules necessary for the administration and implementation of this section.

Source: L. 2018: Entire section added, (SB 18-266), ch. 264, p. 1622, § 1, effective May 29. **L. 2024:** (4)(b) amended and (5)(c) and (6)(b) repealed, (SB 24-176), ch. 152, p. 642, § 39, effective August 7.

25.5-4-423. Targets for investments in primary care.

The state department shall adopt appropriate targets for investments in primary care to support value-based health-care delivery in alignment with the affordability standards developed in accordance with section 10-16-107 (3.5). The state department shall consider the recommendations of the primary care payment reform collaborative created in section 10-16-150. Targets established under this section do not apply in the case of a nonprofit, nongovernmental health maintenance organization with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group.

Source: L. 2019: Entire section added, (HB 19-1233), ch. 194, p. 2123, § 7, effective May 16.

Cross references: For the legislative declaration in HB 19-1233, see section 1 of chapter 194, Session Laws of Colorado 2019.

25.5-4-424. State payments to qualified hospice providers - dually eligible persons - no federal financial participation - rules - legislative declaration - definitions - repeal. (Repealed)

Source: L. 2021: Entire section added, (SB 21-214), ch. 89, p. 367, § 1, effective May 4.

Editor's note: Subsection (5) provided for the repeal of this section, effective July 1, 2022. (See L. 2021, p. 369.)

25.5-4-425. Providers - health-care services related to labor and delivery - reimbursement.

(1) The state department shall reimburse all eligible providers that provide health-care services related to labor and delivery within the scope of the provider's practice in a manner that:

(a) Promotes high-quality, cost-effective, and evidence-based care;

(b) Promotes high-value, evidence-based payment models; and

(c) Prevents risk in subsequent pregnancies.

Source: L. 2021: Entire section added, (SB 21-194), ch. 434, p. 2871, § 6, effective September 7.

25.5-4-426. Supplemental state payment to urban Indian organizations - definition - repeal. (Repealed)

Source: L. 2022: Entire section added, (HB 22-1190), ch. 16, p. 128, § 1, effective March 7.

Editor's note: Subsection (3) provided for the repeal of this section, effective July 1, 2023. (See L. 2022, p. 128.)

25.5-4-427. State payment to the Denver health and hospital authority.

(1) The state department shall distribute money appropriated for a payment to the Denver health and hospital authority created in section 25-29-103.

(2) (Deleted by amendment, L. 2024.)

Source: L. 2023: Entire section added, (SB 23-138), ch. 4, p. 13, § 2, effective March 3. **L. 2024:** Entire section amended, (HB 24-1086), ch. 46, p. 164, § 3, effective April 4; entire section amended, (HB 24-1401), ch. 100, p. 316, § 1, effective April 18.

Cross references: For the legislative declaration in SB 23-138, see section 1 of chapter 4, Session Laws of Colorado 2023. For the legislative declaration in HB 24-1086, see section 1 of chapter 46, Session Laws of Colorado 2024.

25.5-4-428. Prior authorization for a step-therapy exception - rules - definition.

(1) As used in this section, unless the context otherwise requires, "step therapy" means a protocol that requires a member to use a prescription drug or sequence of prescription drugs, other than the drug that the member's health-care provider recommends for the member's treatment, before the state department provides coverage for the recommended prescription drug.

(2) (a) The state department shall review and determine if an exception to step therapy is granted if the prescribing provider submits a prior authorization request with justification and supporting clinical documentation for treatment of a serious or complex medical condition, if required, that states:

(I) The provider attests that the required prescription drug is contraindicated, or will likely cause intolerable side effects, a significant drug-drug interaction, or an allergic reaction to the member;

(II) The required prescription drug lacks efficacy based on the known clinical characteristics of the member and the known characteristics of the prescription drug regimen;

(III) The member has tried the required prescription drug, and the use of the prescription drug by the member was discontinued due to intolerable side effects, a significant drug-drug interaction, or an allergic reaction; or

(IV) The member is stable on a prescription drug selected by the prescribing provider for the medical condition.

(b) (I) Except as provided in subsection (2)(b)(II) of this section, the state department shall provide a response to a prior authorization request for a step-therapy exception within twenty-four hours after receipt of the request.

(II) If a prior authorization request for a step-therapy exception is incomplete or if additional clinically relevant information is required, the state department shall notify the prescribing provider within twenty-four hours after the submission of the request that the request is incomplete or that additional clinically relevant information is required. The state department

shall specify the additional information that is required in order to consider the prior authorization request. If the state department does not receive a response within seventy-two hours after the state department's request for additional information, the prior authorization request is denied. If the state department receives a timely response from the provider, the state department shall provide a response within twenty-four hours after receiving the response.

(c) If the prior authorization request for a step-therapy exception is denied, the state department shall inform the member in writing that the member has the right to appeal the adverse determination pursuant to state department rules.

(3) If the prior authorization request for a step-therapy exception request is granted, the state department shall authorize coverage for the prescription drug prescribed by the member's prescribing provider.

(4) The state department shall make the prior authorization requirements for coverage of prescription drugs and a description of the step-therapy exemption process available on the state department's website.

(5) This section does not prohibit:

(a) The state department from requiring a member to try a generic equivalent of a brand name drug, a biosimilar drug as defined in 42 U.S.C. sec. 262 (i)(2), or an interchangeable biological product as defined in 42 U.S.C. sec. 262 (i)(3), unless such a requirement meets any of the criteria set forth in subsection (2)(a) of this section for an exception to step therapy and a prior authorization request is granted for the requested drug;

(b) The state department from denying a prior authorization request for a step-therapy exception when the request does not meet one of the criteria set forth in subsection (2)(a) of this section based on the justification and supporting clinical documentation submitted by the provider, if applicable; or

(c) A provider from prescribing a drug that, in the provider's clinical judgment, is determined to be medically appropriate.

(6) The state board may promulgate rules to implement this section.

Source: L. 2023: Entire section added, (HB 23-1183), ch. 133, p. 511, § 1, effective May 1. **L. 2024:** (1), (2)(a), (2)(c), (3), and (5)(a) amended, (SB 24-176), ch. 152, p. 643, § 40, effective August 7.

25.5-4-429. Hospital and provider billing requirements - description of service provided - rules.

Beginning July 1, 2024, any patient bill for services rendered must follow industry standard billing practices, including, at a minimum, the date of service, the patient's name, the provider's name, a description of the services provided, and the charges for each service.

Source: L. 2023: Entire section added, (HB 23-1226), ch. 306, p. 1875, § 2, effective August 7.

25.5-4-430. Increasing access to behavioral health care for children and youth - directed payment authority - fee schedule rates. (Repealed)

Source: L. 2023: Entire section added, (HB 23-1269), ch. 377, p. 2262, § 1, effective June 5. **L. 2026:** Entire section repealed, (HB 26-1295), ch. 121, p. 528, § 31, effective August 12.

25.5-4-431. Preauthorization for treatment - request to share with insurance carrier.

Subject to state and federal laws relating to the confidentiality of medical records, at the request and with the consent of an enrollee in the medical assistance program, the state department shall provide a copy of the enrollee's preauthorization for treatment to the enrollee's new insurance carrier within ten days after receipt of the request if the enrollee is no longer enrolled in the medical assistance program.

Source: L. 2024: Entire section added, (SB 24-093), ch. 41, p. 149, § 4, effective January 1, 2025.

Editor's note: Section 5(2) of chapter 41 (SB 24-093), Session Laws of Colorado 2024, provides that the act adding this section applies to health benefit plans issued on or after January 1, 2025.

25.5-4-432. Reimbursement guidance for screening, brief intervention, and referral to treatment.

The state department shall publish guidance for providers concerning reimbursement for all variations of screening, brief intervention, and referral to treatment interventions.

Source: L. 2024: Entire section added, (SB 24-047), ch. 440, p. 3081, § 8, effective June 6.

25.5-4-433. Rural hospital cash fund - creation - definition.

(1) The rural hospital cash fund is created in the state treasury and is referred to in this section as the "fund". The fund consists of money credited to the fund and any other money that the general assembly may appropriate or transfer to the fund.

(2) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the fund.

(3) Money in the fund is continuously appropriated to the department of health care policy and financing for the purpose of distributing money in equal amounts to rural hospitals.

(4) On July 1, 2024, the state treasurer shall transfer one million seven hundred forty-two thousand twenty-nine dollars from the general fund to the fund.

(5) As used in this section, "rural hospital" means a hospital licensed or certified pursuant to section 25-1.5-103 (1)(a) or an affiliate owned or controlled, as defined in section 25.5-4-402.8 (1)(c), by a hospital, and that is located in a county with a population of fewer than fifty thousand residents or in a municipality with a population of fewer than twenty-five thousand residents if the municipality is not contiguous to a municipality with a population of twenty-five thousand or more residents.

Source: L. 2024: Entire section added, (SB 24-221), ch. 457, p. 3159, § 3, effective June 6.

25.5-4-434. Workplace violence in hospital settings - policy - verification of reporting requirements.

(1) (a) Beginning July 1, 2026, and each July thereafter, the state department shall assess whether each hospital has adopted a formal policy to address workplace violence and submitted the reporting requirements to the department of public health and environment pursuant to section 25-3-703 (3)(f) for the next federal fiscal year.

(b) In accordance with section 25-3-703 (4), hospitals with fewer than one hundred beds are exempt from the reporting requirements.

(2) If a hospital has complied with the requirements of subsection (1) of this section, the state department shall affirm the hospital's satisfactory completion of the workplace violence prevention component of the quality incentive payments described in section 25.5-4-402 (3).

Source: L. 2025: Entire section added, (SB 25-166), ch. 169, p. 687, § 2, effective August 6.

25.5-4-435. Reimbursement for sixty-day stay.

The state department shall reimburse an institution for mental diseases, as defined in 42 CFR 435.1010, for providing inpatient mental health treatment to a member for up to sixty days or to the extent permitted by federal law.

Source: L. 2025: Entire section added, (SB 25-042), ch. 28, p. 159, § 3, effective August 6.

25.5-4-436. Transportation by ambulance or other vehicle - treatment on scene of a medical emergency - evaluation by telemedicine - definitions.

(1) On and after January 1, 2027, the state department shall reimburse:

(a) An ambulance service for ground transportation by an ambulance or other appropriately situated vehicle to a hospital or other destination as deemed appropriate by the ambulance service's medical director;

(b) An ambulance service for treatment on the scene of a medical emergency, which treatment does not result in ground transportation; and

(c) A qualified provider, an ambulance service, or an agency providing out-of-hospital services for evaluation by telemedicine of a person being treated by an ambulance service or an agency providing out-of-hospital services for the purpose of preventing the need to transport the person to a hospital. Telemedicine shall be billed using an office or other outpatient services rate and not using an emergency department rate. An ambulance service or an agency providing out-of-hospital services is not required to procure telemedicine for a covered person as a condition of payment.

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

(a) "Ambulance service" has the meaning set forth in section 25-3.5-103 (3).

(b) (I) "Out-of-hospital services" means furnishing any necessary goods and services outside of a hospital setting for the purpose of preventing, alleviating, curing, or healing human illness, a physical disability, a physical injury, or a substance use disorder while responding to an emergency or other health-care condition.

(II) "Out-of-hospital services" does not include prehospital setting transports.

Source: L. 2026: Entire section added, (HB 26-1069), ch. 303, p. 1736, § 4, effective June 2.

25.5-4-437. Registered behavior technicians - reimbursement - definitions.

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

(a) "Applied behavior analysis" has the meaning set forth in section 12-247-103 (1).

(b) "Autism spectrum disorder":

(I) Has the same meaning as set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis; and

(II) Includes the following disorders, as the disorders are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis:

(A) Autism spectrum disorder;

(B) Autistic disorder;

(C) Asperger's disorder; and

(D) Atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified.

(c) "Board certified assistant behavior analyst" means an individual who is designated as a board certified assistant behavior analyst by a certifying entity and who is licensed pursuant to section 12-247-108 when required by section 12-247-106.

(d) "Board certified behavior analyst" means an individual who is certified as a board certified behavior analyst by a certifying entity and who is licensed pursuant to section 12-247-107 when required by section 12-247-106.

(e) "Board certified behavior analyst-doctoral" means an individual who is certified as a board certified behavior analyst by a certifying entity, has received a board certified behavior analyst-doctoral designation from a certifying entity, and is licensed pursuant to section 12-247-107 when required by section 12-247-106.

(f) "Certifying entity" has the meaning set forth in section 12-247-103 (4).

(g) "Registered behavior technician" means a behavior technician, as defined in section 12-247-103 (2), who is certified by a certifying entity and who delivers applied behavior analysis services in compliance with article 247 of title 12 under the supervision of:

(I) A licensed psychologist;

(II) A board certified behavior analyst;

(III) A board certified behavior analyst-doctoral; or

(IV) A board certified assistant behavior analyst.

(2) The state department shall reimburse the applicable applied behavior analysis provider for applied behavior analysis services provided by a registered behavior technician to a member with autism spectrum disorder or other conditions for which coverage may be available under state department policies.

(3) (a) Subject to federal approval, the state department shall reimburse the applicable applied behavior analysis provider for applied behavior analysis services provided by a behavior technician, which behavior technician is required by the state department to be certified by a certifying entity but who is not certified at the time of services, during one temporary period of not less than forty-five days while the behavior technician is pursuing the certification if the entity requesting reimbursement provides the state department with quarterly rosters of the entity's employed behavior technicians, including whether or not each individual has completed minimum training requirements and received their certification from a certifying entity.

(b) A behavior technician who obtains certification after provision of services pursuant to subsection (3)(a) of this section shall maintain the certification to be eligible for reimbursement by the state department for providing applied behavior analysis services.

(c) If a behavior technician does not become certified at the end of the forty-five-day period described in subsection (3)(a) of this section, the entity requesting reimbursement shall stop the reimbursement request until the behavior technician becomes certified.

(d) Before providing applied behavior analysis services to an individual and seeking reimbursement pursuant to subsections (2) and (3) of this section, a behavior technician shall satisfy the following conditions:

(I) Obtain a name-based judicial record check, as defined in section 22-2-119.3 (6)(d);

(II) Complete all training required for certification by a certifying entity; and

(III) Complete abuse and neglect reporting training.

(e) The forty-five-day period described in subsection (3)(a) of this section begins upon a behavior technician's completion of the requirements described in subsection (3)(d) of this section.

(f) Beginning in January 2027, and in January every year thereafter, the state department shall include, as part of its presentation during its "SMART Act" hearing required by section 2-7-203, a determination of the efficacy of this subsection (3) and recommendations on the best way to move forward while ensuring patient safety and provider sustainability, including data on the number of behavior technicians obtaining certification in the preceding six months.

Source: L. 2026: Entire section added, (HB 26-1425), ch. 299, p. 1672, § 5, effective June 2.

Cross references: For the legislative declaration in HB 26-1425, see section 1 of chapter 299, Session Laws of Colorado 2026.

PART 5

STATE PLAN AMENDMENTS - WAIVER AUTHORITY

25.5-4-501. State plan amendment - federal authorization - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1853, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 26-4-105.8 as it existed prior to 2006.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2007. (See L. 2006, p. 1853.)

25.5-4-502. Federal authorization - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1853, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 25.5-1-113 as it existed prior to 2006.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2007. (See L. 2006, p. 1853.)

25.5-4-503. Waiver applications - authorization.

(1) The state department is authorized to apply for health insurance flexibility and accountability waivers that will enable the state to add more flexibility to Colorado's medicaid program and that will result in a cost-effective method of providing health-care services to Coloradans.

(2) The state department shall pursue and, if approved, implement a demonstration waiver that authorizes the state to use federal medical assistance payments authorized pursuant to section 1903(v) of the federal "Social Security Act", as amended, in coordination with the division of insurance to enhance or expand a state-subsidized individual health coverage plan as defined in section 10-16-1203 (15) and, only if needed to maximize federal financial participation, for Coloradans receiving state medical assistance pursuant to section 25.5-2-104 or 25.5-5-201 (6). To the extent such federal funds are used to enhance or expand a state-subsidized individual health coverage plan, as defined in section 10-16-1203 (15), the health insurance affordability enterprise created pursuant to section 10-16-1204 must receive, deposit into the health insurance affordability cash fund created in section 10-16-1206, and allocate the federal share of the medical assistance payments pursuant to section 10-16-1205 (2), subject to any conditions set forth in the approval of the waiver.

Source: L. 2006: Entire article added with relocations, p. 1853, § 7, effective July 1. **L. 2022:** Entire section amended, (HB 22-1289), ch. 399, p. 2841, § 14, effective June 7.

Editor's note: This section is similar to former § 25.5-1-111 as it existed prior to 2006.

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-4-504. Federal authorization - repeal. (Repealed)

Source: L. 2019: Entire section added, (SB 19-222), ch. 226, p. 2265, § 3, effective May 20.

Editor's note: Subsection (3) provided for the repeal of this section, effective July 1, 2020. (See L. 2019, p. 2265.)

Cross references: For the legislative declaration in SB 19-222, see section 1 of chapter 226, Session Laws of Colorado 2019.

25.5-4-505. Federal authorization related to persons involved in the criminal justice system - assessment - report - repeal. (Repealed)

Source: L. 2022: Entire section added, (SB 22-196), ch. 193, p. 1292, § 7, effective May 19. **L. 2023:** (1) amended, (HB 23-1301), ch. 303, p. 1830, § 49, effective August 7.

Editor's note: Subsection (3) provided for the repeal of this section, effective June 30, 2024. (See L. 2022, p. 1292.)

25.5-4-505.5. Federal authorization related to persons involved in the criminal justice system - report - rules - legislative declaration.

(1) (a) The general assembly finds that:

(I) For decades, federal medicaid policy prohibited the use of federal funding for incarcerated medicaid members;

(II) With the emerging opportunity to allow for coverage of incarcerated medicaid members, Colorado is supportive of ensuring these members have access to needed services and treatment; and

(III) Colorado is committed to ensuring medicaid members have access to a civil, community-based system that meets members' needs and ensures Colorado's county jails, juvenile facilities, and prisons do not become primary access points for health-care services for people experiencing behavioral health conditions.

(b) Therefore, the general assembly declares it is in the best interest of all Coloradans, and especially Coloradans living with behavioral health conditions, to require the department of health care policy and financing to seek a federal waiver of the medicaid inmate exclusion policy that includes annual data reporting requirements that:

(I) Inform Coloradans regarding the unmet health needs of individuals involved in the criminal justice system;

(II) Promote the establishment of continuous civil systems of care within communities demonstrably committed to diversion or deflection efforts, including, but not limited to, mobile outreach, co-responder programs, and prosecutor- or judicial-led initiatives; and

(III) Aim to reduce unnecessary involvement with the criminal justice system and increase access to community-based housing, health care, supports, and services.

(2) (a) No later than April 1, 2024, the state department shall seek a federal authorization to provide, through the state medical assistance program, medication-assisted treatment and case management to a member prior to the member's release and a thirty-day supply of prescription medications to a member upon the member's release from a juvenile institutional facility, as defined in section 25-1.5-301 (2)(b), or a department of corrections facility.

(b) Beginning July 1, 2025, and subject to available appropriations, the services described in subsection (2)(a) of this section are available upon receipt of the necessary federal authorization.

(3) (a) (I) No later than April 1, 2025, the state department shall seek a federal authorization to provide, through the state medical assistance program, medication-assisted treatment and case management to a member prior to the member's release from jail and a thirty-day supply of prescription medications to a member upon the member's release from jail.

(II) The state department shall implement subsection (3)(a)(I) of this section only if the state department determines that providing the services described in subsection (3)(a)(I) of this section is budget neutral.

(b) Beginning July 1, 2026, and subject to available appropriations, the services described in subsection (3)(a) of this section are available upon receipt of the necessary federal authorization.

(4) Upon receipt of the necessary federal authorization, the state department shall:

(a) Conduct a rigorous stakeholder process that includes, but is not limited to, receiving feedback from individuals with lived experience in accessing, or the inability to access, behavioral health services in civil settings, county jails, juvenile institutional facilities, and the department of corrections; and

(b) Require each county with a county jail seeking to provide services pursuant to this section to demonstrate a commitment to diversion or deflection efforts, including, but not limited to, mobile outreach, co-responder programs, and prosecutor- or judicial-led initiatives that aim to reduce unnecessary involvement with the criminal justice system and increase access to community-based housing, health care, supports, and services.

(5) (a) The state department shall reimburse a provider who is licensed and authorized to prescribe, dispense, compound, or administer medication-assisted treatment in a jail setting.

(b) The state department shall ensure as part of the state department's quality oversight that licensed providers who administer medication-assisted treatment in a jail setting maintain emergency policies and procedures that address adverse outcomes.

(6) The state department may expand services available pursuant to this section as authorized pursuant to federal law and regulations. If the state department seeks to expand services, the state department shall demonstrate how the state department will ensure quality of care and client safety, which must include addressing quality and safety in administering medications in a jail setting.

(7) (a) Beginning July 1, 2025, and each July 1 thereafter, the state department shall annually report to the house of representatives health and human services committee and the senate health and human services committee, or their successor committees, the following information:

(I) De-identified information of individuals who have accessed services, including each individual's demographics, the type of services the individual accessed, the duration of the services offered in a carceral setting compared to the duration of the same services offered in a civil setting, and the individual's experiences before and after incarceration, including but not limited to:

(A) Emergency room or crisis system visits;

(B) Inpatient stays for a primary behavioral health condition; and

(C) Services accessed in a qualified residential treatment program, as defined in section 19-1-103, or a psychiatric residential treatment facility, as defined in section 25.5-4-103;

(II) The total number of medicaid members who were unhoused before or after incarceration, if available;

(III) The total number of unique incarceration stays by medicaid members, as demonstrated by the services accessed;

(IV) The total number of individuals who accessed services in a civil setting prior to arrest or detainment and were subsequently evaluated for competency, ordered to competency restoration, restored to competency, or found incompetent to proceed in a forensic setting; and

(V) Persistent gaps in continuity of care in least-restrictive civil settings.

(b) Notwithstanding section 24-1-136 (11)(a)(I) to the contrary, the state department's report continues indefinitely.

(8) The state department may promulgate rules for the implementation of this section.

Source: L. 2024: Entire section added, (HB 24-1045), ch. 470, p. 3284, § 18, effective August 7. **L. 2026:** (5) amended, (HB 26-1235), ch. 361, p. 2171, § 6, effective August 12; IP(7)(a) amended, (SB 26-169), ch. 311, p. 1810, § 46, effective August 12.

25.5-4-505.7. Reentry services for justice-involved individuals reinvestment cash fund - creation - definitions.

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

(a) "Federal authorization" means the authorization the state department received from the federal centers for medicare and medicaid services to provide reentry services to justice-involved individuals through the state medical assistance program.

(b) "Fund" means the reentry services for justice-involved individuals reinvestment cash fund created in this section.

(2) The reentry services for justice-involved individuals reinvestment cash fund is created in the state treasury. The fund consists of money appropriated pursuant to subsection (3) of this section and any other money that the general assembly may appropriate or transfer to the fund. In accordance with section 24-36-114 (1), the state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the general fund.

(3) Beginning June 30, 2026, and on June 30 of each year thereafter, the state treasurer shall transfer from the general fund to the fund an amount of money equal to the amount of unspent money that reverted to the general fund in that year from the appropriation from the general fund to the state department for reentry services for justice-involved individuals.

(4) Subject to annual appropriation by the general assembly, the state department may expend money from the fund for medicaid services for individuals who are incarcerated in, are at risk of being incarcerated in, or are being released from a carceral facility, and for related administrative services, as authorized through the federal authorization.

(5) On or after November 1, 2025, and on or after November 1 each year thereafter, the state department shall present to the joint budget committee a recommendation for spending money in the fund to expand and enhance services authorized by the federal authorization. When developing the recommendation, the state department shall consult with state agencies participating in services provided through, and stakeholders who represent the members receiving services included in, the federal authorization.

Source: L. 2025: Entire section added, (SB 25-308), ch. 299, p. 1524, § 3, effective May 30.

25.5-4-506. Coverage for doula services - stakeholder process - federal authorization - scholarship program - training - report - definitions.

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

(a) "Doula" means a trained birth companion who provides personal, nonmedical support to pregnant and postpartum people and their families prior to childbirth, during labor and delivery, and during the postpartum period.

(b) "Maternity advisory committee" means the committee facilitated by the state department composed predominantly of Black, Indigenous, and other people of color with maternity care experience as members.

(2) No later than September 1, 2023, the state department shall initiate a stakeholder process to promote the expansion and utilization of doula services for pregnant and postpartum members in the state. In conducting the stakeholder process, the state department shall:

(a) Design an outreach strategy that includes best practices in community engagement, including, but not limited to:

(I) Engaging trusted community partners to support the work;

(II) Reimbursement of participation costs for individuals who are not otherwise paid to participate;

(III) Reimbursement of child care costs for individuals who participate; and

(IV) Translation services and meeting times that allow diverse and inclusive participation;

(b) Solicit feedback related to:

(I) An approved doula certification process that incorporates national and local training programs;

(II) A billing process for doula services;

(III) Ways to recruit doulas and integrate them into hospital deliveries;

(IV) Support needed to build and retain a doula workforce;

(V) Community outreach to determine how to best promote doula services; and

(VI) The doula scholarship program created in subsection (7) of this section.

(3) Stakeholders must be diverse with regard to race, ethnicity, immigration status, sexual orientation, and gender, and must represent other populations that experience greater health disparities and inequities. The state department may include the following in the stakeholder process:

(a) Doulas and potential doulas who may serve members who include, but are not limited to, Black, Indigenous, and other people of color, refugees, non-English speakers, people living in rural areas, and people who were recently incarcerated;

(b) Individuals indirectly involved in the delivery of doula services, including, but not limited to, clinical providers, hospitals, managed care entities, and state partners, including, but not limited to, the department of public health and environment, department of human services, department of early childhood, and department of regulatory agencies;

(c) Representatives from the division of insurance with subject matter expertise;

(d) Representatives from the maternity advisory committee;

(e) Consumer advocates; and

(f) Experts on perinatal care and quality.

(4) For state fiscal year 2024-25, the state department shall submit a report to the general assembly as part of the state department's "SMART Act" presentation required by section 2-7-203. The report must include findings and recommendations from the stakeholder process as described in subsection (2) of this section. The state department shall work with the maternity advisory committee to create the report.

(5) In carrying out the stakeholder process described in subsection (2) of this section, the state department is exempt from the "Procurement Code", articles 101 to 112 of title 24.

(6) Not later than July 1, 2024, the state department shall seek federal authorization to provide doula services for pregnant and postpartum people to improve health outcomes of pregnant and postpartum people who face a disproportionately greater risk of poor birth outcomes.

(7) (a) Not later than July 1, 2024, the state department shall create a doula scholarship program that grants funds to individuals without sufficient financial resources to complete doula training and certification programs necessary to provide doula services.

(b) In designing the doula scholarship program, the state department shall solicit input from groups identified in subsection (3) of this section.

(c) The state department shall define eligibility criteria for the doula scholarship program that includes, but is not limited to, the following:

(I) Proof of financial hardship;

(II) Proof of state residency; and

(III) A statement of intent to serve as a doula provider in Colorado for pregnant and postpartum members.

(d) The state department shall define criteria for organizations to conduct training and certification programs for doulas that include, but are not limited to:

(I) An approved certification process for doulas;

(II) An equitable approach to doula recruitment and training; and

(III) An approved budget to provide free training to attendees.

(e) The state department may require individuals who receive scholarship money pursuant to the doula scholarship program described in this subsection (7) to submit to the state department, not later than six months after the individual's completion of doula training or certification, documentation that the individual is serving as a doula for members or is working toward enrollment as a doula for members. If an individual does not complete the documentation, the state department may seek repayment of the funds awarded to the individual through the doula scholarship program.

(f) Repealed.

(g) Notwithstanding section 24-1-136 (11)(a)(I), the state department shall report annually beginning in 2025 to the general assembly as part of the state department's "SMART Act" presentation, as required by section 2-7-203, on the utilization and outcomes of the doula scholarship program.

Source: L. 2023: Entire section added, (SB 23-288), ch. 279, p. 1652, § 2, effective May 30. **L. 2024:** (1)(b), IP(2), (3)(a), (7)(c)(III), and (7)(e) amended, (SB 24-176), ch. 152, p. 644, § 41, effective August 7.

Editor's note: Subsection (7)(f)(II) provided for the repeal of subsection (7)(f), effective July 1, 2026. (See L. 2023, p. 1652.)

Cross references: For the legislative declaration in SB 23-288, see section 1 of chapter 279, Session Laws of Colorado 2023.

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Colorado Medical Assistance Act - Services and Programs

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PART 1

MANDATORY PROVISIONS

25.5-5-101. Mandatory provisions - eligible groups - rules.

(1) In order to participate in the medicaid program, the federal government requires the state to provide medical assistance to certain eligible groups. Pursuant to federal law and except as

provided in subsection (2) of this section, any person who is eligible for medical assistance under the mandated groups specified in this section must receive both the mandatory services that are specified in sections 25.5-5-102 and 25.5-5-103 and the optional services that are specified in sections 25.5-5-202 and 25.5-5-203. Subject to the availability of federal financial participation, the following are the individuals or groups that are mandated under federal law to receive benefits under this article 5 and articles 4 and 6 of this title 25.5:

(a) Repealed.

(b) Parents and caretaker relatives living with a dependent child who meet the eligibility criteria pursuant to section 1902 (a)(10)(A) of the federal "Social Security Act", including those who subsequently would have become ineligible under such eligibility criteria because of increased earnings or increased hours of employment whose eligibility is specified for a period of time by the federal government;

(c) Pregnant women whose family income does not exceed one hundred thirty-three percent of the federal poverty line, adjusted for family size, who meet the requirements pursuant to section 1902 (a)(10)(A) of the federal "Social Security Act". Once initial eligibility has been established, the pregnant woman is continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income.

(d) A newborn child born of a woman who is categorically needy. Such child is deemed medicaid-eligible on the date of birth and remains eligible for one year.

(e) Children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the federal "Social Security Act", as amended, including foster care children, pursuant to section 1902 (a)(10)(A)(i)(IX) of the federal "Social Security Act", who are under twenty-six years of age, who were in foster care under the responsibility of the state or a tribe, and who were enrolled in medicaid under the state medicaid plan when they turned eighteen years of age;

(f) Individuals receiving supplemental security income;

(g) Individuals receiving mandatory state supplement, including but not limited to individuals receiving old age pensions;

(h) Institutionalized individuals who were eligible for medical assistance in December 1973;

(i) Individuals who would be eligible except for the increase in old-age, survivors, and disability insurance under Pub.L. 92-336;

(j) Individuals who become ineligible for cash assistance as a result of old-age, survivors, and disability insurance cost-of-living increases after April 1977;

(k) Disabled widows or widowers fifty through sixty years of age who have become ineligible for federal supplemental security income or state supplementation as a result of becoming eligible for federal social security survivor's benefits, in accordance with the social security act, 42 U.S.C. sec. 1383c;

(l) Individuals with income and resources at a level which qualifies them as medicare-eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act";

(m) Children under the age of nineteen who meet the eligibility criteria pursuant to section 1902 (a)(10)(A) of the federal "Social Security Act".

(n) A qualified noncitizen who entered the United States before August 22, 1996, shall receive benefits under this article 5 and articles 4 and 6 of this title 25.5;

(o) A qualified noncitizen who entered the United States on or after August 22,1996, is not eligible for benefits under this article 5 or article 4 or 6 of this title 25.5 for five years after the date of entry in the United States; except that the state department may provide benefits under this article 5 and articles 4 and 6 of this title 25.5 to a pregnant person who is a qualified alien noncitizen and a child under nineteen years old who is a qualified noncitizen, so long as the pregnant person or child meets eligibility criteria other than citizenship. Coverage of individuals in this group is subject to the receipt of federal financial participation, unless state funds are specifically appropriated for coverage of groups for whom federal financial participation is unavailable.

(2) and (3) Repealed.

(4) An asset test shall not be applied as a condition of eligibility for individuals or families described in paragraphs (b), (c), (d), and (e) of subsection (1) of this section.

(5) The county departments responsible for administering benefits programs under the department of health care policy and financing and the department of human services shall identify and review all current county guidance materials, including forms, training materials, websites, and any other materials that reference a prohibition on sponsorship as a condition of eligibility for benefits and shall remove all such references from verbal and digital communications and from all physical materials currently provided to applicants or beneficiaries.

(6) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1854, § 7, effective July 1. **L. 2009:** (2)(b) amended, (HB 09-1353), ch. 360, p. 1869, § 1, effective July 1, 2010. **L. 2010:** (4)(c) added, (HB 10-1043), ch. 92, p. 312, § 1, effective April 15; (1)(m) amended, (HB 10-1422), ch. 419, p. 2110, § 143, effective August 11. **L. 2011:** (3) amended, (HB 11-1303), ch. 264, p. 1168, § 67, effective August 10. **L. 2014:** (1)(a) repealed and (1)(b), (1)(c), (1)(d), (1)(e), (1)(m), and

(4) amended, (SB 14-067), ch. 12, p. 111, § 3, effective February 27. **L. 2022:** IP(1) amended, (SB 22-052), ch. 43, p. 216, § 2, effective March 24; (3) amended, (HB 22-1289), ch. 399, p. 2842, § 15, effective June 7. **L. 2023:** (6) added, (SB 23-182), ch. 118, p. 429, § 1, effective April 27; (3) repealed and (5) added, (HB 23-1117), ch. 65, p. 232, § 3, effective August 7. **L. 2024:** IP(6)(a), (6)(b), and (6)(c) amended, (HB 24-1400), ch. 77, p. 261, § 1, effective April 18. **L. 2026:** (1)(n) and (1)(o) added and (2) repealed, (HB 26-1235), ch. 361, p. 2172, § 7, effective August 12.

Editor's note: (1) This section is similar to former § 26-4-201 as it existed prior to 2006.

(2) Prior to the amendment to subsection (4) in 2014, subsection (4)(b)(II) provided for the repeal of subsection (4)(b), effective July 1, 2007. (See L. 2006, p. 1854.)

(3) Subsection (6)(c) provided for the repeal of subsection (6), effective January 1, 2025. (See L. 2024, p. 261.)

Cross references: (1) For provisions of the federal "Medicare Catastrophic Coverage Act of 1988" referenced in this section, see section 301 of Pub.L. 100-360, codified at 42 U.S.C. sec. 1396a et seq.

(2) For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022. For the legislative declaration in HB 23-1117, see section 1 of chapter 65, Session Laws of Colorado 2023.

25.5-5-102. Basic services for the categorically needy - mandated services - repeal.

(1) Subject to the provisions of subsection (2) of this section and section 25.5-4-104, the program for the categorically needy must include the following services as mandated and defined by federal law:

(a) Inpatient hospital services;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Physicians' services, wherever furnished;

(e) Nursing facility services;

(f) Home health services;

(g) Early and periodic screening, diagnosis, and treatment, as required by federal law;

(h) Family planning, including a one-year supply of any federal food and drug administration-approved contraceptive drug, device, or product, unless the member requests a supply covering a shorter period of time;

(i) Rural health services;

(j) Advanced practice registered nurse services;

(k) and (l) (Deleted by amendment, L. 2008, p. 138, § 2, effective July 1, 2008.)

(m) Federally qualified health centers; and

(n) Nonemergency medical transportation services, as required by 42 U.S.C. sec. 1396a (a)(4)(A).

(2) In order to keep expenditures within approved appropriations, the state board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (2), the state board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

(3) The state department shall classify nonemergency medical transportation expenditures as medical services for all eligible populations and services.

(4) The state department shall, to the extent permitted by federal law, ensure that all eligible nonemergency medical transportation expenditures classified as medical services receive available federal financial participation.

(5) On November 1, 2026, and November 1, 2027, the state department shall submit a report to the joint budget committee and the Colorado healthcare affordability and sustainability enterprise board about state savings expected or received as a result of classifying nonemergency medical transportation as a medical service. The report must include, at a minimum:

(a) The total amount of nonemergency medical transportation expenditures classified as medical services;

(b) The federal financial participation as a result of the classification;

(c) A description of actions taken to implement subsection (3) of this section, including state plan amendments, waivers, or program changes;

(d) Identification of remaining nonemergency medical transportation expenditures not yet classified as medical services and the barriers to the classification; and

(e) Recommendations for additional statutory or administrative changes necessary to maximize federal financial participation.

(6) Subsection (5) of this section is repealed, effective January 1, 2028.

Source: L. 2006: Entire article added with relocations, p. 1856, § 7, effective July 1. **L. 2008:** (1)(j), (1)(k), and (1)(l) amended, p. 138, § 2, effective July 1. **L. 2021:** (1)(h) amended, (SB 21-009), ch. 430, p. 2847, § 3, effective September 7. **L. 2024:** IP(1) and (1)(h) amended, (SB 24-176), ch. 152, p. 645, § 42, effective August 7. **L. 2026:** (1)(m) amended and (1)(n), (3), (4), (5), and (6) added, (HB 26-1328), ch. 388, p. 2444, § 6, effective July 1.

Editor's note: This section is similar to former § 26-4-202 as it existed prior to 2006.

Cross references: (1) For the definition of "federally qualified health centers" in the federal "Social Security Act", see 42 U.S.C. sec. 1395x.

(2) For the legislative declaration in SB 21-009, see section 1 of chapter 430, Session Laws of Colorado 2021.

ANNOTATION

Annotator's note. Since § 25.5-5-102 is similar to § 26-4-202 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-202 is similar to § 26-4-105 as it existed prior to the 1991 repeal and reenactment of article 4 of title 26, relevant cases construing those provisions have been included in the annotations to this section.

Reimbursement for outpatient services. The state board of social services did not exceed its authority in providing reimbursement under this section for outpatient services rendered by hospital-based physicians. City of Colo. Springs v. State, 640 P.2d 870 (Colo. App. 1982).

Abortion is available for cost reimbursement. Abortion is a medical procedure which falls well within the umbrella of "basic services" listed in subsection (1), and therefore is available for cost reimbursement to the categorically needy. Dodge v. State Dept. of Soc. Servs., 657 P.2d 969 (Colo. App. 1982) (decided prior to enactment of former § 26-4-512 (now § 25.5-4-415)).

25.5-5-103. Mandated programs with special state provisions - rules.

(1) This section specifies programs developed by Colorado to meet federal mandates. These programs include but are not limited to:

(a) Repealed.

(b) Special provisions relating to nursing facilities, as specified in sections 25.5-4-402.4 (4.5) and (5.5), 25.5-6-201, 25.5-6-202, 25.5-6-205, and 25.5-6-206;

(c) The program for qualified medicare beneficiaries, as specified in section 25.5-5-104;

(d) The program for qualified disabled and working individuals, as specified in section 25.5-5-105;

(e) Special provisions for the purchase of group health insurance for members, as specified in section 25.5-4-210;

(f) The program to provide health services to students by school districts as specified in section 25.5-5-318.

(2) Repealed.

(3) (a) Emergency medical assistance shall be provided to any person who is not a citizen of the United States, including undocumented aliens, aliens who are not qualified aliens, and qualified aliens who entered the United States on or after August 22, 1996, who has an emergency medical condition and meets one of the categorical requirements set forth in section 25.5-5-101; except that such persons shall not be required to meet any residency requirement other than that required by federal law.

(b) The state board shall adopt rules necessary for the implementation of this subsection (3), including in such rules definitions of "emergency services", "emergency medical condition", "geographic area", and "prenatal care".

(4) (a) The state department shall ensure that benefits under the medical assistance program for behavioral, mental health, and substance use disorder services are no less extensive than benefits for any physical illness and are in compliance with the MHPAEA, as defined in section 25.5-5-403 (5.7), including the quantitative and nonquantitative treatment limitation requirements specified in 42 CFR 438.910 (c) and (d). On or after January 1, 2020, if an MCE, as defined in section 25.5-5-403 (4), denies coverage for a covered behavioral, mental health, or substance use disorder benefit or service based on diagnosis, the state board shall establish, by rule, a procedure to allow for reimbursement of medically necessary state plan services under the medical assistance program. The state department may use multiple payment modalities to comply with this subsection (4).

(b) The state board shall adopt rules establishing the procedures for reimbursement pursuant to this subsection (4) by January 1, 2020.

Source: L. 2006: Entire article added with relocations, p. 1856, § 7, effective July 1. **L. 2014:** (1)(a) repealed, (SB 14-067), ch. 12, p. 113, § 4, effective February 27. **L. 2019:** (4) added, (HB 19-1269), ch. 195, p. 2132, § 11, effective May 16. **L. 2021:** (4)(a) amended, (SB 21-266), ch. 423, p. 2802, § 22, effective July 2. **L. 2024:** (1)(e) amended, (SB 24-176), ch. 152, p. 645, § 43, effective August 7. **L. 2025:** (1)(b) amended, (SB 25-270), ch. 151, p. 598, § 3, effective May 1; (2) repealed, (SB 25-183), ch. 97, p. 444, § 7, effective January 1, 2026.

Editor's note: This section is similar to former § 26-4-203 as it existed prior to 2006.

Cross references: For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

25.5-5-104. Qualified medicare beneficiaries.

Qualified medicare beneficiaries are medicare-eligible individuals with income and resources at a level which qualifies them as eligible under section 301 of Title III of the federal "Medicare Catastrophic Coverage Act of 1988", as amended, or subsequent amending federal legislation. For purposes of this article and articles 4 and 6 of this title, such individuals shall be referred to as "qualified medicare beneficiaries". The state department is hereby designated as the single state agency to administer benefits available to qualified medicare beneficiaries in accordance with Title XIX and this article and articles 4 and 6 of this title. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified medicare beneficiaries the entire range of services set forth in section 25.5-5-102.

Source: L. 2006: Entire article added with relocations, p. 1857, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-510 as it existed prior to 2006.

Cross references: For provisions of the federal "Medicare Catastrophic Coverage Act of 1988" referenced in this section, see section 301 of Pub.L. 100-360, codified at 42 U.S.C. sec. 1396a et seq.

ANNOTATION

Law reviews. For article, "The Impacts of Trusts on Public Benefits for Disabled Persons", see 46 Colo. Law. 43 (Nov. 2017).

25.5-5-105. Qualified disabled and working individuals.

Qualified disabled and working individuals are persons with income and resources and disability status, as determined by the social security administration, which qualify them as "qualified disabled and working individuals" under sections 6012 and 6408 of the federal "Omnibus Budget Reconciliation Act of 1989", or subsequent amending federal legislation. The state department is hereby designated as the single state agency to administer benefits available to qualified disabled and working individuals. Such benefits are limited to medicare cost-sharing expenses as determined by the federal government. Accordingly, the state department shall not be required to provide qualified disabled and working individuals the entire range of services set forth in section 25.5-5-102.

Source: L. 2006: Entire article added with relocations, p. 1858, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-511 as it existed prior to 2006.

Cross references: For provisions of the federal "Omnibus Budget Reconciliation Act of 1989" referenced in this section, see sections 6012 and 6408 of Pub.L. 101-239, codified at 42 U.S.C. secs. 1395i and 1396a.

PART 2

OPTIONAL PROVISIONS

25.5-5-201. Optional provisions - optional groups - rules.

(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 must 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 5 and articles 4 and 6 of this title 25.5:

(a) Individuals who would be eligible for but are not receiving cash assistance;

(b) Individuals who would be eligible for cash assistance except for their institutionalized status;

(c) Individuals receiving home- and community-based services as specified in article 6 of this title;

(d) and (e) Repealed.

(f) Individuals receiving only optional state supplement;

(g) Individuals in institutions who are eligible under a special income level. Colorado's program for citizens sixty-five years of age or older or physically disabled or blind, whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, qualifies for federal funding under this provision.

(h) Persons who are eligible for cash assistance under the works program pursuant to section 26-2-706, C.R.S.;

(i) Persons who are eligible for the breast and cervical cancer prevention and treatment program pursuant to section 25.5-5-308;

(j) Individuals who are qualified noncitizens and were or would have been eligible for supplemental security income as a result of a disability but are not eligible for such supplemental security income as a result of the passage of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996", Public Law 104-193;

(k) Other qualified noncitizens who entered or were present in the United States before August 22, 1996;

(l) Children for whom subsidized adoption assistance payments are made by the state pursuant to article 7 of title 26, C.R.S., or foster care maintenance payments are made by the

state pursuant to article 5 of title 26, C.R.S., but who do not meet the requirements of Title IV-E of the "Social Security Act", as amended;

(m) Parents and caretaker relatives of children who are eligible for the medical assistance program whose family income does not exceed one hundred thirty-three percent of the federal poverty line, adjusted for family size;

(m.5) Pregnant women, whose family income does not exceed one hundred ninety-five percent of the federal poverty line, adjusted for family size;

(n) Repealed.

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

(II) Notwithstanding the provisions of subsection (1)(o)(I) of this section, if the money in the healthcare affordability and sustainability hospital provider fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for individuals with disabilities who are participating in the medicaid buy-in program established in part 14 of article 6 of this title 25.5, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the medical benefits offered or the percentage of the federal poverty line to below four hundred fifty percent or may eliminate this eligibility group.

(III) Repealed.

(p) Subject to federal approval, adults who are childless or without a dependent child in the home, as described in section 1902 (a)(10)(A)(i)(VIII) of the social security act, 42 U.S.C. sec. 1396a, who have attained nineteen years of age but have not attained sixty-five years of age, and whose family income does not exceed one hundred thirty-three percent of the federal poverty line, adjusted for family size;

(q) Children who are continuously eligible for twelve months pursuant to section 25.5-5-204.5;

(r) (I) Persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206 whose family income does not exceed a specified percentage of the federal poverty line, adjusted for family size and as set by the state board by rule, which percentage shall be not more than four hundred fifty percent.

(II) Notwithstanding the provisions of subsection (1)(r)(I) of this section, if the money in the healthcare affordability and sustainability hospital provider fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to

fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for persons eligible for a medicaid buy-in program established pursuant to section 25.5-5-206, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the medical benefits offered, or the percentage of the federal poverty line, or may eliminate this eligibility group.

(III) Repealed.

(2) Repealed.

(3) A lawfully residing person who is receiving medicaid nursing facility care or home- and community-based services on July 1, 1997, must continue to receive such services as long as the person meets the eligibility requirements other than citizen status. State general funds may be used to reimburse such care in the event that federal financial participation is not available.

(4) A pregnant person who is lawfully residing is eligible to receive medical assistance as long as the individual meets eligibility requirements other than those related to citizen or immigration status. State general funds may be used to reimburse such care in the event that federal financial participation is not available.

(4.5) (a) Subject to the receipt of federal financial participation, to the maximum extent allowed under federal law, a person who was eligible for the medical assistance program for the sixty days following the pregnancy remains continuously eligible for all services under the medical assistance program for the twelve-month postpartum period.

(b) The state department shall seek any plan amendment necessary to implement a twelve-month postpartum benefit pursuant to this subsection (4.5) and shall implement the benefit only upon receipt of federal authorization and financial participation, and no later than July 1, 2022.

(c) If permissible under federal law, an eligible individual within the postpartum period may resume coverage under the medical assistance program upon implementation of this section.

(5) An asset test shall not be applied as a condition of eligibility for individuals or families described in paragraphs (a), (h), and (m.5) of subsection (1) of this section.

(6) (a) A pregnant person who is not a citizen and who is not eligible for medical assistance pursuant to subsection (4) of this section is eligible to receive medical assistance pursuant to this subsection (6)(a), subject to the limitations detailed in section 25.5-2-104 (1)(b), if the individual meets the eligibility requirements other than those related to citizenship and immigration status.

(b) A pregnant person who is eligible for medical assistance pursuant to this subsection (6) remains continuously eligible for medical services pursuant to the medical assistance program, subject to the limitations detailed in section 25.5-2-104 (1)(b), for the twelve-month postpartum period, so long as eligibility remains in effect pursuant to subsection (4.5)(a) of this section.

(c) The state department shall seek any necessary federal approvals to maximize any available federal financial participation in implementing this subsection (6). Benefits for services obtained pursuant to this subsection (6) must be provided with only state funds if federal financial participation is unavailable for such services.

(d) (I) During its 2024 presentation to the joint budget committee of the general assembly and in its presentation to the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees, at the hearing held pursuant to section 2-7-203 (2)(a) of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", the state department shall report on its plans and progress in implementing the coverage expansion created pursuant to this subsection (6).

(II) Beginning January 1, 2026, and continuing every January thereafter, the state department, in its presentation to the joint budget committee of the general assembly and in its presentation to the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees, at the hearing held pursuant to section 2-7-203 (2)(a) of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", shall report on the cost savings and health improvements associated with the coverage expansion created pursuant to this subsection (6).

(7) and (8) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1858, § 7, effective July 1. **L. 2007:** (1)(n) added, p. 897, § 1, effective May 15. **L. 2008:** (1)(l) and (1)(n) amended and (1)(o) added, pp. 1532, 2200, §§ 1, 2, effective July 1. **L. 2009:** (1)(m)(I) and (1)(o) amended and (1)(p), (1)(q), and (1)(r) added, (HB 09-1293, ch. 152, p. 645, § 5, effective July 1; (2) amended, (HB 09-1353), ch. 390, p. 1869, § 2, effective July 1, 2010. **L. 2010:** (5)(c) added, (HB 10-1043), ch. 92, p. 312, § 2, effective April 15; (1)(m)(I), (1)(o)(II), (1)(p)(I), (1)(p)(II), (1)(r)(I), and (1)(r)(II) amended, (HB 10-1422), ch. 419, p. 2111, § 144, effective August 11. **L. 2013:** (1)(m) and (1)(p) amended, (SB 13-200), ch. 216, p. 898, § 2, effective May 13. **L. 2014:** (1)(d), (1)(e), and (1)(n) repealed, (1)(m.5) added, and (5) amended, (SB 14-067), ch. 12, p. 113, § 5, effective February 27. **L. 2017:** IP(1), (1)(o)(II), and (1)(r)(II) amended, (SB 17-267), ch. 267, p. 1465, § 19, effective July 1. **L. 2021:** (4.5) added, (SB 21-194), ch. 434, p. 2871, § 7, effective September 7. **L. 2022:** IP(1) and (1)(m.5) amended, (SB 22-052), ch. 43, p. 217, § 3, effective March 24; (3), (4), and (4.5)(a) amended and (6) added, (HB 22-1289), ch. 399, p. 2842, § 16, effective June 7. **L. 2023:** (7) and (8) added, (SB 23-182), ch. 118, p. 430, § 2, effective April 27. **L. 2024:** IP(7)(a), (7)(b), and (7)(c) amended, (HB 24-1400), ch. 77, p. 261, § 2, effective April 18. **L. 2025:** (1)(o)(II) and (1)(r)(II) amended, (SB 25-270), ch. 151, p. 605, § 13, effective May 1. **L. 2026:** (6)(a) and (6)(b) amended, (HB 26-1411), ch. 398, p. 2492, § 2, effective June 4; (1)(j) and (1)(k) amended and (2) repealed, (HB 26-1235), ch. 361, p. 2173, § 8, effective August 12.

Editor's note: (1) This section is similar to former § 26-4-301 as it existed prior to 2006.

(2) Prior to the amendment of subsection (1)(m) in 2013, subsection (1)(m)(II)(B) provided for the repeal of subsection (1)(m)(II), effective January 1, 2007. (See L. 2006, p. 1858.)

(3) Prior to the amendment of subsection (5) in 2014, subsection (5)(b)(II) provided for the repeal of subsection (5)(b), effective July 1, 2007. (See L. 2006, p. 1858.)

(4) Subsection (1)(o)(III)(C) provided for the repeal of subsection (1)(o)(III), effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (1)(o)(III)(B). (See L. 2009, p. 645.) The revisor of statutes received said notice dated March 23, 2012.

(5) Prior to the amendment of subsection (1)(p) in 2013, subsection (1)(p)(III)(C) provided for the repeal of subsection (1)(p)(III), effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (1)(p)(III)(B). (See L. 2009, p. 645.) The revisor of statutes received said notice dated April 2, 2012.

(6) Subsection (1)(r)(III)(C) provided for the repeal of subsection (1)(r)(III), effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (1)(r)(III)(B). (See L. 2009, p. 645.) The revisor of statutes received said notice dated February 17, 2017.

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

(8) Subsection (8)(c) provided for the repeal of subsection (8), effective May 31, 2023. (See L. 2023, p. 430.)

(9) Subsection (7)(c) provided for the repeal of subsection (7), effective January 1, 2025. (See L. 2024, p. 261.)

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-5-202. Basic services for the categorically needy - optional services.

(1) The following are services for which federal financial participation is available and that Colorado has selected to provide as optional services under the medical assistance program:

(a) (I) Prescribed drugs.

(II) Notwithstanding subsection (1)(a)(I) of this section, pursuant to section 25.5-5-503, prescribed drugs are not a covered benefit under the medical assistance program for a member who is enrolled in a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

(a.5) Over-the-counter medications, as specified in section 25.5-5-322;

(b) Clinic services, as defined in sections 25.5-5-301 and 25.5-5-302;

(c) Home- and community-based services, as specified in article 6 of this title 25.5, which include:

(I) Home- and community-based services for individuals who are elderly or blind and individuals with disabilities, as specified in part 3 of article 6 of this title;

(II) Home- and community-based services for persons with intellectual and developmental disabilities, as specified in part 4 of article 6 of this title;

(III) Repealed.

(IV) Home- and community-based services for persons with major mental health disorders, as specified in part 6 of article 6 of this title 25.5;

(V) Home- and community-based services for persons with brain injury, as specified in part 7 of article 6 of this title;

(d) Optometrist services;

(e) Eyeglasses when necessary after surgery;

(f) Prosthetic devices, including medically necessary augmentative communication devices; except that nonsurgically implanted prosthetic devices shall be included only after July 1, 1998, and only if the general assembly approves appropriations for these devices as a new benefit;

(g) Rehabilitation services as appropriate to behavioral health safety net providers as defined in section 27-50-101;

(h) Intermediate care facilities for individuals with intellectual disabilities;

(i) Inpatient psychiatric services for persons under twenty-one years of age;

(j) Inpatient psychiatric services for persons over the age of sixty-five;

(k) Case management;

(l) Therapies under home health services, including:

(I) Speech and audiology;

(II) Physical;

(III) Occupational;

(m) Services of a licensed psychologist;

(n) Private duty nursing services;

(o) Podiatry services;

(p) Hospice care;

(q) The program of all-inclusive care for the elderly;

(r) For any pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1)(c), alcohol and substance use disorder counseling and treatment, including outpatient and residential care but not including room and board while receiving residential care;

(s) (I) Outpatient substance use disorder treatment.

(II) Repealed.

(t) Cervical cancer immunization for all females under twenty years of age;

(u) (I) Screening, brief intervention, and referral to treatment for individuals at risk of substance abuse, including referral to the appropriate level of intervention and treatment.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (u), services relating to screening, brief intervention, and referral to treatment shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of such services.

(v) (I) Counseling by primary care providers and other specialty providers caring for persons with serious, chronic, or terminal illness relating to medical orders for scope of treatment, which counseling may be reimbursed.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (v), counseling relating to medical orders for scope of treatment shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of such services.

(w) Dental services for adults.

(x) (I) Residential and inpatient substance use disorder treatment and medical detoxification services pursuant to section 25.5-5-325.

(II) Notwithstanding the provisions of subsection (1)(x)(I) of this section, residential and inpatient substance use disorder treatment shall not take effect unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation for the costs of such services.

(y) For any perinatal person, comprehensive lactation support services, lactation supplies and equipment, and maintenance of multi-user loaned equipment. An individual trained in advanced lactation support shall provide the lactation support services. Lactation equipment must include a single-user double electric breast pump, pump parts and pump collection kit, and access to a loaned multi-user hospital grade electric breast pump along with a compatible individual collection kit. Individuals must have access to single-user lactation supplies and equipment prior to delivery. Access to multi-user loaned breast pumps shall be authorized by a health-care provider. Access to multi-user loaned breast pumps is prioritized for individuals with premature, medically fragile, low birth weight infants, and with lactation complications. Individuals cannot be required to enroll in separate or additional programs in order to receive covered lactation equipment or lactation support services.

(2) Repealed.

(3) In order to keep expenditures within approved appropriations, the state board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (3), the state board shall provide a summary report of the limitations established by the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

(4) The state department and the behavioral health administration in the department of human services, in collaboration with community mental health services providers and substance use disorder providers, shall establish rules that standardize utilization management authority timelines for the nonpharmaceutical components of medication-assisted treatment for substance use disorders.

(5) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1860, § 7, effective July 1. **L. 2007:** (1)(t) added, p. 1348, § 2, effective May 29. **L. 2010:** (1)(r) amended, (HB 10-1043), ch. 92, p.

313, § 3, effective April 15; (1)(a.5) added, (SB 10-117), ch. 227, p. 985, § 1, effective July 1; (1)(u) added, (HB 10-1033), ch. 346, p. 1601, § 1, effective August 11. **L. 2013:** (1)(h) amended, (SB 13-167), ch. 394, p. 2290, § 2, effective June 5; (1)(u)(II) amended and (1)(w) added, (SB 13-242), ch. 189, p. 761, § 1, effective August 7; (1)(v) added, (HB 13-1202), ch. 117, p. 401, § 1, effective August 7. **L. 2014:** (1)(r) amended, (SB 14-067), ch. 12, p. 114, § 6, effective February 27; (1)(c)(I) and (1)(c)(II) amended, (SB 14-118), ch. 250, p. 985, § 20, effective August 6. **L. 2017:** IP(1), (1)(r), and (1)(s)(I) amended, (SB 17-242), ch. 263, p. 1327, § 199, effective May 25; (1)(s)(II) repealed, (SB 17-294), ch. 264, p. 1409, § 92, effective May 25. **L. 2018:** (1)(x) added, (HB 18-1136), ch. 373, p. 2269, § 1, effective June 5; IP(1)(c) and (1)(c)(IV) amended, (SB 18-091), ch. 35, p. 388, § 25, effective August 8; (1)(c)(III) repealed, (SB 18-093), ch. 62, p. 610, § 3, effective August 8; (4) added, (HB 18-1431), ch. 313, p. 1893, § 14, effective January 1, 2019. **L. 2022:** (1)(y) added, (HB 22-1289), ch. 399, p. 2843, § 17, effective June 7; (4) amended, (HB 22-1278), ch. 222, p. 1513, § 69, effective July 1; (1)(g) amended, (HB 22-1278), ch. 222, p. 1593, § 233, effective July 1, 2024. **L. 2024:** (1)(a)(II) amended, (SB 24-176), ch. 152, p. 645, § 44, effective August 7. **L. 2025:** (5) added, (SB 25-294), ch. 329, p. 1710, § 2, effective May 31. **L. 2026:** (5)(c) amended, (SB 26-188), ch. 316, p. 1859, § 2, effective June 2; IP(1) amended and (2) repealed, (HB 26-1328), ch. 388, p. 2445, § 7, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-302 as it existed prior to 2006.

(2) The legislative audit committee did not adopt a resolution by March 31, 2011, as provided for in subsection (1)(s)(II).

(3) Subsection (5)(c) provided for the repeal of subsection (5), effective July 1, 2026. (See L. 2026, p. 1859.)

(4) For amendments to subsection (5)(c) in effect from June 2, 2026, until July 1, 2026, see SB 26-188 (L. 2026, p. 1859).

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018. For the legislative declaration in SB 18-093, see section 1 of chapter 62, Session Laws of Colorado 2018. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-5-203. Optional programs with special state provisions.

(1) Subject to the provisions of subsection (2) of this section, this section specifies programs developed by Colorado to increase federal financial participation through selecting optional services or optional eligible groups. These programs include but are not limited to:

(a) Pharmaceutical services, as specified in section 25.5-5-504;

(b) The home- and community-based services program for the elderly, blind, and disabled, as specified in part 3 of article 6 of this title;

(c) The home- and community-based services program for the developmentally disabled, as specified in part 4 of article 6 of this title;

(d) Repealed.

(e) The home- and community-based services program for persons with major mental health disorders, as specified in part 6 of article 6 of this title 25.5;

(f) The home- and community-based services program for persons with brain injury, as specified in part 7 of article 6 of this title;

(g) Clinic services, as defined in sections 25.5-5-301 and 25.5-5-302;

(h) The program for private duty nursing, as specified in section 25.5-5-303;

(i) Repealed.

(j) The program of all-inclusive care for the elderly, as specified in section 25.5-5-412;

(k) Hospice care, as specified in section 25.5-5-304;

(l) The treatment program for high-risk pregnant women, as specified in section 27-80-112, C.R.S., and sections 25.5-5-309, 25.5-5-310, and 25.5-5-311;

(m) The program for residential child health care, as specified in section 25.5-6-903;

(n) The children's personal assistance services and family support waiver program, as specified in section 25.5-6-902;

(o) Repealed.

(p) The children with complex needs waiver program, as specified in section 25.5-6-904.

(2) In order to keep expenditures within approved appropriations, the state board may, by rule, establish limits on a service provided pursuant to this section so long as the service provided is sufficient in the amount, duration, and scope to reasonably achieve the purpose of the service as required by federal law or regulation. When a rule is promulgated pursuant to this subsection (2), the state board shall provide a summary report of the limitations established by

the rule and any fiscal impact of the rule to members of the health and human services committees of the senate and house of representatives, or any successor committees, and any other members of the general assembly who request the reports.

Source: L. 2006: Entire article added with relocations, p. 1862, § 7, effective July 1. **L. 2010:** (1)(l) amended, (SB 10-175), ch. 188, p. 801, § 67, effective April 29. **L. 2018:** (1)(d) repealed, (SB 18-093), ch. 62, p. 610, § 4, effective August 8; (1)(e) amended, (SB 18-091), ch. 35, p. 388, § 26, effective August 8; (1)(m) amended, (HB 18-1328), ch. 184, p. 1244, § 5, effective June 7, 2019. **L. 2023:** (1)(o)(II) added by revision, (SB 23-289), ch. 270, pp. 1606, 1611 §§ 2, 19. **L. 2025:** (1)(i) repealed and (1)(p) added, (HB 25-1003), ch. 50, p. 223, § 4, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-303 as it existed prior to 2006.

(2) Section 10 of chapter 184 (HB 18-1328), Session Laws of Colorado 2018, provides that section 5 of the act changing this section takes effect upon notice to the revisor of statutes pursuant to § 25.5-5-306 (6) as enacted in section 2 of the act. For more information, see HB 18-1328. (L. 2018, p. 1247.) On August 14, 2019, the revisor of statutes received the notice referred to in § 25.5-5-306 (6) that the federal department of health and human services approved the waiver on June 7, 2019.

(3) Subsection (1)(o)(II) provided for the repeal of subsection (1)(o), effective July 1, 2025. (See L. 2023, pp. 1606, 1611.)

Cross references: For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018. For the legislative declaration in SB 18-093, see section 1 of chapter 62, Session Laws of Colorado 2018. For the legislative declaration in HB 18-1328, see section 1 of chapter 184, Session Laws of Colorado 2018.

25.5-5-204. Presumptive eligibility - pregnant person - children - long-term care - state plan.

(1) For purposes of this section, "presumptive eligibility" means the self-declaration of income, assets, and status in order to promptly receive medical assistance services prior to the verification of income, assets, and status.

(2) (a) A pregnant person is presumptively eligible for the medical assistance program and shall receive services specified by federal law only if the person declares all pertinent

information relating to the criteria of income, assets, and, only if necessary to administer reimbursement for services, status.

(b) (Deleted by amendment, L. 2022.)

(2.5) A child less than nineteen years of age is presumptively eligible for the medical assistance program and shall receive services specified by federal law only if a parent or legal guardian of the child declares all pertinent information relating to the criteria of income, assets, and, only if necessary to administer reimbursement for services, status of the child's family.

(2.7) (a) The state department is authorized to seek federal authorization to allow a person who is in need of long-term services and supports, as defined in section 25.5-6-1702 (10), to be presumptively eligible for the medical assistance program pursuant to this article 5 and articles 4 and 6 of this title 25.5.

(b) If the state department receives federal authorization pursuant to subsection (2.7)(a) of this section and sufficient spending authority, a person in need of long-term services and supports shall be presumptively eligible for the medical assistance program if the person or the person's legal representative declares all pertinent information relating to the criteria of income, assets, immigration status, and any other information that may be required pursuant to the federal authorization. If required due to limitations of federal authorization or spending authority, the state department may implement this subsection (2.7)(b) as a pilot program rather than statewide.

(c) The state department shall make any necessary changes to the state plan waivers for home- and community-based service programs and any other federal authorizations that are authorized pursuant to this article 5 and articles 4 and 6 of this title 25.5 to comply with this subsection (2.7).

(d) If it is determined that a member was not eligible for medical benefits after the member had been determined to be eligible based upon presumptive eligibility, the state department shall not pursue recovery from a county department for the cost of medical services provided to the member, and the county department shall not be responsible for any federal error rate sanctions resulting from such determination.

(3) The state department shall make any necessary changes to the state plan to comply with this section.

Source: L. 2006: Entire article added with relocations, p. 1864, § 7, effective July 1. **L. 2007:** (2.5) added, p. 1493, § 4, effective January 1, 2008. **L. 2009:** (2.7) added, (HB 09-1103), ch. 160, p. 694, § 1, effective April 22. **L. 2021:** (2.7)(a) and (2.7)(b) amended, (HB 21-1187), ch. 83, p. 332, § 26, effective July 1, 2024. **L. 2022:** (2) and (2.5) amended, (HB 22-1289), ch. 399, p. 2844, § 18, effective June 7. **L. 2024:** (2.7)(c) amended, (HB 24-1229), ch. 323, p. 2150, § 1,

effective August 7; (2.7)(d) amended, (SB 24-176), ch. 152, p. 645, § 45, effective August 7; (2.7)(b) amended, (HB 24-1229), ch. 323, p. 2150, § 1, effective January 1, 2026.

Editor's note: This section is similar to former § 26-4-304 as it existed prior to 2006.

Cross references: For the legislative declaration contained in the 2007 act enacting subsection (2.5), see section 1 of chapter 347, Session Laws of Colorado 2007. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-5-204.5. Continuous eligibility - children.

(1) A child who is determined to be eligible for benefits under this article or under article 4 or 6 of this title shall remain eligible for twelve months subsequent to the last day of the month in which the child was enrolled; except that a child shall no longer be eligible and shall be disenrolled from the state medical assistance program if the state department becomes aware of or is notified that the child has moved out of the state or has reached nineteen years of age.

(2) Notwithstanding the provisions of subsection (1) of this section, if the money in the healthcare affordability and sustainability hospital provider fee cash fund established pursuant to section 25.5-4-402.4, together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may eliminate the continuous enrollment requirement pursuant to this section.

(3) Repealed.

Source: L. 2009: Entire section added, (HB 09-1293), ch. 152, p. 648, § 6, effective July 1. **L. 2017:** (2) amended, (SB 17-267), ch. 267, p. 1466, § 20, effective July 1. **L. 2025:** (2) amended, (SB 25-270), ch. 151, p. 605, § 14, effective May 1.

Editor's note: (1) Subsection (3)(c) provided for the repeal of subsection (3), effective the July 1 following the revisor of statutes' receipt of the notice required pursuant to subsection (3)(b). (See L. 2009, p. 648.) The revisor of statutes received said notice dated February 17, 2017.

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

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-5-205. Baby and kid care program - creation - eligibility. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1864, § 7, effective July 1. **L. 2007:** (3)(d) amended, p. 1493, § 5, effective January 1, 2008. **L. 2010:** (3)(a) and (3)(c)(I) amended, (HB 10-1043), ch. 92, p. 313, § 4, effective April 15. **L. 2011:** (3)(b) amended, (SB 11-250), ch. 219, p. 950, § 1, effective May 27; (3)(c) amended, (SB 11-008), ch. 100, p. 293, § 2, effective September 1. **L. 2014:** Entire section repealed, (SB 14-067), ch. 12, p. 114, § 7, effective February 27.

Editor's note: This section was similar to former § 26-4-508 as it existed prior to 2006.

25.5-5-206. Medicaid buy-in program - disabled children - disabled adults - federal authorization - rules.

(1) (a) Subject to available appropriations, the state department is authorized to seek federal authorization to and to establish a medicaid buy-in program or programs for:

(I) Disabled children; or

(II) Disabled adults who do not qualify for the medicaid buy-in program established pursuant to part 14 of article 6 of this title.

(b) The medicaid buy-in program or programs established pursuant to paragraph (a) of this subsection (1) may provide for premium and cost-sharing charges on a sliding fee scale based upon a family's income.

(2) The state board shall promulgate rules consistent with any federal authorization to implement and administer the medicaid buy-in program or programs established pursuant to paragraph (a) of subsection (1) of this section.

(3) Any premiums or cost-sharing charges paid for the medicaid buy-in programs established pursuant to this section are credited to the healthcare affordability and sustainability medicaid buy-in cash fund created in section 25.5-4-402.4 (5.1).

Source: L. 2009: Entire section added, (HB 09-1293), ch. 152, p. 698, § 6, effective July 1. **L. 2025:** (3) added, (SB 25-228), ch. 150, p. 574, § 2, effective May 1.

25.5-5-207. Adult dental benefit - adult dental fund - creation - legislative declaration.

(1) (a) The general assembly finds that:

(I) As of 2011, Colorado was one of only ten states that did not offer basic oral health services to adults under medicaid;

(II) Research has shown that untreated oral health conditions negatively affect a person's overall health and that gum disease has been linked to diabetes, heart disease, strokes, kidney disease, dementia diseases and related disabilities, and even behavioral or mental health disorders;

(III) Regular dental care and prevention are the most cost-effective methods available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care;

(IV) Further, one in four adults has untreated tooth decay. Early detection and access to preventive and restorative treatments for oral health conditions can be up to ten times less expensive than treating those same conditions in an emergency setting.

(V) Research has also shown that good oral health improves medicaid beneficiaries' ability to obtain and keep employment. Employed adults lose more than one hundred and sixty-four million hours of work each year due to dental problems.

(VI) Children are more likely to receive regular dental services if their parents have access to dental services; and

(VII) Pregnant women are one of the most vulnerable adult populations that are without oral health benefits under medicaid. During pregnancy, the physical changes a woman's body undergoes can negatively affect oral health. Untreated decay and periodontal disease are associated with adverse pregnancy outcomes such as increased risk for preeclampsia, pre-term labor, and low birth weight babies.

(b) Therefore, the general assembly declares that in order to improve overall health, promote savings in medicaid programs, and prevent future health conditions caused by oral health problems, it is in the best interest of the state of Colorado to create a limited oral health benefit for adults in the medicaid program.

(2) (a) Pursuant to section 25.5-5-202 (1)(w), by April 1, 2014, the state department shall design and implement a limited dental benefit for adults using a collaborative stakeholder process to consider the components of the benefit, including but not limited to the cost, best practices, the effect on health outcomes, member experience, service delivery models, and maximum efficiencies in the administration of the benefit.

(b) The state department shall determine the most cost-effective method for providing the adult dental benefit, including but not limited to a comparison of a capitated or fee-for-service method of payment and the purchase of dental insurance.

(c) The state department shall seek any federal authorization necessary to provide the adult dental benefit.

(d) Subject to federal authorization and federal financial participation, on or after July 1, 2016, the diagnosis, development of a treatment plan, instruction to perform an interim therapeutic restoration procedure, or supervision of a dental hygienist performing an interim therapeutic restoration procedure may be provided through telehealth, including store-and-forward transfer, in accordance with section 25.5-5-321.5.

(2.5) Repealed.

(3) If the state department chooses to use an administrative service organization to manage the adult dental benefit:

(a) The contract with the administrative service organization must provide that the contracting entity is prohibited from requiring dental providers to participate in any other public or private program or to accept any other insurance products as a condition of participating as a dental provider; and

(b) The state department shall retain policy-making authority, including but not limited to policies concerning covered benefits and rate setting.

(4) (a) There is hereby created in the state treasury the adult dental fund, referred to in this section as the "fund", consisting of any money that may be appropriated to the fund by the general assembly. The money in the fund is subject to annual appropriation by the general assembly to the state department for the direct and indirect costs associated with implementing the adult dental benefit pursuant to section 25.5-5-202 (1)(w).

(b) The state treasurer may invest any unexpended moneys in the fund as provided by law. The state treasurer shall credit all interest and income derived from the investment and deposit of moneys in the fund to the fund.

(c) Any unexpended and unencumbered moneys remaining in the fund at the end of a fiscal year remain in the fund and shall not be credited or transferred to the general fund or another fund.

Source: L. 2013: Entire section added, (SB 13-242), ch. 189, p. 761, § 2, effective August 7. **L. 2015:** (2)(d) added, (HB 15-1309), ch. 326, p. 1334, § 7, effective August 5. **L. 2017:** IP(1)(a) and (1)(a)(II) amended, (SB 17-242), ch. 263, p. 1327, § 200, effective May 25. **L. 2018:** (1)(a)(II) amended, (HB 18-1091), ch. 74, p. 642, § 3, effective August 8. **L. 2019:** (4)(a) amended, (SB 19-088), ch. 110, p. 467, § 11, effective July 1, 2020. **L. 2020:** (2.5) added, (HB 20-1361), ch. 161, p. 756, § 1, effective June 29. **L. 2021:** (2.5) repealed, (SB 21-211), ch. 86, p. 358, § 1, effective May 4. **L. 2024:** (2)(a) amended, (SB 24-176), ch. 152, p. 646, § 46, effective August 7. **L. 2026:** (4)(a) amended, (HB 26-1401), ch. 253, p. 1412, § 3, effective July 1.

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

25.5-5-208. Additional services - training - grants - screening, brief intervention, and referral.

(1) On or after July 1, 2018, the state department shall grant, through a competitive grant program, one million five hundred thousand dollars to one or more organizations to operate a substance use screening, brief intervention, and referral to treatment practice. The grant program must require:

(a) Training for health-care professionals statewide, including providers who serve women of childbearing age, that is evidence-based and that may be attended either in person or online. The training must include training for reimbursement and billing codes in the "Colorado Medical Assistance Act", articles 4 to 6 of this title 25.5.

(a.3) Implementation of a statewide adolescent substance use screening, brief intervention, and referral practice that includes training and technical assistance for appropriate professionals in Colorado schools, with the purpose of identifying students who would benefit from screening, brief intervention, and potential referral to resources, including treatment;

(a.5) Implementation of a statewide substance use screening, brief intervention, and referral practice that includes training and technical assistance for pediatricians and professionals in

pediatric settings, with the purpose of identifying adolescent patients who would benefit from screening, brief intervention, and potential referral to resources, including treatment;

(b) Consultation and technical assistance for health-care providers, health-care organizations, and stakeholders;

(c) Outreach, communication, and education to providers and patients;

(d) Coordination with primary care, mental health care, integrated health care, and substance use prevention, treatment, and recovery efforts; and

(e) Campaigning to increase public awareness of the risks related to alcohol, marijuana, tobacco, and drug use and to reduce any stigma associated with treatment.

(2) (a) The state department contractor shall develop a patient education tool for women of childbearing age to learn about the risks of substance-exposed pregnancies, to be deployed for public use in the state.

(b) Repealed.

Source: L. 2015: Entire section added, (HB 15-1367), ch. 271, p. 1078, § 17, effective January 1, 2016. **L. 2018:** Entire section amended, (HB 18-1003), ch. 224, p. 1428, § 4, effective May 21. **L. 2024:** IP(1) amended and (1)(a.3) and (1)(a.5) added, (SB 24-047), ch. 440, p. 3081, § 9, effective June 6.

Editor's note: (1) Section 23(2) of chapter 271 (HB 15-1367), Session Laws of Colorado 2015, provides that this section takes effect only if a majority of voters approve the ballot issue referred in accordance with section 39-28.8-603 (1) at the November 2015 statewide election. If the voters approve the ballot measure, this section is effective on the date of the official declaration of the vote by the governor, or January 1, 2016, whichever is later. The ballot issue was approved by voters on November 3, 2015. The governor's proclamation was issued on December 28, 2015, establishing an effective date of January 1, 2016, for this section. The vote count for the measure was as follows:

FOR: 847,380

AGAINST: 373,734

(2) Subsection (2)(b)(II) provided for the repeal of subsection (2)(b), effective September 1, 2019. (See L. 2018, p. 1428.)

Cross references: For the legislative declaration in HB 15-1367, see section 1 of chapter 271, Session Laws of Colorado 2015.

PART 3

SERVICES WITH SPECIAL STATE PROVISIONS

25.5-5-301. Clinic services.

(1) As used in this article and articles 4 and 6 of this title, unless the context otherwise requires, "clinic services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to outpatients.

(2) Under the federal option for clinic services, Colorado has selected clinic services provided by the following:

(a) Comprehensive community behavioral health providers, as defined in section 27-50-101;

(b) Case management agencies;

(c) Birthing centers;

(d) Ambulatory surgery facilities;

(e) Freestanding dialysis clinics.

(3) "Clinic services" also means preventive, therapeutic, or palliative items or services that are furnished to patients by county or district public health agencies or county or district boards of health established pursuant to part 5 of article 1 of title 25, C.R.S., that are recommended for certification by the department of public health and environment as qualified to receive payments pursuant to this article and articles 4 and 6 of this title.

(4) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished to a pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1)(c) or 25.5-5-201 (1)(m.5) in a facility that is not a part of a hospital but is organized and operated as a freestanding substance use disorder treatment program approved and licensed by the behavioral health administration in the department of human services pursuant to section 27-80-108 (1)(c).

(5) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to children up to age twenty-one or to high-risk pregnant women in a facility which is not a part of a hospital but is organized and operated as a school-based clinic.

(6) "Clinic services" also means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are furnished to students by a school district, board of cooperative services, or state educational institution within the scope of the "Colorado Medical Assistance Act" pursuant to the provisions of section 25.5-5-318.

Source: L. 2006: Entire article added with relocations, p. 1866, § 7, effective July 1. **L. 2010:** (4) amended, (HB 10-1043), ch. 92, p. 314, § 5, effective April 15; (4) amended, (SB 10-175), ch. 188, p. 801, § 68, effective April 29; (3) amended, (HB 10-1422), ch. 419, p. 2113, § 145, effective August 11. **L. 2014:** (4) amended, (SB 14-067), ch. 12, p. 116, § 12, effective February 27. **L. 2017:** (4) amended, (SB 17-242), ch. 263, p. 1328, § 201, effective May 25. **L. 2021:** (2)(b) amended, (HB 21-1187), ch. 83, p. 332, § 27, effective July 1, 2024. **L. 2022:** (4) amended, (HB 22-1278), ch. 222, p. 1513, § 70, effective July 1. **L. 2025:** (2)(a) amended, (HB 25-1326), ch. 309, p. 1611, § 5, effective August 6.

Editor's note: (1) This section is similar to former § 26-4-513 as it existed prior to 2006.

(2) Amendments to subsection (4) by House Bill 10-1043 and Senate Bill 10-175 were harmonized.

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

25.5-5-302. Clinic services - children and pregnant women - utilization of certain providers.

(1) The state department shall utilize, to the extent possible and appropriate, county or district public health agencies or boards of health established pursuant to part 5 of article 1 of title 25, C.R.S., that are certified by the department of public health and environment as qualified to receive payments pursuant to this article and articles 4 and 6 of this title and that meet the requirements and standards set forth in rules promulgated by the state board in the state department pursuant to section 25.5-4-104 to provide clinic services to patients who are children under age seven or patients who are pregnant women.

(2) In complying with the provisions of subsection (1) of this section, the state department shall utilize, to the extent possible and appropriate, the county or district public health agencies and boards of health specified in subsection (1) of this section to provide outreach to eligible pregnant women and children and to provide clinic services:

(a) Upon the referral of any physician; or

(b) When there exists no primary care physician who agrees to provide clinic services to such patients.

Source: L. 2006: Entire article added with relocations, p. 1867, § 7, effective July 1. **L. 2010:** (1) and IP(2) amended, (HB 10-1422), ch. 419, p. 2113, § 146, effective August 11.

Editor's note: This section is similar to former § 26-4-514 as it existed prior to 2006.

25.5-5-303. Private-duty nursing.

(1) The medical assistance program in this state shall include private-duty nursing to persons who are technology dependent and otherwise eligible as provided under this section.

(2) A member is eligible for private-duty nursing services if the member:

(a) Is dependent on technology at least part of each day;

(b) Requires private-duty nursing care as determined in accordance with state department rules;

(c) Is able to be served safely under the limitations of the private-duty nursing benefit and within the availability of services; and

(d) Is not residing in a nursing facility or hospital at the time of the delivery of the private-duty nursing services.

(3) (a) The state board shall establish rules in accordance with this section that identify medical criteria for determining the circumstances under which private-duty nursing services will be delivered to assure that only persons who need the services receive them and only to the extent medically necessary.

(b) Private-duty nursing services shall not be provided as twenty-four-hour care except in special circumstances and for limited time periods as established by the state department pursuant to this section.

(c) The home health agency, in conjunction with the family or in-home caregiver and the attending physician, shall include in a care plan that includes private-duty nursing services a process by which the eligible person may receive necessary care, which may include respite care, if the family or in-home caregiver is unavailable due to an emergency situation or to unforeseen

circumstances. The family or in-home caregiver shall be duly informed by the home health agency of these alternative care provisions at the time the care plan is initiated.

(4) As used in this section, unless the context otherwise requires, "private-duty nursing" means nursing care that is more individualized and continuous than both the nursing care available under the home health benefit and the nursing care routinely provided in a hospital or nursing facility.

Source: L. 2006: Entire article added with relocations, p. 1867, § 7, effective July 1. **L. 2024:** IP(2) amended, (SB 24-176), ch. 152, p. 646, § 47, effective August 7.

Editor's note: This section is similar to former § 26-4-517 as it existed prior to 2006.

25.5-5-304. Hospice care.

(1) The medical assistance program in this state shall include hospice care. Except as otherwise provided in subsection (2) of this section, hospice care shall be provided for a period of up to two hundred ten days in accordance with rules adopted by the state board, which rules shall comply with 42 U.S.C. sec. 1396d, and shall include at least the following requirements:

(a) That a person shall obtain a certified medical prognosis indicating a life expectancy of nine months or less, which certification shall comply with rules adopted by the state board;

(b) That a person shall execute a waiver of other medical benefits available under this article and articles 4 and 6 of this title, which election shall be executed in accordance with rules adopted by the state board;

(c) That the service shall be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

(2) Hospice care may be provided to a person beyond two hundred ten days if such person is recertified by a physician or hospice medical director as terminally ill in accordance with subsection (1) of this section.

(3) (a) Subject to the receipt of any necessary federal authorization, for a person who has executed the waiver described in paragraph (b) of subsection (1) of this section and who is a resident in a class I facility, as defined in section 25.5-6-201 (13), the class I facility shall bill the state department and the state department shall pay the class I facility for the room and board costs of the person.

(b) Subject to the receipt of any necessary federal authorization, the hospice care provided pursuant to this section may include room and board in a hospice inpatient facility licensed pursuant to section 25-3-101, C.R.S. The state department is authorized to establish the reimbursement rate for the costs for room and board at a licensed hospice inpatient facility for patients eligible for the routine level of hospice care.

(c) (I) If required, the state department shall seek the appropriate federal authorization, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, to make the payment described in paragraph (a) of this subsection (3) and to include room and board at a licensed hospice inpatient facility as described in paragraph (b) of this subsection (3). On or before January 15, 2011, the state department shall submit a brief report to the members of the health and human services committees of the senate and house of representatives, or any successor committees, on the status of any request for authorization pursuant to this subparagraph (I). If federal authorization to implement the changes described in paragraphs (a) and (b) of this subsection (3) is obtained, the state department shall request, through the state budget process, that the changes be implemented during the fiscal year following the year in which the approval is obtained.

(II) The state department is authorized to seek and accept gifts, grants, or donations from private or public sources for the purpose of providing for the administrative costs of preparing and submitting the request for federal approval for the payments described in paragraphs (a) and (b) of this subsection (3). All such private and public funds received through gifts, grants, or donations shall be transmitted to the state treasurer, who shall credit the same to the hospice care account in the department of health care policy and financing cash fund created pursuant to section 25.5-1-109, which account is hereby created. Moneys in the account shall be subject to appropriation and shall only be used for the purposes described in this subparagraph (II).

(d) For the provision of pediatric hospice care, the state department shall seek an exemption from the following federal medicaid requirements for the eligibility of and election for hospice care:

(I) The mandatory do-not-resuscitate order;

(II) A physician's certification that a patient is expected to live less than six months; and

(III) The nonallowance of curative care therapies concurrent with palliative and hospice care.

(4) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1868, § 7, effective July 1. **L. 2010:** IP(1) and (1)(a) amended and (4) added, (HB 10-1027), ch. 274, p. 1256, § 1, effective August 11; (3) added, (SB 10-061), ch. 247, p. 1104, § 1, effective August 11. **L. 2025:** (3)(d) added, (HB 25-1003), ch. 50, p. 222, § 2, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-520 as it existed prior to 2006.

(2) Subsection (4)(b) provided for the repeal of subsection (4), effective the July 1 following the revisor of statutes' receipt of the required notice. (See L. 2010, p. 1256.) The revisor of statutes received the required notice on May 31, 2012.

25.5-5-305. Pediatric hospice care - legislative declaration - federal authorization - rules - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1868, § 7, effective July 1. **L. 2025:** (7) added, (SB 25-264), ch. 129, p. 506, § 37, effective April 25; (6) amended, (SB 25-264), ch. 129, p. 507, § 38, effective July 1; (8) added by revision, (HB 25-1003), ch. 50, p. 223, §§ 6, 7.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-533 as it existed prior to 2006.

(2) Subsection (8) provided for the repeal of this section, effective July 1, 2026. (See L. 2025, p. 223.)

25.5-5-306. Residential child health care - waiver - program - rules - notice to revisor - repeal. (Repealed)

Source: L. 2006: (1) and (3) amended and (4) added, p. 1202, § 2, effective May 26; entire article added with relocations, p. 1871, § 7, effective July 1. **L. 2008:** (3) amended, p. 1517, § 1, effective May 28. **L. 2010:** (1) amended, (SB 10-175), ch. 188, p. 801, § 69, effective April 29. **L. 2013:** (1) amended, (HB 13-1314), ch. 323, p. 1809, § 45, effective March 1, 2014. **L. 2016:** (1) amended, (SB 16-189), ch. 210, p. 773, § 68, effective June 6. **L. 2018:** (5) and (6) added, (HB 18-1328), ch. 184, p. 1242, § 2, effective July 1; (1) amended, (SB 18-092), ch. 38, p. 445, § 111, effective August 8. **L. 2019:** (3) and (4) amended, (HB 19-1172), ch. 136, p. 1708, § 181, effective October 1.

Editor's note: (1) This section was similar to former § 26-4-527 as it existed prior to 2006.

(2) Subsection (6) provided for the repeal of this section, effective June 7, 2019. On August 14, 2019, the revisor of statutes received the notice referred to in subsection (6) related to the repeal. For more information about the repeal and notice, see HB 18-1328. (L. 2018, p. 1242.)

Cross references: (1) For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018. For the legislative declaration in HB 18-1328, see section 1 of chapter 184, Session Laws of Colorado 2018.

(2) For current provisions relating to the residential health care program, see § 25.5-6-903.

25.5-5-307. Child mental health treatment and family support program.

(1) The general assembly finds that many parents in Colorado who have experienced challenging circumstances because their children have significant mental health needs and who have attempted to care for their children or seek services on their behalf often are burdened with the excessive financial and personal costs of providing such care. Private insurance companies may not cover mental health services and rarely cover residential mental health treatment services; those that do seldom cover a sufficient percentage of the expense to make such mental health treatment a viable option for many families in need. The result is that many families do not have the ability to obtain the mental health services that they feel their children desperately need. The general assembly finds that it is in the best interests of these families and the citizens of the state to encourage the preservation of family units by making mental health treatment available to these children pursuant to article 67 of title 27, C.R.S.

(2) In order to make mental health treatment available, it is the intent of the general assembly that each medicaid-eligible child who is diagnosed as a person with a mental health disorder, as that term is defined in section 27-65-102 (11.5), must receive mental health treatment, which may include in-home family mental health treatment, other family preservation services, residential treatment, or any post-residential follow-up services, that must be paid for through federal medicaid funding.

Source: L. 2006: Entire article added with relocations, p. 1872, § 7, effective July 1; (2) amended, p. 1389, § 19, effective August 7. **L. 2010:** Entire section amended, (SB 10-175), ch. 188, p. 802, § 70, effective April 29. **L. 2017:** (2) amended, (SB 17-242), ch. 263, p. 1328, § 202, effective May 25.

Editor's note: (1) This section is similar to former § 26-4-509.5 as it existed prior to 2006.

(2) Amendments to section 26-4-509.5 (2) by House Bill 06-1277 were harmonized with subsection (2) as it appeared in Senate Bill 06-219.

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

25.5-5-308. Breast and cervical cancer prevention and treatment program - creation - legislative declaration - definitions - funds - repeal.

(1) The general assembly hereby finds and declares that breast and cervical cancer are significant health problems for women in this state. The general assembly further finds and declares that these cancers can and should be prevented and treated whenever possible. It is therefore the intent of the general assembly to enact this section to provide for the prevention and treatment of breast and cervical cancer to women where it is not otherwise available for reasons of cost.

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

(a) "Eligible person" means a person who:

(I) (A) Has been screened for breast or cervical cancer under the centers for disease control and prevention's national breast and cervical cancer early detection program established under Title XV of the federal "Public Health Service Act", 42 U.S.C. sec. 300k et seq., in accordance with the requirements of section 1504 of such act, 42 U.S.C. sec. 300n, on or after July 1, 2002, unless the federal centers for medicare and medicaid services approves the state department's amendment to the medical assistance plan and the state department is able to implement the breast and cervical cancer prevention and treatment program before such date, then the person must be screened on or after the implementation date of such program; or

(B) Has been screened for breast or cervical cancer by any provider, within the provider's scope of practice, who does not receive funds through the federal centers for disease control and prevention's national breast and cervical cancer early detection program but whose screening activities are recognized by the department of public health and environment as part of screening activities under the centers for disease control and prevention's national breast and cervical cancer early detection program;

(II) Has been diagnosed with breast or cervical cancer and is in need of breast or cervical cancer treatment;

(III) Has not yet attained sixty-five years of age; and

(IV) Does not have any creditable coverage as defined under federal law pursuant to 42 U.S.C. sec. 300gg-3 (c).

(b) "Qualified entity" shall be defined pursuant to 42 U.S.C. sec. 1396r-1b(b)(2).

(3) There is hereby created a breast and cervical cancer prevention and treatment program to provide medical benefits to eligible persons under this section.

(4) (a) Benefits for medical assistance to an eligible person shall be made available beginning on the day on which a determination is made that the person is eligible for medical assistance and throughout the period in which such person meets the definition of an eligible person.

(b) Benefits for medical assistance to an eligible person shall also be available for the following period of presumptive eligibility:

(I) Such period of presumptive eligibility shall begin when a qualified entity determines that the eligible person is in need of treatment for breast or cervical cancer.

(II) Such period of presumptive eligibility shall end with the earlier of:

(A) The day on which a determination is made that the person is eligible or not eligible for medical assistance; or

(B) If the eligible person does not file a simplified application for medical assistance developed by the state department and approved by the federal centers for medicare and medicaid services on or before the last day of the month following the month during which the eligible person was found to be qualified for services under this section, then benefits shall end on such last day.

(5) The state department shall have the following powers and duties:

(a) To establish, operate, and monitor the breast and cervical cancer prevention and treatment program to provide medical assistance to eligible persons in accordance with the provisions of the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000", enacted October 24, 2000, Pub.L. 106-354, as amended;

(b) To amend the state's medical assistance plan to incorporate the breast and cervical cancer prevention and treatment program. The state department shall submit such proposed amendment to the federal centers for medicare and medicaid services regional office for approval.

(c) To accept and expend any grant or award of moneys from the federal government, any moneys appropriated by the general assembly, any moneys received through gifts, grants, or donations from nonprofit or for-profit entities, and any interest and income earned on such moneys for the purposes set forth in this section;

(d) To inform the joint budget committee of the general assembly in writing as soon as practicable about any change in the rate of federal financial participation in the program.

(6) The state board shall adopt such rules as are necessary to carry out the provisions of this section.

(7) The breast and cervical cancer prevention and treatment program is subject to the annual financial and compliance audit of the "Colorado Medical Assistance Act" performed by the state auditor's office and shall not be considered a tobacco settlement program for purposes of section 2-3-113, C.R.S.

(8) (a) (I) There is created in the state treasury the breast and cervical cancer prevention and treatment fund, referred to in this subsection (8) as the "fund". The fund consists of money credited to the fund pursuant to section 24-22-115 (1); any gifts, grants, and donations; any money appropriated or transferred to the fund by the general assembly; and money credited to the fund pursuant to section 42-3-217.5 (3)(c). All money credited to the fund and all interest and income earned on the money in the fund remains in the fund for the purposes set forth in this section. Any unexpended and unencumbered money remaining in the fund at the end of a fiscal year remains in the fund and shall not be credited or transferred to the general fund or another fund. The state department is encouraged to secure private gifts, grants, and donations to fund the state costs of the breast and cervical cancer prevention and treatment program.

(II) Moneys in the fund may be used to cover the administrative costs of the department of public health and environment to recognize providers in accordance with sub-subparagraph (B) of subparagraph (I) of paragraph (a) of subsection (2) of this section as providing screening activities under the centers for disease control and prevention's national breast and cervical cancer early detection program.

(b) to (c) Repealed.

(9) (a) For the fiscal year 2005-06, the general assembly shall appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and fifty percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(b) For the fiscal year 2006-07, the general assembly shall appropriate seventy-five percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and twenty-five percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(c) For the fiscal year 2007-08, the general assembly shall appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(d) For the fiscal year 2008-09, the general assembly shall appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(e) For the fiscal years 2009-10 through 2011-12, the general assembly shall annually appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(f) For the fiscal years 2012-13 and 2013-14, the general assembly shall annually appropriate fifty percent of the state costs of the breast and cervical cancer prevention and treatment program from the general fund and fifty percent from the moneys credited to the breast and cervical cancer prevention and treatment fund pursuant to section 24-22-115 (1), C.R.S., to such program.

(g) For the fiscal years 2014-15 through 2028-29, the general assembly shall annually appropriate one hundred percent of the state costs of the breast and cervical cancer prevention and treatment program from the money credited to the breast and cervical cancer prevention and treatment fund to the program; except that, if the money in the breast and cervical cancer prevention and treatment fund is insufficient to fully fund the program, the general assembly shall appropriate sufficient money from the general fund.

(h) For the 2024-25, 2025-26, and 2026-27 state fiscal years, the state treasurer shall transfer five hundred thousand dollars from the fund to the breast cancer screening fund created in section 25-4-1503.

(10) This section is repealed, effective July 1, 2029, unless, in any fiscal year before such date, money received as federal financial participation provided pursuant to the federal "Breast and Cervical Cancer Prevention and Treatment Act of 2000", enacted October 24, 2000, Pub.L. 106-354, as amended, is no longer available to the fund or the rate of federal financial participation has been decreased, in which case the general assembly may repeal this section at the regular session of the general assembly immediately following such decrease or discontinuation of federal money.

Source: L. 2006: (8) amended, p. 1117, § 2, effective May 25; entire article added with relocations, p. 1872, § 7, effective July 1. **L. 2008:** (8)(a), (9)(b), (9)(c), and (10) amended and (9)(d) and (9)(e) added, p. 1830, § 1, effective June 2. **L. 2009:** (9)(e) amended and (9)(f) added, (SB 09-262), ch. 202, p. 912, § 1, effective May 1; (2)(a)(I) and (8)(a) amended and (8)(c) added, (HB 09-1164), ch. 215, p. 973, § 4, effective May 2. **L. 2013:** (8)(a)(I) and (8)(c)(II) amended, (8)(b) repealed, and (8)(b.5) added, (SB 13-276), ch. 256, p. 1352, § 8, effective May 23. **L. 2014:** (2)(a)(I)(B), (8)(a)(I), and (10) amended, (8)(c) repealed, and (9)(g) added, (HB 14-1045), ch. 137, p. 468, § 1, effective July 1. **L. 2015:** (7) amended, (SB 15-189), ch. 104, p. 304, § 5,

effective April 16. **L. 2018:** (2)(a)(IV) and (8)(b.5) amended, (HB 18-1375), ch. 274, p. 1714, § 64, effective May 29. **L. 2019:** (9)(g) and (10) amended, (HB 19-1302), ch. 193, p. 2115, § 1, effective May 16. **L. 2023:** (2)(a)(I)(B), (4)(b)(II)(B), and (5)(b) amended, (HB 23-1301), ch. 303, p. 1831, § 50, effective August 7. **L. 2024:** (8)(a)(I) amended, (8)(b.5) repealed, and (9)(h) added, (SB 24-086), ch. 413, p. 2843, § 2, effective June 5; (8)(b.5) amended (HB 24-1360), ch. 324, p. 2167, § 8, effective July 1; (2)(a)(I)(A) amended, (HB 24-1450), ch. 490, p. 3420, § 62, effective August 7.

Editor's note: (1) This section is similar to former § 26-4-532 as it existed prior to 2006.

(2) Subsection (8) was originally numbered as § 26-4-532 (7), and the amendments to it in Senate Bill 06-128 were harmonized with subsection (8) as it appeared in Senate Bill 06-219.

(3) Subsection (8)(b.5) was amended in HB 24-1360, effective July 1, 2024. Those amendments were superseded by the repeal of subsection (8)(b.5) in SB 24-086, effective June 5, 2024.

Cross references: (1) For the "Breast and Cervical Cancer Prevention and Treatment Act of 2000", Pub.L. 106-354, see 42 U.S.C. sec. 1396r-1b.

(2) For the legislative declaration in HB 09-1164, see section 1 of chapter 215, Session Laws of Colorado 2009. For the legislative declaration in HB 24-1360, see section 1 of chapter 324, Session Laws of Colorado 2024.

25.5-5-309. Pregnant women - needs assessment - referral to treatment program - definition.

(1) The health-care practitioner for each pregnant woman who is enrolled or eligible for services pursuant to section 25.5-5-101 (1)(c) or 25.5-5-201 (1)(m.5) is encouraged to identify as soon as possible after the woman is determined to be pregnant whether the woman is at risk of a poor birth outcome due to substance use during the prenatal period and in need of special assistance in order to reduce the risk. If the health-care practitioner makes such determination regarding any pregnant woman, the health-care practitioner is encouraged to refer the woman to any entity approved and licensed by the behavioral health administration in the department of human services for the performance of a needs assessment. Any county department of human or social services may refer an eligible woman for a needs assessment, or any pregnant woman who is eligible for services pursuant to section 25.5-5-201 (1)(m.5) may refer herself for a needs assessment.

(2) For the purposes of this section, unless the context otherwise requires, a "needs assessment" means an assessment that is designed to determine the services that are needed for a pregnant woman to minimize the occurrence of a poor birth outcome due to substance use by the pregnant woman.

Source: L. 2006: Entire article added with relocations, p. 1875, § 7, effective July 1. **L. 2010:** (1) amended, (HB 10-1043), ch. 92, p. 314, § 6, effective April 15. **L. 2014:** (1) amended, (SB 14-067), ch. 12, p. 116, § 13, effective February 27. **L. 2019:** Entire section amended, (HB 19-1193), ch. 272, p. 2568, § 2, effective May 23. **L. 2022:** (1) amended, (HB 22-1278), ch. 222, p. 1513, § 71, effective July 1.

Editor's note: This section is similar to former § 26-4-508.2 as it existed prior to 2006.

Cross references: For the legislative declaration in HB 19-1193, see section 1 of chapter 272, Session Laws of Colorado 2019.

25.5-5-310. Treatment program for high-risk pregnant and parenting women - cooperation with private entities - definition.

(1) (a) As used in this section, "parenting woman" means a woman up to one year postpartum who is in need of substance use disorder services.

(b) The state department, the behavioral health administration in the department of human services, the department of human services, and the department of public health and environment shall cooperate with any organizations that desire to assist the departments and the administration in the provision of services connected with the treatment program for high-risk pregnant and parenting women. Organizations may provide services that are not provided to persons pursuant to this article 5 or article 4 or 6 of this title 25.5 or article 2 of title 26, which services may include but are not limited to needs assessment services, preventive services, rehabilitative services, care coordination, nutrition assessment, psychosocial counseling, intensive health education, home visits, transportation, development of provider training, child care, child care navigation, and other necessary components of residential or outpatient treatment or care.

(2) (a) Health-care practitioners and county departments of human or social services are encouraged to identify any pregnant or parenting woman. If a practitioner or county department of human or social services makes such determination regarding any pregnant or parenting woman up to one year postpartum, the practitioner or county department of human or social services is encouraged to refer the woman to any entity approved and licensed by the behavioral

health administration in the department of human services for a needs assessment in order to improve outcomes for the pregnant or parenting woman and child and reduce the likelihood of out-of-home placement. Any pregnant or parenting woman up to one year postpartum may also refer herself for a needs assessment.

(b) The behavioral health administration in the department of human services is authorized to use state money to provide services to women, including women enrolled in the medical assistance program established pursuant to this article 5 and articles 4 and 6 of this title 25.5, who enroll, up to one year postpartum, in residential substance use disorder treatment and recovery services, until such time as those services are covered by the medical assistance program. The behavioral health administration in the department of human services may continue to use state money to enroll parenting women in residential services who qualify as indigent but who are not eligible for services under the medical assistance program.

(c) Facilities approved and licensed by the behavioral health administration in the department of human services to provide substance use disorder services to high-risk pregnant and parenting women and that offer child care services must allow a woman to begin treatment without first presenting up-to-date health records for her child, including those referenced in section 25-4-902. The parenting woman in treatment must present up-to-date health records for her child, including those referenced in section 25-4-902, within thirty days after commencing treatment.

Source: L. 2006: Entire article added with relocations, p. 1875, § 7, effective July 1. **L. 2019:** Entire section amended, (HB 19-1193), ch. 272, p. 2568, § 3, effective May 23. **L. 2021:** (2)(b) amended, (HB 21-1021), ch. 256, p. 1511, § 5, effective September 7. **L. 2022:** (1)(b) and (2) amended, (HB 22-1278), ch. 222, p. 1514, § 72, effective July 1.

Editor's note: This section is similar to former § 26-4-508.4 as it existed prior to 2006.

Cross references: For the legislative declaration in HB 19-1193, see section 1 of chapter 272, Session Laws of Colorado 2019.

25.5-5-311. Treatment program for high-risk pregnant and parenting women - data collection.

The state department, in cooperation with the behavioral health administration in the department of human services, shall create a data collection mechanism regarding persons receiving services pursuant to the treatment program for high-risk pregnant and parenting women

that includes the collection of any data that the state department and behavioral health administration in the department of human services deem appropriate.

Source: L. 2006: Entire article added with relocations, p. 1875, § 7, effective July 1. **L. 2019:** Entire section amended, (HB 19-1193), ch. 272, p. 2569, § 4, effective May 23. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1514, § 73, effective July 1.

Editor's note: This section is similar to former § 26-4-508.5 as it existed prior to 2006.

Cross references: For the legislative declaration in HB 19-1193, see section 1 of chapter 272, Session Laws of Colorado 2019.

25.5-5-312. Treatment program for high-risk pregnant and parenting women - extended coverage - federal approval.

(1) The state department shall seek federal approval to continue providing substance use disorder treatment and recovery services for twelve months following a pregnancy to women who are eligible to receive services under the medical assistance program, who are receiving services pursuant to the treatment program for high-risk pregnant and parenting women, and who continue to participate in the treatment program. The state department shall implement the continued services to the extent allowed by the federal government.

(2) The state department is authorized to request any federal changes necessary to permit high-risk pregnant and parenting women to further access treatment for pregnant and parenting women with substance use disorders. Any changes to federal waiver programs for this population must preserve the family-oriented specialty services needed by pregnant and parenting women and their dependent children, including those services described in section 25.5-5-310 (1).

Source: L. 2006: Entire article added with relocations, p. 1876, § 7, effective July 1. **L. 2019:** Entire section amended, (HB 19-1193), ch. 272, p. 2570, § 5, effective May 23. **L. 2021:** (1) amended, (HB 21-1021), ch. 256, p. 1511, § 6, effective September 7.

Editor's note: This section is similar to former § 26-4-508.6 as it existed prior to 2006.

Cross references: For the legislative declaration in HB 19-1193, see section 1 of chapter 272, Session Laws of Colorado 2019.

25.5-5-313. Outpatient substance abuse treatment - report of state auditor - amendment to state plan - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1876, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 26-4-536 as it existed prior to 2006.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2011. (See L. 2006, p. 1876.)

25.5-5-314. Substance use disorder treatment for Native Americans - federal approval.

(1) The state department shall request federal approval, conditioned on the receipt of gifts, grants, or donations sufficient to provide for the state's administrative costs of preparing and submitting the request, to include any substance use disorder treatment benefits available to Native Americans in which there is one hundred percent federal financial participation.

(2) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1876, § 7, effective July 1. **L. 2014:** (2) repealed, (HB 14-1363), ch. 302, p. 1269, § 30, effective May 31. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1328, § 203, effective May 25.

Editor's note: This section is similar to former § 26-4-422 as it existed prior to 2006.

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

25.5-5-315. Acceptance of gifts, grants, and donations - Native American substance abuse treatment cash fund.

(1) The executive director may accept and expend money from gifts, grants, and donations for purposes of providing for the administrative costs of preparing and submitting the request for federal approval to provide substance use disorder treatment and recovery services to Native Americans as provided for in section 25.5-5-314. All such gifts, grants, and donations must be transmitted to the state treasurer who shall credit the same to the Native American substance abuse treatment cash fund, which fund is created and referred to in this section as the "fund". The money in the fund is subject to annual appropriation by the general assembly. All investment earnings derived from the deposit and investment of money in the fund remains in the fund and shall not be transferred or revert to the general fund of the state at the end of any fiscal year.

(2) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1876, § 7, effective July 1. **L. 2014:** (2) repealed, (HB 14-1363), ch. 302, p. 1269, § 31, effective May 31. **L. 2017:** (1) amended, (SB 17-242), ch. 263, p. 1328, § 204, effective May 25. **L. 2021:** (1) amended, (HB 21-1021), ch. 256, p. 1511, § 7, effective September 7.

Editor's note: This section is similar to former § 26-4-423 as it existed prior to 2006.

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

25.5-5-316. Legislative declaration - state department - disease management programs authorization - report.

(1) The general assembly finds that, because Colorado is faced with rising health-care costs and limited resources, it is necessary to seek new ways to ensure the availability of high-quality, cost-efficient care for medicaid members. The general assembly further finds that disease management is a patient-focused, integrated approach to providing all components of care with attention to both quality of care and total cost. In addition, the general assembly finds that this approach may include coordination of physician care with pharmaceutical and institutional care. The general assembly further finds that disease management also addresses the various aspects of a disease state, including meeting the needs of persons who have multiple chronic illnesses. The general assembly declares that the improved coordination in disease management helps to provide chronically ill patients with access to the latest advances in treatment and teaches them

how to be active participants in their health care through health education, thus reducing total health-care costs.

(2) The state department, in consultation with the department of public health and environment, is authorized to develop and implement disease management programs, for fee-for-service and primary care physician program recipients, that are designed to address over- or under-utilization or the inappropriate use of services or prescription drugs and that may affect the total cost of health-care utilization by a particular medicaid member with a particular disease or combination of diseases. The disease management programs shall target medicaid members who are receiving prescription drugs or services in an amount that exceeds guidelines outlined by the state department. The state department shall not restrict a medicaid member's access to the most cost-effective and medically appropriate prescription drugs or services. The state department may contract on a contingency basis for the development or implementation of the disease management programs authorized in this subsection (2).

(3) If the state department implements any disease management programs authorized in subsection (2) of this section, the state department shall report to the joint budget committee of the general assembly an estimate of the fiscal implications generated by the implementation of the disease management programs. Such report shall be made on or before February 1 of the year following the implementation of a disease management program and on or before each February 1 thereafter in which such program is in place.

Source: L. 2006: Entire article added with relocations, p. 1877, § 7, effective July 1. **L. 2008:** (2) amended, p. 800, § 2, effective May 14. **L. 2024:** (1) and (2) amended, (SB 24-176), ch. 152, p. 646, § 48, effective August 7.

Editor's note: This section is similar to former § 26-4-408.5 as it existed prior to 2006.

25.5-5-317. Obesity treatment pilot program - development and implementation - report - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1878, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 26-4-534 as it existed prior to 2006.

(2) Subsection (4) provided for the repeal of this section, effective July 1, 2010. (See L. 2006, p. 1878.)

25.5-5-318. Health services - provision by school districts - repeal.

(1) As used in this section:

(a) "School district" means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado school for the deaf and the blind, created in article 80 of title 22, C.R.S., and any public school district organized under the laws of Colorado, except a local college district.

(b) "Underinsured" means a person who has some health insurance, but whose insurance does not adequately cover the types of health services for which a school district may receive federal matching funds under this section.

(2) (a) Any school district may contract with the state department under this section to receive federal matching funds for amounts spent in providing health services through the public schools to students who are receiving medicaid benefits pursuant to this article and articles 4 and 6 of this title.

(a.5) Repealed.

(b) Approval of contracts under this section does not constitute a commitment by the general assembly to continue providing health services to students through the public schools using state general funds if federal matching funds are not available in the future. Any moneys provided to a school district pursuant to a contract entered into under this section shall not supplant state or local moneys provided to school districts pursuant to the provisions of articles 20 to 28 or article 54 of title 22, C.R.S.

(c) Nothing in this section shall be construed as requiring any school district to enter into a contract as provided in this section. Participation in a contract by a school district is voluntary.

(d) The state department may make contracting and reimbursement of moneys under this section contingent upon either:

(I) The contracting school district certifying to the state department, through the department of education, that it has expended local and state moneys in an amount sufficient to meet the nonfederal share of expenditures being claimed for federal financial participation; or

(II) The contracting school district meeting the requirements of the intergovernmental transfer provisions of the federal medicaid law, 42 U.S.C. sec. 1396 et seq.

(3) Each year, by a date established by rule of the state board, the department of education shall notify the state department concerning any school district that chooses to enter into a contract as provided in this section and the anticipated level of funding for the school district.

Nothing in this section shall be construed to require a school district to maintain the same level of funding or services from year to year.

(4) (a) (I) Each school district that chooses to enter into a contract as provided in this section shall develop a services plan with input from the local community that identifies the types of health services needed by students within the school district and the services it anticipates providing. Except for medical emergencies and services related to allegations of child abuse, a student's participation in any psychological, behavioral, social, or emotional services, including counseling or referrals, shall be optional and shall require the prior written and informed consent of a parent or legal guardian of the student.

(II) (A) Any health questionnaire or form related to services funded in part through this section shall only relate to the student's personal health, habits, or conduct and shall not include questions concerning the habits or conduct of any other member of the student's family.

(B) No medical or health data or information identifying the student or the student's family shall be disclosed to any person other than a person specifically authorized to receive the information or data without the prior written and informed consent of a parent or legal guardian of the student.

(b) Each school district that chooses to enter into a contract as provided in this section shall perform an assessment of the health-care needs of its uninsured and underinsured students and may spend an appropriate portion, not to exceed thirty percent, of the federal moneys received on health care for low-income students. For purposes of this paragraph (b), "low-income students" means students whose families are below one hundred eighty-five percent of the federal poverty line.

(c) The school district shall submit the services plan to the department of education with a notice of participation for purposes of technical assistance evaluation and to the executive director for approval.

(5) Each year not less than ninety days prior to the notification date established pursuant to subsection (3) of this section, the state department shall provide information through the department of education to school districts regarding the amount of available moneys and the administrative activities required to enter into a contract for federal matching funds for that year. To the extent allowed by existing resources, the department of education shall provide technical assistance to school districts in determining levels of funding, meeting administrative requirements, and developing services plans.

(6) Following the notification date established pursuant to subsection (3) of this section, each contracting school district, through the department of education, shall enter into a contract with the state department specifying the health services to be provided by the school district, the amount to be expended in providing the services, and the amount of federal matching funds for which the school district is eligible under the contract.

(7) The state department is authorized to accept and expend donations, contributions, grants, including federal matching funds, and other moneys that it may receive to finance the costs associated with implementing this section.

(8) (a) Under the contract entered into pursuant to this section, a contracting school district shall receive from the state department all of the federal matching funds for which it is eligible under the contract, less the amount of state administrative costs allowed under paragraph (b) of this subsection (8). All moneys received by a school district pursuant to this section shall be used only to offset costs incurred for provision of student health services by the school district or to cash fund student health services in the school district.

(b) Total allowable state administrative costs for contracts entered into under this section for both the state department and the department of education shall not exceed ten percent of the total annual amount of federal funds reflected by the general assembly for such contracts in the annual general appropriations bill. State administrative costs include costs incurred in evaluating the implementation of this section.

(9) The state board shall specify by rule the types of health services for which a school district may receive federal matching funds under a contract created under this section, including but not limited to:

(a) Basic primary, physical, dental, and mental health services;

(b) Rehabilitation services;

(c) Early and periodic screening, diagnosis, and treatment services; and

(d) Service coordination, outreach, enrollment, and administrative support.

(10) (a) A school district that provides health services under contract pursuant to this section may provide the health services directly or through contractual relationships or agreements with public or private entities, as allowed by applicable federal regulations. However, no moneys shall be expended in any form for abortions, except as provided in section 25.5-4-415 or as required by federal law.

(b) Where possible, the school district shall coordinate the provision of health services to a student with the student's primary health-care provider. Except for those services that are required by an individualized educational program developed pursuant to section 22-20-108 (4), C.R.S., or by a section 504 plan developed pursuant to the federal "Rehabilitation Act of 1973", 29 U.S.C. sec. 701 et seq., school districts shall not claim reimbursement under this section for direct services to students enrolled in health maintenance organizations that would normally be provided to students by their health maintenance organization.

(11) (a) The executive director shall apply for and secure any federal waivers and state plan amendments required to implement this section.

(b) This section shall remain in effect only for so long as federal financial participation is available for reimbursements to school districts. In the event, as specified in writing by the attorney general to the governor that federal law does not allow or is amended to disallow reimbursements to school districts or otherwise prevent the implementation of this section, this section is repealed, effective on the date of the attorney general's opinion.

(12) The state department and the department of education shall work with the office of state planning and budgeting and the joint budget committee in implementing this section.

(13) The state department and the department of education shall enter into an interagency agreement to provide for the implementation of this section. The state board and the state board of education are authorized to promulgate rules as may be necessary in accordance with the agreement.

(14) The state department shall annually, or more often as necessary, hold a public hearing to receive comments from school districts, state agencies, and interested persons regarding implementation of this section.

(15) On or before December 15, 2002, the state department shall submit a formal evaluation of the implementation of this section to the committees on education and the committees on health and human services of the house of representatives and the senate, or any successor committees.

Source: L. 2006: Entire article added with relocations, p. 1878, § 7, effective July 1. **L. 2009:** (2)(a.5) added, (SB 09-264), ch. 204, p. 928, § 6, effective May 1. **L. 2010:** (4)(b) amended, (HB 10-1422), ch. 419, p. 2113, § 147, effective August 11.

Editor's note: (1) This section is similar to former § 26-4-531 as it existed prior to 2006.

(2) Subsection (2)(a.5)(II) provided for the repeal of subsection (2)(a.5), effective July 1, 2011. (See L. 2009, p. 928.)

25.5-5-319. Family planning pilot program - rules - federal waiver - repeal.

(1) There is hereby established a family planning pilot program for the provision of family planning services to categorically eligible individuals who are at or below a percentage of the federal poverty line established pursuant to the federal waiver sought pursuant to subsection (2) of this section. The state board shall promulgate rules setting forth the family planning services to be provided under the family planning pilot program.

(2) The executive director of the state department, in consultation with the department of public health and environment, shall seek a federal waiver that is cost-neutral to the state general fund for the implementation of the family planning pilot program established pursuant to this section such that ten percent of the family planning services provided to low-income families pursuant to the program as described in subsection (1) of this section would be funded with state general fund moneys and ninety percent would be funded with federal matching funds. In the federal waiver, the executive director shall not seek authority to waive or disregard the provisions of 42 U.S.C. sec. 1396a (a)(23)(B).

(3) (a) Upon issuance of the federal waiver sought pursuant to subsection (2) of this section, the departments of health care policy and financing and public health and environment shall seek the necessary appropriation of general funds through the normal budgetary process for the implementation of this act.

(b) The executive director of the state department is authorized to accept and expend on behalf of the state any funds, grants, gifts, and donations from any private or public source for the purpose of implementing the family planning pilot program established in this section; except that no gift, grant, donation, or funds shall be accepted if the conditions attached thereto require the expenditure thereof in a manner contrary to law.

(4) The executive director of the state department, or such executive director's designee, shall prepare a written report for the members of the general assembly concerning the findings of the department based upon the family planning pilot program. Such report shall be provided to the members of the general assembly not more than three years after commencement of the program. The report shall address the number of individuals served, the type of services provided, the cost of the program, and such other information as the executive director deems appropriate.

(5) The implementation of this section is conditioned upon the issuance of any necessary waiver by the federal government and available appropriations pursuant to paragraph (a) of subsection (3) of this section. The provisions of this section shall be implemented to the extent authorized by federal waiver. The pilot program established by this section shall continue for five years from the receipt of the federal waiver or for so long as specified in the federal waiver. The executive director of the state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this section shall be repealed, effective July 1 five years after the issuance of the federal waiver or July 1 in the year in which the waiver is terminated, whichever occurs first.

Source: L. 2006: Entire article added with relocations, p. 1882, § 7, effective July 1. **L. 2008:** (1) and (2) amended, p. 41, § 1, effective March 13. **L. 2010:** (1) amended, (HB 10-1422), ch. 419, p. 2113, § 148, effective August 11.

Editor's note: (1) This section is similar to former § 26-4-414.7 as it existed prior to 2006.

(2) As of publication date, the revisor of statutes has not received the notice referred to in subsection (5).

25.5-5-320. Telemedicine - reimbursement - disclosure statement - rules - definition.

(1) On or after July 1, 2006, in-person contact between a health-care or mental health-care provider and a patient is not required under the state's medical assistance program for health-care or mental health-care services delivered through telemedicine that are otherwise eligible for reimbursement under the program. The state department shall promulgate rules specifically relating to entities that deliver health-care or mental health-care services exclusively or predominately through telemedicine. Any health-care or mental health-care service delivered through telemedicine must meet the same standard of care as an in-person visit. Telemedicine may be provided through interactive audio, interactive video, or interactive data communication, including but not limited to telephone, relay calls, interactive audiovisual modalities, and live chat, as long as the technologies are compliant with the federal "Health Insurance Portability and Accountability Act of 1996", Pub.L. 104-191, as amended. The health-care or mental health-care services are subject to reimbursement policies developed pursuant to the medical assistance program. This section also applies to managed care organizations that contract with the state department pursuant to the statewide managed care system only to the extent that:

(a) Health-care or mental health-care services delivered through telemedicine are covered by and reimbursed under the medicaid per diem payment program; and

(b) Managed care contracts with managed care organizations are amended to add coverage of health-care or mental health-care services delivered through telemedicine and any appropriate per diem rate adjustments are incorporated.

(2) The reimbursement rate for a telemedicine service shall, as a minimum, be set at the same rate as the medical assistance program rate for a comparable in-person service. The state department may consider setting the reimbursement rate on a monthly basis as well as on a daily or per-visit basis.

(2.1) For the purposes of reimbursement for services provided by home care agencies, as defined in section 25-27.5-102 (3), the services may be supervised through telemedicine or telehealth.

(2.5) (a) A telemedicine service meets the definition of a face-to-face encounter for a rural health clinic, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(2). The reimbursement rate for a telemedicine service provided by a rural health clinic must be set at a rate that is no less than the medical assistance program rate for a comparable face-to-face encounter or visit.

(b) A telemedicine service meets the definition of a face-to-face encounter for a medical care program of the federal Indian health service. The reimbursement rate for a telemedicine service provided by a medical care program of the federal Indian health service must be set at a rate that is no less than the medical assistance program rate for a comparable face-to-face encounter or visit.

(c) A telemedicine service meets the definition of a face-to-face encounter for a federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4). The reimbursement rate for a telemedicine service provided by a federally qualified health center must be set at a rate that is no less than the medical assistance program rate for a comparable face-to-face encounter or visit.

(3) The state department shall establish rates for transmission cost reimbursement for telemedicine services, considering, to the extent applicable, reductions in travel costs by health-care or mental health-care providers and patients to deliver or to access such services and such other factors as the state department deems relevant.

(4) A health-care or mental health-care provider who delivers health-care or mental health-care services through telemedicine shall provide to each patient, before treating that patient through telemedicine for the first time, the following written statements:

(a) That the patient retains the option to refuse the delivery of the services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;

(b) That all applicable confidentiality protections shall apply to the services; and

(c) That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

(5) Subsection (4) of this section shall not apply in an emergency.

(6) Repealed.

(7) As used in this section, "health-care or mental health-care services" includes speech therapy, physical therapy, occupational therapy, dental care, hospice care, home health care, substance use disorder treatment, and pediatric behavioral health care.

Source: L. 2006: Entire section added, p. 1548, § 5, effective July 1. **L. 2008:** (1), (3), IP(4), and (4)(a) amended, p. 112, § 3, effective August 5. **L. 2020:** IP(1) amended and (2.1), (2.5), (6), and (7) added, (SB 20-212), ch. 235, p. 1141, § 5, effective July 6. **L. 2021:** (7) amended, (SB 21-139), ch. 113, p. 443, § 2, effective May 7; IP(1) amended, (HB 21-1256), ch. 193, p. 1017, §

1, effective May 27. **L. 2024:** (7) amended, (HB 24-1045), ch. 470, p. 3287, § 19, effective August 7.

Editor's note: (1) This section was enacted as § 26-4-421.5 in Senate Bill 06-165. Section 9 of the bill provided for the renumbering of that section. (See L. 2006, p. 1552.)

(2) Subsection (6)(b) provided for the repeal of subsection (6), effective July 1, 2022. (See L. 2020, p. 1141.)

Cross references: For the legislative declaration contained in the 2006 act enacting this section, see section 1 of chapter 312, Session Laws of Colorado 2006. For the legislative declaration in SB 20-212, see section 1 of chapter 235, Session Laws of Colorado 2020.

25.5-5-321. Telemedicine - home health care - home health telemedicine cash fund - rules.

(1) On or after August 11, 2010, at-home telemedicine shall be eligible for reimbursement under the state's medical assistance program. The services delivered through telemedicine shall be subject to reimbursement policies promulgated by rule of the state board after consultation with home health-care and home- and community-based services providers. This section also applies to managed care organizations that contract with the state department pursuant to the statewide managed care system, but only to the extent that:

(a) Home health care or home- and community-based services delivered through telemedicine are covered by and reimbursed under the medicaid program; and

(b) Managed care contracts with managed care organizations are amended to add coverage of home health care or home- and community-based services delivered through telemedicine.

(2) (a) The reimbursement rate for home health care or home- and community-based services delivered through telemedicine that are otherwise eligible for reimbursement under the medical assistance program shall be set by rule of the state board and shall be:

(I) In the form of a flat fee in one or more levels, depending on acuity.

(II) (Deleted by amendment, L. 2010, (HB 10-1005), ch. 345, p. 1598, § 1, effective August 11, 2010.)

(b) Any cost savings identified pursuant to this section shall be considered for use in paying for home- and community-based services under part 6 of this article, community-based long-term care, and home health services.

(c) For the first two years after August 11, 2010, gifts, grants, and donations shall be used to implement this section. Gifts, grants, and donations made for this purpose shall be transferred to the home health telemedicine cash fund, which is hereby created in the state treasury. Moneys in the home health telemedicine cash fund shall be appropriated to the state board and used to implement this section. Moneys in the fund shall remain in the fund and not be transferred to the general fund at the end of any fiscal year. After two years or if the moneys in the cash fund are depleted, the department is authorized to go through the normal budget process to continue implementation of this section.

(3) (a) Reimbursement shall not be provided for purchase or lease of telemedicine equipment.

(b) Repealed.

(4) (a) A home health-care or home- and community-based services provider who delivers services through telemedicine shall provide to each patient, before treating that patient through telemedicine for the first time, the following written statements:

(I) That the patient retains the option to refuse the delivery of home health care or home- and community-based services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;

(II) That all applicable confidentiality protections shall apply to the services; and

(III) That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records.

(b) The provisions of paragraph (a) of this subsection (4) shall not apply in an emergency.

(5) Nothing in this section shall be construed to:

(a) Alter the scope of practice of any home health-care or home- and community-based services provider; or

(b) Authorize the delivery of home health care or home- and community-based services in a setting or manner not otherwise authorized by law.

Source: L. 2007: Entire section added, p. 1182, § 2, effective January 1, 2008. **L. 2010:** (1), (2), and (3) amended, (HB 10-1005), ch. 345, p. 1598, § 1, effective August 11. **L. 2021:** (3) amended, (SB 21-286), ch. 395, p. 2627, § 3, effective June 30.

Editor's note: Subsection (3)(b)(II) provided for the repeal of subsection (3)(b), effective July 1, 2025. (See L. 2021, p. 2627.)

25.5-5-321.5. Telehealth - interim therapeutic restorations - reimbursement - definitions.

(1) Subject to federal authorization and federal financial participation, on or after July 1, 2016, in-person contact between a health-care provider and a member is not required under the state's medical assistance program for the diagnosis, development of a treatment plan, instruction to perform an interim therapeutic restoration procedure, or supervision of a dental hygienist performing an interim therapeutic restoration procedure. A health-care provider may provide these services through telehealth, including store-and-forward transfer, and is entitled to reimbursement for the delivery of those services via telehealth to the extent the services are otherwise eligible for reimbursement under the program when provided in person. The services are subject to the reimbursement policies developed pursuant to the state medical assistance program.

(2) As used in this section:

(a) "Interim therapeutic restoration" has the same meaning as set forth in section 12-220-104 (10).

(b) "Store-and-forward transfer" means the asynchronous transmission of medical or dental information to be reviewed by a dentist at a later time at a distant site without the patient present in real time.

Source: L. 2015: Entire section added, (HB 15-1309), ch. 326, p. 1334, § 8, effective August 5. **L. 2019:** (2) amended, (HB 19-1172), ch. 136, p. 1709, § 182, effective October 1. **L. 2021:** (2)(b) amended, (SB 21-102), ch. 31, p. 130, § 10, effective September 1. **L. 2024:** (1) amended, (SB 24-176), ch. 152, p. 647, § 49, effective August 7.

25.5-5-322. Over-the-counter medications - rules.

(1) (a) Subject to approval through the state budget process described in subsection (1)(b) of this section, the state board shall adopt by rule a system to allow pharmacies to be reimbursed for providing certain over-the-counter medications to members if prescribed by a licensed practitioner authorized to prescribe prescription drugs or, subject to the limitations contained in subsection (2) of this section, a licensed pharmacist. Over-the-counter medications subject to reimbursement pursuant to this section must be identified through the drug utilization review

process established in section 25.5-5-506, and are limited to medications that, if reimbursed, result in overall cost savings to the state.

(b) After the list of over-the-counter medications is identified pursuant to paragraph (a) of this subsection (1), the state department shall request, through the state budget process, that the reimbursements be implemented. The state department shall report to the joint budget committee annually concerning the amount of any savings realized from the reimbursements.

(2) (a) The state board, in consultation with the state board of pharmacy created pursuant to section 12-280-104, shall establish by rule standards for when a licensed pharmacist may prescribe over-the-counter medications as provided under this section for purposes of receiving reimbursement under the medical assistance program.

(b) When prescribing over-the-counter medications under this section, a licensed pharmacist shall consult with the member to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health-care professionals.

Source: L. 2010: Entire section added, (SB 10-117), ch. 227, p. 985, § 2, effective July 1. **L. 2012:** (2)(a) amended, (HB 12-1311), ch. 281, p. 1628, § 75, effective July 1. **L. 2019:** (2)(a) amended, (HB 19-1172), ch. 136, p. 1709, § 183, effective October 1. **L. 2024:** (1)(a) and (2)(b) amended, (SB 24-176), ch. 152, p. 647, § 50, effective August 7.

25.5-5-323. Complex rehabilitation technology - no prior authorization - metrics - report - rules - legislative declaration - definitions.

(1) The general assembly finds and declares it is in the best interests of the people of the state of Colorado to:

(a) Continue to protect access to important technology and supporting services for eligible members;

(b) Establish and improve current safeguards relating to the delivery, provision, and repair of medically necessary complex rehabilitation technology;

(c) Continue to provide supports for members accessing complex rehabilitation technology to stay in the home or community setting; engage in basic activities of daily living and instrumental activities of daily living, including employment; prevent institutionalization; and prevent hospitalization and other costly secondary complications; and

(d) Continue adequate pricing for complex rehabilitation technology for the purpose of allowing continued access to appropriate products and related services including maintenance and repair.

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

(a) "Complex rehabilitation technology" means individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designated options and accessories classified as durable medical equipment that:

(I) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living, including employment, identified as medically necessary to promote mobility in the home and community or prevent hospitalization or institutionalization of the member;

(II) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury; and

(III) Require certain services provided by a qualified complex rehabilitation technology provider to ensure appropriate design, configuration, and use of such items, including patient evaluation or assessment of the member by a health-care professional, and that are consistent with the member's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

(b) "Individually configured" means that a device has features, adjustments, or modifications specific to a member that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, adapting, and maintaining the device so that the device is consistent with an assessment or evaluation of the member by a health-care professional and consistent with the member's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

(c) "Qualified complex rehabilitation technology professional" means an individual who is certified by the rehabilitation engineering and assistive technology society of North America or other nationally recognized accrediting organizations as an assistive technology professional.

(d) "Qualified complex rehabilitation technology supplier" means a company or entity that:

(I) Is accredited by a recognized accrediting organization as a supplier of complex rehabilitation technology;

(II) Meets the supplier and quality standards established for durable medical equipment suppliers under the medicare or medicaid program;

(III) Employs at least one qualified complex rehabilitation technology professional for each location to:

(A) Analyze the needs and capacities of members for a complex rehabilitation technology item in consultation with the evaluating clinical professionals;

(B) Assist in selecting appropriate complex rehabilitation technology items for such needs and capacities; and

(C) Provide the member technology-related training in the proper use and maintenance of the selected complex rehabilitation technology items;

(IV) Has the qualified complex rehabilitation technology professional directly involved with the assessment and determination of the appropriate individually configured complex rehabilitation technology for the member, with the involvement to include seeing the member visually either in person or by any other real-time means within a reasonable time frame during the determination process.

(V) Maintains a reasonable supply of parts, adequate physical facilities, and qualified service or repair technicians to provide members with prompt service and repair of all complex rehabilitation technology it sells or supplies; and

(VI) Provides the member written information at the time of sale as to how to access service and repair.

(3) The state department shall provide a separate recognition within the state's medicaid program established pursuant to this article 5 and articles 4 and 6 of this title 25.5 for complex rehabilitation technology and shall make other required changes to protect member access to appropriate products and services. The separate recognition must take into consideration the customized nature of complex rehabilitation technology and the broad range of related services necessary to meet the unique medical and functional needs of members and include the following:

(a) The state department notifying the qualified rehabilitation technology suppliers concerning the parameters of the complex rehabilitation technology benefit, which benefit must include the use of qualified rehabilitation technology suppliers as well as billing procedures that specify the types of equipment identified and included in the complex rehabilitation technology benefit. The state department shall create complex rehabilitation technology benefit parameters that are easily understood by and accessible to members and qualified rehabilitation technology suppliers. The state department shall provide public notice no later than thirty days prior to a collaborative process that includes discussion of any proposed changes to the types of equipment identified and included in the complex rehabilitation technology benefit.

(b) Adopting specific supplier standards, as described in paragraph (d) of subsection (2) of this section, for companies or entities that provide complex rehabilitation technology and

restricting the provision of complex rehabilitation technology to those companies or entities that are qualified complex rehabilitation suppliers;

(c) Ensuring that members receiving complex rehabilitation technology are evaluated or assessed, as needed, by:

(I) A qualified health-care professional, including but not limited to a licensed physical therapist, a licensed occupational therapist, or other licensed health-care professional who has no financial relationship with the qualified complex rehabilitation technology supplier and performs specialty evaluations within his or her scope of practice; and

(II) A qualified complex rehabilitation technology professional employed by the qualified complex rehabilitation technology supplier. The assessment and determination performed by the qualified complex rehabilitation technology professional employed by the qualified complex rehabilitation supplier shall continue to be included in the reimbursement for the purchased or rented complex rehabilitation technology;

(d) Continuing pricing policies for complex rehabilitation technology, unless specifically prohibited by the federal centers for medicare and medicaid services, including the following:

(I) Continuing to ensure that the reimbursement amounts for complex rehabilitation technology, repairs, and supporting clinical complex rehabilitation technology services are adequate to ensure that eligible members have access to the items, taking into account the unique needs of the members and the complexity and customization of complex rehabilitation technology. This includes developing pricing policies that ensure access to adequate and timely repairs.

(II) Exempting complex rehabilitation technology from inclusion in competitive bidding programs or similar processes; and

(III) Preserving the option for complex rehabilitation technology to be billed and paid for as a purchase allowing for lump sum payments for devices with a length of need of one year or greater, excluding approved crossover claims for members enrolled in medicare and medicaid; and

(e) Making other changes as needed to protect access to complex rehabilitation technology for members.

(4) The state department shall not require prior authorization for any repair of complex rehabilitation technology.

(5) (a) No later than October 1, 2023, the state board shall promulgate rules establishing repair metrics for all complex rehabilitation technology suppliers and complex rehabilitation technology professionals. At a minimum, the metrics must include requirements for repairing complex rehabilitation technology in a timely manner and the expected quality of each repair.

Prior to promulgating rules pursuant to this subsection (5)(a), the state department shall engage in a stakeholder process, which process must include qualified complex rehabilitation technology professionals, qualified complex rehabilitation technology suppliers, and complex rehabilitation technology members.

(b) Beginning January 2024, and each January thereafter, the state department shall report on the metrics developed pursuant to subsection (5)(a) of this section and compliance with the metrics as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" hearing required by section 2-7-203.

(6) Three years after the date the repair metric rules are established pursuant to subsection (5)(a) of this section, the state department may engage in a stakeholder process to determine the need for additional accountability of a qualified complex rehabilitation technology supplier through financial penalties, audits, or similar tools, for violations of the repair metrics rules. If a stakeholder process is convened, the process must include qualified complex rehabilitation technology professionals, qualified complex rehabilitation technology suppliers, complex rehabilitation members, and an advocacy group for persons with disabilities.

(7) Beginning December 1, 2024, the state department shall reimburse labor costs for repairs of complex rehabilitation technology at a rate that is twenty-five percent higher for members residing in rural areas than the rate for members residing in urban areas.

Source: L. 2014: Entire section added, (HB 14-1211), ch. 253, p. 1008, § 1, effective January 1, 2015. **L. 2022:** (4), (5), (6), and (7) added, (HB 22-1290), ch. 328, p. 2313, § 1, effective June 2. **L. 2023:** IP(3)(d) amended, (HB 23-1301), ch. 303, p. 1831, § 51, effective August 7. **L. 2024:** (1)(a), (1)(c), (2)(a)(I), (2)(a)(III), (2)(b), (2)(d)(III)(A), (2)(d)(III)(C), (2)(d)(IV), (2)(d)(V), (2)(d)(VI), IP(3), (3)(a), IP(3)(c), (3)(d)(I), (3)(d)(III), (3)(e), (5)(a), (6), and (7) amended, (SB 24-176), ch. 152, p. 647, § 51, effective August 7.

25.5-5-324. Nonemergency medical transportation - urgent and secure transportation need - report - repeal. (Repealed)

Source: L. 2018: Entire section added, (HB 18-1321), ch. 346, p. 2064, § 1, effective May 30. **L. 2019:** (4)(a) amended, (SB 19-252), ch. 254, p. 2452, § 5, effective August 2. **L. 2021:** (4)(a) amended, (HB 21-1085), ch. 355, p. 2311, § 3, effective June 27; (4)(a) amended, (SB 21-266), ch. 423, p. 2802, § 23, effective July 2.

Editor's note: Subsection (4)(c) provided for the repeal of this section, effective July 1, 2025. (See L. 2018, p. 2064.)

25.5-5-325. Partial hospitalization and residential and inpatient substance use disorder treatment - medical detoxification services - federal approval - performance review report.

(1) Subject to available appropriations and to the extent permitted under federal law, the medical assistance program pursuant to this article 5 and articles 4 and 6 of this title 25.5 includes partial hospitalization and residential and inpatient substance use disorder treatment and medical detoxification services. Participation in partial hospitalization and the residential and inpatient substance use disorder treatment and medical detoxification services benefit is limited to persons who meet nationally recognized, evidence-based level of care criteria for partial hospitalization or residential and inpatient substance use disorder treatment and medical detoxification services. The benefit must serve persons with substance use disorders, including those with co-occurring mental health disorders. All levels of nationally recognized, evidence-based levels of care for partial hospitalization and residential and inpatient substance use disorder treatment and medical detoxification services must be included in the benefit.

(2) (a) No later than October 1, 2018, the state department shall seek federal authorization to provide residential and inpatient substance use disorder treatment and medical detoxification services with full federal financial participation. Residential and inpatient substance use disorder treatment and medical detoxification services shall not take effect until federal approval has been obtained.

(b) Prior to seeking federal approval pursuant to subsection (2)(a) of this section, the state department shall seek input from relevant stakeholders, including existing providers of substance use disorder treatment and medical detoxification services and behavioral health administrative services organizations. The state department shall seek input and involve stakeholders in decisions regarding:

(I) The coordination of benefits with behavioral health administrative services organizations and the department of human services;

(II) The most appropriate entity for administration of the benefit;

(III) The provision of wraparound services needed during treatment and the provision of required services following treatment that may not be covered through the medical assistance program;

(IV) The authorization process for approval of services; and

(V) The development of a reimbursement rate methodology to ensure sustainability that considers a provider's cost of providing care, including lower-volume providers in rural areas.

(2.5) No later than July 1, 2026, the state department shall seek federal authorization to provide partial hospitalization for substance use disorder treatment with full federal financial participation. Partial hospitalization for substance use disorder treatment shall not take effect until federal approval has been obtained.

(3) (a) No later than January 15, 2022, the state department shall prepare and submit a performance review report to the joint budget committee and to the joint health and human services committee, or any successor committees, concerning the residential and inpatient substance use disorder treatment pursuant to this section, including, at a minimum:

(I) The number of persons who received services pursuant to this section and the service provided;

(II) The length of time that services were provided;

(III) The location where services were provided;

(IV) The effectiveness of the services provided, including the rate of relapse to substance use disorder following treatment; and

(V) Any other information as determined by the state department that is relevant to the benefit.

(b) After considering the state department's performance review report, the general assembly may enact legislation modifying or repealing the benefit.

Source: L. 2018: Entire section added, (HB 18-1136), ch. 373, p. 2269, § 2, effective June 5. **L. 2022:** IP(2)(b) and (2)(b)(I) amended, (HB 22-1278), ch. 222, p. 1597, § 242, effective August 10. **L. 2023:** (2)(b)(I) amended, (HB 23-1236), ch. 206, p. 1054, § 14, effective May 16. **L. 2024:** (1) amended and (2.5) added, (HB 24-1045), ch. 470, p. 3287, § 20, effective August 7.

25.5-5-326. Access to clinical trials - definitions.

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

(a) "Approved clinical trial" means a phase I, II, III, or IV clinical trial involving the prevention, detection, diagnosis, or treatment of a life-threatening or debilitating disease or condition if any one of the following conditions apply:

(I) The clinical trial is conducted under an investigational new drug application or an investigational device exemption reviewed by the federal food and drug administration, or is exempted from review by the federal food and drug administration; or

(II) The clinical trial is approved or funded by:

(A) The national institutes of health;

(B) The centers for disease control and prevention;

(C) The agency for health care research and quality;

(D) The federal centers for medicare and medicaid services;

(E) A cooperative group or center of any of the entities described in subsections (1)(a)(II)(A) to (1)(a)(II)(D) of this section, the federal department of defense, or the federal department of veterans affairs;

(F) A qualified nongovernmental research entity identified in guidelines issued by the national institutes of health for center support grants; or

(G) The federal department of veterans affairs, the federal department of defense, or the federal department of energy, provided that review and approval of the clinical trial occurs through a system of peer review that is comparable to the peer review of clinical trials performed by the national institutes of health, including an unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(b) "Life-threatening or debilitating disease or condition" means a disease or condition from which the likelihood of death is probable, or the disease or condition is progressive or significantly debilitating, unless the course of the disease or condition is interrupted.

(c) "Qualified individual" means an individual who is eligible for and enrolled in the state medical assistance program and who a treating physician determines has a life-threatening or debilitating disease or condition and meets the selection criteria for the approved clinical trial.

(d) (I) "Routine costs" means medically necessary items and services that are included under the medical assistance program for a medical assistance member, to the extent that the provision of the items or services to the individual outside the course of such participation would otherwise be covered under the medical assistance program, without regard to whether the member is enrolled in a clinical trial. For medical assistance members participating in an approved clinical trial, "routine costs" include medically necessary items and services that are not otherwise excluded pursuant to subsection (1)(d)(II)(D) of this section, relating to the detection and treatment of complications arising from the medical assistance member's medical care, including complications relating to participation in the clinical trial, to the extent that the provision of the items or services to the individual outside the course of such participation would otherwise be included under the medical assistance program.

(II) "Routine costs" do not include:

(A) The investigational item, device, or service itself;

(B) Items and services provided solely to satisfy the data collection and analysis needs of the clinical trial;

(C) Items, drugs, or services customarily provided free of charge to any qualified individual enrolled in the clinical trial; or

(D) Items, drugs, or services that the clinical trial is required to provide.

(2) The medical assistance program established pursuant to this article 5 and articles 4 and 6 of this title 25.5 must include coverage and payment for the routine costs associated with participation in an approved clinical trial for a qualified individual.

Source: L. 2020: Entire section added, (HB 20-1232), ch. 266, p. 1277, § 1, effective July 10. **L. 2024:** (1)(d)(I) amended, (SB 24-176), ch. 152, p. 650, § 52, effective August 7.

25.5-5-327. Eligible peer support services - reimbursement - definitions.

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

(a) "Peer support professional" has the same meaning as defined in section 27-60-108 (2)(b).

(b) "Recovery support services organization" has the same meaning as defined in section 27-60-108 (2)(c).

(2) Subject to available appropriations and to the extent permitted under federal law, the medical assistance program pursuant to this article 5 and articles 4 and 6 of this title 25.5 includes peer support professional services provided to members through a recovery support services organization. Peer support professional services must not be provided to members until federal approval has been obtained.

Source: L. 2021: Entire section added, (HB 21-1021), ch. 256, p. 1509, § 2, effective September 7. **L. 2024:** (2) amended, (SB 24-176), ch. 152, p. 650, § 53, effective August 7.

25.5-5-328. Secure transportation for behavioral health crises - benefit - funding.

(1) On or before January 1, 2023, the state department shall create a benefit for secure transportation services, as defined in section 25-3.5-103 (11.4). The state department shall research and create a plan to establish secure transportation services, which may include supplemental and coordinated community response services, to be implemented on or before July 1, 2023. The state department shall collaborate with the behavioral health administration in

the department of human services in its research and planning efforts to determine how this benefit may align with co-responder, mobile crisis, and emergency crisis dispatch.

(2) The state department is authorized to seek, accept, and expend gifts, grants, and donations from public or private sources for the purpose of funding the urgent transportation needs within the existing nonemergency medical transportation benefit and secure transportation services benefit under the medical assistance program, as set forth in subsection (1) of this section and section 25.5-5-324 (1).

Source: L. 2021: Entire section added, (HB 21-1085), ch. 355, p. 2312, § 4, effective June 27. **L. 2022:** (1) amended, (HB 22-1278), ch. 222, p. 1515, § 75, effective July 1.

25.5-5-329. Family planning services - federal authorization - rules - definitions.

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

(a) "Eligible individual" means an individual who is not pregnant and whose income does not exceed the state's current effective income level for pregnant women under the children's basic health plan established pursuant to article 8 of title 25.5, and whose income is adjusted for family size based on the methodology allowed under federal law to count the applicant as a household of two in addition to any other household members, and who meets other requirements under federal law.

(b) "Family-planning-related services" means services provided in a family planning setting as part of or as a follow-up to a family planning visit, including:

(I) Medically necessary evaluations or preventive services, such as tobacco utilization screening, counseling, testing, and cessation services;

(II) Cervical cancer screening and prevention;

(III) Diagnosis or treatment of a sexually transmitted infection or sexually transmitted disease and medication and supplies to prevent a sexually transmitted infection or sexually transmitted disease; and

(IV) Any other medical diagnosis, treatment, or preventive service that is routinely provided pursuant to a family planning visit, including abortion care.

(c) "Family planning services" means all services covered by the federal Title X family planning program, regardless of an individual's age, sex, or gender identity, or the age, sex, or gender identity of the individual's partner, including but not limited to:

(I) All contraception, as defined in section 2-4-401 (1.5);

(II) Health-care and counseling services focused on preventing, delaying, or planning for a pregnancy;

(III) Follow-up visits to evaluate or manage problems associated with contraceptive methods;

(IV) Sterilization services, regardless of an individual's sex; and

(V) Basic fertility services.

(d) "Presumptive eligibility" has the same meaning as defined in section 25.5-5-204 (1).

(2) (a) No later than January 31, 2022, the state department shall seek federal authorization through an amendment to the state medical assistance plan to provide family planning services to eligible individuals.

(b) The state plan amendment must:

(I) Not impose age, sex, or gender identity limitations on eligible individuals; and

(II) Include a process by which an eligible individual may be presumptively eligible to receive family planning services.

(3) Upon approval of the state plan amendment, the state department shall:

(a) Unless requested otherwise by the eligible individual, ensure that an eligible individual receives a one-year supply of self-administered hormonal contraceptives at one time as permitted by the eligible individual's prescription; and

(b) Collaborate with the state insurance marketplace, health-care consumer advocates, and other interested stakeholders to educate eligible individuals about all available health-care coverage options and encourage eligible individuals to enroll in full health insurance coverage through available sources, including the medical assistance program, the children's basic health plan, a public benefit corporation, or the state insurance marketplace.

(4) The state department shall promulgate any rules necessary to implement this section, including rules establishing the specific family-planning-related services and family planning services identified in subsections (1)(b) and (1)(c) of this section. Prior to promulgating the rules, the state department shall engage in a stakeholder process that attempts to include individuals who have received family planning services through the state's medical assistance program or the children's basic health plan, representatives of consumer advocacy organizations, and family planning providers. The stakeholders must be diverse with regard to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic region of the state.

Source: L. 2021: Entire section added, (SB 21-025), ch. 432, p. 2855, § 2, effective September 7. **L. 2025:** (1)(b)(IV) amended, (SB 25-183), ch. 97, p. 444, § 4, effective January 1, 2026.

Cross references: For the legislative declaration in SB 21-025, see section 1 of chapter 432, Session Laws of Colorado 2021.

25.5-5-330. Screening for perinatal mood and anxiety disorder.

(1) For the caregiver of each child enrolled in the medical assistance program in the state, the program must include screening for perinatal mood and anxiety disorders in accordance with the health resources and services administration guidelines.

(2) The screening must be made available to the caregiver of each child enrolled in the medical assistance program, regardless of whether the caregiver is enrolled in the medical assistance program, so long as the caregiver's child is enrolled in the medical assistance program.

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2366, § 12, effective June 28.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

25.5-5-331. Federally qualified health center - reimbursement - rules.

(1) Costs associated with services provided by clinical pharmacists through a federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4), are considered allowable costs for the purpose of a federally qualified health center's cost report and must be included in the calculation of the reimbursement rate for a patient visit at a federally qualified health center.

(2) (a) A federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4), may establish a separate subsidiary company for the purpose of providing fee-for-service services outside of the federally qualified health center's standard cost report if:

(I) The subsidiary is providing fee-for-service services that have historically been provided and reimbursed on a fee-for-service basis; and

(II) The state department determines that the subsidiary's reimbursements would be budget neutral.

(b) Upon receiving any necessary federal authorization, the state department shall reimburse a subsidiary company, as described in subsection (2)(a) of this section, on a fee-for-service basis for services that are eligible for fee-for-service reimbursement.

(c) A subsidiary that receives reimbursement pursuant to this section may pass through money received from the reimbursement directly to the federally qualified health center operating as the subsidiary's parent corporation.

(d) (I) The state department shall exclude all costs associated with a subsidiary company established pursuant to this subsection (2) from the calculation of a federally qualified health center's reimbursement rates.

(II) The state department shall require a federally qualified health center that establishes a separate subsidiary company pursuant to this subsection (2) to include the costs associated with the subsidiary in its cost report that is necessary to calculate reimbursement rates.

(3) The state department shall promulgate rules to implement the provisions of this section.

Source: L. 2021: Entire section added, (HB 21-1275), ch. 470, p. 3379, § 2, effective September 7. **L. 2025:** Entire section amended, (HB 25-1288), ch. 260, p. 1332, § 3, effective May 27.

Cross references: For the legislative declaration in HB 25-1288, see section 1 of chapter 260, Session Laws of Colorado 2025.

25.5-5-332. Therapy using equine movement - federal authorization - definition.

(1) Subject to federal authorization and federal financial participation, on or after July 1, 2024, therapy using equine movement may be provided by a physical therapist licensed pursuant to article 285 of title 12, an occupational therapist licensed pursuant to article 270 of title 12, or a speech-language pathologist certified pursuant to article 305 of title 12.

(2) As used in this section, unless the context otherwise requires, "therapy using equine movement" means therapeutic activities that leverage horse-human interactions to facilitate progression toward meeting therapeutic goals.

Source: L. 2022: Entire section added, (HB 22-1068), ch. 311, p. 2229, § 2, effective June 2.

Cross references: For the legislative declaration in HB 22-1068, see section 1 of chapter 311, Session Laws of Colorado 2022.

25.5-5-333. Primary care and behavioral health statewide integration grant program - creation - report - definition - repeal.

(1) As used in this section, unless the context otherwise requires, "grant program" means the primary care and behavioral health statewide integration grant program created in subsection (2) of this section.

(2) There is created in the state department the primary care and behavioral health statewide integration grant program to provide grants to physical and behavioral health-care providers for implementation of evidence-based clinical integration care models, as defined by the state department, in collaboration with the behavioral health administration in the department of human services.

(3) (a) Grant recipients may use the money received through the grant program for the following purposes:

(I) Developing infrastructure for primary care, pediatric, and behavioral health-care providers to better serve individuals with behavioral health needs in outpatient health-care settings;

(II) Increasing access to quality health care for individuals with behavioral health needs;

(III) Investing in early interventions for children, youth, and adults that reduce escalation and exacerbation of behavioral health conditions;

(IV) Addressing the need to expand the behavioral health-care workforce;

(V) Developing and implementing alternative payment models, including the development of protocols, processes, work flow, and partnerships; and

(VI) Training primary care providers in trauma-informed care, adverse childhood experiences, and trauma recovery.

(b) Any money received through the grant program must supplement and not supplant existing health-care services. Grant recipients shall not use money received through the grant program for:

(I) Ongoing or existing executive and senior staff salaries;

(II) Services already covered by medicaid or a member's other insurance; or

(III) Ongoing or existing electronic health records costs.

(c) (I) (A) If a grant recipient is a hospital-owned or hospital-affiliated practice that is not part of a hospital system and has less than ten percent total profit as measured by state department transparency reporting, the grant recipient shall provide a twenty-five percent match for the awarded amount. The grant recipient may use community benefit funds, in-kind personnel time, or federal relief funding for the twenty-five percent match required pursuant to this subsection (3)(c)(I)(A).

(B) If a grant recipient is a hospital-owned or hospital-affiliated practice that is part of a hospital system or has ten percent or more total profit as measured by state department transparency reporting, the grant recipient shall provide a fifty percent match for the awarded amount. The grant recipient may use community benefit funds, in-kind personnel time, or federal relief funding for the fifty percent match required pursuant to this subsection (3)(c)(I)(B).

(C) If a grant recipient is a critical access hospital, as defined in section 10-16-1303 (2), the grant recipient shall provide a ten percent match for the awarded amount. The grant recipient may use community benefit funds, in-kind personnel time, or federal relief funding for the ten percent match required pursuant to this subsection (3)(c)(I)(C).

(II) For the purposes of this subsection (3)(c), "hospital-affiliated" means there is a contractual relationship between a hospital or an entity that is owned by or under common ownership and control with the hospital in which the contractual relationship enables the hospital or entity that is owned by or under common ownership and control with the hospital to exercise control over one of the following entities:

(A) Another hospital;

(B) An entity owned by or under common ownership and control with another hospital; or

(C) A physician group practice.

(d) The state department may provide funding to physical and behavioral health-care providers through infrastructure building and population-based payment mechanisms.

(e) Grant recipients shall participate in technical assistance education and training and related workgroups as determined by the state department.

(4) (a) The state department shall administer the grant program and, subject to available appropriations, shall award grants as provided in this section. Subject to available appropriations, grants shall be paid out of the behavioral and mental health cash fund created in section 24-75-230.

(b) In order to support real-time transformation and access to care, the state department shall ensure timely payment to grant recipients for services related to the grant program.

(5) Grant applicants shall demonstrate a commitment to maintaining models and programs that, at a minimum:

(a) Measurably increase access to behavioral health screening, referral, treatment, and recovery care;

(b) Implement or expand evidence-based models for integration that improve patient health as evidenced by relevant and meaningful outcomes measures, including patient-reported outcomes;

(c) Leverage multidisciplinary treatment teams;

(d) Serve publicly funded consumers;

(e) Maintain a plan for how to address a member with emergency needs;

(f) Maintain a plan for how technology will be leveraged for whole-person care, which may include plans for data security, electronic health records reforms, care management platforms, and telehealth implementation or expansion; and

(g) Implement or engage in state-department-specified tools and shared learning and resources, including but not limited to:

(I) Peer learning collaboratives to develop sustainable population-based payment models led by the state department;

(II) Use of electronic tools for screening, measurement-based care management, and referrals; and

(III) Data-sharing best practices.

(6) In selecting grant recipients, the state department shall first prioritize applicants that serve priority populations that experience disparities in health-care access and outcomes, including but not limited to historically marginalized and underserved communities, determined by the communities with the highest proportion of patients receiving assistance through the "Colorado Medical Assistance Act", this article 5 and articles 4 and 6 of this title 25.5. The state department shall then prioritize applicants that meet as many of the following criteria as possible:

(a) Serve individuals with co-occurring and complex care needs, serious mental illnesses, or disabilities;

(b) Serve children and youth;

(c) Include opportunities to build out community health worker, behavioral health aide, or similar programs, supported by population-based payments;

(d) Serve pregnant and postpartum people;

(e) The practice is considered a small and independent practice;

(f) Demonstrate the ability and intent to serve culturally diverse populations and populations with limited English proficiency;

(g) Include workforce capacity-building components;

(h) Include high-intensity outpatient services;

(i) Improve data exchange and data integration that supports whole-person care;

(j) Utilize telehealth;

(k) Align with or participate in commercial alternative payment models;

(l) Demonstrate community partnerships; or

(m) Participate in the regional health connector program created in section 25-20.5-2001.

(7) (a) The state department shall establish a set of statewide resources to support grant recipients. At a minimum, the resources must include:

(I) A clinical consultation and practice transformation support team provided by the Colorado health extension system in the practice innovation program; and

(II) A sustainable billing and data partnership team that will train and support grant recipients in meeting standards and core competencies for alternative payment models, transforming the primary care providers' payment systems to focus on integrative, whole-person care, and creating and implementing data-sharing practices and policies that support mental health disorders, substance use disorders, and co-occurring disorders.

(b) The state department may enter into interagency agreements or procure contracts to establish the resources pursuant to this subsection (7).

(8) The state department may procure a grant application and support team to assist the state department with drafting the grant application, reviewing applications, and administering and processing grant awards.

(9) A grant recipient must spend or obligate any money received pursuant to this section in accordance with section 24-75-226 (4)(d).

(10) (a) The state department shall establish a steering committee to:

(I) Provide continuous input into grant application requirements;

(II) Provide feedback and direction on data collection standards and review; and

(III) Engage with community partners who will help support the integrated care practices through referrals and trusted communications.

(b) The state department shall select a state department employee to chair the steering committee, staff the steering committee, and reimburse any participant who is not a state employee for reasonable travel expenses.

(11) The state department shall, in collaboration with the behavioral health administration and the division of insurance, prepare a report that includes recommendations on best practices for sustaining integrated care models. In preparing the report, the state department shall collect data from each grant recipient related to clinical quality improvement and access to care. Grant recipients shall provide data to the state department in a timely manner, as determined by the state department. The state department is authorized to recoup or discontinue grant funding for grant recipients that do not comply with the data reporting requirements or grant standards set by the state department.

(12) The state department and any person who receives money from the state department pursuant to this section shall comply with the compliance, reporting, record-keeping, and program evaluation requirements established by the office of state planning and budgeting and the state controller in accordance with section 24-75-226 (5).

(13) This section is repealed, effective July 1, 2027.

Source: L. 2022: Entire section added, (HB 22-1302), ch. 180, p. 1195, § 2, effective May 18; (9) amended, (HB 22-1411), ch. 271, p. 1960, § 15, effective May 27. **L. 2023:** IP(6) and (6)(m) amended, (HB 23-1244), ch. 436, p. 2570, § 5, effective August 7. **L. 2024:** (3)(b)(II), (5)(d), and (5)(e) amended, (SB 24-176), ch. 152, p. 651, § 54, effective August 7.

Cross references: For the legislative declaration in HB 22-1302, see section 1 of chapter 180, Session Laws of Colorado 2022. For the legislative declaration in HB 23-1244, see section 1 of chapter 436, Session Laws of Colorado 2023.

25.5-5-334. Community health worker services - federal authorization - reporting - rules - definition.

(1) As used in this section, unless the context otherwise requires, "community health worker" means a frontline public health worker who serves as a liaison between health-care providers or social service providers and community members in order to facilitate access to physical, behavioral, or dental health-related services, or services to address social determinants of health, and who improves the quality and cultural responsiveness of health-related service delivery.

(2) No later than July 1, 2024, the state department shall seek federal authorization from the federal centers for medicare and medicaid services to provide reimbursement for community

health worker services including, but not limited to, the delivery of preventive services, group and individual health education and health coaching, health navigation, transitions of care supports, screening and assessment for nonclinical and social needs, and individual support and health advocacy.

(3) Prior to seeking federal authorization, the state department shall hold at least four public stakeholder meetings to facilitate public engagement and solicit input from relevant stakeholders on the development of the required elements for federal authorization. Relevant stakeholders include, but are not limited to, community health workers, representatives from a statewide group representing community health workers, consumer advocates, local public health agencies, public health nonprofits and institutes, representatives from Colorado department of public health and environment-recognized training programs for health navigators and community health workers, health-care providers, managed care entities, representatives from schools and school-based health centers, and the Colorado department of public health and environment. At a minimum, the state department shall seek input from stakeholders regarding:

(a) Ways to ensure community health workers serve to reduce health disparities and increase health equity;

(b) Minimum qualifications for community health workers, such as training and skills-based experience requirements;

(c) Methods for minimizing the burden of entering into the community health workforce;

(d) A patient safety monitoring responsibilities and grievance process;

(e) What services provided by a community health worker will be considered covered services and noncovered services;

(f) Processes and requirements regarding provider types, provider enrollment, billing codes, places of service, and any other operational component necessary for implementation in the medicaid management information system;

(g) Reimbursement using the fee-for-service managed care or values-based payment models for community health workers with consideration of the use of alternative payment methodologies in the future;

(h) New provider types that could facilitate community health worker services outside of traditional health-care settings, such as community-based organizations; and

(i) Clarification on community health workers' role and scope of practice as part of a delivery system that may include case management, care management, and care coordination services provided by managed care entities, community-centered boards, single entry points, behavioral health administrative service organizations, case management agencies, and health-care providers.

(4) In consideration of opportunities for future expansion of the community health worker workforce, the Colorado department of public health and environment is encouraged to partner with the state department and stakeholders to make recommendations for training and competency standards related to specialization that would enable community health workers to specialize their work with different populations and health conditions.

(5) Costs associated with services provided by community health workers through a federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4), are considered allowable costs for the purposes of a federally qualified health center's cost report. The state department shall work with stakeholders to determine how services provided by community health workers will be captured in federally qualified health centers' cost reports.

(6) Costs associated with services provided by community health workers through a rural health clinic, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(2), are considered allowable costs for the purposes of a rural health clinic's cost report. The state department shall work with stakeholders to determine how services provided by community health workers will be captured in rural health centers' cost reports.

(7) The state department shall consult with the Colorado department of public health and environment in promulgating rules concerning the voluntary competency-based community health worker registry managed by the Colorado department of public health and environment and any additional criteria or standards that may be necessary.

(8) For purposes of medicaid reimbursement, a community health worker shall:

(a) Work under the supervision of a clinician or within a licensed or otherwise approved and medicaid-enrolled health provider agency; and

(b) Meet the minimum qualifications and credentialing requirements of the voluntary competency-based community health worker registry as defined in section 25-20.5-112.

(9) The state department shall ensure that reimbursement policies and federal authorities for existing unlicensed health workers, such as peer support professionals, recovery professionals, managed care navigation staff, and others, are aligned and incorporated with the community health worker payment models.

(10) On or before January 31, 2027, the state department shall report on ways community health workers are being utilized through the state medical assistance program and include available data or any identified costs or savings associated with community health worker services and considerations for the general assembly to expand community health worker services in community-based organizations that are outside of the traditional health-care setting in its presentation to the joint budget committee of the general assembly and in its presentation to the health and human services committee of the senate and the health and insurance committee

of the house of representatives, or any successor committees, at the "SMART Act" hearing held pursuant to section 2-7-203.

(11) Subject to available appropriations, upon receiving any necessary federal authorization, beginning January 1, 2026, the state department shall reimburse community health workers who comply with the requirements of subsection (8) of this section.

Source: L. 2023: Entire section added, (SB 23-002), ch. 157, p. 679, § 2, effective August 7. **L. 2024:** (2) amended, (HB 24-1450), ch. 490, p. 3420, § 63, effective August 7. **L. 2025:** (10) amended and (11) added, (SB 25-229), ch. 220, p. 1011, § 1, effective May 20.

Cross references: For the legislative declaration in SB 23-002, see section 1 of chapter 157, Session Laws of Colorado 2023.

25.5-5-335. Continuous medical coverage for children and adults feasibility study - federal authorization - rules - report - definition.

(1) The state department shall study the feasibility of extending continuous medical coverage for additional children and adults and how to better meet the health-related social needs of medical assistance program members.

(2) At a minimum, the feasibility study must consider the costs; implementation factors, including county workload, training, and administrative burdens on the counties, information technology systems, upgrades, and associated costs; potential health benefits for individuals and communities, including disadvantaged and marginalized groups; impacts of increased use of preventive and high-value health services; administrative savings, including, but not limited to, reducing or eliminating eligibility processing for populations during the continuous eligibility period; reductions in administrative turnover and coverage loss; and, to the extent practicable, social and economic impacts with respect to the following:

(a) Allowing an eligible child, as defined in this article 5 and articles 2, 3, 6, and 8 of this title 25.5, including children eligible under section 25.5-2-104, to remain continuously eligible for medical assistance for twenty-four months after the last day of the month in which the child was enrolled;

(b) Allowing an eligible child, as defined in this article 5 and articles 2, 3, 6, and 8 of this title 25.5, including children eligible under section 25.5-2-104 who are less than six years old, to remain continuously eligible for medical assistance without regard to a change in household income until the child reaches six years old;

(c) Allowing an eligible adult to remain continuously eligible for medical assistance without regard to income for twelve months and twenty-four months after the last day of the month in which the adult was enrolled. For purposes of this subsection (2)(c), an "eligible adult" includes a person eighteen years of age or older who:

(I) Has an income under thirty-three percent of the federal poverty line;

(II) Is experiencing homelessness; or

(III) Has been in community corrections, is on parole, or has been released from another carceral setting, including jail or federal prison. For purposes of this subsection (2)(c)(III), continuous eligibility starts on the individual's medicaid approval date.

(d) Allowing an adult who is eligible for medical assistance at the time of enrollment to remain continuously eligible for medical assistance without regard to income for twelve months after the last day of the month in which the adult was enrolled.

(3) In addition to the study topics detailed in subsection (2) of this section, the feasibility study must study how to best meet the health-related social needs of medical assistance program members who are historically disadvantaged and underserved and must give consideration to concerns related to housing and food security.

(4) In conducting the feasibility study pursuant to this section, the state department shall take into consideration the efforts of other states to improve the health-related social needs of medical assistance program members, including, but not limited to, housing and nutritional needs, initiatives to pay for rental housing assistance for up to six months, the needs of perinatal members, youth in or transitioning out of foster care, former foster care youth, people with substance use disorders, high-risk infants and children, and the needs of low-income individuals impacted by natural disasters, and the state department shall seek input from relevant stakeholders. In conducting the stakeholder process, the state department shall:

(a) Engage directly with:

(I) Impacted individuals who are enrolled in medical assistance or the children's basic health plan and whose coverage, or whose children's coverage, would be extended if legislation were passed to extend continuous medical coverage for individuals pursuant to subsections (2)(a) to (2)(d) of this section;

(II) Service providers, particularly those whose patients are predominantly medical assistance program members or are uninsured;

(III) Advocacy organizations;

(IV) Counties;

(V) Organizations that assist with enrollment into the medical assistance programs and the Colorado health exchange; and

(VI) Individuals working in or representing communities that are diverse with regard to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic region of the state and are affected by higher rates of health disparities and inequities;

(b) Publicly conduct stakeholder meetings, report on the outcomes of the meetings, and publicize the reports in English as well as two other commonly spoken languages in Colorado;

(c) Include opportunities for participation in the stakeholder process outside of regular work hours; and

(d) Hold at least three stakeholder meetings.

(5) On or before January 1, 2026, the state department shall submit a report detailing the findings and recommendations from the feasibility study to the joint budget committee of the senate and the house of representatives, or its successor committee, the governor, and to the house of representatives public and behavioral health and human services committee and the senate health and human services committee, or any successor committees. The state department shall also make the report available to the public on the state department's website.

(6) Nothing in this section prohibits or limits the state department's ability to amend any approved federal authorization or to seek other federal permissions necessary to expand continuous eligibility coverage to additional populations prior to the completion of the feasibility study described in this section.

(7) (a) No later than April 1, 2024, the state department shall seek federal authorization from the federal centers for medicare and medicaid services to provide continuous medical coverage for eligible children and eligible adults described in subsections (7)(b) and (7)(c) of this section, and to continue enrollment for individuals with no income, as described in subsection (7)(d) of this section.

(b) For purposes of seeking federal authorization pursuant to subsection (7)(a) of this section, an eligible child is as defined in this article 5 and articles 2, 3, 6, and 8 of this title 25.5, including a child eligible pursuant to section 25.5-2-104, and must be under three years old. An eligible child remains continuously eligible without regard to household income until the eligible child reaches three years old; except that a child is no longer eligible and must be disenrolled from a medical assistance program if the state department becomes aware that the child has moved out of the state, the state department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the state department determines eligibility was erroneously granted, or the child is deceased.

(c) For purposes of seeking federal authorization pursuant to subsection (7)(a) of this section, an eligible adult is limited to an adult who has been released from a Colorado department of

corrections facility after serving a sentence. An eligible adult shall remain continuously eligible for medical assistance without regard to income for a period of twelve months beginning on the date of the eligible adult's release; except that an adult is no longer eligible and must be disenrolled from the medical assistance program if the state department becomes aware that the adult has moved out of the state, the state department or county possesses facts indicating that the adult has requested voluntary disenrollment, the state department determines eligibility was erroneously granted, or the adult is deceased.

(d) To facilitate the renewal process for the medical assistance program for individuals with no income, including those who are experiencing homelessness, the state department shall seek federal authorization, to the extent allowable by the federal centers for medicare and medicaid services, to complete the income determination for ex parte renewals without requesting additional income information or documentation, if:

(I) An attestation of zero-dollar income was verified within the last twelve months at the initial application or the previous renewal; and

(II) The state department has checked financial data sources in accordance with its eligibility verification plan as required by the federal centers for medicare and medicaid services and no information is received.

(e) Upon approval of the federal authorization sought pursuant to this subsection (7), the state department shall implement the continuous eligibility coverage requirements pursuant to this subsection (7) by January 1, 2026. In implementing the continuous eligibility requirements of this section, the state department shall take all necessary steps to relieve the obligation of the state department and counties to promptly evaluate information that does not affect eligibility for continuous coverage cases under this section, unless required for program administration or as approved by the federal authorization.

(f) The continuous eligibility sought pursuant to this subsection (7) is dependent on the receipt of federal financial participation, to the maximum extent allowed under federal law, through federal authorization, state plan amendment, or otherwise, by the federal centers for medicare and medicaid services.

(g) The state board may promulgate rules as necessary to implement the requirements of this section.

Source: L. 2023: Entire section added, (HB 23-1300), ch. 302, p. 1810, § 2, effective June 1. **L. 2024:** (1), (3), IP(4), and (4)(a)(II) amended, (SB 24-176), ch. 152, p. 651, § 55, effective August 7; IP(7)(d) and (7)(d)(II) amended, (HB 24-1450), ch. 490, p. 3421, § 64, effective August 7. **L. 2026:** (2)(a), (2)(b), and (7)(b) amended, (HB 26-1411), ch. 398, p. 2493, § 7, effective June 4.

Cross references: For the legislative declaration in HB 23-1300, see section 1 of chapter 302, Session Laws of Colorado 2023.

25.5-5-336. Prohibition on using the body mass index or ideal body weight - medical necessity criteria.

(1) (a) Beginning July 1, 2023, the state medical assistance program shall not utilize the body mass index, ideal body weight, or any other standard requiring an achieved weight when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder, including but not limited to, bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(b) Subsection (1)(a) of this section does not apply when determining medical necessity or the appropriate level of care for an individual diagnosed with anorexia nervosa, restricting subtype; however, body mass index, ideal body weight, or any other standard requiring an achieved body weight must not be the determining factor when assessing medical necessity or the appropriate level of care for an individual diagnosed with anorexia nervosa, restricting subtype.

(2) The following factors, at a minimum, must be considered when determining medical necessity or the appropriate level of care for an individual diagnosed with an eating disorder:

(a) The individual's eating behaviors;

(b) The individual's need for supervised meals and support interventions;

(c) Laboratory results, including but not limited to, the individual's heart rate, renal or cardiovascular activity, and blood pressure;

(d) The recovery environment; and

(e) Co-occurring disorders the individual may have.

Source: L. 2023: Entire section added, (SB 23-176), ch. 275, p. 1626, § 2, effective May 30.

25.5-5-337. Telehealth remote monitoring services for outpatient clinical services - grant program - federal authorization - rules - definitions.

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

(a) "Grant program" means the telehealth remote monitoring grant program created in subsection (6) of this section.

(b) "Member" means any person who has been determined eligible to receive benefits or services under this title 25.5.

(c) "Telehealth remote monitoring" means the ongoing remote assessment and monitoring of clinical data through technological equipment in order to detect changes in a member's clinical status, which allows health-care providers to intervene before a health condition exacerbates and requires emergency intervention or inpatient hospitalization.

(2) (a) On or before September 1, 2024, the state department shall initiate a stakeholder process to determine the billing structure for telehealth remote monitoring for outpatient clinical services.

(b) The state department stakeholder process, required by subsection (2)(a) of this section, must engage with health-care providers who serve rural and underserved populations, including rural health clinics and federally qualified health centers, to ensure the billing structure is sustainable in these health-care settings.

(c) On or before June 30, 2025, the state board shall promulgate rules regarding the billing structure based on feedback from the stakeholder process required in subsections (2)(a) and (2)(b) of this section.

(3) (a) Beginning July 1, 2025, the state department shall provide reimbursement for the use of telehealth remote monitoring for outpatient clinical services if:

(I) The member's health-care provider determines that telehealth remote monitoring is medically necessary based on the member's medical condition or status;

(II) The member's health-care provider determines that telehealth remote monitoring would likely prevent the member's admission or readmission to a hospital, emergency department, nursing facility, or other clinical setting;

(III) The member is cognitively and physically capable of operating the telehealth remote monitoring device or equipment or the member has a caregiver who is able and willing to assist with the telehealth remote monitoring device or equipment; and

(IV) The member resides in a setting that is suitable for telehealth remote monitoring and does not have health-care staff on site.

(b) The state board shall promulgate rules regarding additional eligibility requirements. The eligibility requirements must prioritize members with chronic conditions and members who are pregnant and carrying a high-risk pregnancy.

(4) The assessment and monitoring of the health data transmitted by telehealth remote monitoring must be performed by one of the following licensed health-care professionals:

(a) Physician;

(b) Podiatrist;

(c) Advanced practice registered nurse;

(d) Physician assistant;

(e) Respiratory therapist;

(f) Pharmacist; or

(g) Licensed health-care professional working under the supervision of a medical director.

(5) The state department may seek any federal authorization necessary to implement subsections (3) and (4) of this section.

(6) (a) There is created in the state department the telehealth remote monitoring grant program to provide grants to outpatient health-care facilities located in a designated rural county or a designated health-care professional shortage area to assist the hospitals and clinics with the financial costs associated with providing telehealth remote monitoring for outpatient clinical services.

(b) The state department shall administer the grant program and, subject to available appropriations, shall award grants as provided in this subsection (6).

(c) To be eligible for a grant, an outpatient health-care facility must:

(I) Apply for a grant in the manner prescribed by the state department;

(II) Be located in a designated rural county or designated health-care professional shortage area; and

(III) Have a demonstrated need for financial assistance to purchase equipment to provide telehealth remote monitoring for outpatient clinical services.

(d) The state department may award up to five grants through the grant program. Each grant awarded must be in the amount of one hundred thousand dollars.

(e) In selecting grant recipients, the state department shall prioritize applicants that serve populations experiencing disparities in health-care access and outcomes, including, but not limited to, historically marginalized and underserved communities, determined by the

communities with the highest proportion of patients receiving assistance through the "Colorado Medical Assistance Act", this article 5 and articles 4 and 6 of this title 25.5.

(f) Grant recipients may use money received through the grant program to implement telehealth remote monitoring for outpatient clinical services and includes the following:

(I) Training staff to use, assess, and monitor telehealth remote monitoring equipment and devices; and

(II) Acquiring telehealth remote monitoring equipment and devices.

(g) Money allocated to the grant program must not be considered in rate-setting for federally qualified health centers, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4).

(7) The state department is authorized to receive and expend gifts, grants, and donations from individuals, private organizations, foundations, or any governmental unit; except that no gift, grant, or donation may be accepted by the state department if it is subject to a condition that is inconsistent with this section or any other law of this state.

(8) This section does not apply to home health-care benefits provided pursuant to section 25.5-5-321.

Source: L. 2024: Entire section added, (SB 24-168), ch. 281, p. 1875, § 2, effective August 7.

Cross references: For the legislative declaration in SB 24-168, see section 1 of chapter 281, Session Laws of Colorado 2024.

25.5-5-338. Continuous glucose monitors - coverage - federal authorization - definition.

(1) As used in this section, unless the context otherwise requires, "continuous glucose monitor" means an instrument or a device designed for the purpose of aiding in the treatment of diabetes by measuring glucose levels on demand or at set intervals through a small electronic sensor that slightly penetrates an individual's skin when applied and that is designed to remain in place and active for at least seven days.

(2) (a) Beginning November 1, 2025, the state department shall provide coverage for a continuous glucose monitor and related supplies to members under the medicaid medical and pharmacy benefit.

(b) Coverage criteria must align with the current glucose monitor local coverage determination standards issued by the centers for medicare and medicaid that are used to

determine coverage for medicare-eligible individuals, including individuals with gestational diabetes not being treated with insulin.

(3) Coverage pursuant to this section includes the cost of any necessary repairs or replacement parts for the continuous glucose monitor.

(4) The state department may seek any federal authorization necessary to implement this section.

(5) The state department is authorized to receive and expend gifts, grants, and donations from individuals, private organizations, foundations, or any governmental unit; except that no gift, grant, or donation may be accepted by the state department if it is subject to a condition that is inconsistent with this section or any other law of this state.

Source: L. 2024: Entire section added, (SB 24-168), ch. 281, p. 1878, § 3, effective August 7.

Cross references: For the legislative declaration in SB 24-168, see section 1 of chapter 281, Session Laws of Colorado 2024.

25.5-5-339. Coverage for services addressing health-related social needs feasibility study - federal authorization - rules.

(1) (a) The state department shall study the feasibility of providing nutrition, housing, and tenant supportive services that address members' health-related social needs in order to determine whether to seek a federal authorization to provide the services.

(b) The feasibility study must address the costs, implementation factors, affected populations, federal and state funding mechanisms, and timeline for the state department to seek a federal authorization that, at a minimum, provides:

(I) Housing-related services and tenant supportive services, including up to six months of rental assistance or temporary housing and utility assistance, where applicable, for:

(A) Individuals transitioning out of institutional care or a congregate care setting, or individuals at risk of institutionalization;

(B) Individuals who are experiencing homelessness, at risk of homelessness, or transitioning out of an emergency shelter, noncongregate shelter, or micro-community; and

(C) Youth in or transitioning out of foster care, or former foster care youth; and

(II) Nutrition-related services, including up to three medically tailored meals per day, initially for up to six months with the possibility of continuing the meals upon a state department determination to continue the meals, delivered to a member's home or other private residence if the member has an eligible health-related medical or health-related social need, as determined by the state department.

(c) The feasibility study must also address the costs, implementation factors, timeline, provider types, settings, and full range of services to be covered for the state department to seek a federal authorization that provides:

(I) Pre-tenancy and tenancy-sustaining services, including, but not limited to, tenant rights education and eviction prevention;

(II) Housing transition navigation services, including, but not limited to, individualized case management, skills building, and peer support services;

(III) One-time housing transition and moving costs, including, but not limited to, security deposits; first month's rent; movers; relocation expenses; and costs associated with utility activation, identification requirements, and housing applications and inspections;

(IV) Pantry stocking or up to three meals per day, delivered to the member's home or other private residence for a child or youth under twenty-one years of age or a pregnant person for up to six months; and

(V) Nutrition prescriptions that are targeted to medically vulnerable populations, as determined by the state department, and tailored to the member's health and social risk, nutrition-sensitive health conditions, or have a demonstrated outcome improvement, including fruit and vegetable prescriptions and protein boxes for up to six months.

(2) In addition to the study topics detailed in subsection (1) of this section, the feasibility study must address how to best:

(a) Ensure the housing-related services and tenant supportive services described in subsection (1) of this section supplement and integrate with other existing housing-related services and tenant supportive services;

(b) Coordinate eligibility and priority determinations for the housing-related services and tenant supportive services described in subsection (1) of this section with existing processes, including wait lists and coordinated entry systems;

(c) Align temporary housing assistance described in subsection (1)(b)(I) of this section with existing long-term rental assistance program requirements and processes;

(d) Ensure the nutrition-related services described in subsection (1) of this section supplement rather than supplant existing federal, state, and local nutrition-related services;

(e) Coordinate with state agencies and county departments to connect members experiencing food insecurity to other state and federal nutrition programs, including the federal special supplemental food program for women, infants, and children, 42 U.S.C. sec. 1786, as amended; the supplemental nutrition assistance program, established in part 3 of article 2 of title 26; and temporary assistance for needy families, as defined in section 26-2-703;

(f) Coordinate with other state and local housing authorities to assist members in obtaining other existing housing-related services and tenant supportive services;

(g) Ensure that all health-related social needs services provided pursuant to subsection (1) of this section are:

(I) Medically appropriate, as determined by state-defined clinical and social risk criteria; and

(II) Optional for members, who may opt out at any time; and

(h) Utilize managed care entities, as defined in section 25.5-5-403, to coordinate services that address the health-related social needs of members described in subsection (1) of this section.

(3) (a) In conducting the feasibility study pursuant to this section, the state department shall determine:

(I) What provider types may be reimbursed for housing-related services and tenant supportive services, which must not be limited to clinical providers;

(II) The types of housing-related services and tenant supportive services, including supportive or wraparound services, that are required to keep people stably housed and that are available for reimbursement, including, but not limited to, case management, on-site physical and behavioral health care, peer support services, skill-building services, and navigation services; and

(III) The housing settings in which housing-related services and tenant supportive services may be provided, including, but not limited to, traditional congregate shelters, noncongregate shelters, and micro-communities, where people are transitionally housed.

(b) In determining the reimbursement methodology for housing-related services and tenant supportive services pursuant to subsection (3)(a) of this section, the state department shall consider a per member per month lump sum payment combined with housing vouchers and other available subsidies rather than a direct reimbursement model.

(c) In conducting the feasibility study pursuant to this section, the state department shall consider how best to leverage available state-designated health program funding.

(4) In conducting the feasibility study pursuant to this section, the state department shall take into consideration examples of federal authorizations granted to other states in order to

streamline the development of a potential federal authorization for health-related social needs in Colorado and increase the likelihood of its approval.

(5) If, in conducting the feasibility study pursuant to this section, the state department determines that providing nutrition, housing, and tenant supportive services that address members' health-related social needs through federal authorization would be budget neutral to the general fund due to offsetting reductions in medical services expenditures or other state expenditures, then the state department shall seek federal authorization no later than July 1, 2025, to provide any of the nutrition, housing, and tenant supportive services described in this section.

(6) Repealed.

(7) The state department may hire a consultant to assist with developing the feasibility study and related report; the process of seeking federal authorization; and any resulting monitoring, renewal, or amendment processes.

(8) The state department may seek, accept, and expend gifts, grants, or donations from private or public sources for the purposes of conducting the feasibility study pursuant to this section.

(9) The state board shall promulgate any rules necessary to implement and administer this section.

(10) The state department shall continue to cover the costs of current housing-related and tenant supportive services through the statewide supportive services expansion pilot program until federal authorization is granted.

(11) To provide peer support services in compliance with the terms of the federal authorization, the state department shall develop a workforce to provide peer support services.

Source: L. 2024: Entire section added, (HB 24-1322), ch. 362, p. 2449, § 1, effective June 3. **L. 2025:** (12) added, (SB 25-308), ch. 299, p. 1524, § 2, effective May 30. **L. 2026:** (6) repealed, (HB 26-1295), ch. 121, p. 524, § 19, effective August 12.

Editor's note: (1) This section was numbered as § 25.5-5-338 in HB 24-1322 but was renumbered on revision for ease of location.

(2) Subsection (11) was numbered as subsection (12) in SB 25-308 but was renumbered on revision for ease of location.

25.5-5-340. Health-related social needs reinvestment cash fund - creation - definitions.

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

(a) "Federal authorization" means the authorization the state department received from the federal centers for medicare and medicaid services to provide coverage for health-related social needs through the state medical assistance program.

(b) "Fund" means the health-related social needs reinvestment cash fund created in this section.

(2) (a) The health-related social needs reinvestment cash fund is created in the state treasury. The fund consists of money transferred to the fund pursuant to subsection (3) of this section and any other money that the general assembly may appropriate or transfer to the fund.

(b) In accordance with section 24-36-114 (1), the state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the general fund.

(3) Beginning June 30, 2026, and on June 30 of each year thereafter, the state treasurer shall transfer from the general fund to the fund an amount of money equal to the amount of unspent money that reverted to the general fund in that year from the appropriation from the general fund to the state department for health-related social needs.

(4) Subject to annual appropriation by the general assembly, the state department may expend money from the fund for services that support health-related social needs and related administrative services, as authorized by the federal authorization.

(5) On or after November 1, 2025, and on or after November 1 each year thereafter, the state department shall present to the joint budget committee a recommendation for spending money in the fund to expand and enhance services authorized by the federal authorization. When developing the recommendation, the state department shall consult with state agencies participating in services provided through, and stakeholders who represent the members receiving services included in, the federal authorization.

Source: L. 2025: Entire section added, (SB 25-308), ch. 299, p. 1523, § 1, effective May 30.

PART 4

STATEWIDE MANAGED CARE SYSTEM

25.5-5-401. Short title.

This part 4 shall be known and may be cited as the "Statewide Managed Care System".

Source: L. 2006: Entire article added with relocations, p. 1883, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-111 as it existed prior to 2006.

25.5-5-402. Statewide managed care system - rules - definitions - repeal.

(1) The state board shall adopt rules to implement a statewide managed care system for Colorado medical assistance members pursuant to the provisions of this article 5 and articles 4 and 6 of this title 25.5. The statewide managed care system shall be implemented to the extent possible.

(2) The statewide managed care system implemented pursuant to this article 5 does not include:

(a) The services delivered pursuant to the residential child health-care program described in section 25.5-6-903;

(b) Long-term care services and the program of all-inclusive care for the elderly, as described in section 25.5-5-412. For purposes of this subsection (2), "long-term care services" means nursing facilities and home- and community-based services provided to eligible members who have been determined to be in need of such services pursuant to the "Colorado Medical Assistance Act" and the state board's rules.

(c) (I) The services delivered in a qualified residential treatment program, as defined in section 26-5.4-102, or in a psychiatric residential treatment facility, as defined in section 25.5-4-103, to members who are in the care and custody of a county department of human or social services.

(II) This subsection (2)(c) is repealed, effective July 1, 2027.

(3) The statewide managed care system must include a statewide system of community behavioral health care that must:

(a) Address the economic, social, and personal costs to the state of Colorado and its citizens of untreated behavioral health disorders, including mental health and substance use disorders;

(b) Approach behavioral health disorders as treatable conditions not unlike other chronic health issues that require a combination of behavioral change and medication or other treatment;

(c) Offer timely access through multiple points of entry to a full continuum of culturally responsive behavioral health services, including prevention, early intervention, crisis response, treatment, and recovery services, that support individuals living full, productive lives;

(c.5) Provide coordination of care for the full continuum of substance use disorder and mental health treatment and recovery, including support for individuals transitioning between levels of care;

(d) Feature a comprehensive and integrated system of quality behavioral health care that is individualized and coordinated to meet individuals' changing needs;

(e) Be paid for by the state department establishing capitated rates specifically for behavioral health services that account for a comprehensive continuum of needed services such as those provided by licensed behavioral health providers, including essential and comprehensive community behavioral health providers, as defined in section 27-50-101;

(f) Make the behavioral health system's administrative processes, service delivery, and funding more effective and efficient to improve outcomes for Colorado citizens;

(g) In addition to network adequacy requirements determined by the state department, require each MCE to offer an enrollee an initial or subsequent nonurgent care visit within a reasonable period where medically necessary and at appropriate therapeutic intervals, as determined by state board rule;

(h) Specify that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health service; and

(i) Require an MCE to cover all medically necessary covered treatments for covered behavioral health diagnoses, regardless of any co-occurring conditions.

(3.5) (a) No later than July 1, 2023, the state department, in collaboration with the behavioral health administration in the department of human services and other state agencies, shall develop the universal contract as described in section 27-50-203.

(b) Repealed.

(4) The statewide managed care system must promote the utilization of the medical home model of care for all enrolled members. The medical home model of care establishes a focal point of care for comprehensive primary care and efficient coordination with specialty care providers and other health-care systems. The medical home model has proven effective in promoting early intervention and prevention, improving individuals' health, and reducing health-care costs.

(5) The statewide managed care system builds upon the lessons learned from previous managed care and community behavioral health-care programs in the state in order to reduce barriers that may negatively impact medicaid member experience, medicaid member health, and efficient use of state resources. The statewide managed care system is authorized to provide services under a single MCE type or a combination of MCE types.

(6) (a) The state department is authorized to assign a medicaid member to a particular MCE, consistent with federal requirements and rules promulgated by the state board.

(b) For a child or youth who obtains eligibility for services under the state's medicaid program through a dependency and neglect action resulting in out-of-home placement pursuant to article 3 of title 19 or a juvenile delinquency action resulting in out-of-home placement pursuant to article 2.5 of title 19, the state department shall assign the child or youth to the MCE covering the county with jurisdiction over the action. The state department shall only change the assignment if the change is requested by the county with jurisdiction over the action or by the child's or youth's legal guardian.

(7) The state department is authorized to enter into a contract with MCOs, PCCM Entities, prepaid ambulatory health plans, and prepaid inpatient health plans, subject to the receipt of any required federal authorizations and pursuant to the requirements of this section.

(7.3) (a) Beginning January 1, 2026, for a claim that must be reprocessed as a result of updating the provider rates, an MCO shall issue payment to the contracted provider within one year after the provider rate is updated.

(b) The state department shall notify the MCOs of any change to the provider rates within sixty days of changing the provider rates.

(7.5) (a) The state department shall offer to enter into a direct contract for physical health-care services with the MCO operated by or under the control of Denver health and hospital authority, created pursuant to article 29 of title 25, from July 1, 2025, until June 30, 2032, as long as the MCO meets all MCO criteria required by the state department. If the state department designates an MCE other than the MCO operated by or under the control of Denver health and hospital authority to manage behavioral health-care services pursuant to this article 5, Denver health and hospital authority, or any subsidiary, shall collaborate with the MCE during the term of contract.

(b) The MCO operated by or under the control of Denver health and hospital authority shall:

(I) Maintain adequate financials to ensure proper solvency as a risk manager;

(II) Accept rates determined by the state department, through standard methodologies, to cover the population it is serving. Rates paid by the MCO to contracted providers must not be higher than the state department's medicaid fee-for-service rates unless the provider enters into a quality incentive agreement with the MCO.

(III) Maintain service and quality metrics, as determined by the state department; and

(IV) Meet statewide managed care system standards and operate as part of the overall managed care system.

(8) **Waivers.** The implementation of this part 4 is conditioned, to the extent applicable, on the issuance of necessary waivers by the federal government. The provisions of this part 4 must be implemented to the extent authorized by federal waiver, if so required by federal law.

(9) **Bidding.**

(a) The state department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203 for MCEs seeking to provide, arrange for, or otherwise be responsible for the provision of services to its members. The state department is authorized to award contracts to more than one offeror. The state department shall use competitive bidding procedures to encourage competition and improve the quality of care available to medicaid members over the long term that meets the requirements of this section and section 25.5-5-406.1.

(b) (I) On or before January 1, 2023, in order to promote transparency and accountability, the state department shall require each MCE that has twenty-five percent or more ownership by providers of behavioral health services to comply with the following conflict of interest policies:

(A) Providers who have ownership or board membership in an MCE shall not have control, influence, or decision-making authority in the establishment of provider networks.

(B) Each MCE shall report quarterly the number of providers who applied to join the network and were denied and a comparison of rate ranges for providers who have ownership or board membership versus providers who do not.

(C) An employee of a contracted provider of an MCE shall not also be an employee of the MCE unless the employee is a clinical officer or utilization management director of the MCE. If the individual is also an employee of a provider that has board membership or ownership in the MCE, the MCE shall develop policies, approved by the executive director of the state department, to mitigate any conflict of interest the employee may have.

(D) An MCE's board shall not have more than fifty percent of contracted providers as board members, and the MCE is encouraged to have a community member on the MCE's board.

(II) No later than July 1, 2025, the state department shall appropriately address perceived or actual provider ownership and control of MCEs participating in the statewide managed care system in the interest of transparency and accountability. In designing a competitive bidding process, the state department shall incorporate community feedback and have a public process related to governing requirements, including how to address conflicts of interest.

(III) As used in this subsection (9)(b):

(A) "Clinical officer" means a physician who provides the clinical vision for the MCE or provides clinical direction to network management, quality improvement, utilization management, or credentialing divisions.

(B) "MCE" means a managed care entity responsible for the statewide system of community behavioral health care, as described in section 25.5-5-402 (3), and is not owned, operated by, or affiliated with an instrumentality, municipality, or political subdivision of the state.

(C) "Ownership" means an individual who is a legal proprietor of an organization, including a provider or individual who owns assets of an organization, or has a financial stake, interest, or governance role in the MCE.

(D) "Utilization management director" means a licensed health-care professional with behavioral health clinical experience who leads and develops the utilization management program or manages the medical review and authorization process.

(10) An MCE that is contracting for a defined scope of services under a risk contract shall certify the financial stability of the MCE pursuant to criteria established by the division of insurance.

(11) The state department shall conduct a review of each MCE, in accordance with federal requirements, prior to the implementation of a contract to assess the ability and capacity of the MCE to satisfactorily perform the operational requirements of the contract.

(12) **Graduate medical education.** The state department shall continue the graduate medical education, referred to in this subsection (12) as "GME", funding to teaching hospitals that have graduate medical education expenses in their medicare cost report and are participating as providers under one or more MCEs with a contract with the state department under this part 4. GME funding for members enrolled in an MCE is excluded from the premiums paid to the MCE and must be paid directly to the teaching hospital. The state board shall adopt rules to implement this subsection (12) and establish the rate and method of reimbursement.

(13) Nothing in this part 4 creates an exemption from the applicable provisions of title 10.

(14) Nothing in this part 4 creates an entitlement to an MCE to contract with the state department.

(15) On or before July 1, 2020, the state department shall include utilization management guidelines for the MCEs in the state board's managed care rules.

(16) The state department shall provide information on its website specifying how the public may request the network adequacy plan and quarterly network reports for an MCE. The plan must include actions taken by the MCE to ensure that all necessary and covered primary care, care coordination, and behavioral health services are provided to enrollees with reasonable promptness. Such actions include, without limitation:

(a) Utilizing single case agreements with out-of-network providers when necessary; and

(b) Using financial incentives to increase network participation.

(17) If the state department receives a complaint from the office of the ombudsman for behavioral health access to care established pursuant to part 3 of article 80 of title 27 that relates to possible violations of subsection (3) of this section or the MHPAEA, the state department shall examine the complaint, as requested by the office, and shall report to the office in a timely manner any actions taken related to the complaint.

Source: L. 2006: Entire article added with relocations, p. 1883, § 7, effective July 1. **L. 2008:** (3) and (5) amended, p. 390, § 1, effective August 5. **L. 2012:** (6) added, (HB 12-1281), ch. 246, p. 1187, § 3, effective June 4. **L. 2018:** Entire section amended with relocations, (HB 18-1431), ch. 313, p. 1877, § 1, effective August 8; IP(2) and (2)(a) amended, (HB 18-1328), ch. 184, p. 1244, § 6, effective June 7, 2019. **L. 2019:** (3)(e) amended and (3)(g), (3)(h), (3)(i), (15), (16), and (17) added, (HB 19-1269), ch. 195, p. 2133, § 12, effective May 16; (7.5) added, (HB 19-1285), ch. 392, p. 3501, § 1, effective August 2. **L. 2020:** (6) amended, (HB 20-1237), ch. 271, p. 1319, § 1, effective July 11; (3)(c.5) added, (SB 20-007), ch. 286, p. 1391, § 7, effective July 13. **L. 2021:** (6)(b) amended, (SB 21-059), ch. 136, p. 747, § 123, effective October 1. **L. 2022:** (9) amended, (SB 22-106), ch. 196, p. 1309, § 1, effective May 20; (3.5) added, (HB 22-1302), ch. 180, p. 1200, § 3, effective July 1; (3)(e) amended, (HB 22-1278), ch. 222, p. 1594, § 234, effective July 1, 2024. **L. 2024:** (7.5)(a) and (7.5)(b)(II) amended, (HB 24-1086), ch. 46, p. 164, § 2, effective April 4; (1), (2)(b), (5), (6)(a), (9)(a), and (12) amended, (SB 24-176), ch. 152, p. 652, § 56, effective August 7. **L. 2025:** (2)(a) amended and (2)(c) added, (SB 25-294), ch. 329, p. 1710, § 1, effective May 31; (7.3) added, (HB 25-1213), ch. 276, p. 1438, § 5, August 6. **L. 2026:** (2)(c)(II) amended, (SB 26-188), ch. 316, p. 1859, § 3, effective June 2.

Editor's note: (1) This section is similar to former § 26-4-113 as it existed prior to 2006.

(2) Section 10 of chapter 184 (HB 18-1328), Session Laws of Colorado 2018, provides that section 6 of the act changing this section takes effect upon notice to the revisor of statutes pursuant to § 25.5-5-306 (6) as enacted in section 2 of the act. For more information, see HB 18-1328. (L. 2018, p. 1247.) On August 14, 2019, the revisor of statutes received the notice referred to in § 25.5-5-306 (6) that the federal department of health and human services approved the waiver on June 7, 2019.

(3) Amendments to subsections IP(2) and (2)(a) by HB 18-1328 and HB 18-1431 were harmonized, effective June 7, 2019.

(4) Provisions of this section are similar to provisions of former §§ 25.5-5-402, 25.5-5-404, 25.5-5-406, and 25.5-5-411, as they existed prior to 2018. For a detailed comparison of this section, see the comparative tables located at the back of the index.

(5) Subsection (3.5)(b)(II) provided for the repeal of subsection (3.5)(b), effective July 1, 2024. (See L. 2022, p. 1200.)

Cross references: (1) For the legislative declaration in HB 18-1328, see section 1 of chapter 184, Session Laws of Colorado 2018. For the legislative declaration in HB 22-1302, see section 1 of chapter 180, Session Laws of Colorado 2022. For the legislative declaration in HB 24-1086, see section 1 of chapter 46, Session Laws of Colorado 2024.

(2) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

25.5-5-403. Definitions.

As used in this part 4, unless the context otherwise requires:

(1) Repealed.

(2) "Essential community provider", referred to in this part 4 as an "ECP", means a health-care provider that:

(a) Has historically served medically needy or medically indigent patients and that demonstrates a commitment to serve low-income and medically indigent populations who comprise a significant portion of its patient population or, in the case of a sole community provider, serves the medically indigent patients within its medical capability; and

(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a member's financial limitations.

(2.5) "Global payment" means a population-based payment mechanism that is constructed on a per-member, per-month calculation. Global payments must account for prospective local community or health system cost trends and value, as measured by quality and satisfaction metrics, and incorporate community cost experience and reported encounter data to the greatest extent possible to address regional variation and improve longitudinal performance. Risk adjustments, risk-sharing, and aligned payment incentives may be utilized to achieve performance improvement. The rate calculations for global payment are exempt from the provisions of section 25.5-5-408. An entity that uses global payment pursuant to section 25.5-5-402 shall meet the applicable financial solvency requirements of sections 25.5-5-402 (10) and 25.5-5-408 (1)(f) and the essential community provider requirements of sections 25.5-5-406.1 (1)(f)(II) and 25.5-5-408 (1)(d).

(3) (a) "Managed care" means a health-care delivery system organized to manage costs, utilization, and quality. Medicaid managed care provides for the delivery of medicaid health

benefits and additional services through contracted arrangements between state medicaid agencies and MCEs.

(b) Nothing in this section affects the benefits authorized for members of the state medical assistance program.

(4) "Managed care entity", referred to in this part 4 as an "MCE", means an entity that enters into a contract to provide services in the statewide managed care system, including MCOs, prepaid inpatient health plans, prepaid ambulatory health plans, and PCCM Entities.

(5) "Managed care organization", referred to in this part 4 as an "MCO", means an entity contracting with the state department that meets the definition of managed care organization as defined in 42 CFR 438.2.

(5.5) "Medical home" means an appropriately qualified medical health-care practice that verifiably ensures continuous access to comprehensive, accessible, and coordinated community-based primary care. All medical homes may have, but are not limited to, the following:

(a) Health maintenance and preventive care;

(b) Anticipatory guidance and health education;

(c) Acute and chronic illness care;

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

(e) Provider participation in hospital care; and

(f) Mental health care, oral health care, and other related services, as appropriate.

(5.7) "MHPAEA" means the federal "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008", Pub.L. 110-343, as amended, and all of its implementing and related regulations.

(6) "Prepaid ambulatory health plan", referred to in this part 4 as a "PAHP", means an entity contracting with the state department that meets the definition of prepaid ambulatory health plan as defined in 42 CFR 438.2.

(7) "Prepaid inpatient health plan", referred to in this part 4 as "PIHP", means an entity contracting with the state department that meets the definition of prepaid inpatient health plan as defined in 42 CFR 438.2.

(7.5) "Primary care case management entity", referred to in this part 4 as a "PCCM Entity", means an entity contracting with the state department that meets the definition of primary care case management entity as defined in 42 CFR 438.2.

(8) "Primary care case manager", referred to in this part 4 as a "PCCM", means a physician, a physician group practice, or other practitioner as identified by the state that meets the definition of primary care case manager as defined in 42 CFR 438.2.

Source: L. 2006: Entire article added with relocations, p. 1884, § 7, effective July 1. **L. 2007:** (1)(a) amended, p. 1354, § 3, effective May 29. **L. 2008:** Entire section amended, p. 390, § 2, effective August 5. **L. 2012:** (2.5) added, (HB 12-1281), ch. 246, p. 1187, § 4, effective June 4. **L. 2018:** (1) repealed, (2.5), (3)(a), (4), and (8) amended, and (5.5) and (7.5) added (HB 18-1431), ch. 313, p. 1881, § 2, effective August 8. **L. 2019:** (5.7) added, (HB 19-1269), ch. 195, p. 2134, § 13, effective May 16. **L. 2024:** (2)(b) and (3) amended, (SB 24-176), ch. 152, p. 653, § 57, effective August 7.

Editor's note: This section is similar to former § 26-4-114 as it existed prior to 2006.

Cross references: (1) For additional definitions applicable to this part 4, see § 25.5-4-103.

(2) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

25.5-5-404. Selection of managed care entities. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1885, § 7, effective July 1. **L. 2008:** Entire section amended, p. 392, § 3, effective August 5. **L. 2014:** (1)(v) added, (HB 14-1211), ch. 253, p. 1011, § 2, effective January 1, 2015. **L. 2018:** Entire section repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8.

Editor's note: (1) This section was similar to former § 26-4-115 as it existed prior to 2006.

(2) Provisions of this section were relocated to §§ 25.5-5-402 and 25.5-5-406.1 in 2018. For a detailed comparison of this section, see the comparative tables located at the back of the index.

25.5-5-405. Quality measurements. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1889, § 7, effective July 1. **L. 2018:** Entire section repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8.

Editor's note: This section was similar to former § 26-4-116 as it existed prior to 2006.

25.5-5-406. Required features of managed care system. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1889, § 7, effective July 1. **L. 2008:** Entire section amended, p. 396, § 4, effective August 5. **L. 2012:** (2) amended, (HB 12-1281), ch. 246, p. 1187, § 5, effective June 4. **L. 2016:** (1)(f)(I) amended, (HB 16-1081), ch. 22, p. 53, § 9, effective August 10. **L. 2018:** Entire section repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8.

Editor's note: (1) This section was similar to former § 26-4-117 as it existed prior to 2006.

(2) Provisions of this section were relocated to §§ 25.5-5-402 and 25.5-5-406.1 in 2018. For a detailed comparison of this section, see the comparative tables located at the back of the index.

25.5-5-406.1. Required features of statewide managed care system.

(1) **General features.** All medicaid managed care programs must contain the following general features, in addition to others that the federal government, state department, and state board consider necessary for the effective and cost-efficient operation of those programs:

(a) The MCE shall accept all enrollees that the state department assigns to the MCE in the order in which they are assigned, without restriction, regardless of health status or need for health-care services;

(b) The MCE shall not discriminate against enrolled members on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity, gender expression, disability, religion, creed, or political beliefs, and shall not use any policy or practice that has the effect of discriminating on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity, gender expression, disability, religion, creed, or political beliefs;

(c) The MCE shall allow each enrolled member to choose his or her network provider to the extent possible and appropriate;

(d) Notwithstanding any waivers authorized by the federal department of health and human services, or any successor agency, each contract between the state department and an MCE selected to participate in the statewide managed care system under this part 4 shall comply with the requirements of 42 U.S.C. sec. 1396a (a)(23)(B);

(e) The MCE shall ensure access to care for all enrolled members in need of medically necessary services covered in the contract;

(f) The MCE shall create, administer, and maintain a network of providers, building on the current network of medicaid providers, to serve the health-care needs of its members. In doing so, the MCE shall:

(I) Support providers in serving the medicaid population and implement value-based payment methodologies for network providers that incentivize and reward providers for the effective and efficient delivery of high-quality services to enrolled members;

(II) (A) Seek proposals from each ECP in a county in which the MCE is enrolling members for those services that the MCE provides or intends to provide and that an ECP provides or is capable of providing. The MCE shall consider such proposals in good faith and shall, when deemed reasonable by the MCE based on the needs of its members, contract with ECPs. Each ECP shall be willing to negotiate on reasonably equitable terms with each MCE. ECPs making proposals under this subsection (1)(f)(II) must be able to meet the contractual requirements of the MCE. The requirements of this subsection (1)(f)(II) do not apply to an MCE in areas in which the MCE operates entirely as a group health maintenance organization.

(B) In selecting MCEs, the state department shall not penalize an MCE for paying cost-based reimbursement to federally qualified health centers as defined in the federal "Social Security Act".

(III) Demonstrate that there are sufficient Indian health-care providers participating in the provider network to ensure timely access to services available under the contract from such providers for Indian enrollees who are eligible to receive services.

(IV) Enter into single case agreements with willing providers of behavioral health services enrolled in the medical assistance program when network development and access standards established by the state department are not met and a member needs access to a medically necessary behavioral health service covered under the scope of the MCE's contract with the state department. The MCE:

(A) Shall consider any behavioral health provider enrolled in the medical assistance program for a single case agreement if the MCE cannot provide a covered service through its contracted provider network;

(B) Shall ensure all care coordination staff and staff who provide member and provider support are trained in the single case agreement process;

(C) Can refuse to offer single case agreements based on factors of provider cost and quality concerns;

(D) Shall offer both member and out-of-network providers assistance in navigating its single case agreement process;

(E) Shall ensure the single case agreement process is executed within the standards and timeliness requirements established by the state department;

(F) Shall not require providers that enter into a single case agreement to serve additional members; and

(G) Shall complete single case agreements on a timeline that is informed by stakeholder input.

(g) The MCE shall ensure that its contracted network providers are capable of serving all members, including contracting with providers with specialized training and expertise across all ages, levels of ability, gender identities, and cultural identities;

(h) The MCE shall meet the network adequacy standards, as established by the state department, describing the maximum time and distance an enrolled member is expected to travel in order to access the provider types covered under the state contract;

(i) The MCE shall meet, and require its network providers to meet, standards as established by the state department for timely access to care and services, taking into account the urgency of the need for services;

(j) (I) The MCE shall not interfere with appropriate medical care decisions rendered by its contracted network providers;

(II) A prepaid inpatient health plan shall not require prior authorization for outpatient psychotherapy services, as defined in the most recent version of the "Current Procedural Terminology", as developed and copyrighted by the American Medical Association or its successor entity;

(k) The MCE shall comply with the state department's transition of care policy to ensure continued access to services during a transition from fee-for-service to an MCE or transition from one MCE to another when an enrollee, in the absence of continued access to services, would suffer serious detriment to his or her health or be at risk of hospitalization or institutionalization;

(l) The MCE shall provide and facilitate the delivery of services in a culturally competent manner to all members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and disabilities, and regardless of gender, sexual orientation, gender identity, or gender expression;

(m) The MCE shall provide communications in a manner and format that may be easily understood and is readily accessible by members;

(n) **Grievances and appeals.**

(I) (A) Each MCE shall establish a grievance and appeal system that complies with rules established by the state board and federal government.

(B) An enrollee is entitled to designate a representative, including but not limited to an attorney, the ombudsman for medicaid managed care, a lay advocate, or the enrollee's physician, to file and pursue a grievance or appeal on behalf of the enrollee. The procedure must allow for the unencumbered participation of physicians.

(II) The MCE shall have an established grievance system that allows for member expression of dissatisfaction at any time about any matter related to the MCE's contracted services, other than an adverse benefit determination. The grievance system must provide timely resolution of the matters in a manner consistent with the medical needs of the individual member.

(III) (A) The MCE shall have an appeal system for review of any determination by the MCE to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

(B) Each MCE shall utilize an appeal process for expedited reviews that complies with rules established by the state board. The appeal process for expedited reviews must provide a means by which an enrollee may complain and seek resolution concerning any action or failure to act in an emergency situation that immediately impacts the enrollee's access to quality health-care services, treatments, or providers.

(C) The state department shall establish the position of ombudsman for medicaid managed care. The ombudsman shall, if the enrollee requests, act as the enrollee's representative in resolving appeals with the MCE. It is the intent of the general assembly that the ombudsman for medicaid managed care be independent from the state department and selected through a competitive bidding process. In the event the state department is unable to contract with an independent ombudsman, an employee of the state department may serve as the ombudsman for medicaid managed care. An enrollee whose appeal is not resolved to his or her satisfaction by a procedure described in this subsection (1)(n), or whose appeal is deemed exhausted, is entitled to request a state fair hearing by an independent hearing officer, further judicial review, or both, as provided for by federal law and any state statute or rule.

(o) The MCE shall maintain and participate in an ongoing comprehensive quality assessment and performance improvement program that must include but not be limited to the following:

(I) Performance improvement projects designed to achieve significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction;

(II) The collection and submission of performance measurement data as required by the state department;

(III) The implementation and maintenance of mechanisms to detect overutilization and underutilization of services and to assess the quality and appropriateness of care furnished to its members, including members with special health-care needs; and

(IV) Annual participation in an independent quality review and validation of performance improvement projects, performance measures, and other contract requirements;

(p) (I) The MCE shall administer a program integrity system to ensure compliance with all requirements established by the federal government, state of Colorado, state department, and state board that includes, but is not limited to:

(A) Procedures to detect and prevent fraud, waste, and abuse;

(B) Screening and disclosure processes to prevent relationships with individuals or entities that are debarred, suspended, or otherwise excluded from participating in any federal health-care program, procurement activities, or nonprocurement activities; and

(C) Treatment of recoveries of overpayment to providers;

(II) Prepaid inpatient health plans shall not retroactively recover provider payments if:

(A) A member was initially determined to be eligible for medical benefits pursuant to section 25.5-4-205 when the provider has an eligibility guarantee number for the member; or

(B) The prepaid inpatient health plan makes an error processing the claim but the claim is otherwise accurately submitted by the provider.

(III) (A) Prepaid inpatient health plans shall not retroactively recover provider payments after twelve months from the date a claim was paid, except when medicare, commercial insurance, or third-party liability is the primary payer for a claim; the claim is the subject of a state or federal audit, including audits contractually required by the state department; the claim is subject to a law enforcement investigation; the claim submitted is a duplicate; the claim is fraudulent; the provider improperly bills the claim; or the claim is submitted with a billing code or diagnosis code that inaccurately or incorrectly resulted in reimbursement or bypassed prior authorization requirements.

(B) If a prepaid inpatient health plan retroactively recovers a provider payment that is equal to one thousand dollars or more, the prepaid inpatient health plan shall work with the provider to develop a payment plan if the provider requests a payment plan.

(q) **Billing medicaid members.** Notwithstanding any federal regulations or the general prohibition of section 25.5-4-301 against providers billing medicaid members, a provider may bill a medicaid member who is enrolled with a specific medicaid PCCM or MCE and, in

circumstances defined by the rules of the state board, receives care from a medical provider outside that organization's network or without referral by the member's PCCM;

(r) **Marketing.** In marketing coverage to medicaid members, all MCEs shall comply with all applicable provisions of title 10 regarding health plan marketing. The state board is authorized to promulgate rules concerning the permissible marketing of medicaid managed care. The purposes of the rules must include but not be limited to the avoidance of biased selection among the choices available to medicaid members.

(s) **Prescription drugs.** All MCEs that have prescription drugs as a covered benefit shall provide prescription drug coverage in accordance with the provisions of section 25.5-5-202 (1)(a) as part of a comprehensive health benefit and with respect to any formulary or other access restrictions:

(I) The MCE shall supply participating providers who may prescribe prescription drugs for MCE enrollees with a current copy of such formulary or other access restrictions, including information about coverage, payment, or any requirement for prior authorization;

(II) The MCE shall provide to all medicaid members at periodic intervals, and prior to and during enrollment upon request, clear and concise information about the prescription drug program in language understandable to the medicaid members, including information about such formulary or other access restrictions and procedures for gaining access to prescription drugs, including off-formulary products; and

(III) The MCE shall follow state department policies for prescribing any prescription drugs that are not covered under the MCE contract;

(t) Each MCE must include the following statements prominently in the enrollee handbook, on the state department's website, and on the MCE's enrollment website:

(I) A statement indicating that the MCE is subject to the MHPAEA and that a denial, restriction, or withholding of benefits for behavioral health services that are covered under the medical assistance program could be a potential violation of that act; and

(II) A statement directing the enrollee to contact the office of the ombudsman for behavioral health access to care established pursuant to part 3 of article 80 of title 27 if the enrollee wants further assistance pursuing action regarding potential parity violations, which statement must include the telephone number for the office and a link to the office's website.

Source: L. 2018: Entire section added with relocations, (HB 18-1431), ch. 313, p. 1882, § 3, effective August 8. **L. 2019:** (1)(t) added, (HB 19-1269), ch. 195, p. 2134, § 14, effective May 16; (1)(o)(IV) amended, (SB 19-241), ch. 390, p. 3473, § 38, effective August 2. **L. 2021:** (1)(b) and (1)(l) amended, (HB 21-1108), ch. 156, p. 896, § 40, effective September 7. **L. 2022:** (1)(j)

and (1)(p) amended, (SB 22-156), ch. 153, p. 978, § 1, effective January 1, 2023. **L. 2023:** (1)(f)(IV) added, (HB 23-1200), ch. 429, p. 2522, § 1, effective August 7. **L. 2024:** (1)(f)(II)(A), (1)(n)(II), (1)(p)(II)(A), (1)(q), (1)(r), and (1)(s)(II) amended, (SB 24-176), ch. 152, p. 653, § 58, effective August 7.

Editor's note: Provisions of this section are similar to provisions of former §§ 25.5-5-404, 25.5-5-405, and 25.5-5-406, as they existed prior to 2018. For a detailed comparison of this section, see the comparative tables located at the back of the index.

Cross references: (1) For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

(2) For the legislative declaration in HB 21-1108, see section 1 of chapter 156, Session Laws of Colorado 2021.

25.5-5-407. State department recommendations - primary care physician program. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1893, § 7, effective July 1. **L. 2018:** Entire section repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8.

Editor's note: This section was similar to former § 26-4-118 as it existed prior to 2006.

25.5-5-407.5. Prepaid inpatient health plan agreements - rules. (Repealed)

Source: L. 2007: Entire section added, p. 1351, § 1, effective May 29. **L. 2009:** (1.5) added, (SB 09-265), ch. 205, p. 936, § 3, effective May 1. **L. 2010:** (1.5) repealed, (HB 10-1382), ch. 217, p. 939, § 2, effective May 6. **L. 2013:** (2)(a) amended, (SB 13-044), ch. 54, p. 180, § 1, effective March 22. **L. 2018:** Entire section repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8.

Editor's note: Subsection (2)(a) was relocated to § 25.5-5-408 (13) in 2018. For a detailed comparison of this section, see the comparative tables located at the back of the index.

25.5-5-407.7. Disability care coordination organization - rules. (Repealed)

Source: L. 2007: Entire section added, p. 1352, § 1, effective May 29. **L. 2008:** Entire section amended, p. 1909, § 109, effective August 5. **L. 2013:** Entire section repealed, (SB 13-276), ch. 256, p. 1353, § 9, effective May 23.

25.5-5-408. Capitation payments - availability of base data - adjustments - rate calculation - capitation payment proposal - preference - assignment of medicaid members - definition.

(1) (a) The state department shall make capitation payments to MCEs based upon a defined scope of services under a risk contract.

(b) A certification by a qualified actuary retained by the state department is conclusive evidence that the state department has correctly calculated the direct health-care cost of providing these same services on an actuarially equivalent Colorado medicaid population group.

(c) Except as otherwise provided in subsection (1)(d) of this section and where the state department has instituted a program of competitive bidding provided in section 25.5-5-402 (9), the state department may utilize a market rate set through the competitive bid process for a set of defined services. The state department shall only use market rate bids that do not discriminate and are adequate to assure quality and network sufficiency. A certification of a qualified actuary, retained by the state department, to the appropriate lower limit is conclusive evidence of the state department's compliance with the requirements of this subsection (1)(c). For the purposes of this subsection (1), a "qualified actuary" means a person deemed as such under rules promulgated by the commissioner of insurance.

(d) The state department shall reimburse a federally qualified health center, as defined in the federal "Social Security Act", 42 U.S.C. sec. 1395x (aa)(4), for the total reasonable costs incurred by the center in providing health-care services to all members of medical assistance.

(e) An MCE shall certify, as a condition of entering into a contract with the state department, that the capitation payments set forth in the contract between the MCE and the state department are sufficient to ensure the financial stability of the MCE with respect to delivery of services to the medicaid members covered in the contract.

(f) (I) Except as provided in subsection (1)(f)(II) of this section, for capitation payments effective on and after July 1, 2003, an MCE that is contracting for a defined scope of services under a risk contract shall certify, through a qualified actuary retained by the MCE, that the capitation payments set forth in the contract between the MCE and the state department comply with all applicable federal and state requirements that govern the capitation payments. For purposes of this subsection (1)(f)(I), a "qualified actuary" means a person deemed as such by rule promulgated by the commissioner of insurance.

(II) An MCO providing services under the PACE program as described in section 25.5-5-412 shall certify that the capitation payments are in compliance with applicable federal and state requirements that govern said capitation payments and that the capitation payments are sufficient to ensure the financial viability of the MCO with respect to the delivery of services to the PACE program participants covered in the contract.

(2) The state department shall develop capitation rates for MCEs contracting for a defined scope of services under a risk contract that include risk adjustments, reinsurance, or stop-loss funding methods. Payments to plans may vary when it is shown through diagnoses or other relevant data that certain populations are expected to cost more or less than the capitated population as a whole.

(3) The state board, in consultation with recognized medical authorities, shall develop a definition of special needs populations that includes evidence of diagnosed or medically confirmed health conditions. The state department shall develop a method for adjusting payments to plans for such special needs populations when diagnoses or other relevant data indicates these special needs populations would cost significantly more than similarly capitated populations.

(4) Under no circumstances shall the risk adjustments, reinsurance, or stop-loss methods developed by the state department pursuant to subsection (2) of this section cause the average per capita medicaid payment to a plan to be greater than the projected medicaid expenditures for treating medicaid enrollees of that plan under fee-for-service medicaid.

(5) The state department may develop quality incentive payments to recognize superior quality of care or service provided by a managed care plan.

(6) Within two hundred ten days from the beginning of each fiscal year, the state department, in cooperation with the MCEs, shall set a timeline for the rate-setting process for the following fiscal year's rates and for the provision of base data to the MCEs that is used in the calculation of the rates, which must include but not be limited to the information included in subsection (7) of this section.

(7) The state department shall identify and make available to the MCEs the base data used in the calculation of the direct health-care cost of providing these same services on an actuarially equivalent Colorado medicaid population group. The state department shall consult with the

MCEs regarding any and all adjustments in the base data made to arrive at the capitation payments.

(8) For capitation payments effective on and after July 1, 2003, the state department shall recalculate the base calculation every three years. The three-year cycle for the recalculation of the base calculation shall begin with capitation payments effective for fiscal year 2003-04. In the years in which the base calculation is not recalculated, the state department shall annually trend the base calculation after consulting with the MCEs. The state department shall take into consideration when trending the base calculation any public policy changes that affect reimbursement under the "Colorado Medical Assistance Act".

(9) The rate-setting process referenced in subsection (6) of this section must include a time period after the MCEs have received the direct health-care cost of providing these same services on an actuarially equivalent Colorado medicaid population group for each MCE to submit to the state department the MCE's capitation payment proposal, which must not exceed one hundred percent of the direct health-care cost of providing these same services on an actuarially equivalent Colorado medicaid population group. The state department shall provide to the MCEs the MCE's specific adjustments to be included in the calculation of the MCE's proposal. Each MCE's capitation payment proposal must meet the requirements of subsections (1)(e) and (1)(f) of this section and section 25.5-5-402 (10).

(10) For capitation payments effective on and after July 1, 2003, unless otherwise required by federal law, the state department shall certify, through a qualified actuary retained by the state department, that the capitation payments set forth in the contract between the state department and the MCEs comply with all applicable federal and state requirements that govern said capitation payments.

(11) Effective on and after July 1, 2003, the capitation payments certified by the qualified actuary under subsection (10) of this section shall not be subject to any dispute resolution process, including any such process set forth in any settlement agreement entered into prior to July 1, 2002.

(12) Nothing in this section shall prevent, to the extent possible, an MCE that is also a government-owned entity from using certified public expenditure or other federally recognized financing mechanisms to provide the state share for the federal match to enhance capitation payments up to or above the one hundred percent limit contained in subsection (9) of this section. The state shall not be obligated to increase any general fund expenditures because of the use of certified public expenditure or other federally recognized financing mechanism pursuant to this subsection (12).

(13) A PIHP agreement may include a provision for a quality incentive payment that is distributed to the contractor within a reasonable period of time, as specified in the contract, following the end of each fiscal year if the contractor substantially exceeds predetermined

quality indicators. The quality indicators must be based upon broadly accepted measures of performance adopted by rule of the state board and agreed upon at the outset of the contract period, and must include, but need not be limited to, the health plan employers data and information set measures. The quality incentive payment may be made proportional if the state board establishes multiple quality measurements. The quality incentive payments must not exceed the total cost savings created under the PIHP agreement, as determined by comparison of the PIHP members with an actuarially equivalent fee-for-service population, and the quality incentive payment must not exceed five percent of the total medicaid payments received by the contractor during the performance period of the PIHP agreement.

Source: L. 2006: Entire article added with relocations, p. 1893, § 7, effective July 1. **L. 2007:** (1)(b) and (9) amended and (12) added, p. 1354, § 4, effective May 29. **L. 2008:** (1)(a), (2), (6), (7), (8), (9), (10), and (12) amended, p. 400, § 5, effective August 5. **L. 2009:** (1)(a) amended, (SB 09-265), ch. 205, p. 936, § 4, effective May 1. **L. 2010:** (1)(a)(II) repealed, (HB 10-1382), ch. 217, p. 939, § 3, effective May 6. **L. 2018:** (1) amended with relocations, (6), (7), and (9) amended, and (13) added with relocations, (HB 18-1431), ch. 313, p. 1887, § 4, effective August 8. **L. 2020:** (1)(d) amended, (SB 20-136), ch. 70, p. 289, § 28, effective September 14. **L. 2024:** (1)(d) and (1)(e) amended, (SB 24-176), ch. 152, p. 654, § 59, effective August 7.

Editor's note: (1) This section is similar to former § 26-4-119 as it existed prior to 2006.

(2) Provisions of subsection (1) are similar to provisions of former § 25.5-5-404, as it existed prior to 2018, and provisions of subsection (13) are similar to former § 25.5-5-407.5 (2)(a), as it existed prior to 2018. For a detailed comparison of this section, see the comparative tables located at the back of the index.

Cross references: For the legislative declaration in SB 20-136, see section 1 of chapter 70, Session Laws of Colorado 2020.

25.5-5-409. State department - privatization. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1896, § 7, effective July 1. **L. 2018:** Entire section repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8.

Editor's note: This section was similar to former § 26-4-120 as it existed prior to 2006.

25.5-5-410. Data collection for managed care programs.

(1) Repealed.

(2) The state department of human services, in conjunction with the state department, shall continue its existing efforts, which include obtaining and considering member input, to develop managed care systems for the developmentally disabled population and to consider a pilot program for a certificate system to enable the developmentally disabled population to purchase managed care services or fee-for-service care, including long-term care community services. The department of human services shall not implement any managed care system for developmentally disabled services without the express approval of the joint budget committee. Any proposed implementation of fully capitated managed care in the developmental disabilities community service system requires legislative review.

(3) In addition to any other data collection and reporting requirements, each managed care organization shall submit the following types of data to the state department or its agent:

(a) Medical access;

(b) Member outcomes based on statistics maintained on individual members as well as the total member populations served;

(c) Member satisfaction;

(d) Member utilization;

(e) Health status of members; and

(f) Uncompensated care delivered.

Source: L. 2006: Entire article added with relocations, p. 1896, § 7, effective July 1. **L. 2008:** (1) amended, p. 402, § 6, effective August 5. **L. 2016:** (1) repealed and (2) amended, (HB 16-1081), ch. 22, p. 51, § 3, effective August 10. **L. 2024:** (2) and (3) amended, (SB 24-176), ch. 152, p. 655, § 60, effective August 7.

Editor's note: This section is similar to former § 26-4-121 as it existed prior to 2006.

25.5-5-411. Medicaid community mental health services - legislative declaration - administration - rules. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1897, § 7, effective July 1. **L. 2007:** (3) amended, p. 331, § 1, effective August 3. **L. 2008:** (1.5) added, p. 289, § 1, effective April 3. **L. 2009:** (1.5)(c) added, (SB 09-265), ch. 205, p. 936, § 5, effective May 1. **L. 2010:** (4)(c) repealed, (HB 10-1382), ch. 217, p. 940, § 4, effective May 6; entire section amended, (SB 10-153), ch. 295, p. 1372, § 3, effective May 26. **L. 2018:** Entire section repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8; (4)(b) amended, (HB 18-1007), ch. 225, p. 1432, § 5, effective January 1, 2019; (4)(b) repealed, (HB 18-1431), ch. 313, p. 1893, § 13, effective January 1, 2019.

Editor's note: (1) This section was similar to former § 26-4-123 as it existed prior to 2006.

(2) Provisions of this section were relocated to § 25.5-5-402 in 2018. For a detailed comparison of this section, see the comparative tables located at the back of the index.

25.5-5-412. Program of all-inclusive care for the elderly - services - eligibility - rules - legislative declaration - definitions.

(1) (a) The general assembly hereby finds and declares that it is the intent of this section to replicate the ON LOK program in San Francisco, California, that has proven to be cost-effective at both the state and federal levels. The PACE program is part of a national replication project authorized in section 9412(b)(2) of the federal "Omnibus Budget Reconciliation Act of 1986", as amended. The general assembly finds that, by coordinating an extensive array of medical and nonmedical services, the needs of the participants will be met primarily in an outpatient environment in an adult day health center, in their homes, or in an institutional setting. The general assembly finds that such a service delivery system will enhance the quality of life for the participant and offers the potential to reduce and cap the costs to Colorado of the medical needs of the participants, including hospital and nursing home admissions.

(b) Repealed.

(2) The general assembly has determined on the recommendation of the state department that the PACE program is cost-effective. As a result of such determination and after consultation with the joint budget committee of the general assembly, application has been made to and waivers have been obtained from the federal health care financing administration to implement the PACE program as provided in this section. The general assembly, therefore, authorizes the state department to implement the PACE program in accordance with this section. In connection with the implementation of the program, the state department shall:

(a) Provide a system for reimbursement for services to the PACE program pursuant to this section;

(b) Develop and implement a contract with any public, private, nonprofit, or for-profit entity providing the PACE program, as permitted by federal law, that sets forth contractual obligations for the PACE program as required by the state department, including but not limited to reporting and monitoring of utilization of services and of the costs of the program, quality of care, and a comprehensive assessment of the provider's fiscal soundness;

(c) Acknowledge that it is participating in the national PACE project as initiated by congress;

(d) Be responsible for certifying the eligibility for services of all PACE program participants.

(3) The general assembly declares that the purpose of this section is to provide services that would foster the following goals:

(a) To maintain eligible persons at home as an alternative to long-term institutionalization;

(b) To provide optimum accessibility to various important social and health resources that are available to assist eligible persons in maintaining independent living;

(c) To provide that eligible persons who are frail elderly but who have the capacity to remain in an independent living situation have access to the appropriate social and health services without which independent living would not be possible;

(d) To coordinate, integrate, and link such social and health services by removing obstacles that impede or limit improvements in delivery of these services;

(e) To provide the most efficient and effective use of capitated funds in the delivery of such social and health services.

(f) Repealed.

(4) Within the context of the PACE program, the state department may include any or all of the services listed in sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203, as applicable.

(5) An eligible person may elect to receive services from the PACE program as described in subsection (4) of this section. If such an election is made, the eligible person shall not remain eligible for services or payment through the regular medicare or medicaid programs. All services provided by said programs shall be provided through the PACE program in accordance with this section. An eligible person may elect to disenroll from the PACE program at any time.

(6) The state department, in cooperation with the case management agencies established in section 25.5-6-1703, shall develop and implement a coordinated plan to provide education about PACE program site operations under this section. The state board shall adopt rules:

(a) To ensure that case managers and any other appropriate state department staff discuss the option and potential benefits of participating in the PACE program with all eligible long-term care members. These rules must require additional and ongoing training of the case management agency case managers in counties where a PACE program is operating. This training must be

provided by a federally approved PACE provider. In addition, each case management agency may designate case managers who have knowledge about the PACE program.

(b) To allow PACE providers to contract with an enrollment broker to include the PACE program in its marketing materials to eligible long-term members.

(6.5) An eligible person who is enrolled in a managed care organization, an organization contracted with the state department pursuant to part 4 of article 5 of this title, or other risk-bearing entity may elect to withdraw from or terminate such enrollment and enroll in and receive services through a PACE program. The state board's rules shall define how such election is made. The effective date of an eligible person's election shall not be more than thirty days after the eligible person's date of election.

(7) For purposes of this section:

(a) "Dually eligible person" means a person who is eligible for assistance or benefits under both medicaid and medicare.

(b) "Eligible person" means a frail elderly individual who voluntarily enrolls in the PACE program and whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, whose resources do not exceed the limit established by the state department of human services for individuals receiving a mandatory minimum state supplementation of SSI benefits pursuant to section 26-2-204, or in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101, and for whom a physician licensed pursuant to article 240 of title 12 certifies that such a program provides an appropriate alternative to institutionalized care. "Eligible person" may also include a dually eligible person.

(c) "Frail elderly" means an individual who meets functional eligibility requirements, as established by the state department, for nursing home care and who is fifty-five years of age or older.

(d) "Upper payment limit" means a federal upper payment limit on the amount of the medicaid payment for which federal financial participation is available for a class of services and a class of health-care providers, as specified in 42 CFR 447.

(8) Using a risk-based financing model, any public, private, nonprofit, or for-profit entity providing the PACE program, as permitted by federal law, shall assume responsibility for all costs generated by PACE program participants, and shall create and maintain a risk reserve fund that will cover any cost overages for any participant. The PACE program is responsible for the entire range of services in the consolidated service model, including hospital and nursing home care, according to participant need as determined by the multidisciplinary team. Any public, private, nonprofit, or for-profit entity providing the PACE program, as permitted by federal law, is responsible for the full financial risk at the conclusion of the demonstration period and when permanent waivers from the federal health care financing administration are granted. Specific

arrangements of the risk-based financing model shall be adopted and negotiated by the federal health care financing administration, any public, private, nonprofit, or for-profit entity providing the PACE program, as permitted by federal law, and the state department.

(9) Nothing in this section requires a PACE program site operator to hold a certificate of authority as a health maintenance organization under part 4 of article 16 of title 10, C.R.S., for purposes of the PACE program.

(10) (a) The state department shall perform a feasibility study, conditioned on the receipt of sufficient gifts, grants, and donations, in order to identify viable communities that may support a PACE program site. This study shall be completed on or before May 1, 2003.

(b) The state department, consistent with the results of the feasibility study, shall use its best efforts to have in operation:

(I) One additional PACE program site by July 1, 2004;

(II) A total of four additional PACE program sites by July 1, 2005; and

(III) A total of six additional PACE program sites by July 1, 2006.

(c) (I) No later than May 30, 2003, the executive director of the state department shall submit to the joint budget committee of the general assembly and to the health and human services committees of the house of representatives and the senate, or any successor committees, a written report of the results of the feasibility study conducted under paragraph (a) of this subsection (10).

(II) No later than January 1, 2007, the executive director of the state department shall submit to the joint budget committee of the general assembly and to the health and human services committees of the house of representatives and the senate, or any successor committees, a final written report detailing the expansion of PACE program sites across the state.

(11) The state board shall promulgate such rules, pursuant to article 4 of title 24, C.R.S., as are necessary to implement this section.

(12) (a) The general assembly shall make appropriations to the state department to fund services under this section provided at a monthly capitated rate. For the 2019-20 fiscal year, and each fiscal year thereafter, the state department shall annually renegotiate, pursuant to the provisions set forth in this subsection (12), a monthly capitated rate for the contracted services.

(b) The monthly capitated rate negotiated with the state department must be included in the contract with the PACE organization and must be based upon a prospective monthly capitation payment to a PACE organization for a medicaid participant enrolled in a PACE program that is less than what would otherwise have been paid under the state medicaid plan if the participant were not enrolled in the PACE program.

(c) In determining the monthly capitated rate, the state department, with the participation of Colorado PACE organizations, shall develop an actuarially sound upper payment limit methodology that complies with federal law relating to PACE organizations.

(d) Repealed.

(13) The state department may accept grants and donations from private sources for the purpose of implementing this section.

(14) (a) No later than sixty days prior to the closing or effective date of a conversion of a nonprofit PACE provider to a for-profit PACE provider, the nonprofit PACE provider shall:

(I) Transmit a conversion plan and written notice of the conversion to the attorney general, which conversion plan must include, at a minimum:

(A) A copy of the results of an independent valuation of the fair market value of the business that proposes to convert;

(B) A detailed explanation of the plans for distribution of the proceeds of the conversion, including whether the proceeds will be distributed to a new nonprofit entity or to an existing organization and, if to an existing nonprofit organization, which organization and the reasons for selecting that organization, or, if to a new nonprofit organization, how the initial board of directors will be selected;

(C) Information about any compensation, bonus, or inducement to any officers or directors of the converting entity resulting from the conversion; and

(D) The PACE organization's audited financial statements for its three most recent fiscal years for Colorado, and separately, for those operations outside of Colorado, for any such operations that may be related to the conversion; and

(II) Bear all costs associated with public oversight and review by the attorney general of the conversion, including the retention of outside experts, if any.

(b) Within ten days after the receipt of the conversion plan, the attorney general shall post the complete conversion plan on its website and receive public comments about the plan, which shall also be posted as soon as practicable to the attorney general's website. Public comment shall be received for a minimum of thirty days and available on the website for at least the duration of the comment period.

(c) Nothing in this section shall be construed to affect the common law authority of the attorney general.

(15) (a) No later than June 30, 2023, the state department, in conjunction with the department of public health and environment, shall develop a regulatory plan to establish formal

oversight requirements for PACE entities. In developing the plan, the departments shall consider, at a minimum:

(I) Input from executive agencies; any local governments within a PACE service area, including cities and counties; aging and older adult advocacy organizations; PACE participants; family members of PACE participants; disability advocacy organizations; urban PACE entities; rural PACE entities; and PACE trade organizations;

(II) State department demographic data to determine the feasibility of potential or existing PACE entities to establish or expand within a specific geographical area with an established PACE program;

(III) Utilization, quality, and performance data of each PACE entity and associated PACE entities;

(IV) Business continuity and solvency information of each PACE entity or associated PACE entities;

(V) Measurable innovative practices of PACE entities;

(VI) Staffing practices of PACE entities;

(VII) Transportation data of each PACE entity, including the number of trips, travel time, and pick-up and drop-off processes;

(VIII) Satisfaction and exit survey data of each PACE entity;

(IX) Audits, complaints, and grievances of each PACE entity;

(X) Current PACE oversight processes, including home health regulatory requirements and licensure;

(XI) Any duplication of federal oversight processes;

(XII) Due process and appeal rights of PACE entities; and

(XIII) Citations, fines, and suspension remedies to ensure compliance with regulations to protect the health, safety, and welfare of medicaid members.

(b) No later than March 1, 2024, the state department shall establish, administer, and enforce minimum regulatory standards and rules for the PACE program, including for contracted entities of the PACE program. The standards and rules must be sufficient to ensure the health, safety, and welfare of PACE participants.

(c) The state department shall continually analyze the reimbursement methodology for PACE entities and provide an update to the house of representatives health and human services committee, the senate health and human services committee, and the joint budget committee, or

their successor committees, of any new methodology requirements that incorporate encounter data and any associated cost to the state department in overseeing PACE entities.

Source: L. 2006: Entire article added with relocations, p. 1898, § 7, effective July 1. **L. 2008:** (12) amended, p. 1749, § 1, effective June 2. **L. 2009:** (12) amended, (SB 09-265), ch. 205, p. 936, § 6, effective May 1. **L. 2010:** (12)(b) repealed, (HB 10-1382), ch. 217, p. 940, § 5, effective May 6. **L. 2012:** (6) and (7) amended and (6.5) added, (SB 12-023), ch. 94, p. 308, § 1, effective April 12. **L. 2013:** (3)(f) repealed, (HB 13-1300), ch. 316, p. 1690, § 81, effective August 7. **L. 2015:** (1)(a), (2)(b), and (8) amended, (1)(b) repealed, and (14) added, (SB 15-137), ch. 163, pp. 496, 498, §§ 1, 2, effective August 5. **L. 2016:** (7)(d) added and (12) amended, (SB 16-199), ch. 270, p. 1117, § 1, effective June 10. **L. 2019:** (12) amended, (SB 19-209), ch. 124, p. 534, § 1, effective April 17; (7)(b) amended, (HB 19-1172), ch. 136, p. 1709, § 184, effective October 1. **L. 2021:** IP(6) and (6)(a) amended, (HB 21-1187), ch. 83, p. 333, § 28, effective July 1, 2024. **L. 2022:** (15) added, (SB 22-203), ch. 450, p. 3168, § 1, effective August 10. **L. 2024:** (6)(a) and (6)(b) amended, (SB 24-176), ch. 152, p. 655, § 61, effective August 7. **L. 2026:** (15)(c) amended, (SB 26-169), ch. 311, p. 1810, § 47, effective August 12.

Editor's note: (1) This section is similar to former § 26-4-124 as it existed prior to 2006.

(2) Subsection (12)(d)(III) provided for the repeal of subsection (12)(d), effective July 1, 2020. (See L. 2019, p. 534.)

Cross references: For the federal laws creating the Program of All-Inclusive Care for the Elderly (PACE), see section 9412 (b)(2) of the "Omnibus Budget Reconciliation Act of 1986", Pub.L. 99-509, and section 4802 of the federal "Balanced Budget Act of 1997", Pub.L. 105-33, codified at 42 U.S.C. secs. 1395 and 1396.

25.5-5-413. Direct contracting with providers - legislative declaration. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1902, § 7, effective July 1. **L. 2018:** Entire section repealed, (HB 18-1431), ch. 313, p. 1891, § 7, effective August 8.

Editor's note: This section was similar to former § 26-4-127 as it existed prior to 2006.

25.5-5-414. Telemedicine - legislative intent.

(1) It is the intent of the general assembly to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health-care provider without person-to-person contact with a provider.

(2) Repealed.

(3) On or after January 1, 2002, face-to-face contact between a health-care provider and a patient is not required under the statewide managed care system created in this part 4 for services appropriately provided through telemedicine, subject to reimbursement policies developed by the state department to compensate providers who provide health-care services covered by the program created in section 25.5-4-104. Telemedicine services may only be used in areas of the state where the technology necessary for the provision of telemedicine exists. The audio and visual telemedicine system used must, at a minimum, have the capability to meet the procedural definition of the most recent edition of the current procedural terminology that represents the service provided through telemedicine. The telecommunications equipment must be of a level of quality to adequately complete all necessary components to document the level of service for the current procedural terminology fourth edition codes that are billed. If a peripheral diagnostic scope is required to assess the patient, it must provide adequate resolution or audio quality for decision-making.

(4) Repealed.

(5) The statewide managed care system is not required to pay for consultation provided by a provider by telephone or facsimile machines.

(6) The state department may accept and expend gifts, grants, and donations from any source to conduct the valuation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the statewide managed care system.

(7) Nothing in this section shall be construed to:

(a) Alter the scope of practice of any health-care provider; or

(b) Authorize the delivery of health-care services in a setting or manner not otherwise authorized by law.

Source: L. 2006: Entire article added with relocations, p. 1903, § 7, effective July 1; (3) amended and (7) added, p. 1547, § 4, effective July 1. **L. 2018:** (3), (5), and (6) amended and (4) repealed, (HB 18-1431), ch. 313, p. 1889, § 5, effective August 8. **L. 2019:** (2) amended, (HB 19-1172), ch. 136, p. 1710, § 185, effective October 1. **L. 2021:** (2) repealed, (HB 21-1190), ch. 152, p. 875, § 4, effective May 18.

Editor's note: (1) This section is similar to former § 26-4-421 as it existed prior to 2006.

(2) (a) Amendments to section 26-4-421 (3) by Senate Bill 06-165 were harmonized with subsection (3) as it appeared in Senate Bill 06-219.

(b) Subsection (7) was enacted as 26-4-421 (7) in Senate Bill 06-165 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

Cross references: For the legislative declaration contained in the 2006 act amending subsection (3) and enacting subsection (7), see section 1 of chapter 312, Session Laws of Colorado 2006.

25.5-5-415. Medicaid payment reform and innovation pilot program - creation - selection of payment projects - report - rules - legislative declaration.

(1) (a) The general assembly finds that:

(I) Increasing health-care costs in Colorado's medicaid program creates challenges for the state's budget. Further, the increasing health-care costs do not necessarily reflect improvements in either health outcomes for patients or in patient satisfaction with the care received;

(II) Moreover, the fee-for-service payment model may not support or align financially with evolving care coordination and delivery systems;

(III) The reform of medicaid payment policies offers a significant opportunity for the state to contain costs and improve quality;

(IV) New payment methodologies, including global payments, have been developed to respond to rising costs and the complexities of health-care delivery. Opportunities now exist to explore, test, and implement such payment reforms in the medicaid program.

(V) The state department should explore how these new payment methodologies may result in improved health outcomes and patient satisfaction and support the financial sustainability of the medicaid program; and

(VI) The state department shall evaluate how successful payment projects could be replicated and incorporated within the state department's statewide managed care system.

(b) Therefore, the general assembly declares that Colorado should build upon ongoing reforms of health-care delivery in the medicaid program by implementing a pilot program within the structure of the state department's statewide managed care system that encourages the use of new and innovative payment methodologies, including global payments.

(2) (a) There is created the medicaid payment reform and innovation pilot program for purposes of fostering the use of innovative payment methodologies in the medicaid program that are designed to provide greater value while ensuring good health outcomes and member satisfaction.

(b) (I) The state department shall create a process for interested contractors of the state department's statewide managed care system to submit payment projects for consideration under the pilot program. Payment projects submitted pursuant to the pilot program may include, but need not be limited to, global payments, risk adjustment, risk sharing, and aligned payment incentives, including but not limited to gainsharing, to achieve improved quality and to control costs.

(II) The design of the payment project or projects must address the member population of the state department's statewide managed care system and be tailored to the region's health-care needs and the resources of the state department's statewide managed care system.

(III) A contractor of the state department's statewide managed care system shall work in coordination with the providers and MCEs contracted with the contractor of the state department's statewide managed care system in developing the payment project or projects.

(c) (I) The state department shall review and select payment projects to be included in the pilot program.

(II) For purposes of selecting payment projects for the pilot program, the state department shall consider, at a minimum:

(A) The likely effect of the payment project on quality measures, health outcomes, and member satisfaction;

(B) The potential of the payment project to reduce the state's medicaid expenditures;

(C) The state department's ability to ensure that inpatient and outpatient hospital reimbursements are maximized up to the upper payment limits, as defined in 42 CFR 447.272 and 42 CFR 447.321 and calculated by the state department periodically;

(D) The member population served by the state department's statewide managed care system and the particular health needs of the region;

(E) The business structure or structures likely to foster cooperation, coordination, and alignment and the ability of the contractor of the state department's statewide managed care system to implement the payment project, including the resources available to the contractor of the state department's statewide managed care system and the technological infrastructure required; and

(F) The ability of the contractor of the state department's statewide managed care system to coordinate among providers of physical health care, behavioral health care, oral health care, and the system of long-term care services and supports.

(III) For payment projects not selected by the state department, the state department shall respond to the contractor of the state department's statewide managed care system, in writing, stating the reason or reasons why the payment project was not selected. The state department shall send a copy of the response to the joint budget committee of the general assembly, the health and human services committee of the senate, and the health, insurance, and environment committee of the house of representatives, or any successor committees.

(d) (I) The payment projects selected for the program must be for a period of at least one year and must not extend beyond the length of the contract with the contractor of the state department's statewide managed care system. The provider contract must specify the payment methodology utilized in the payment project.

(II) Repealed.

(III) MCEs participating in the pilot program are subject to the requirements of sections 25.5-5-402 (10) and 25.5-5-408 (1)(e) and (1)(f), as applicable.

(IV) Payments made to MCEs under the pilot program shall account for prospective, local community or health system cost trends and values, as measured by quality and satisfaction measures, and shall incorporate community cost experience and reported encounter data to the extent possible to address regional variation and improve longitudinal performance.

(V) Notwithstanding any provisions of this section or state board rules to the contrary, it is the intent of the general assembly that total payments, adjustments, and incentives will be budget-neutral with respect to state expenditures. The state department shall not enter into a contract with a provider pursuant to this section if the state department estimates that total payments to the provider will be greater than without the contract.

(3) Pilot program participants shall provide data and information to the state department and any designated evaluator concerning health outcomes, cost, provider participation and satisfaction, member satisfaction, and any other data and information necessary to evaluate the efficacy of the payment methodology.

(4) (a) The state department shall submit a report to the joint budget committee of the general assembly, the health and human services committee of the senate, or any successor committee, and the health and environment committee of the house of representatives, or any successor committee, as follows:

(I) On or before February 1, 2013, concerning the design and implementation of the pilot program, including a description of any payment projects received by the state department and the time frame for implementation;

(II) On or before September 15, 2014, concerning the pilot program as implemented, including but not limited to an analysis of the initial data and information concerning the utilization of the payment methodology, quality measures, and the impact of the payment methodology on health outcomes, cost, provider participation and satisfaction, and patient satisfaction;

(III) On or before September 15, 2015, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across patients utilizing existing state department data;

(IV) On or before April 15, 2017, and each April 15 that the program is being implemented, concerning the program as implemented, including but not limited to an analysis of the data and information concerning the utilization of the payment methodology, including an assessment of how the payment methodology drives provider performance and participation and the impact of the payment methodology on quality measures, health outcomes, cost, provider satisfaction, and patient satisfaction, comparing those outcomes across patients utilizing existing state department data. Specifically, the report must include:

(A) An evaluation of all current payment projects and whether the state department intends to extend any current payment project into the next fiscal year;

(B) The state department's plans to incorporate any payment project into the larger medicaid payment framework;

(C) A description of any payment project proposals received by the state department since the prior year's report, and whether the state department intends to implement any new payment projects in the upcoming fiscal year; and

(D) The results of the state department's evaluation of payment projects pursuant to paragraph (a.5) of this subsection (4).

(a.5) The state department shall evaluate each payment project to determine:

(I) Whether the payment project offers the potential for better patient outcomes or improved care and the impact of better outcomes and improved care on medicaid costs;

(II) Whether the payment project creates the opportunity for administrative efficiency in the medicaid program;

(III) Whether the payment project is budget neutral or generates savings for the medicaid program; and

(IV) Whether the payment project resulted in changes in provider participation in the medicaid program, and the nature of those changes.

(b) For purposes of evaluating the pilot program and payment methodologies, the state department may collaborate with a nonprofit entity or an institution of higher education to analyze and verify data and information received from pilot participants and to evaluate quality measures and the cost-effectiveness of the payment reforms.

(5) The state department shall seek any federal authorization necessary to implement the pilot program.

(6) The state department may promulgate any rules necessary to implement the pilot program.

Source: L. 2012: Entire section added, (HB 12-1281), ch. 246, p. 1182, § 2, effective June 4. **L. 2016:** (1)(a)(V), (2)(c)(I), (2)(c)(III), (2)(d)(I), (4)(a)(II), and (4)(a)(III) amended and (1)(a)(VI), (4)(a)(IV), and (4)(a.5) added, (HB 16-1407), ch. 152, p. 453, § 1, effective May 4. **L. 2018:** (1)(a)(VI), (1)(b), (2)(b), (2)(c)(II), (2)(c)(III), (2)(d)(I), and (2)(d)(III) amended and (2)(d)(II) repealed, (HB 18-1431), ch. 313, p. 1889, § 6, effective August 8. **L. 2024:** (2)(a), (2)(b)(II), (2)(c)(II)(A), (2)(c)(II)(D), and (3) amended, (SB 24-176), ch. 152, p. 656, § 62, effective August 7.

Editor's note: Subsection (2)(c)(II)(C) is similar to former § 25.5-5-402 (6)(b)(II), as it existed prior to 2018. For a detailed comparison of this section, see the comparative tables located at the back of the index.

25.5-5-416. Report concerning efficient contracting in managed care - legislative declaration - repeal. (Repealed)

Source: L. 2012: Entire section added, (HB 12-1281), ch. 246, p. 1186, § 2, effective June 4.

Editor's note: Subsection (3) provided for the repeal of this section, effective July 1, 2013. (See L. 2012, p. 1186.)

25.5-5-417. Reducing unnecessary duplicative services in the accountable care collaborative program - repeal. (Repealed)

Source: L. 2013: Entire section added, (HB 13-1196), ch. 201, p. 817, § 1, effective August 7.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 15, 2018. (See L. 2013, p. 817.)

25.5-5-418. Primary care provider sustainability fund - creation - use of fund - repeal. (Repealed)

Source: L. 2016: Entire section added, (HB 16-1408), ch. 153, p. 468, § 18, effective July 1. **L. 2025:** Entire section amended, (SB 25-264), ch. 129, p. 507, § 39, effective April 25.

Editor's note: (1) For the amendments in SB 25-264 in effect from April 25, 2025, to July 1, 2025, see chapter 129, Session Laws of Colorado 2025. (L. 2025, p. 507.)

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2025. (See L. 2025, p. 507.)

25.5-5-419. Accountable care collaborative - reporting - rules.

(1) In 2011, the state department created the accountable care collaborative, also referred to in this title 25.5 as the medicaid coordinated care system. The state department shall continue to provide care delivery through the accountable care collaborative. The goals of the accountable care collaborative are to improve member health and reduce costs in the medicaid program. To achieve these goals, the state department's implementation of the accountable care collaborative must include, but need not be limited to:

(a) Establishing primary care medical homes for medicaid members within the accountable care collaborative;

(b) Providing regional care coordination and provider network support;

(c) Providing data to regional entities and providers to help manage member care;

(d) Integrating the delivery of behavioral health, including mental health and substance use disorders, and physical health services for members;

(e) Connecting primary care with specialty care and nonhealth community supports;

(f) Promoting member choice and engagement;

(g) Promoting telehealth and telemedicine;

(h) Utilizing innovative care models and provider payment models as part of the care delivery system, including capitated managed care models within the broader accountable care collaborative;

(i) Receiving feedback from affected stakeholder groups;

(j) Establishing a flexible structure that would allow for the efficient operation of the accountable care collaborative to further include medicaid populations and services, including long-term care services and supports; and

(k) Establishing a care delivery system and provider payment platform that can adapt to changing federal financial participation models or funding levels.

(2) The state department shall facilitate transparency and collaboration in the development, performance management, and evaluation of the accountable care collaborative through the creation of stakeholder advisory committees.

(3) The state department shall collect information concerning the accountable care collaborative and include this information in its annual report submitted to the joint budget committee, the health and human services committee of the house of representatives, and the health and human services committee of the senate, or any successor committees, pursuant to section 25.5-5-415 (4)(a). Notwithstanding the provisions of section 24-1-136 (11)(a)(I), the report required pursuant to this subsection (3) continues indefinitely. At a minimum, the state department's report must include the following information concerning the accountable care collaborative:

(a) The number of medicaid members enrolled in the program;

(b) Performance results with an emphasis on member health impacts;

(c) Current administrative fees and costs for the program;

(d) Fiscal performance;

(e) A description of activities that promote access to services for medicaid members in rural and frontier counties;

(f) A description of the state department's coordination with entities that authorize long-term care services for medicaid members;

(g) Information on any advisory committees created, including the participants, focus, stakeholder feedback, and outcomes of the work of the advisory committees;

(h) Future areas of program focus and development, including, among others, a plan to study the costs and benefits of further coverage of substance use disorder treatment; and

(i) Information concerning efforts to reduce medicaid waste and inefficiencies through the accountable care collaborative, including:

(I) The specific efforts within the accountable care collaborative, including a summary of technology-based efforts, to identify and implement best practices relating to cost containment; reducing avoidable, duplicative, variable, and inappropriate uses of health-care resources; and the outcome of those efforts, including cost savings, if known;

(II) Any statutes, policies, or procedures that prevent regional entities from realizing efficiencies and reducing waste within the medicaid system; and

(III) Any other efforts by regional entities or the state department to ensure that those who provide care for medicaid members are aware of and actively participate in reducing waste within the medicaid system.

(4) On or before December 1, 2017, the state department shall submit a report to the joint budget committee, the public health care and human services committee of the house of representatives, and the health and human services committee of the senate, or any successor committees, outlining the statutory changes needed to part 4 of this article 5 relating to the statewide managed care system, as well as any other sections of the Colorado Revised Statutes, in order to align Colorado law with the federal "Medicaid and CHIP Managed Care Final Rule", CMS-2390-F.

(5) The state board shall promulgate rules implementing the accountable care collaborative.

(6) The state department shall consider new technologies and business practices for medical management reform that would reduce medical costs due to misuse, overuse, waste, fraud, and abuse. Better drug management, especially of avoidable prescriptions and inefficient use of specialty drugs, would allow the entire prescription drug cost continuum to be managed more effectively to contain costs and achieve better patient outcomes. New technologies and business practices for medical management reform may also benefit Colorado by providing a more powerful medicaid enrollment platform that properly enrolls only those individuals who are truly eligible for medicaid benefits.

Source: L. 2017: Entire section added, (HB 17-1353), ch. 231, p. 895, § 2, effective May 23. **L. 2024:** IP(3) amended, (SB 24-135), ch. 34, p. 115, § 24, effective March 22; (1)(a), (1)(c),

(1)(d), (3)(a), (3)(f), and (3)(i)(III) amended, (SB 24-176), ch. 152, p. 656, § 63, effective August 7.

25.5-5-420. Advancing care for exceptional kids.

Within one hundred twenty days of the enactment of the federal "Advancing Care for Exceptional Kids Act", subject to available appropriations, the state department shall seek any federal approval necessary to fund, in cooperation with hospitals that meet the specified requirements, the implementation of an enhanced pediatric health home for children with complex medical conditions. Requirements for participation by the state department, along with the requirement of an enhanced pediatric health home, are stipulated by the "Advancing Care for Exceptional Kids Act" and shall be complied with accordingly.

Source: L. 2017: Entire section added, (SB 17-267), ch. 267, p. 1466, § 21, effective May 30.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017.

25.5-5-421. Parity reporting - state department - public input.

(1) The state department shall require each MCE contracted with the state department to disclose all necessary information in order for the state department, by June 1, 2020, and by each June 1 thereafter, to submit a report to the health and insurance committee and the public health care and human services committee of the house of representatives, or their successor committees, and to the health and human services committee of the senate, or its successor committee, regarding behavioral, mental health, and substance use disorder parity. The report must contain the following information for the prior calendar year:

(a) A description of the process used to develop or select the medical necessity criteria for behavioral, mental health, and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;

(b) Identification of all nonquantitative treatment limitations that are applied to behavioral, mental health, and substance use disorder benefits and to medical and surgical benefits within each classification of benefits and a statement that the state is complying with 42 U.S.C. sec. 300gg-26 (a)(3)(A)(ii), as required by 42 U.S.C. sec. 1396u-2 (b)(8), prohibiting the application of nonquantitative treatment limitations to behavioral, mental health, and substance use disorder benefits that do not apply to medical and surgical benefits within any classification of benefits;

(c) (I) The results of analyses demonstrating that, for the medical necessity criteria described in subsection (1)(a) of this section and each nonquantitative treatment limitation identified in subsection (1)(b) of this section, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to benefits for behavioral, mental health, and substance use disorders within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits.

(II) A report on the results of the analyses specified in this subsection (1)(c) must, at a minimum:

(A) Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected;

(B) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to design and apply each nonquantitative treatment limitation, as written, and the written processes and strategies used to apply each nonquantitative treatment limitation for medical and surgical benefits;

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for benefits for behavioral, mental health, and substance use disorders are comparable to, and are applied no more stringently than, the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) Disclose the specific findings and conclusions that indicate that the state is in compliance with this section and with the MHPAEA.

(2) By October 1, 2019, for purposes of obtaining meaningful public input during the assessment process described in subsection (1) of this section, the state department shall seek input from stakeholders who may have competency in benefit and delivery systems, utilization management, managed care contracting, data and reporting, or compliance and audits. The state department shall consider the input received in conducting the analyses and developing the report pursuant to subsection (1) of this section.

(3) Notwithstanding section 24-1-136 (11)(a)(I), the reporting requirement specified in this section continues indefinitely.

(4) The state department shall contract with an external quality review organization at least annually to monitor MCEs' utilization management programs and policies, including those that govern adverse determinations, to ensure compliance with the MHPAEA. The quality review report must be readily available to the public.

Source: L. 2019: Entire section added, (HB 19-1269), ch. 195, p. 2134, § 15, effective May 16.

Cross references: For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

25.5-5-422. Medication-assisted treatment - limitations on MCEs - definition.

(1) As used in this section, "FDA" means the food and drug administration in the United States department of health and human services.

(2) Notwithstanding any provision of law to the contrary, each MCE that provides prescription drug benefits or methadone administration for the treatment of substance use disorders shall:

(a) Not impose any prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders, regardless of the dosage amount;

(b) Not impose any step therapy requirements as a prerequisite to authorizing coverage for a prescription medication approved by the FDA for the treatment of substance use disorders;

(c) Not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered; and

(d) Set the reimbursement rate for take-home methadone treatment and office-administered methadone treatment at the same rate.

Source: L. 2019: Entire section added, (HB 19-1269), ch. 195, p. 2136, § 15, effective May 16. **L. 2024:** (2) amended, (HB 24-1045), ch. 470, p. 3288, § 21, effective August 7.

Cross references: For the short title ("Behavioral Health Care Coverage Modernization Act") in HB 19-1269, see section 1 of chapter 195, Session Laws of Colorado 2019.

25.5-5-423. Independent review organization - review denial of residential and inpatient substance use disorder treatment claims - contract.

No later than July 1, 2023, the state department shall contract with one or more independent review organizations to conduct external medical reviews requested for review by a medicaid provider when there is a denial or reduction for residential or inpatient substance use disorder treatment and medicaid appeals processes have been exhausted.

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2364, § 9, effective June 28.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

25.5-5-424. Residential and inpatient substance use disorder treatment - MCE standardized utilization management process - medical necessity - report.

(1) On or before October 1, 2021, the state department shall consult with the behavioral health administration in the department of human services, residential treatment providers, and MCEs to develop standardized utilization management processes to determine medical necessity for residential and inpatient substance use disorder treatment. The processes must incorporate the version of "The ASAM Criteria" used by the state department and align with federal medicaid payment requirements.

(2) On or before January 1, 2022, the state department shall incorporate the standards developed pursuant to subsection (1) of this section into existing MCE contracts, and each MCE shall adhere to the standards when conducting utilization management for residential and inpatient substance use disorder treatment.

(3) On or before January 1, 2022, each MCE's notice of an adverse benefit determination must demonstrate how each dimension of the version of "The ASAM Criteria" used by the state department was considered when determining medical necessity.

(4) (a) Beginning July 1, 2024, and quarterly thereafter, the state department shall report on the residential and inpatient substance use disorder utilization management statistics on the state department's website.

(I) to (III) (Deleted by amendment, L. 2024.)

(b) (Deleted by amendment, L. 2024.)

(c) Any information reported pursuant to subsection (4)(a) of this section may be aggregated as necessary to ensure confidentiality pursuant to 42 CFR part 2.

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2365, § 10, effective June 28. **L. 2022:** (1) and IP(4)(a) amended, (HB 22-1278), ch. 222, p. 1515, § 76, effective July 1. **L. 2024:** (1), (3), and (4) amended, (SB 24-135), ch. 34, p. 115, § 25, effective March 22.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

25.5-5-425. Audit of MCE denials for residential and inpatient substance use disorder treatment authorization - report.

(1) No later than July 1, 2022, the state department shall contract with an independent third-party vendor to audit thirty-three percent of all denials of authorization for inpatient and residential substance use disorder treatment for each MCE.

(2) Beginning no later than January 31, 2025, and no later than each January 31 thereafter, the state department shall submit the results of the audit conducted pursuant to subsection (1) of this section and any recommended changes to the residential and inpatient substance use disorder benefit to the house of representatives health and human services committee, the senate health and human services committee, or their successor committees, and the joint budget committee.

Source: L. 2021: Entire section added, (SB 21-137), ch. 362, p. 2366, § 11, effective June 28. **L. 2024:** (2) amended, (SB 24-135), ch. 34, p. 116, § 26, effective March 22.

Cross references: For the short title ("Behavioral Health Recovery Act of 2021") and the legislative declaration in SB 21-137, see sections 1 and 2 of chapter 362, Session Laws of Colorado 2021.

25.5-5-426. Managed care entities - behavioral health providers - disclosure of reimbursement rates.

(1) The state department shall require each MCE that contracts with the state department to disclose the aggregated average and lowest rates of reimbursement for a set of behavioral health services determined by the state department.

(2) Behavioral health providers are authorized to disclose the reimbursement rates paid by an MCE to the behavioral health provider.

Source: L. 2024: Entire section added, (HB 24-1045), ch. 470, p. 3288, § 23, effective August 7.

Editor's note: This section was numbered as § 25.5-5-427 in HB 24-1045 but was renumbered on revision for ease of location.

25.5-5-427. Managed care entities - disclosure of payment and medical loss ratio - definition.

(1) The state department shall include in each new contract with, or renewal of a contract with, an MCE a provision requiring the MCE to submit to the state department, on an annual basis, the amount the MCE is paid for delivering services and the MCE's medical loss ratio.

(2) The state department shall annually publish the following information on its website:

(a) The information received pursuant to subsection (1) of this section;

(b) Historical medical loss ratio data for each MCE; and

(c) Audit findings regarding an MCE's most recently completed medical loss ratio audit.

(3) For purposes of subsection (1) of this section, "medical loss ratio" means the percentage of premium revenue that the MCE spends on health-care services and quality improvement activities.

Source: L. 2025: Entire section added, (HB 25-1213), ch. 276, p. 1438, § 6, effective August 6.

25.5-5-428. Secure transportation providers - accessible list.

The state department shall publish on the state department's website an easily accessible list of secure transportation providers, as defined in section 27-65-102, that have contracts with managed care entities. The list must include the contact information for the secure transportation provider, including an active phone number or website.

Source: L. 2026: Entire section added, (HB 26-1063), ch. 322, p. 1878, § 1, effective August 12.

PART 5

PRESCRIPTION DRUGS

25.5-5-500.3. Authorization to bill third party.

As a condition of doing business in the state, each provider is deemed to authorize the state department, or an independent contractor retained by the state department, to bill a third party, as defined in section 25.5-4-209 (2)(g)(II), on behalf of the provider if the third party is determined to be liable to pay for care pursuant to sections 25.5-4-209 and 25.5-4-300.4.

Source: L. 2010: Entire section added, (SB 10-167), ch. 296, p. 1379, § 9, effective May 26.

Cross references: For the legislative declaration in SB 10-167, see section 1 of chapter 296, Session Laws of Colorado 2010.

25.5-5-501. Providers - drug reimbursement.

(1) (a) As to drugs for which payment is made, the state board's rules for payment must include the requirement that the generic equivalent of a brand-name drug be prescribed if the generic equivalent is a therapeutic equivalent to the brand-name drug, except when reimbursement to the state for a brand-name drug makes the brand-name drug less expensive than the cost of the generic equivalent. The state department shall grant an exception to this requirement if the patient has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand-name drug would be unacceptably disruptive. The requirements of this subsection (1) do not apply to medications for the treatment of behavioral or mental health

disorders, cancer, epilepsy, or human immunodeficiency virus and acquired immune deficiency syndrome.

(b) The provisions of this subsection (1) shall apply to fee-for-service and primary care physician program recipients.

(2) It is the general assembly's intent that requiring the use of a generic equivalent of a brand-name drug will produce savings within the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the administrative review process required by subsection (1) of this section.

Source: L. 2006: Entire article added with relocations, p. 1904, § 7, effective July 1. **L. 2013:** (1)(a) amended, (HB 13-1266), ch. 217, p. 992, § 63, effective May 13. **L. 2017:** (1)(a) amended, (SB 17-242), ch. 263, p. 1329, § 205, effective May 25.

Editor's note: This section is similar to former § 26-4-406 as it existed prior to 2006.

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

25.5-5-502. Unused medications - reuse - rules - definition.

(1) As used in this section, unless the context otherwise requires, "medication" means prescription medication that is not a controlled substance.

(2) A pharmacist participating in the medical assistance program may accept unused medication from a licensed facility, as defined in section 12-280-135 (1)(b), or a licensed health-care provider for the purpose of dispensing the medication to another person. A pharmacist shall reimburse the state department for the cost of medications that the state department has paid to the pharmacist if medications are returned to a pharmacist and the medications are available to be dispensed to another person. Medications shall only be available to be dispensed to another person under this section if the medications are:

(a) Liquid and the vial is still sealed and properly stored;

(b) Individually packaged and the packaging has not been damaged; or

(c) In the original, unopened, sealed, and tamper-evident unit dose packaging.

(3) Medication dispensed pursuant to this section shall bear an expiration date that is later than six months after the date the drug was donated.

(4) Any savings realized through reimbursements received pursuant to subsection (2) of this section shall fund the administration of this section.

(5) The state board, in consultation with the state board of pharmacy, shall adopt rules for the implementation of this section.

Source: L. 2006: Entire article added with relocations, p. 1904, § 7, effective July 1. **L. 2012:** IP(2) amended, (HB 12-1311), ch. 281, p. 1621, § 76, effective July 1. **L. 2019:** IP(2) amended, (HB 19-1172), ch. 136, p. 1710, § 186, effective October 1. **L. 2021:** (4) amended, (SB 21-266), ch. 423, p. 2803, § 24, effective July 2.

Editor's note: This section is similar to former § 26-4-406.3 as it existed prior to 2006.

25.5-5-503. Prescription drug benefits - authorization - dual-eligible participation.

(1) The state department is authorized to ensure the participation of Colorado medical assistance members who are also eligible for medicare in any federal prescription drug benefit enacted for medicare recipients.

(2) Prescribed drugs are not a covered benefit under the medical assistance program for a member who is eligible for a prescription drug benefit program under medicare; except that, if a prescribed drug is not a covered Part D drug as defined in the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", Pub.L. 108-173, the prescribed drug may be a covered benefit if it is otherwise covered under the medical assistance program and federal financial participation is available.

Source: L. 2006: Entire article added with relocations, p. 1905, § 7, effective July 1. **L. 2007:** (2) amended, p. 1631, § 1, effective July 1. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 657, § 64, effective August 7.

Editor's note: This section is similar to former § 26-4-406.5 as it existed prior to 2006.

Cross references: For additional information on the federal "Medicare Prescription Drug, Improvement, and Modernization Act of 2003", see Pub.L. 108-173.

25.5-5-504. Providers of pharmaceutical services.

(1) Consistent with the provisions of section 25.5-4-401 (1) and subsections (2) and (3) of this section, and subject to available appropriations, no provider of pharmaceutical services who meets the conditions imposed by this article 5 and articles 4 and 6 of this title 25.5 and who complies with the terms and conditions established by the state department and contracting health maintenance organizations and prepaid health plans shall be excluded from contracting for the provision of pharmaceutical services to members authorized in this article 5 and articles 4 and 6 of this title 25.5.

(2) This provision does not apply to a health maintenance organization or prepaid health plan that enrolls less than forty percent of all the resident medicaid members in any county with over one thousand medicaid members.

(3) The state board shall establish specifications in rules in order to provide criteria to health maintenance organizations and prepaid health plans that ensure the accessibility and quality of service to members and the terms and conditions for pharmaceutical contracts.

Source: L. 2006: Entire article added with relocations, p. 1905, § 7, effective July 1. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 657, § 65, effective August 7.

Editor's note: This section is similar to former § 26-4-407 as it existed prior to 2006.

25.5-5-505. Prescribed drugs - mail order - rules.

(1) (a) (I) The state board shall adopt by rule a system to allow medical assistance recipients the option to receive through the mail prescribed maintenance medications used to treat chronic medical conditions.

(II) The state board rules must include the definition of maintenance medications. The rules may allow a medical assistance member to receive through the mail up to a three-month supply, or the maximum allowed under federal law, of maintenance medications used to treat chronic medical conditions.

(b) To the extent allowed by federal law, the state department shall require that a medical assistance member receiving prescription medication through the mail pay the same copayment

amount as a medical assistance member receiving prescription medication through any other method. The state department shall encourage medical assistance members who choose to receive maintenance medications through the mail to use local retail pharmacies for mail delivery.

(c) A pharmacy may provide maintenance medications through the mail to medical assistance recipients in accordance with all applicable state and federal laws if the pharmacy is enrolled as a provider with the state department and is registered with the state board of pharmacy, created and existing pursuant to section 12-280-104.

(d) A nonresident prescription drug outlet doing business in this state shall provide a means for recipients of state medical assistance who have third-party insurance with whom the nonresident prescription drug outlet has a contractual relationship to receive their required pharmacy benefits at a cost to the recipients of no more than the legally allowed state medical assistance copayment. If a third-party insurance carrier's copayment or deductible for pharmacy benefits is larger than the legally allowed state medical assistance copayment, the prescription drug outlet may bill the state medical assistance program for the difference pursuant to state medical assistance reimbursement rules.

(1.5) The state department shall publish on its website and include in the member handbook the following information for members enrolled in fee-for-service medical assistance programs:

(a) That a medical assistance member may use the pharmacy of the member's choice;

(b) That a medical assistance member may use a local retail pharmacy for mail delivery of maintenance medications, if offered; and

(c) That the copayment amount for prescription medications is the same at any pharmacy enrolled in the medical assistance program.

(2) The state department shall seek any federal authorization necessary to implement this section.

Source: L. 2006: Entire article added with relocations, p. 1905, § 7, effective July 1. **L. 2008:** (1) amended, p. 890, § 1, effective May 20. **L. 2009:** (1)(a)(I)(B) amended, (SB 09-252), ch. 271, p. 1228, § 1, effective May 18. **L. 2016:** (1) amended and (1.5) added, (SB 16-027), ch. 208, p. 745, § 1, effective August 10. **L. 2019:** (1)(c) amended, (HB 19-1172), ch. 136, p. 1710, § 187, effective October 1. **L. 2024:** (1)(a)(II), (1)(b), and (1.5) amended, (SB 24-176), ch. 152, p. 658, § 66, effective August 7.

Editor's note: This section is similar to former § 26-4-407.5 as it existed prior to 2006.

25.5-5-506. Prescribed drugs - utilization review.

(1) The state department shall develop and implement a drug utilization review process to assure the appropriate utilization of drugs by patients receiving medical assistance in the fee-for-service and primary care physician programs. The review process shall include the monitoring of prescription information and shall address at a minimum underutilization and overutilization of benefit drugs. Periodic reports of findings and recommendations shall be forwarded to the state department.

(2) It is the general assembly's intent that the implementation of a drug utilization review process for the fee-for-service and primary care physician programs will produce savings within the state's medicaid program. The state department, therefore, is authorized to use savings in the medical services premiums appropriations to fund the development and implementation of a drug utilization review process for these programs, as required by subsection (1) of this section. The state department may contract on a contingency basis for the development or implementation of the review process required by subsection (1) of this section.

(3) (a) The state department shall implement drug utilization mechanisms, including, but not limited to, prior authorization, to control costs in the medical assistance program associated with prescribed drugs. The state board shall promulgate a rule that outlines a process in which any interested party may be notified of and comment on the implementation of any prior authorization for a class of prescribed drugs before the class is prior authorized.

(b) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1906, § 7, effective July 1. **L. 2016:** (3)(b) repealed, (HB 16-1081), ch. 22, p. 51, § 4, effective August 10.

Editor's note: This section is similar to former § 26-4-408 as it existed prior to 2006.

25.5-5-507. Prescription drug information and technical assistance program - rules.

There is hereby created the prescription drug information and technical assistance program. The program shall provide advice on the prudent use of prescription drugs to persons who receive prescription drug benefits pursuant to this part 5. The state department shall contract with licensed pharmacists for statewide medicaid pharmacy services and pharmacy consultations for persons receiving prescription drug benefits pursuant to this part 5 regarding how each person may, with the approval of the appropriate prescribing health-care provider, avoid dangerous drug

interactions, improve patient outcomes, and save the state money for the drugs prescribed. The state department shall promulgate rules to establish and administer the program and to provide incentive payments to pharmacists and physicians who participate in the program. The state department shall design a calculation for savings under the program.

Source: L. 2007: Entire section added, p. 1631, § 2, effective July 1.

25.5-5-508. Electronic prescriptions - study - report - repeal. (Repealed)

Source: L. 2009: Entire section added, (HB 09-1073), ch. 282, p. 1286, § 1, effective August 5.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2010. (See L. 2009, p. 1286.)

25.5-5-509. Substance use disorder - prescription drugs - opioid antagonist - definition.

(1) Notwithstanding any provisions of this part 5 to the contrary, for the treatment of a substance use disorder, in promulgating rules, and subject to any necessary federal authorization, the state board shall authorize reimbursement for at least one federal food and drug administration-approved ready-to-use opioid overdose reversal drug without prior authorization.

(2) (a) As used in this subsection (2), unless the context otherwise requires, "opioid antagonist" has the same meaning as set forth in section 12-30-110 (7)(d).

(b) A hospital or emergency department shall receive reimbursement under the medical assistance program for the cost of an opioid antagonist if, in accordance with section 12-30-110, a prescriber, as defined in section 12-30-110 (7)(h), dispenses an opioid antagonist upon discharge to a medical assistance member who is at risk of experiencing an opioid-related drug overdose event or to a family member, friend, or other person in a position to assist a medical assistance member who is at risk of experiencing an opioid-related drug overdose event.

(c) The state department shall seek federal financial participation for the cost of reimbursement for the opioid antagonist but shall provide reimbursement to the hospital or emergency department for the opioid antagonist using state money until federal financial participation is available.

Source: L. 2018: Entire section added (HB 18-1007), ch. 225, p. 1433, § 6, effective January 1, 2019. **L. 2022:** Entire section amended (HB 22-1326), ch. 225, p. 1670, § 50, effective July 1. **L. 2024:** (2) amended, (HB 24-1037), ch. 458, p. 3173, § 23, effective June 6; (2)(b) amended, (SB 24-176), ch. 152, p. 658, § 67, effective August 7.

Editor's note: Amendments to subsection (2)(b) by HB 24-1037 and SB 24-176 were harmonized.

Cross references: For the legislative declaration in HB 22-1326 stating the purpose of, and the provision directing legislative staff agencies to conduct, a post-enactment review pursuant to § 2-2-1201 scheduled in 2025, see sections 1 and 55 of chapter 225, Session Laws of Colorado 2022. To obtain a copy of the review, once completed, go to "Legislative Resources and Requirements" on the Colorado General Assembly's website.

25.5-5-510. Pharmacy reimbursement - substance use disorder - injections.

A pharmacy administering injectable antagonist medication for medication-assisted treatment for substance use disorders shall receive an enhanced dispensing fee that aligns with the administration fee paid to a provider in a clinical setting.

Source: L. 2018: Entire section added, (HB 18-1007), ch. 225, p. 1433, § 7, effective January 1, 2019. **L. 2019:** Entire section amended, (HB 19-1172), ch. 136, p. 1710, § 188, effective October 1. **L. 2024:** Entire section amended, (HB 24-1045), ch. 470, p. 3289, § 24, effective August 7.

25.5-5-511. Reimbursement for pharmacists' services - legislative declaration.

(1) (a) The general assembly finds and declares that:

(I) Pharmacists are highly trained and educated doctorate-level health-care professionals specializing in the effective use of medications and their outcomes;

(II) Pharmacists provide health care throughout the entire health-care system, practicing in community pharmacies, hospitals, provider clinic offices, and specialty areas;

(III) With ninety percent of Americans living within five miles of a pharmacy, pharmacists are able to provide valuable public health services to communities and to provide those services in novel ways, including during nontraditional hours and without appointments;

(IV) As part of an integrated team, pharmacists have been proven to lower the overall cost of health care and improve long-term chronic disease outcomes; however, despite these recognized benefits, pharmacists are not considered reimbursable medical providers;

(V) Further, pharmacists in integrated medical homes under the medical assistance program are not supported by the same funding mechanisms as other providers, including rate setting for federally qualified health centers or through fee-for-service billing;

(VI) Without the ability to generate revenue through direct reimbursement or new value-based models, the services pharmacists provide are not sustainable;

(VII) Colorado has recognized that there is a shortage in primary care providers for individuals enrolled in the medical assistance program; and

(VIII) Pharmacists can help address this shortage by providing certain primary care services as a follow-up to physician care through collaborative practice models, including the provision of chronic disease management.

(b) Therefore, the general assembly declares that the ability of pharmacists to generate revenue for the same services provided by other health-care providers would be equitable, would help fund staff and services in medical homes, and would alleviate barriers to access of care in community settings.

(2) (a) A pharmacist is eligible to receive reimbursement under the medical assistance program for medically necessary services that are within the pharmacist's scope of practice pursuant to article 280 of title 12 and that are not duplicative of other pharmacist services or programs reimbursed under the medical assistance program.

(b) The state department shall include the services reimbursed pursuant to subsection (2)(a) of this section in the review of provider rates required pursuant to section 25.5-4-401.5.

(3) The state department shall request any federal authorization necessary to receive federal financial participation under the medical assistance program.

Source: L. 2021: Entire section added, (HB 21-1275), ch. 470, p. 3377, § 1, effective September 7. **L. 2026:** (2)(a) amended, (HB 26-1336), ch. 236, p. 1363, § 4, effective August 12.

25.5-5-512. Pharmacy benefit - mental health and substance use disorders - legislative declaration.

(1) (a) The general assembly finds and declares that:

(I) It is estimated that over one million Coloradans experience a mental health or substance use disorder each year, yet less than half of the adult population in this state receives the care it needs;

(II) It is well documented that access to appropriate treatments, including medication, can lead to better outcomes for individuals dealing with these diagnoses;

(III) For this reason, policies that restrict access to medications lead to poorer outcomes and increased health-care costs;

(IV) Pharmacists also play an important role in improving access to treatments for serious mental illness and substance use disorders; and

(V) The use of extended-release injectable medications for serious mental illness and substance use disorders has research-proven clinical benefits compared to oral medications, including medication adherence and significant delay and reduction in relapse, which decreases criminal recidivism and emergency room visits for patients from vulnerable populations, particularly those experiencing homelessness.

(b) Therefore, the general assembly declares that access to these treatments through a pharmacy benefit under the medical assistance program will improve access to mental health providers by allowing pharmacists to dispense, administer, and be reimbursed for these important and effective medications.

(2) A pharmacist or pharmacy that dispenses or administers extended-release injectable medications for the treatment of mental health or substance use disorders may seek reimbursement for those medications under the medical assistance program either as a pharmacy benefit or as a medical benefit.

Source: L. 2021: Entire section added, (HB 21-1275), ch. 470, p. 3377, § 1, effective September 7.

25.5-5-512.5. Medications for opioid use disorder - pharmacists - reimbursement - definition.

(1) As used in this section, unless the context otherwise requires, "medications for opioid use disorder" or "MOUD" has the meaning as set forth in section 12-280-103 (27.5).

(2) The state department shall reimburse a licensed pharmacist for prescribing or administering medications for opioid use disorder, if the pharmacist is authorized pursuant to article 280 of title 12, at a rate equal to the reimbursement provided to a physician, physician assistant, or advanced practice registered nurse for the same services.

(3) The state department shall seek any federal authorization necessary to implement this section.

Source: L. 2024: Entire section added, (HB 24-1045), ch. 470, p. 3289, § 25, effective August 7.

25.5-5-513. Pharmacy benefits - prescription drugs - rebates - analysis.

(1) Beginning in 2023, the state department shall, in collaboration with the administrator of the all-payer health claims database described in section 25.5-1-204, conduct an annual analysis of the prescription drug rebates received in the previous calendar year, by health insurance carrier and prescription drug tier. The analysis, using data from the all-payer health claims database and other sources, must be completed on or before May 1 of each year.

(2) The state department shall make the analysis conducted in subsection (1) of this section available to the public on an annual basis.

Source: L. 2022: Entire section added, (HB 22-1370), ch. 184, p. 1237, § 7, effective August 10.

25.5-5-514. Prescription drugs used for treatment or prevention of HIV - prohibition on utilization management - definition.

(1) As used in this section, "HIV" means human immunodeficiency virus.

(2) (a) Before July 1, 2027, the state department shall not restrict by prior authorization or step therapy requirements any prescription drug approved by the federal food and drug administration that is used for the treatment or prevention of HIV if a prescribing practitioner licensed pursuant to title 12 has determined the prescription drug to be medically necessary for the treatment or prevention of HIV for a member. Prescription drugs used for the treatment or prevention of HIV include protease inhibitors, non-nucleoside reverse transcriptase inhibitors, nucleoside reverse transcriptase inhibitors, antivirals, integrase inhibitors, long-acting medications, and fusion inhibitors.

(b) Nothing in this subsection (2) prevents the state department from performing drug utilization review that may be necessary for patient safety or for ensuring the prescribed use is for a medically accepted indication, as required by section 1927 of the federal "Social Security Act of 1935".

Source: L. 2023: Entire section added, (SB 23-189), ch. 69, p. 260, § 9, effective April 14. **L. 2024:** (2)(a) amended, (SB 24-176), ch. 152, p. 659, § 68, effective August 7; (2)(b) amended, (HB 24-1450), ch. 490, p. 3421, § 65, effective August 7.

25.5-5-515. Pharmacy reimbursement - vaccine administration to children - legislative declaration.

(1) (a) The general assembly finds and declares that:

(I) Pharmacists are highly trained and educated, doctorate-level health-care professionals specializing in the effective use of medications and their outcomes;

(II) Pharmacists provide health care throughout the entire health-care system, practicing in community pharmacies, hospitals, provider clinic offices, and specialty areas;

(III) With ninety percent of Americans living within five miles of a pharmacy, pharmacists are able to provide valuable public health services to communities and to provide those services in novel ways, including during nontraditional hours and without appointments; and

(IV) Convenient access to vaccines through a neighborhood pharmacy can help ensure that more children receive their childhood vaccinations according to federal recommended guidelines.

(b) Therefore, the general assembly declares that allowing reimbursement under the medical assistance program to a pharmacist or pharmacy that dispenses or administers childhood vaccinations is an important tool in ensuring the health of Colorado children through immunization.

(2) Pursuant to the requirements set forth in subsection (3) of this section, a pharmacist or pharmacy that dispenses or administers vaccinations to children under nineteen years of age pursuant to the federal centers for disease control and prevention's guidelines pertaining to the childhood immunization schedule may seek reimbursement for the dispensing or administration of vaccines under the medical assistance program either as a pharmacy benefit or as a medical benefit, as applicable.

(3) (a) To be eligible to receive reimbursement pursuant to subsection (2) of this section for administering vaccines to children, a pharmacy or pharmacist must be enrolled in good standing with the vaccines for children program administered by the department of public health and environment.

(b) Until the department of public health and environment determines a framework for participation by pharmacies and pharmacists in the vaccines for children program, nothing in this

section requires the department of public health and environment to enroll pharmacies receiving reimbursement for the administration of vaccines through the medical assistance program as vaccines for children providers.

(c) As used in this subsection (3), "vaccines for children program" means the federal centers for disease control and prevention "vaccines for children program" administered by the department of public health and environment, or any successor program.

Source: L. 2023: Entire section added, (SB 23-162), ch. 148, p. 630, § 4, effective August 7.

25.5-5-516. Serious mental illness - prescribed drugs.

Notwithstanding any provisions of this part 5 to the contrary, and subject to any necessary federal authorization, the state board shall require a review for coverage of a new drug approved by the federal food and drug administration for a serious mental illness within ninety days after the approval of the drug.

Source: L. 2023: Entire section added, (HB 23-1130), ch. 394, p. 2356, § 3, effective August 7.

25.5-5-517. Prescription drugs for treating mental health disorders or conditions - prior authorization - rules - definitions.

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

(a) "Mental health disorder or mental health condition" refers to the mental health disorders described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

(b) "Prescription drug" has the same meaning as set forth in section 12-280-103.

(c) "Unsuccessfully treated" refers to the clinically appropriate guidelines used to determine a patient's failure on a medication and may include a lack of efficacy during a six-week medication trial, an allergic reaction, intolerable side effects, significant drug-to-drug interactions, or a known interacting genetic polymorphism that prevents safe preferred medication dosing as attested to by the provider.

(2) The state department shall not require an adult to be prescribed an antipsychotic prescription drug that is included on the preferred drug list and used to treat a mental health disorder or mental health condition, as indicated on federally approved labels, if:

(a) During the preceding three hundred sixty-five days, the adult was prescribed and unsuccessfully treated with an antipsychotic prescription drug that is included on the preferred drug list and used to treat a mental health disorder or mental health condition and for which a single claim is paid; or

(b) The adult is stable on an antipsychotic drug used to treat a mental health disorder or mental health condition that is not included on the preferred drug list.

(3) This section applies to a fee-for-service medical assistance plan and a health maintenance organization that has a contract with the state department and provides coverage for prescription drugs.

(4) This section does not prohibit the state department from contracting with a managed care organization for pharmaceutical services offered under the state medical assistance program pursuant to this article 5 and articles 4 and 6 of this title 25.5, if the contract complies with this section.

(5) This section does not prohibit or discourage the use of a generic drug.

(6) This section does not prevent the state department from performing a drug utilization review that is necessary for patient safety or to ensure the prescribed use is for a medically accepted indication, as required by section 1927 of the federal "Social Security Act of 1935".

(7) This section does not prevent the state department from requiring the prescribing provider to electronically attest that the adult meets the requirements of subsection (2)(a) or (2)(b) of this section prior to providing coverage for an antipsychotic drug used to treat a mental health disorder or mental health condition that is not included on the preferred drug list. The attestation must be automatically processed and must automatically override the preferred drug coverage requirement upon the attestation being made.

Source: L. 2024: Entire section added, (SB 24-110), ch. 363, p. 2456, § 2, effective June 3.

Cross references: For the legislative declaration in SB 24-110, see section 1 of chapter 363, Session Laws of Colorado 2024.

25.5-5-518. Coverage for choline dietary supplements - rules.

(1) No later than July 1, 2025, the state board shall promulgate rules to include coverage under the medical assistance program for over-the-counter choline dietary supplements for pregnant persons.

(2) The state department shall seek federal approval, as necessary, for the coverage described in subsection (1) of this section.

Source: L. 2024: Entire section added, (SB 24-175), ch. 433, p. 3040, § 5, effective June 5.

25.5-5-519. Pharmacy reimbursement - parenteral nutrition - report - definitions.

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

(a) "Infusion pharmacy" means a prescription drug outlet that prepares and dispenses a solution that includes parenteral nutrition for direct administration into a patient's bloodstream. The solution may contain medications or other treatments and may be administered in a patient's home or in a health-care facility.

(b) "Parenteral nutrition" means a form of nutritional support that provides a patient with needed nutrients, including, at a minimum, carbohydrates, amino acids, and lipids, through an intravenous infusion.

(2) (a) Upon receiving any necessary federal approval pursuant to subsection (2)(c) of this section, beginning on or before January 1, 2026, the state department shall create specific professional dispensing fees for the preparation and dispensing of parenteral nutrition to encourage an adequate level of market participation among infusion pharmacies.

(b) During the year beginning January 1, 2026, the specific professional dispensing fees must not exceed thirty percent of infusion pharmacy administrative costs for the preparation and dispensing of parenteral nutrition.

(c) The state department shall seek federal authorization, as necessary, to implement the professional dispensing fees pursuant to this subsection (2).

(3) Notwithstanding section 24-1-136 (11)(a)(I), on or before November 1, 2026, and on or before every November 1 thereafter, the state department shall, within existing appropriations, report in its presentation to the joint budget committee and its "SMART Act" hearing held pursuant to section 2-7-203 on:

(a) The total number and geographic distribution of infusion pharmacies throughout Colorado that provide parenteral nutrition to members;

(b) The number of new infusion pharmacies participating in the medical assistance program;

(c) Separate data on the parenteral nutrition needs of adult and child members and the sufficiency of the infusion pharmacy network to serve each; and

(d) Any regulatory or reimbursement changes the state department has undertaken to encourage an adequate level of market participation among infusion pharmacies to meet the parenteral nutrition needs of members.

Source: L. 2025: Entire section added, (SB 25-084), ch. 275, p. 1432, § 2, effective August 6.

Cross references: For the legislative declaration in SB 25-084, see section 1 of chapter 275, Session Laws of Colorado 2025.

PART 6

PROGRAM FOR TEEN PREGNANCY AND DROPOUT PREVENTION

25.5-5-601 to 25.5-5-605. (Repealed)

Editor's note: (1) This part 6 was added in 1995. For amendments to this part 6 prior to its repeal in 2016, consult the 2015 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

(2) Section 25.5-5-605 provided for the repeal of this part 6, effective September 1, 2016. (See L. 2011, p. 1458.)

PART 7

TELEMEDICINE PILOT PROGRAMS FOR CHRONIC MEDICAL CONDITIONS

25.5-5-701 to 25.5-5-703. (Repealed)

Source: L. 2010: Entire part repealed, (HB 10-1322), ch. 29, p. 105, § 1, effective March 18.

Editor's note: This part 7 was added in 2006 and was not amended prior to its repeal in 2010. For the text of this part 7 prior to 2010, consult the 2009 Colorado Revised Statutes.

PART 8

CHILDREN AND YOUTH BEHAVIORAL HEALTH SYSTEM IMPROVEMENTS

Cross references: For the legislative declaration in SB 19-195, see section 1 of chapter 190, Session Laws of Colorado 2019.

25.5-5-801. Legislative declaration.

(1) The general assembly finds and declares that:

(a) In order to provide quality behavioral health services to families of children and youth with behavioral health challenges, behavioral health services should be coordinated among state departments and political subdivisions of the state and should be culturally competent, cost-effective, and provided in the least restrictive settings;

(b) The behavioral health system and child- and youth-serving agencies are often constrained by resource capacity and systemic barriers that can create difficulties in providing appropriate and cost-effective interventions and services for children and youth;

(c) Children and youth with behavioral health challenges may require a multi-system level of care that can lead to duplication and fragmentation of services. To avoid these problems, keep families together, and support caregivers during a child's or youth's behavioral health challenge, departments and political subdivisions of the state must collaborate with one another.

(d) The Colorado state innovation model, an initiative housed in the office of the governor, has worked to integrate behavioral health and physical health, has made significant progress advancing the use of alternative payment models, and has created infrastructure for screening and innovative payment reforms. However, future work is needed to further expand and improve integrated services for children and families, with a focus on early and upstream interventions.

(2) The general assembly further finds and declares that, building upon work completed by Colorado's trauma-informed system of care, Colorado must implement a model of comprehensive system of care for families of children and youth with behavioral health challenges.

Source: L. 2019: Entire part added, (SB 19-195), ch. 190, p. 2098, § 2, effective August 2.

25.5-5-802. Definitions.

As used in this part 8, unless the context otherwise requires:

(1) "At risk of out-of-home placement" means a child or youth who is eligible for medical assistance pursuant to articles 4, 5, and 6 of this title 25.5 and the child or youth:

(a) Has been diagnosed as having a mental health disorder, as defined in section 27-65-102 (11.5), or a behavioral health disorder; and

(b) May require a level of care that is provided in a residential child care facility, inpatient psychiatric hospital, or other intensive care setting outside of the child's or youth's home. "At risk of out-of-home placement" includes a child or youth who:

(I) Is entering the division of youth services; or

(II) Is at risk of child welfare involvement.

(2) "Behavioral health disorder" means a substance use disorder, mental health disorder, or one or more substantial disorders of the cognitive, volitional, or emotional processes that grossly impair judgment or capacity to recognize reality or to control behavior, including serious emotional disturbances. "Behavioral health disorder" also includes those mental health disorders listed in the most recent versions of the diagnostic statistical manual of mental health disorders, the diagnostic classification of mental health and developmental disorders of infancy and early childhood, and the international statistical classification of diseases and related health problems.

(3) "Behavioral health services" or "behavioral health system" means the child and youth service system that encompasses prevention and promotion of emotional health, prevention and treatment services for mental health and substance use conditions, and recovery support.

(4) "Child and youth" means a person who is twenty-six years of age or younger.

(5) "Managed care entity" means an entity that enters into a contract to provide services in the statewide managed care system pursuant to articles 4, 5, and 6 of this title 25.5.

(6) "Mental health professional" means an individual licensed as a mental health professional pursuant to article 245 of title 12 or a professional person as defined in section 27-65-102 (17).

(7) "Out-of-home placement" means a child or youth who is eligible for medical assistance pursuant to articles 4, 5, and 6 of this title 25.5 and the child or youth:

(a) Has been diagnosed as having a mental health disorder, as defined in section 27-65-102 (11.5), or a behavioral health disorder; and

(b) May require a level of care that is provided in a residential child care facility, inpatient psychiatric hospital, or other intensive care setting outside of the child's or youth's home. "Out-of-home placement" includes a child or youth who:

(I) Has entered the division of youth services; or

(II) Is at risk of child welfare involvement.

(8) "Wraparound" means a high-fidelity, individualized, family-centered, strengths-based, and intensive care planning and management process used in the delivery of behavioral health services for a child or youth with a behavioral health disorder, commonly utilized as part of the system of care framework.

Source: L. 2019: Entire part added, (SB 19-195), ch. 190, p. 2098, § 2, effective August 2.

Cross references: For additional definitions applicable to this part 8, see § 25.5-4-103.

25.5-5-803. High-fidelity wraparound services for children and youth - federal approval - reporting.

(1) Subject to available appropriations, the state department shall seek federal authorization from the federal centers for medicare and medicaid services to provide wraparound services for eligible children and youth who are at risk of out-of-home placement or in an out-of-home placement. Prior to seeking federal authorization, the state department shall seek input from relevant stakeholders including counties, managed care entities participating in the statewide managed care system, families of children and youth with behavioral health disorders, communities that have previously implemented wraparound services, mental health professionals, the behavioral health administration in the department of human services, and other relevant departments. The state department shall consider tiered care coordination as an approach when developing the wraparound model.

(2) Upon federal authorization, and subject to available appropriations, the state department shall require managed care entities to implement wraparound services, which may be contracted out to a third party. Subject to available appropriations, the state department shall contract with the department of human services and the behavioral health administration in the department of human services to ensure care coordinators and those responsible for implementing wraparound services have adequate training and resources to support children and youth who may have co-occurring diagnoses, including behavioral health disorders and physical or intellectual or developmental disabilities. Attention must also be given to the geographic diversity of the state in designing this program in rural communities.

(3) Upon implementation of the wraparound services, the state department, the department of human services, and the behavioral health administration in the department of human services shall monitor and report the annual cost savings associated with eligible children and youth

receiving wraparound services to the public through the annual hearing, pursuant to the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", part 2 of article 7 of title 2. The state department shall require managed care entities to report data on the utilization and effectiveness of wraparound services.

(4) Subject to available appropriations, the state department shall work collaboratively with the department of human services, the behavioral health administration in the department of human services, counties, and other departments, as appropriate, to develop and implement wraparound services for children and youth at risk of out-of-home placement or in an out-of-home placement. The behavioral health administration in the department of human services shall oversee that the wraparound services are delivered with fidelity to the model. As part of routine collaboration, and subject to available appropriations, the state department shall develop a model of sustainable funding for wraparound services in consultation with the department of human services and the behavioral health administration in the department of human services. Wraparound services provided to eligible children and youth pursuant to this section must be covered under the "Colorado Medical Assistance Act", articles 4, 5, and 6 of this title 25.5, subject to available appropriations. The state department may use targeting criteria to ramp up wraparound services as service capacity increases, or temporarily, as necessary, to meet certain federal financial participation requirements.

Source: L. 2019: Entire part added, (SB 19-195), ch. 190, p. 2100, § 2, effective August 2. **L. 2020:** (1), (2), and (4) amended, (HB 20-1384), ch. 172, p. 789, § 2, effective June 29. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1516, § 77, effective July 1. **L. 2023:** (1) amended, (HB 23-1236), ch. 206, p. 1054, § 15, effective May 16.

25.5-5-804. Integrated funding pilot.

Subject to available appropriations, the state department, in conjunction with the behavioral health administration in the department of human services, counties, and other relevant departments, shall design and recommend a child and youth behavioral health delivery system pilot program that addresses the challenges of fragmentation and duplication of behavioral health services. The pilot program shall integrate funding for behavioral health intervention and treatment services across the state to serve children and youth with behavioral health disorders. To implement the provisions of this section, the state department shall collaborate with the behavioral health administration in the department of human services and other relevant stakeholders, including counties, managed care entities, and families.

Source: L. 2019: Entire part added, (SB 19-195), ch. 190, p. 2101, § 2, effective August 2. **L. 2020:** Entire section amended, (HB 20-1384), ch. 172, p. 790, § 3, effective June 29. **L. 2022:** Entire section amended, (HB 22-1278), ch. 222, p. 1517, § 78, effective July 1.

ARTICLE 6

Colorado Medical Assistance Act - Long-term Care

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PART 1

LONG-TERM CARE ADMINISTRATION

25.5-6-101. Spousal protection - protection of income and resources for community spouse - definitions - amounts retained - responsibility of state department - right to appeal.

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

(a) "Community spouse" means the spouse of a person who is in an institution or nursing facility, the spouse of a person who is enrolled in the PACE program authorized pursuant to section 25.5-5-412, or the spouse of a person who is receiving home- and community-based services pursuant to this article.

(b) "Community spouse monthly income allowance" means the amount by which the minimum monthly maintenance needs allowance exceeds the amount of monthly income that is available to the community spouse.

(c) "Community spouse resource allowance" means the amount of assets, excluding the value of the home and other exempt resources under federal law, that the community spouse shall be allowed to retain and that shall not be available to cover an institutionalized spouse's cost of care.

(d) (I) "Institutionalized spouse" means an individual who is in an institution or nursing facility who is married to a spouse who is not in an institution or nursing facility.

(II) For purposes of this section, "institutionalized spouse" includes an individual who is enrolled in the PACE program authorized pursuant to section 25.5-5-412 or is receiving home- and community-based services pursuant to this article, and who is married to a spouse who is not enrolled in the PACE program or receiving home- and community-based services.

(e) (I) (A) "Minimum monthly maintenance needs allowance" means an amount which is equal to an applicable percent of the nonfarm income official poverty line (increased annually by the consumer price index for all urban consumers), as defined by the federal office of management and budget, for a family unit of two members.

(B) For the purposes of sub-subparagraph (A) of this subparagraph (I), the applicable percent shall be: As of September 30, 1989, one hundred twenty-two percent; as of July 1, 1991, one hundred thirty-three percent; as of July 1, 1992, one hundred fifty percent.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (e), the minimum monthly maintenance needs allowance may be increased on an individual basis if:

(A) The community spouse has shelter and utilities expenses that exceed thirty percent of the minimum monthly maintenance needs allowance; except that the total allowance shall not exceed fifteen hundred dollars (increased annually by the consumer price index for all urban consumers);

(B) Either spouse is responsible for a dependent family member, including children, parents, or siblings who reside with the community spouse; or

(C) The community spouse has exceptional circumstances which would result in significant financial duress.

(2) (a) In order to implement the medical assistance program in compliance with the federal "Medicare Catastrophic Coverage Act of 1988", as amended, the state department shall ensure, when an institutionalized spouse is eligible for medical assistance under this article and articles 4 and 5 of this title, that the community spouse retain a community spouse monthly income allowance but only to the extent that income of the institutionalized spouse is made available to the community spouse.

(b) (I) The resources available to the married couple shall be calculated at the beginning of a continuous period of institutionalization of the institutionalized spouse. The community spouse shall retain the remainder of the couple's countable resources up to the federal maximum resource allowance as a community spouse resources allowance. The institutionalized spouse may keep an amount up to the amount of resources allowed under the federal medicaid program.

(II) Notwithstanding the provisions of subparagraph (I) of this paragraph (b), if either spouse establishes that the community spouse resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, an amount adequate to provide the minimum monthly maintenance needs allowance shall be substituted.

(3) The state board shall have the authority to promulgate any rules that are necessary to implement the provisions of this section in accordance with the federal "Medicare Catastrophic Coverage Act of 1988", as amended. The rules adopted by the state board shall include, as a minimum, provisions regarding the following matters:

(a) The treatment of a married couple's income and resources before and after eligibility for medical assistance is established, including the basis for dividing such income and resources between the two parties;

(b) The process for appealing any determinations regarding income and resources that are made pursuant to these rules.

Source: L. 2006: Entire article added with relocations, p. 1907, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-506 as it existed prior to 2006.

Cross references: For provisions of the federal "Medicare Catastrophic Coverage Act of 1988" referenced in this section, see section 303 of Pub.L. 100-360, codified at 42 U.S.C. sec. 1396r-5.

ANNOTATION

Subsections (1)(d)(I) and (1)(d)(II) must be read in the disjunctive. In determining whether a spouse is entitled to the community spouse resource allowance, an institutionalized spouse can be either a person described in (1)(d)(I) or in (1)(d)(II). Under federal law, the fact that the wife received home- and community-based services did not make her ineligible to receive the community spouse resource allowance based upon her husband's institutionalization. Koehler v. Colo. Dept. of Health Care Policy & Fin., 252 P.3d 1174 (Colo. App. 2010).

25.5-6-102. Court-approved trusts - transfer of property for persons seeking medical assistance for nursing home care - undue hardship - legislative declaration.

(1) The general assembly finds, determines, and declares that:

(a) The state makes significant expenditures for nursing home care under the "Colorado Medical Assistance Act";

(b) A large number of persons do not have enough income to afford nursing home care, but have too much income to qualify for state medical assistance, a situation popularly referred to as the "Utah gap";

(c) Some persons in the Utah gap, through innovative court-approved trust arrangements, have become qualified for state medical assistance, thereby increasing state medical assistance expenditures;

(d) It is therefore appropriate to enact state laws that limit court-approved trusts in a manner that is consistent with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396 et seq., as amended, and which provide that persons who qualify for assistance as a result of the creation of such trusts are treated the same as any other member of medical assistance for nursing home care;

(e) In enacting this section, the general assembly intends only to limit certain court-approved trusts and court-approved transfers of property. It is not the general assembly's intent to approve or disapprove of privately created trusts or private transfers of property made under the same or similar circumstances.

(2) The county department shall verify that an applicant for medical assistance for nursing home care, pursuant to the provisions of this title, meets applicable eligibility criteria for assistance other than those set forth in subsection (3) of this section. Upon verification, for eligibility purposes and in accordance with subsection (3) of this section, the county department shall make a determination of the status of any court-approved trust established for or court-approved transfer of property made by or for the applicant.

(3) (a) If a person who applies for medical assistance for nursing home care would be deemed ineligible for assistance as a result of deeming a court-approved trust established for the applicant as a medicaid qualifying trust or as a result of deeming property in the court-approved trust as an improper transfer of assets, the person's application shall, nonetheless, be treated as a case of undue hardship and the person shall be eligible for medical assistance for said care if the establishment of the court-approved trust meets the following criteria:

(I) The applicant's monthly gross income from all sources, without reference to the court-approved trust, exceeds the income eligibility standard for medical assistance then in effect but is less than the average private pay rate for nursing home care for the geographic region in which the applicant lives;

(II) The property used to fund the trust shall be limited to monthly unearned income owned by the applicant, including any pension payment;

(III) The applicant and the state medical assistance program shall be the sole beneficiaries of the trust. The entire corpus of the trust, or as much of the corpus as may be distributed each month without violating federal requirements for federal financial participation, shall be distributed each month for expenses related to the beneficiary's nursing home care that are approved under the medical assistance program; except that an amount reasonably necessary to maintain the existence of the trust and to comply with federal requirements may be retained in the trust. Deductions may be distributed from the trust to the same extent deductions from the income of a nursing home resident who is not a trust beneficiary are allowed under the medical assistance program, which shall include the following:

(A) A monthly personal needs allowance;

(B) Payments to the beneficiary's community spouse or dependent family members as provided and in accordance with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396r-5, as amended, and section 25.5-6-101;

(C) Specified health insurance costs and special medical services provided under Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396a(r), as amended; and

(D) Any other deduction provided in the rules of the state department.

(IV) Upon the death of the beneficiary, a remainder interest in the corpus of the trust shall pass to the state agency responsible for administering the state medical assistance program;

(V) The trust shall not be subject to modification by the beneficiary or the trustee unless otherwise provided by this section or section 15-14-412.5, C.R.S.

(b) For the purposes of this subsection (3), "medicaid qualifying trust" shall have the same meaning as set forth in Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396a(k).

(4) The state board shall adopt rules as are necessary for the implementation of this section and as are necessary to comply with federal law. In addition, the state department shall amend the state medical assistance plan in a manner that is consistent with the provisions of this section.

(5) This section shall take effect January 1, 1992, and shall apply to any court-approved trust established for or court-approved transfer of property made by or for a protected person applying for or receiving medical assistance for nursing home care pursuant to the provisions of this title, on or after said date; except that a court-approved trust created before said date that does not comply with this section shall be modified to comply with this section no later than July 1, 1992, before which time the court-approved trust or court-approved transfer of property to a trust shall not render the protected person ineligible for medical assistance.

(6) The provisions of this section shall not apply if federal funds are not available for persons who would qualify for medical assistance as a result of a court-approved trust that meets the criteria set forth in this section.

(7) This section shall apply to trusts established or transfers of property made prior to July 1, 1994. The provisions set forth in sections 15-14-412.6 to 15-14-412.9, C.R.S., and any rules adopted by the state board pursuant to section 25.5-6-103 shall apply to trusts established or property transferred on or after that date.

Source: L. 2006: Entire article added with relocations, p. 1908, § 7, effective July 1. **L. 2024:** IP(1) and (1)(d) amended, (SB 24-176), ch. 152, p. 659, § 69, effective August 7.

Editor's note: This section is similar to former § 26-4-506.5 as it existed prior to 2006.

ANNOTATION

Law reviews. For article, "The Impacts of Trusts on Public Benefits for Disabled Persons", see 46 Colo. Law. 43 (Nov. 2017).

25.5-6-103. Court-approved trusts - transfer of property for persons seeking medical assistance - rule-making authority for trusts created on or after July 1, 1994 - undue hardship.

(1) The state board shall adopt such rules as are necessary with respect to trusts established pursuant to sections 15-14-412.6 to 15-14-412.9. The state board shall adopt rules that address, but need not be limited to, the following:

(a) The definition, including any limitations, of permissible distributions from trusts, taking federal guidelines into consideration;

(b) Reasonable financial reimbursement or incentives to the state department, county departments of human or social services, and any other designated agencies for the efforts and expenses in monitoring trusts, and where necessary, for the recovery of trust property that has been improperly distributed or otherwise expended.

(2) The state board shall comply with Title XIX of the federal "Social Security Act", 42 U.S.C. sec. 1396p (d)(5), as amended, which requires the state medicaid agency to establish procedures, in accordance with standards specified by the secretary of the United States department of health and human services, under which the state medicaid agency may waive the application of the general rules for considering trust property in determining eligibility for medical assistance if the applicant for medical assistance establishes that the application of the general rules would work an undue hardship on the individual.

(3) The state department shall determine the feasibility of providing ongoing support of dependents by using the trust corpus during the life of the person for whom a trust is created or using the remainder of the trust after the death of the person for whom the trust was created. If the state department determines that it is feasible to provide that support, the state department shall seek a waiver from the federal government to permit the use of trust property for that purpose.

Source: L. 2006: Entire article added with relocations, p. 1911, § 7, effective July 1. **L. 2018:** IP(1) and (1)(b) amended, (SB 18-092), ch. 38, p. 445, § 112, effective August 8.

Editor's note: This section is similar to former § 26-4-506.6 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018.

25.5-6-104. Long-term care placements - comprehensive and uniform client assessment instrument - report - legislative declaration - definitions - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1911, § 7, effective July 1. **L. 2007:** (4) added, p. 1393, § 2, effective May 30. **L. 2008:** (3)(b) amended, p. 437, § 1, effective August 5. **L. 2016:** (5) added, (SB 16-192), ch. 256, p. 1051, § 1, effective June 8. **L. 2018:** (3)(b)(VIII) repealed, (SB 18-093), ch. 62, p. 610, § 5, effective August 8; IP(3)(d) and (3)(d)(IV) amended, (HB 18-1091), ch. 74, p. 643, § 4, effective August 8. **L. 2021:** (6) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2024:** (1)(b), (1)(c), (2)(b), (2)(d), (2)(e), (2)(f), (2)(i), (2)(j), (2)(k), (3)(a), IP(3)(b), (3)(b)(VII), (3)(c), IP(3)(d), IP(3)(d)(I), (3)(d)(II), (3)(d)(III), (3)(d)(V), (3)(e), and (5)(a) amended, (SB 24-176), ch. 152, p. 659, § 70, effective August 7.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-507 as it existed prior to 2006.

(2) SB 24-176 amended several provisions of this section, effective August 7, 2024, but those amendments did not take effect due to the repeal of this section, effective July 1, 2024.

(3) Subsection (6) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-6-105. Legislative declaration relating to implementation of single entry point system - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1914, § 7, effective July 1. **L. 2021:** (3) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2024:** IP(1), (1)(b), and (1)(c) amended, (SB 24-176), ch. 152, p. 662, § 71, effective August 7.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-521 as it existed prior to 2006.

(2) SB 24-176 amended subsections IP(1), (1)(b), and (1)(c), effective August 7, 2024, but those amendments did not take effect due to the repeal of this section, effective July 1, 2024.

(3) Subsection (3) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-6-106. Single entry point system - authorization - phases for implementation - services provided - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1915, § 7, effective July 1. **L. 2012:** (2)(b)(IV) amended and (2)(c)(IX.5) added, (SB 12-023), ch. 94, p. 309, § 2, effective April 12. **L. 2017:** (2)(a) amended, (SB 17-242), ch. 263, p. 1329, § 206, effective May 25; (3)(e) added, (HB 17-1284), ch. 272, p. 1505, § 11, effective May 31. **L. 2018:** (2)(b)(III) repealed, (SB 18-093), ch. 62, p. 610, § 6, effective August 8. **L. 2021:** (4) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2024:** IP(2)(b), IP(2)(c), (2)(c)(III), (2)(c)(IV), (2)(c)(V), and (3)(b) amended, (SB 24-176), ch. 152, p. 662, § 72, effective August 7.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-522 as it existed prior to 2006.

(2) SB 24-176 amended several provisions of this section, effective August 7, 2024, but those amendments did not take effect due to the repeal of this section, effective July 1, 2024.

(3) Subsection (4) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-6-107. Financing of single entry point system - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1917, § 7, effective July 1. **L. 2021:** (3) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2024:** IP(1), (1)(c)(II), and (2) amended, (SB 24-176), ch. 152, p. 663, § 73, effective August 7.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-525 as it existed prior to 2006.

(2) SB 24-176 amended subsections IP(1), (1)(c)(II), and (2), effective August 7, 2024, but those amendments did not take effect due to the repeal of this section, effective July 1, 2024.

(3) Subsection (3) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-6-108. Legislative declaration - advisory committee - long-term care - report - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1917, § 7, effective July 1.

Editor's note: (1) This section was similar to former § 26-4-425 as it existed prior to 2006.

(2) Subsection (9) provided for the repeal of this section, effective July 1, 2007. (See L. 2006, p. 1917.)

25.5-6-108.5. Community long-term care studies - authority to implement - alternative care facility report.

(1) (a) Subject to the receipt of sufficient funding pursuant to subsection (1)(c) of this section, the state department shall contract for one or more studies of the population of members receiving services under the home- and community-based waivers authorized pursuant to this article 6. The state department shall make necessary data available to the contractor, including but not limited to data on activities of daily living. In selecting a contractor to perform any study conducted pursuant to this subsection (1), the state department is not required to follow the competitive bidding requirements of the "Procurement Code", articles 101 to 112 of title 24. The state department shall provide copies of all studies conducted pursuant to this subsection (1) to members of the health and human services committees of the general assembly, or any successor committees, and to the members of the joint budget committee.

(b) If a study conducted pursuant to this subsection (1) concludes that a program of home- and community-based services would result in cost savings, the state department shall seek any necessary federal authorization to implement the program. If federal authorization to implement the program is obtained, the state department shall request, through the state budget process, that the program be implemented. The state department shall report to the joint budget committee annually concerning the amount of any savings realized from the program.

(c) The state department is authorized to seek and accept gifts, grants, or donations from private and public sources for the purposes of this subsection (1); except that the state department may not accept a gift, grant, or donation that is subject to conditions that are inconsistent with this subsection (1) or any other law of the state. The state department shall transmit all private and public moneys received through gifts, grants, or donations to the state treasurer, who shall credit the same to the department of health care policy and financing cash fund created in section 25.5-1-109.

(2) (a) Subject to the receipt of sufficient funding, one of the studies contracted for pursuant to subsection (1) of this section must include research and analysis of:

(I) The number of members with incontinence, Alzheimer's disease, dementia, or other diagnoses of a chronic incapacitating condition that severely limit the member's activities of daily living who would benefit from receiving additional services through an alternative care facility to avoid nursing home placement;

(II) The actuarially sound rate for providing services for the members at an alternative care facility;

(III) The amount of savings associated with providing services at an alternative care facility;

(IV) Recommendations for utilization controls or program controls for a program to provide services at an alternative care facility;

(V) The experiences of the program of all-inclusive care for the elderly, created pursuant to section 25.5-5-412, with tiered rates for alternative care facilities, including cost savings or cost avoidance;

(VI) Other states' experiences with tiered rates for alternative care facilities, including cost savings or cost avoidance; and

(VII) Recommendations for maintaining or improving quality of care.

(b) The study conducted pursuant to this subsection (2) shall be completed by January 1, 2012, and, if federal approval is obtained prior to final figure-setting for the fiscal year commencing July 1, 2012, the state department shall submit a request through the budget process for implementation of the approved changes for that fiscal year.

Source: L. 2010: Entire section added, (HB 10-1053), ch. 276, p. 1264, § 2, effective May 26. **L. 2011:** (2)(b) amended, (HB 11-1242), ch. 271, p. 1231, § 2, effective July 1. **L. 2024:** (1)(a), IP(2)(a), (2)(a)(I), and (2)(a)(II) amended, (SB 24-176), ch. 152, p. 663, § 74, effective August 7.

Cross references: For the legislative declaration in the 2010 act adding this section, see section 1 of chapter 276, Session Laws of Colorado 2010.

25.5-6-109. Community long-term care - coordinated care pilot program - federal authorization - rules - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1921, § 7, effective July 1. **L. 2007:** (1) and (7) amended, p. 2016, § 1, effective June 1. **L. 2010:** (2)(b) amended, (HB 10-1422), ch. 419, p. 2114, § 149, effective August 11.

Editor's note: (1) This section was similar to former § 26-4-426 as it existed prior to 2006.

(2) Subsection (7) provided for the repeal of this section, effective July 1, 2012. (See L. 2007, p. 2016.)

25.5-6-110. Private-public partnership education and information program concerning long-term care insurance authorized.

(1) The general assembly hereby declares that:

(a) A large number of Coloradans are in need of long-term health care;

(b) The cost of long-term care, especially nursing home care, is significant;

(c) Many persons in need of long-term care are ineligible for state medical assistance due to countable resources. When faced with the need for long-term care, such persons expend such resources to pay for nursing home care.

(d) A person's resources may cover only a relatively short period of care, often resulting in rendering such person impoverished, and after which time the person must rely on state medical assistance;

(e) Expenditures for long-term care represent a significant portion of the state's medical assistance budget;

(f) Unless Colorado implements new methods for financing long-term care, which methods include participation by the private sector, the cost to the state for long-term care will increase astronomically; and

(g) It is therefore appropriate to enact legislation that allows the state department, upon a determination by the executive director of the state department that it is feasible, to design and implement a private-public partnership for financing long-term care in this state.

(2) The state department shall cooperate with the division of insurance in the department of regulatory agencies in a private-public partnership for financing long-term care in this state through the availability of long-term care insurance policies that result in a reduction of total dependency on the medical assistance program to finance such care. It is the general assembly's intent that such partnership shall be designed to encourage individuals to purchase long-term care insurance, which, with respect to middle to higher income individuals, will have the result of eliminating or delaying the individual's need for medical assistance.

(3) Under the partnership described in subsection (2) of this section, the division of insurance shall implement statutory changes to article 19 of title 10, C.R.S., concerning long-term care policies that the general assembly hereby declares are necessary to accomplish the purpose of the partnership described in this section. In addition, the state department is encouraged to implement a public education-awareness program based on recommendations from an advisory committee that the executive director of the state department is hereby authorized to establish.

(4) The state department is authorized to seek and accept funds, grants, or donations from any private entity for implementing the public education-awareness program. In addition, if necessary, the state department may assess a fee in connection with conducting any public education-awareness training program or seminar. Any such fee collected shall be transmitted to the state treasurer, who shall credit the same to the long-term care insurance fund, which fund is hereby created. The moneys in the fund shall be subject to annual appropriation by the general assembly for the sole purpose of public education-awareness training programs and seminars.

(5) In addition to administering the public education-awareness program under the partnership, the state department shall seek a federal waiver from the requirement of section 13612 of the federal "Omnibus Budget Reconciliation Act of 1993" (OBRA), Public Law 103-66, that prevents the state department from granting medical assistance applicants a full or partial resource exemption in determining eligibility for medical assistance and an exemption from estate recovery requirements.

(6) The state department, if funds are available, shall contract with a public or private entity to conduct an evaluation of the public education-awareness program on or before December 1, 2000.

(7) With respect to a policyholder who has allowed his or her private long-term care insurance policy to lapse, if the person is found to be eligible for the medical assistance program, the state department is authorized to pay the premium for a reinstated policy pursuant to section 10-19-107 (2), C.R.S., if the state department finds that to do so is feasible and cost-efficient.

Source: L. 2006: Entire article added with relocations, p. 1922, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-506.7 as it existed prior to 2006.

25.5-6-111. Pilot program for coordinated care for people with a disability - fund - repeal. (Repealed)

Source: L. 2006: Entire section added, p. 1115, § 1, effective May 25. **L. 2013:** (1), (2), (3), (5), (6), and (7) repealed and (4) amended, (SB 13-276), ch. 256, p. 1350, §§ 1, 2, effective May 23.

Editor's note: (1) This section was enacted as 26-4-537 in Senate Bill 06-128 but was relocated due to its harmonization with this article as it appeared in Senate Bill 06-219.

(2) Subsection (4)(b) provided for the repeal of subsection (4), effective July 1, 2014. (See L. 2013, p. 1350.)

25.5-6-112. Plan of financial operation - purpose - approval - financial audits - rules - repeal. (Repealed)

Source: L. 2007: Entire section added, p. 1352, § 2, effective May 29. **L. 2013:** Entire section repealed, (SB 13-276), ch. 256, p. 1353, § 10, effective May 23.

25.5-6-113. Health home - integrated services - contracting - legislative declaration - definitions.

(1) (a) The general assembly finds and declares that:

(I) The state demography office in the department of local affairs estimates that between 2005 and 2015, the portion of Colorado's population that is over sixty-five years of age will increase by more than twenty-three percent;

(II) This drastic increase in the population that is over sixty-five years of age is driven by the aging "baby boomer" generation and will result in a parallel increase in a demand for community long-term care services;

(III) Older adults, persons with disabilities, and their families need quality health-care coverage and choice and flexibility in accessing community long-term care services that support their independence and ability to live in the least restrictive environment;

(IV) Research has shown that older adults suffer from higher rates of depression, have a higher risk of suicide, and have an increased misuse of prescription and illicit drugs, making the need for behavioral health-care services essential to long-term care services;

(V) Coloradans deserve to have access to the proper level of health care;

(VI) The state needs a long-term care delivery system that addresses the needs of older adults, persons with disabilities, and their families, and health-care coverage and coordination should not be fragmented or difficult to access; instead, it should be integrated to meet the needs of older adults, persons with disabilities, and their families;

(VII) A community long-term care system should be integrated, person-centered, and provide maximum service delivery and make efficient use of available public funds; and

(VIII) The system must ensure a comprehensive approach to long-term care that addresses the different demographic and geographic challenges in the state and the various long-term care services and supports that members need.

(b) Therefore, the general assembly declares that a comprehensive approach to long-term care requires that programs and policies integrating and coordinating care under the medicaid program be flexible and allow for full participation by providers of long-term care services to ensure quality of care for members and efficient use of limited resources.

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

(a) "Dually eligible person" means a person who is eligible for assistance or benefits under both medicaid and medicare.

(b) "Health home" means a provider or group of providers that operate in coordination with a team of health-care professionals that shall include primary care providers selected by an eligible individual with chronic conditions to provide health home services, as the term is defined in section 2703 of the federal "Patient Protection and Affordable Care Act", 42 U.S.C. sec. 1396w-4.

(3) (a) In determining the structure of health homes for chronic conditions for purposes of the federal "Patient Protection and Affordable Care Act", 42 U.S.C. sec. 1396w-4, and state plan amendments to the medicaid program, the state department shall include, to the extent permitted

under federal law, provisions allowing providers of long-term care services and supports to participate as health homes or as part of a health home that provides:

(I) Comprehensive care management;

(II) Care coordination and health promotion;

(III) Comprehensive transitional care;

(IV) Patient and family support;

(V) Referral to community and social support services; and

(VI) The use of health information technology to link services, as is feasible and appropriate.

(b) The health home may consist of a multi-disciplinary team, including primary care management providers, behavioral health-care providers, case managers, and providers of long-term services and supports, including, but not limited to, case management agencies, as defined in section 25.5-6-1702, nursing homes, alternative care facilities, day programs for the elderly, home care agencies, comprehensive community behavioral health providers, as defined in section 27-50-101, and hospice and palliative care centers.

(4) To the extent provided under federal law, in integrating dually eligible persons, persons with chronic conditions, or persons needing long-term care services and supports in an organization with which the state department contracts pursuant to part 4 of article 5 of this title, the state department shall permit providers of long-term services and supports to contract as health homes or to provide some or all of the services provided by the organization contracted with the state department, which services may include, but need not be limited to, navigation of primary, specialty, or long-term care supports.

(5) Dually eligible members may voluntarily elect to participate in a recognized medicare coordinated care system and may voluntarily elect to participate in the state department's medicaid coordinated care system.

Source: L. 2012: Entire section added, (SB 12-127), ch. 132, p. 453, § 1, effective April 23. **L. 2021:** (3)(b) amended, (HB 21-1187), ch. 83, p. 333, § 29, effective July 1, 2024. **L. 2024:** IP(1)(a), (1)(a)(VIII), (1)(b), and (5) amended, (SB 24-176), ch. 152, p. 664, § 75, effective August 7. **L. 2025:** (3)(b) amended, (HB 25-1326), ch. 309, p. 1611, § 6, effective August 6.

25.5-6-114. Alternative care facilities - reimbursement programs - legislative declaration - report - repeal. (Repealed)

Source: L. 2012: Entire section added, (SB 12-128), ch. 275, p. 1452, § 1, effective August 8.

Editor's note: Subsection (5) provided for the repeal of this section, effective July 1, 2015. (See L. 2012, p. 1452.)

25.5-6-115. Notification of federal immigration consequences.

The state department shall consult with stakeholders, including people with lived experience, immigrants rights advocates, health-care advocates, and immigration lawyers, to provide clear and accurate information and referrals regarding current public charge policies.

Source: L. 2022: Entire section added, (HB 22-1289), ch. 399, p. 2844, § 19, effective June 7.

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-6-116. Community placement transformation - creation - report - repeal. (Repealed)

Source: L. 2022: Entire section added, (HB 22-1302), ch. 180, p. 1200, § 4, effective May 27. **L. 2024:** (1) amended, (SB 24-176), ch. 152, p. 664, § 76, effective August 7.

Editor's note: Subsection (4) provided for the repeal of this section, effective July 1, 2025. (See L. 2022, p. 1200.)

25.5-6-117. Determination of need-based services - professional medical information document - definition.

(1) As used in this section, unless the context otherwise requires, "professional medical information document" means documented medical information signed by a licensed medical professional and used as a component of the functional assessment for long-term services and supports that verifies a member's need for long-term services and supports.

(2) On or before December 31, 2026, the state department shall modify the professional medical information document used to assess a member's need for long-term services and supports to reduce the number of medical questions required in the documentation that are obtained from medical professionals.

(3) A treating licensed medical professional, as defined in rule by the state board as it relates to home- and community-based services, who has a bona fide physician-patient relationship with a member shall sign a professional medical information document for the member.

Source: L. 2025: Entire section added, (HB 25-1162), ch. 335, p. 1769, § 2, effective August 6.

25.5-6-118. Plan of care - rehabilitation therapy - requirements - definition.

(1) As used in the section, unless the context otherwise requires, "plan of care" has the same meaning as set forth in section 25.5-6-403.

(2) The state department shall not impose signature requirements beyond what is required by the federal centers for medicare and medicaid services pursuant to 42 CFR 409.43 on a physician or practitioner certifying a member's plan of care that involves physical therapy, occupational therapy, or speech therapy services.

Source: L. 2025: Entire section added, (HB 25-1213), ch. 276, p. 1439, § 7, effective August 6.

25.5-6-119. Long-term care for members with permanent disability.

(1) For a member receiving services through a long-term care program pursuant to parts 3 to 10 of this article 6, if a service the member receives is discontinued or is no longer a covered service, the state department must confirm the timeline for continuity of treatment with the federal centers for medicare and medicaid during the transition period of the benefit or service being discontinued. Upon confirmation, the state department shall communicate the timeline to the member impacted by the benefit or service being discontinued.

(2) This section applies to members who are functionally and financially eligible to receive long-term care services pursuant to parts 3 to 10 of this article 6.

Source: L. 2025: Entire section added, (HB 25-1213), ch. 276, p. 1439, § 8, effective August 6.

25.5-6-120. Home- and community-based service provider agencies - disclosure of direct care service cost ratio to administrative cost ratio - definition.

(1) As used in this section, unless the context otherwise requires, "direct care service cost to administrative cost ratio" means the percentage of medicaid services revenue that a home- and community-based service provider agency that renders base wage qualifying services spends on direct care workforce compensation and direct care service related training and supports as compared to administrative and general expenses.

(2) (a) The state department shall collect the following information from each home- and community-based service provider agency that serves more than thirty members and is subject to the base wage requirements set by the state department in rule, and may collect the following information from a home- and community-based service provider agency that serves thirty or fewer members:

(I) The total medical assistance program reimbursement and volume data for home- and community-based services that are subject to the base wage requirements, sorted by service codes and submitted separately for employees and independent contractors;

(II) Direct wages and cash compensation, which are limited to wages, overtime pay, bonuses, and other direct monetary compensation paid to direct care workers;

(III) Paid leave and employee benefits, which are limited to paid leave, health insurance, retirement contributions, and other insurance benefits, wellness support, transportation benefits, and other monetary or non-monetary employment benefits;

(IV) Employer payroll taxes and statutory employment costs, which are limited to employer payroll taxes, state unemployment insurance contributions, and federal unemployment insurance contributions;

(V) Workforce recruitment, retention, and incentive supports, which are limited to stipends, reimbursements, allowances, incentive programs, and other benefits designed to recruit, retain, and support the well-being of direct care workers;

(VI) Workforce supervision, training, and operational support, which are limited to costs related to supervising direct care workers, providing training, and maintaining workforce support services necessary for safe service delivery and regulatory compliance;

(VII) Operational and compliance costs tied to employment of direct care workers, which are limited to employer expenses necessary to recruit, employ, supervise, support, and retain direct

care workers, including operational costs required to safely deliver medical assistance services and comply with medical assistance program requirements; and

(VIII) Existing base wage reporting and attestation documentation verifying that direct care worker wages meet the state base wage requirements.

(b) A home- and community-based service provider agency shall submit to the state department its direct care service cost to administrative cost ratio and the information required pursuant to this subsection (2) no later than September 30, 2027.

(3) The state department shall submit a report detailing the information collected pursuant to subsection (2) of this section to the house of representatives and senate health and human services committees and the joint budget committee, or any successor committees, no later than December 31, 2027.

(4) The data collected and published pursuant to this section must be used solely for legislative informational purposes and is not subject to disclosure under the "Colorado Open Records Act", part 2 of article 72 of title 24.

Source: L. 2026: Entire section added, (HB 26-1235), ch. 361, p. 2173, § 9, effective August 12.

PART 2

NURSING FACILITIES

25.5-6-201. Special definitions relating to nursing facility reimbursement.

As used in this part 2, unless the context otherwise requires:

(1) "Acquisition cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

(2) "Actual cost" or "cost" means the audited cost of providing services.

(3) "Administration and general services costs" means costs in the following categories:

(a) Advertising, recruitment, and public relations, to the extent that such costs are necessary, reasonable, and patient-related;

(b) Travel and training of facility staff, unless the travel includes residents of the facility or the training is for the facility staff described in paragraph (a) of subsection (15) of this section; and

(c) All other costs that are not direct or indirect health-care services, raw food costs, or capital-related assets.

(4) "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal must be based on a nationally recognized valuation system determined by the state department. The depreciated cost of replacement appraisal must be redetermined at least every four years by new appraisals of the nursing facilities. The new appraisals must be based upon rules promulgated by the state board.

(5) "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all medicaid-participating nursing facility providers in the state.

(6) (a) "Base value" means:

(I) For the fiscal year 1986-87 and every fourth year thereafter, the appraised value of a capital-related asset;

(II) For each year in which an appraisal is not done pursuant to subparagraph (I) of this paragraph (a), the most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index.

(b) For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

(c) An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

(7) "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

(8) "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

(9) "Case-mix adjusted direct health-care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to registered nurses, licensed practical nurses, and nurses' aides.

(9.5) "Case-mix group" means the system determined by the state department for grouping a nursing facility's residents according to their clinical and functional status as identified from data

supplied by the facility's minimum data set as published by the United States department of health and human services.

(10) "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.

(11) "Case-mix neutral" means the direct health-care costs of all facilities adjusted to a common case-mix.

(12) "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's medicaid residents as further specified in this section.

(13) "Class I facility" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health-care conditions, including residents who are behaviorally challenged by virtue of a severe behavioral or mental health disorder.

(14) "Direct health-care services costs" means those costs subject to case-mix adjusted direct health-care services costs.

(15) "Direct or indirect health-care services costs" means the costs incurred for patient support services, including the following:

(a) Salaries, payroll taxes, workers' compensation payments, training, and other employee benefits for registered nurses, licensed practical nurses, aides, medical records librarians, social workers, and activity personnel;

(b) Nonprescription drugs ordered by a physician;

(c) Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians, and therapies;

(d) Purchases, rentals, and costs incurred to operate, maintain, or repair health-care equipment;

(e) Supplies for nurses, medical records personnel, social workers, activity personnel, and therapy personnel;

(f) Medical director fees;

(g) Therapies and other medically related services, including the following:

(I) Utilization review;

(II) Dental care, when required by federal law;

(III) Audiology;

(IV) Psychology;

(V) Physical therapy;

(VI) Recreational therapy;

(VII) Occupational therapy; and

(VIII) Speech therapy;

(h) Other patient support services determined and defined by the state board pursuant to rule;

(i) Raw food costs that do not include the costs of equipment, staff, or other costs associated with meal preparation;

(j) Malpractice insurance;

(k) Depreciation and interest for major health-care equipment, such as equipment purchased for the sole purpose of providing care to facility residents; and

(l) Photocopying related to health-care purposes such as medical records of patients.

(15.5) "Eligible nursing facility provider" means a nursing facility, as defined in section 25.5-4-103.

(16) "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each case-mix group as of a specific point in time.

(17) "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

(18) "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.

(19) "Index" means the RSMeans construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.

(20) "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.

(20.5) Repealed.

(21) "Median per diem cost" means the average daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.

(22) "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the federal medicare and medicaid programs.

(23) "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.

(24) "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health-care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.

(25) "Nursing facility provider" means a facility provider that meets the state nursing home licensing standards established pursuant to section 25-1.5-103 (1)(a), C.R.S., and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

(26) "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurses' aides.

(27) "Nursing weights" means numeric scores assigned to each category of the case-mix groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.

(28) "Occupancy-imputed days" means the use of a predetermined number for patient days rather than actual patients days in computing per diem cost.

(29) "Per diem cost" means the daily cost of care and services per patient for a nursing facility provider.

(30) "Per diem rate" means the daily dollar amount of reimbursement that the state department shall pay a nursing facility provider per patient.

(31) "Provider fee" means a licensing fee, assessment, or other mandatory payment that is related to health-care items or services as specified under 42 CFR 433.55.

(32) "Raw food" means the products and substances, including but not limited to nutritional supplements, that are consumed by residents.

(33) "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

(34) Repealed.

(35) "Statewide average per diem rate" means the average daily dollar amount of the per patient payments to all medicaid-participating facility providers in the state.

(36) "Supplemental medicaid payment" means a lump sum payment that is made in addition to a provider's per diem rate. A supplemental medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

(37) "Wage enhancement supplemental payment" means a supplemental payment to an eligible nursing facility provider that is subject to available appropriations and not a rate enhancement.

Source: L. 2006: Entire article added with relocations, p. 1924, § 7, effective July 1. **L. 2008:** Entire section R&RE, p. 1773, § 2, effective July 1. **L. 2009:** (36) added, (SB 09-263), ch. 203, p. 914, § 1, effective May 1. **L. 2017:** (13) amended, (SB 17-242), ch. 263, p. 1329, § 207, effective May 25. **L. 2019:** (15.5) and (20.5) added, (HB 19-1210), ch. 320, p. 2976, § 6, effective January 1, 2020. **L. 2021:** (4), (16), and (27) amended, (9.5) added, and (34) repealed, (HB 21-1227), ch. 192, p. 1015, § 2, effective September 7. **L. 2022:** (15.5) amended, (20.5) repealed, and (37) added, (HB 22-1333), ch. 140, p. 930, § 1, effective August 10.

Editor's note: This section is similar to former § 26-4-502 as it existed prior to 2006.

Cross references: For the legislative declaration contained in the 2008 act repealing and reenacting this section, see section 1 of chapter 383, Session Laws of Colorado 2008. For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in HB 19-1210, see section 1 of chapter 320, Session Laws of Colorado 2019.

ANNOTATION

The department's rule assigning 25 of the variables required under the Boeckh system as default variables is consistent with the general assembly's mandate that the Boeckh system be the method used for property assessments. Thus, the administrative law judge did not have authority to require three of the variables assigned as default variables to be specifically calculated. State Dept. of Soc. Servs. v. Hillhaven Corp., 923 P.2d 129 (Colo. App. 1995) (decided prior to the 2006 amendments relocating article 4 of title 26 to title 25.5).

25.5-6-202. Providers - nursing facility provider reimbursement - exemption - rules.

(1) to (7) Repealed.

(8) Repealed/(deleted by amendment, L. 2009, (SB 09-263), ch. 203, p. 912, § 2, effective May 1, 2009.)

(9) Repealed.

(10) The state board shall promulgate rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, C.R.S.,to implement this section, including establishing uniform accounting, reporting, and payment procedures consistent with this section, to determine a nursing facility provider's costs and payments to the provider.

(11) (Deleted by amendment, L. 2009, (SB 09-263), ch. 203, p. 912, § 2, effective May 1, 2009.)

(12) The state department may exempt facilities with five or fewer medicaid beds from the methodology described in this section and instead require the facilities to be reimbursed at the statewide average rate.

(13) (a) As a condition of receiving medicaid funds, the state department may require a nursing facility to submit any documentation necessary to ensure the state's interest in transparency, stability, and sound fiscal stewardship, including, but not limited to:

(I) Annual audited financial statements, prepared by an independent accountant, for a facility, management company, and any related party conducting business with a medicaid-certified nursing facility, including audited and consolidated financial statements for any parent company that accepts, or whose subsidiaries accept, medicaid payments from the state of Colorado;

(II) Details on transactions between related parties or entities that have common ownership; and

(III) Ownership interest in real estate, management companies, facility operators, and all related parties.

(b) The state department shall determine the format for the documentation provided by each nursing facility.

(c) The state board shall establish by rule any penalties for noncompliance with the financial reporting required pursuant to this subsection (13).

(d) The costs associated with the financial reporting required pursuant to this subsection (13), including any audit costs incurred by a nursing facility, are an allowable expense on the

medicaid cost report and must be incorporated as a component of the overall reimbursement methodology.

(14) The general assembly finds that the inflexible nature of statutorily fixed reimbursement rates is not in the best interest of the state of Colorado. Therefore, the state department shall develop and implement a transition plan to regulate nursing facility reimbursement aimed at improving the health and safety of residents, promoting innovation and improved infection control efforts, improving access to care, and promoting innovation in Colorado nursing facilities. As part of this process, the state department shall:

(a) No later than July 1, 2026, define "nursing home reimbursement" through rules promulgated by the state board and provide payments to nursing facilities consistent with the promulgated rules;

(b) Engage with stakeholders regularly to seek input on any proposed methodology changes and ensure the methodology is reasonable and adequate to meet the costs of an efficiently and economically operated nursing facility that provides care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards based on the most recent audit and finalized cost and utilization data available; and

(c) From November 1, 2023, to November 1, 2026, submit an annual report to the joint budget committee of the general assembly regarding the implementation progress described in this subsection (14), including, at a minimum:

(I) Records of stakeholder engagement;

(II) Conclusions drawn from financial oversight activities;

(III) Issues regarding payment equity and access to care coordination; and

(IV) Expected budgetary impacts of any methodology change.

(15) (a) Each nursing facility that receives medicaid funds shall develop and submit a plan to the state department that meets state department standards and demonstrates how the nursing facility will:

(I) Improve the health and safety of the nursing facility's residents, including infection control and staffing;

(II) Increase access to care;

(III) Improve financial sustainability, including opportunities for diversification of business lines and stabilization of revenue streams; and

(IV) Promote innovation to meet the emerging needs of individuals with disabilities and aging and older adults.

(b) The state board shall promulgate rules implementing this subsection (15).

(16) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1925, § 7, effective July 1. **L. 2008:** Entire section R&RE, p. 1777, § 3, effective July 1. **L. 2009:** (1)(a), (3), (5), (6), (7), (8), (9)(b), and (11) amended and (9)(b.3), (9)(b.5), and (9)(b.7) added, (SB 09-263), ch. 203, p. 912, § 2, effective May 1. **L. 2010:** (9)(b)(III) added, (HB 10-1324), ch. 14, p. 69, § 1, effective March 1; (9)(b)(III) and (9)(b.7)(II) amended, (HB 10-1379), ch. 214, p. 930, §§ 1, 2, effective May 6. **L. 2011:** (9)(b)(IV) added, (SB 11-215), ch. 148, p. 514, § 1, effective May 5. **L. 2012:** (9)(b)(V) added, (HB 12-1340), ch. 154, p. 552, § 1, effective May 3. **L. 2013:** (9)(b)(III) and (9)(b)(IV) repealed, (9)(b)(V) amended, and (9)(b)(VI) added, (HB 13-1152), ch. 162, p. 520, § 1, effective May 3. **L. 2018:** IP(6), (6)(b), and (9)(b.3)(II) amended, (HB 18-1091), ch. 74, p. 643, § 5, effective August 8. **L. 2020:** (9)(b)(VII) added, (HB 20-1362), ch. 203, p. 1005, § 1, effective June 30. **L. 2021:** (2) amended and (12) added, (HB 21-1227), ch. 192, p. 1016, § 3, effective September 7. **L. 2023:** (5), (6), (9)(b)(I), and (9)(c)(I) amended, (9)(b)(I.5), (13), (14), (15), and (16) added, and (9)(c)(II) repealed, (HB 23-1228), ch. 278, p. 1643, § 1, effective May 30. **L. 2025:** (5), (6), (7), (9)(b.3), and (9)(d) repealed and IP(9)(b)(I), (9)(b)(II), and (9)(b)(VI) amended, (SB 25-270), ch. 151, p. 598, § 4, effective May 1.

Editor's note: (1) This section is similar to former § 26-4-502.5 as it existed prior to 2006.

(2) Subsection (9)(b.7)(III) provided for the repeal of subsection (9)(b.7), effective July 1, 2011. (See L. 2009, p. 912.)

(3) Subsection (9)(b)(V)(B) provided for the repeal of subsection (9)(b)(V), effective July 1, 2014. (See L. 2012, p. 552.)

(4) Subsection (3)(c)(III) provided for the repeal of subsection (3)(c), effective July 1, 2015. (See L. 2009, p. 912.)

(5) Subsection (16) provided for the repeal of subsections (1) to (9) and (16), effective July 1, 2026. (See L. 2023, p. 1643.)

Cross references: For the legislative declaration contained in the 2008 act repealing and reenacting this section, see section 1 of chapter 383, Session Laws of Colorado 2008.

25.5-6-203. Nursing facilities - provider fees - federal waiver - fund created - rules - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1926, § 7, effective July 1. **L. 2008:** Entire section R&RE, p. 1781, § 4, effective July 1. **L. 2009:** (1)(a), (1)(g), and (2)(b) amended and (1)(j) added, (SB 09-263), ch. 203, p. 918, § 3, effective May 1; (1)(c)(I) amended, (SB 09-292), ch. 369, p. 1975, § 98, effective August 5. **L. 2010:** (2)(b)(II.7) added, (HB 10-1324), ch. 14, p. 69, § 2, effective March 1. **L. 2011:** (1)(a)(II) and (2) amended, (SB 11-125), ch. 208, p. 900, § 1, effective August 10. **L. 2013:** (1)(c)(I) and (1)(g) amended, (HB 13-1199), ch. 63, p. 209, § 2, effective March 22. **L. 2014:** (2)(b)(I) amended, (SB 14-143), ch. 191, p. 712, § 1, effective May 15. **L. 2018:** (2)(b)(IV) amended, (HB 18-1091), ch. 74, p. 644, § 6, effective August 8. **L. 2020:** (2)(b)(VII) added, (HB 20-1385), ch. 173, p. 797, § 3, effective June 29. **L. 2021:** (2)(b)(VII) amended, (SB 21-213), ch. 88, p. 365, § 3, effective May 4. **L. 2023:** (1)(c) amended, (HB 23-1228), ch. 278, p. 1647, § 2, effective May 30. **L. 2025:** (1) repealed and (2)(a.5) and (3) added, (SB 25-270), ch. 151, p. 600, § 5, effective May 1.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-503 as it existed prior to 2006.

(2) For the amendments in SB 25-270 in effect from May 1, 2025, to July 1, 2025, see chapter 151, Session Laws of Colorado 2025. (L. 2025, p. 600.)

(3) Subsection (3) provided for the repeal of this section, effective July 1, 2025. (See L. 2025, p. 600.)

25.5-6-204. Providers - reimbursement - intermediate care facility for individuals with intellectual disabilities - reimbursement - maximum allowable.

(1) (a) For the purpose of making payments to intermediate care facilities for individuals with intellectual disabilities, the state department shall establish a price schedule to be readjusted every twelve months, that shall reimburse, subject to available appropriations, each provider, as nearly as possible, for its actual or reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health-care services costs as defined in section 25.5-6-201 (9), and a fair rental allowance for capital-related assets as defined in section 25.5-6-201 (7). The state board shall adopt rules, including uniform accounting or reporting procedures, in order to determine the actual or reasonable cost of services and case-mix adjusted direct health-care services costs and the reimbursement therefor. The provisions of this paragraph (a) shall not apply to state-operated intermediate care facilities for individuals with intellectual disabilities.

(b) State-operated intermediate care facilities for individuals with intellectual disabilities shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health-care services, and such costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period. Reimbursement to state-operated intermediate care facilities for individuals with intellectual disabilities shall be adjusted retrospectively at the close of each twelve-month period. The state board shall adopt rules to be effective by June 30, 1988, implementing the provisions of this paragraph (b). In the implementation of such rules, the state department shall ensure, by the establishment of classes of facilities, that the reimbursement to private, nonprofit, or proprietary state-operated intermediate care facilities for individuals with intellectual disabilities, as defined in section 25.5-10-202, is not adversely impacted.

(c) Repealed.

(2) (a) In addition to the actual or reasonable costs and the reimbursement therefor, the state department shall, subject to available appropriations, include an allowance equal to the change in the national bureau of labor statistics consumer price index from the preceding year to compensate for fluctuating costs. This amount shall be determined every twelve months when the statewide average cost is determined by adjusting for inflation. The provider's allowable cost shall be multiplied by the change in the consumer price index measured from the midpoint of the provider's cost report period to the midpoint of the provider's rate period. This allowance is applied to all costs, including case-mix adjusted direct health-care services costs as defined in section 25.5-6-201 (9), less interest, up to the reasonable cost established and will be allowed to proprietary, nonprofit, and tax-supported homes; except that the allowance shall not be applied to the costs of state-operated intermediate facilities for individuals with intellectual disabilities.

(b) (I) The state board shall adopt rules to:

(A) Determine and pay to privately owned intermediate care facilities for individuals with intellectual disabilities a reasonable share of the amount by which the reasonable costs of the categories of administration, property, and room and board, excluding food costs, exceed the actual cost in these categories only. The reasonable share shall be defined as twenty-five percent of the amount in the categories for each facility, not to exceed twelve percent of the reasonable cost.

(B) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(II) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(c) to (e) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(3) to (5) (Deleted by amendment, L. 2008, p. 1783, § 5, effective July 1, 2008.)

(6) and (7) Repealed.

Source: L. 2006: (5)(b) amended and (6) added, p. 1615, §§ 4, 3, effective June 2; entire article added with relocations, p. 1927, § 7, effective July 1. **L. 2007:** (7) added, p. 1802, § 2, effective July 1. **L. 2008:** (1)(a) and (2) to (5) amended, p. 1783, § 5, effective July 1. **L. 2013:** Entire section amended, (SB 13-167), ch. 394, p. 2290, § 3, effective June 5; (1)(b), (1)(c)(I), and (1)(c)(II) amended, (HB 13-1314), ch. 323, p. 1809, § 46, effective March 1, 2014. **L. 2025:** (1)(c) amended, (SB 25-270), ch. 151, p. 602, § 6, effective May 1.

Editor's note: (1) This section is similar to former § 26-4-410 as it existed prior to 2006.

(2) (a) Amendments to section 26-4-410 (5)(b) by Senate Bill 06-131 were harmonized with subsection (5)(b) as it appeared in Senate Bill 06-219.

(b) Subsection (6) was enacted as § 26-4-410 (6) in Senate Bill 06-131 but was relocated due to its harmonization with this section as it appeared in Senate Bill 06-219.

(3) Subsection (6)(c) provided for the repeal of subsection (6), effective July 1, 2007. (See L. 2006, p. 1615.)

(4) Subsection (7)(c) provided for the repeal of subsection (7), effective July 1, 2008. (See L. 2007, p. 1802.)

(5) Amendments to this subsections (1)(b), (1)(c)(I), and (1)(c)(II) by House Bill 13-1314 and Senate Bill 13-167 were harmonized.

(6) For the amendments to subsection (1)(c) in SB 25-270 in effect from May 1, 2025, to July 1, 2025, see chapter 151, Session Laws of Colorado 2025. (L. 2025, p. 602.)

(7) Subsection (1)(c)(III)(B) provided for the repeal of subsection (1)(c), effective July 1, 2025. (See L. 2025, p. 602.)

Cross references: For the legislative declaration contained in the 2006 act amending subsection (5)(b) and enacting subsection (6), see section 1 of chapter 324, Session Laws of Colorado 2006. For the legislative declaration contained in the 2008 act amending subsections (1)(a) and (2) to (5), see section 1 of chapter 383, Session Laws of Colorado 2008.

ANNOTATION

Annotator's note. Since § 25.5-6-204 is similar to § 26-4-410 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-410 is similar to § 26-4-110 (5) as it existed prior to the 1991 repeal and reenactment of article 4 of

title 26, relevant cases construing those provisions have been included in the annotations to this section.

Department of social services regulation which prohibits a nursing home from charging more for medicaid patients than private-pay patients is valid because it confirms the legislative intent to pay nursing homes the reasonable cost of rendering services. Smith, Harst & Assocs., Inc. v. Dept. of Soc. Servs., 780 P.2d 20 (Colo. App. 1989).

Colorado rate structure and classification system is not arbitrarily or capriciously established or applied where the reimbursement rate was based upon and took into consideration plaintiff's actual costs in providing services needed by all of its patients, including intensive management patients, and where there was no evidence that necessary services cannot be provided to intensive management patients by other available and qualified providers if plaintiffs are unable to continue their present patient mix. Bethesda Found. v. Dept. of Health, 902 P.2d 863 (Colo. App. 1995).

25.5-6-205. Collection of penalties assessed against nursing facilities - creation of cash fund.

(1) (a) The state department shall assess, enforce, and collect any civil penalties that are recommended by the department of public health and environment pursuant to the authority granted under section 25-1-107.5, C.R.S.

(b) Prior to the denial of medicaid payments or the assessment of a civil money penalty against a nursing facility, the nursing facility shall be offered by the state department an opportunity for a hearing in accordance with the provisions of section 24-4-105, C.R.S. Enforcement and collection of the denial of medicaid payments or civil money penalty shall occur following the decision reached at such hearing.

(2) In conjunction with the authority granted under subsection (1) of this section, the state board shall promulgate rules that:

(a) Provide any nursing facility assessed a civil penalty the opportunity to appeal such assessment;

(b) Govern the procedures for such appeals, including the right of a nursing facility to thirty days' notice prior to the collection of any civil money penalty; and

(c) Are otherwise necessary to implement this section.

(3) (a) Any civil penalties collected by the state department pursuant to this section shall be transmitted to the state treasurer, who shall credit the same to the nursing home penalty cash fund, which fund is hereby created.

(b) (I) On and after July 1, 2021, the money in the fund is subject to annual appropriation by the general assembly to the state department and the department of public health and environment for the purposes set forth in section 25-1-107.5. Pursuant to section 25-1-107.5 (4)(b)(II)(B), the money in the fund is continuously appropriated to the state department and the department of public health and environment for the purpose of emergency funding needs.

(II) Such moneys shall be used in the manner prescribed in section 25-1-107.5, C.R.S., and the rules promulgated thereunder.

(c) (I) For state fiscal years commencing on or before July 1, 2024, and on or after July 1, 2026, all interest derived from the deposit and investment of money in the nursing home penalty cash fund shall be credited to the nursing home penalty cash fund.

(II) For the state fiscal year commencing on July 1, 2025, in accordance with section 24-36-114 (1), the state treasurer shall credit all interest and income derived from the deposit and investment of money in the nursing home penalty cash fund to the general fund.

(III) Repealed.

(d) At the end of any fiscal year, all unexpended and unencumbered moneys remaining in the fund shall remain therein and shall not be credited or transferred to the general fund or any other fund.

Source: L. 2006: Entire article added with relocations, p. 1933, § 7, effective July 1. **L. 2021:** (3)(b)(I) amended, (SB 21-128), ch. 302, p. 1817, § 2, effective June 23. **L. 2025:** (3)(c) amended, (SB 25-317), ch. 385, p. 2161, § 42, effective June 3.

Editor's note: (1) This section is similar to former § 26-4-505 as it existed prior to 2006.

(2) Subsection (3)(c)(III)(B) provided for the repeal of subsection (3)(c)(III), effective July 1, 2026. (See L. 2025, p. 2161.)

Cross references: For the legislative declaration in SB 25-317, see section 1 of chapter 385, Session Laws of Colorado 2025.

25.5-6-206. Personal needs benefits - amount - patient personal needs trust fund required - funeral and final disposition expenses - penalty for illegal retention and use.

(1) The state department, pursuant to its rules, may include in medical care benefits provided under this article 6 and articles 4 and 5 of this title 25.5 reasonable amounts for the personal

needs of any member receiving nursing facility services or intermediate care facilities for individuals with intellectual disabilities, if the member is not otherwise eligible for the amounts from other categories of public assistance, but the amounts for personal needs must not be less than the minimum amount provided for in subsection (2) of this section. Payments for funeral and final disposition expenses upon the death of a member may be provided under rules of the state department in the same manner as provided to recipients of public assistance as defined by section 26-2-103 (8).

(2) (a) The basic minimum amount payable pursuant to subsection (1) of this section for personal needs to any member admitted to a nursing facility or intermediate care facility for individuals with intellectual disabilities is seventy-five dollars monthly; except that, commencing January 1, 2015, and each January 1 thereafter, the basic minimum amount must increase annually by the same percentage applied to the general fund share of the aggregate statewide average of the per diem net of patient payment pursuant to section 25.5-6-202 (9)(b)(I). Commencing with the fiscal year beginning July 1, 2014, and each fiscal year thereafter, the reduction to patient payments received by nursing facilities resulting from an increase in the basic minimum amount is funded in full by general fund and applicable federal funds.

(b) On and after October 1, 1992, the basic minimum amount payable pursuant to subsection (1) of this section for personal needs is ninety dollars for the following persons:

(I) A medical assistance member who receives a non-service connected disability pension from the United States veterans administration, has no spouse or dependent child, and is admitted to or is residing in a nursing facility; and

(II) A medical assistance member who is a surviving spouse of a person who received a non-service connected disability pension from the United States veterans administration, has no dependent child, and is admitted to or is residing in a nursing facility.

(3) (a) All personal needs funds shall be held in trust by the nursing facility or intermediate care facility for individuals with intellectual disabilities, or its designated trustee, separate and apart from any other funds of the facility. The facility shall deposit any personal needs funds of a resident in an amount of fifty or more dollars in an interest-bearing checking account or accounts or savings account or any combination thereof established to protect and separate the personal needs funds of the patients. Any interest earned on a resident's personal needs funds shall be credited to such account or accounts. In the event residents' personal needs funds are maintained in a pooled account, separate accountings shall be made for each resident's share of the pooled account. Any personal needs funds of a resident in an amount less than fifty dollars shall be maintained in a non-interest-bearing account, an interest-bearing account, or a petty cash fund.

(b) At all times, the principal and all income derived from said principal in the patient personal needs trust fund shall remain the property of the participating patients, and the facility or its designated trustee is bound by all of the duties imposed by law upon fiduciaries in the

handling of such fund. Those duties include but are not limited to providing notice to a resident when the resident's personal needs account accumulates two hundred dollars less than the federal supplemental security income resource limit for one person.

(c) The facility or its designated trustee shall post a surety bond in an amount to assure the security of all personal needs funds deposited in the patient personal needs trust fund or shall otherwise demonstrate to the satisfaction of the state department that the security of residents' personal needs funds is assured.

(d) Within sixty days after a resident's death, the facility shall transfer the resident's personal needs funds and a final accounting of the funds to the person responsible for settling the resident's estate or, if there is none, to the resident's heirs in accordance with the provisions of title 15, C.R.S. Within fifteen days after receiving the funds, the executor, administrator, or other appropriate representative of the resident's estate shall provide written notice to the state department regarding the receipt of the funds. Upon receipt of the notice, the state department may bring an action to recover the funds pursuant to the provisions of this article and articles 4 and 5 of this title.

(4) The state department shall establish rules concerning the establishment of a patient personal needs trust fund and procedures for the maintenance of a system of accounting for expenditures of each patient's personal needs funds. The facility shall use an accounting system that assures a complete and separate accounting of residents' personal needs funds based on generally accepted accounting principles and that precludes the commingling of a resident's personal needs funds with the facility's funds or the funds of any other person other than the personal needs funds of another resident. These rules shall provide that the nursing facility or intermediate care facility for individuals with intellectual disabilities shall maintain complete records of all receipts and expenditures involving the patient personal needs trust fund, that all expenditures shall be approved by the patient, legal custodian, guardian, or conservator prior to an expenditure, and that each patient or such patient's legal custodian, guardian, or conservator shall be given at least a quarterly accounting of the receipts and expenditures of such funds. In addition, the rules shall require that the person who maintains the patient personal needs trust fund for the facility and who is responsible for the deposit of moneys into such trust fund shall deposit any personal needs funds received from a patient or from the state department no later than sixty days after the receipt of such moneys.

(5) All patient personal needs trust funds shall be subject to audit by the state department. A record of a patient's personal needs trust fund shall be kept by the facility for a period of three years from the date of the patient's discharge from the facility or until such records have been audited by the state department, whichever occurs later.

(6) Any overpayment of personal needs funds to a nursing facility or an intermediate care facility for individuals with intellectual disabilities by the state department due to the omission, error, fraud, or defalcation of the nursing facility or intermediate care facility for individuals with

intellectual disabilities or any shortage in an audited patient personal needs trust fund is recoverable by the state on behalf of the member in the same manner and following the same procedures as specified in section 25.5-4-301 (2) for an overpayment to a provider.

(7) Nothing in this section shall prevent a nursing facility or intermediate care facility for individuals with intellectual disabilities patient from excluding himself or herself from participation in the patient personal needs trust fund.

(8) (a) It is unlawful for any person to knowingly fail to deposit personal needs funds received from a patient or from the state department for a patient's personal needs into the patients' personal needs trust fund within sixty days after the receipt of such moneys or to knowingly apply, spend, commit, pledge, or otherwise use a patient personal needs trust fund, or any other moneys paid by a patient or the state department for patient personal needs, for any purpose other than the personal needs of the patient to purchase necessary clothing, incidentals, or other items of personal needs that are not reimbursed by any federal or state program. Deposit or use of personal needs funds, including the use of a petty cash fund for personal needs purposes, is not a violation of this section if such deposit or use is in substantial compliance with applicable rules of the state department. Sums later ordered repaid to the patients' personal needs trust fund as a result of an audit adjustment related to simple accounting errors such as data entry errors, mathematical errors, or posting errors or a dispute related to a proration of patient payment is not a violation of this section.

(b) Any person who knowingly violates any of the provisions of this subsection (8) by failing to deposit personal needs funds within sixty days after the receipt of such moneys commits the crime of unlawful retention of patient personal needs funds. Any person who violates any of the provisions of this subsection (8) by applying, spending, committing, pledging, or otherwise using a patient personal needs trust fund for any purpose other than the purposes permitted by this subsection (8) commits the crime of unlawful use of a patient personal needs trust fund.

(c) Unlawful retention of patient personal needs funds is:

(I) A petty offense if the amount is less than three hundred dollars;

(II) A class 2 misdemeanor if the amount is three hundred dollars or more but less than one thousand dollars;

(III) A class 1 misdemeanor if the amount is one thousand dollars or more but less than two thousand dollars;

(IV) A class 6 felony if the amount is two thousand dollars or more but less than five thousand dollars;

(V) A class 5 felony if the amount is five thousand dollars or more but less than twenty thousand dollars;

(VI) A class 4 felony if the amount is twenty thousand dollars or more but less than one hundred thousand dollars;

(VII) A class 3 felony if the amount is one hundred thousand dollars or more but less than one million dollars; and

(VIII) A class 2 felony if the amount is one million dollars or more.

(d) Unlawful use of a patient personal needs trust fund is:

(I) A petty offense if the amount is less than three hundred dollars;

(II) A class 2 misdemeanor if the amount is three hundred dollars or more but less than one thousand dollars;

(III) A class 1 misdemeanor if the amount is one thousand dollars or more but less than two thousand dollars;

(IV) A class 6 felony if the amount is two thousand dollars or more but less than five thousand dollars;

(V) A class 5 felony if the amount is five thousand dollars or more but less than twenty thousand dollars;

(VI) A class 4 felony if the amount is twenty thousand dollars or more but less than one hundred thousand dollars;

(VII) A class 3 felony if the amount is one hundred thousand dollars or more but less than one million dollars; and

(VIII) A class 2 felony if the amount is one million dollars or more.

(e) Any person who is convicted of violating this subsection (8) may not own or operate a nursing facility that receives medical assistance pursuant to this article or article 4 or 5 of this title. For the purposes of this paragraph (e), "convicted" means the entry of a plea of guilty, including a plea of guilty entered pursuant to a deferred sentence under section 18-1.3-102, C.R.S., the entry of a plea of no contest accepted by the court, or the entry of a verdict of guilty by a judge or jury.

Source: L. 2006: Entire article added with relocations, p. 1934, § 7, effective July 1. **L. 2012:** (8)(a) and (8)(d) amended, (HB 12-1310), ch. 20, p. 1400, § 20, effective June 7. **L. 2013:** (1), (2)(a), (3)(a), (4), (6), and (7) amended, (SB 13-167), ch. 394, p. 2292, § 4, effective June 5. **L. 2014:** (2)(a) amended, (SB 14-130), ch. 338, p. 1504, § 1, effective July 1. **L. 2021:** (1) amended, (SB 21-006), ch. 123, p. 497, § 25, effective September 7; (8)(c) and (8)(d) amended, (SB 21-271), ch. 462, p. 3241, § 483, effective March 1, 2022. **L. 2024:** (1), (2), and (6)

amended, (SB 24-176), ch. 152, p. 664, § 77, effective August 7. **L. 2026:** (1) amended, (SB 26-169), ch. 311, p. 1810, § 48, effective August 12.

Editor's note: This section is similar to former § 26-4-504 as it existed prior to 2006.

ANNOTATION

Law reviews. For article, "Trust Protection of Personal Injury Recoveries from Public Creditors", see 19 Colo. Law. 2187 (1990).

Annotator's note. Since § 25.5-6-206 is similar to § 26-4-504 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-504 is similar to § 26-4-116 as it existed prior to the 1991 repeal and reenactment of article 4 of title 26, a relevant case construing that provision has been included in the annotations to this section.

Former subsection (3.5) is remedial in nature and does not remove or impair any vested rights acquired under existing law, does not create a new obligation, impose a new duty, or attach a new disability with respect to transactions or considerations already past. This subsection gives the department of social services the power to recover by setoff monies improperly withdrawn by a nursing home from patient personal needs trust fund accounts. Dept. of Soc. Serv. v. Smith, Harst & Assoc., 803 P.2d 964 (Colo. 1991).

25.5-6-207. Class I nursing facility reimbursement rates - study - report - repeal. (Repealed)

Source: L. 2006: Entire section added, p. 1614, § 2, effective June 2. **L. 2007:** (1) and (3) amended, p. 1802, § 1, effective June 1. **L. 2008:** Entire section repealed, p. 1788, § 6, effective July 1.

Editor's note: This section was enacted as § 26-4-410.1 in Senate Bill 06-131. Section 6 of the bill provided for the renumbering of that section. (See L. 2006, p. 1616.)

Cross references: For the legislative declaration contained in the 2008 act repealing this section, see section 1 of chapter 383, Session Laws of Colorado 2008.

25.5-6-208. Nursing facility provider reimbursement - rules - definition - repeal. (Repealed)

Source: L. 2019: Entire section added, (HB 19-1210), ch. 320, p. 2976, § 7, effective January 1, 2020. **L. 2022:** Entire section amended, (HB 22-1333), ch. 140, p. 931, § 2, effective August 10. **L. 2023:** (7) added, (HB 23-1228), ch. 278, p. 1648, § 3, effective May 30. **2026:** (6.5) added, (HB 26-1177), ch. 1, p. 1, § 1, effective February 27.

Editor's note: (1) Subsection (6.5) was added in HB 26-1177, effective February 27, 2026. For the amendments in effect from February 27, 2026, to July 1, 2026, see chapter 1, Session Laws of Colorado 2026. (L. 2026, p. 1.)

(2) Subsection (7) provided for the repeal of this section, effective July 1, 2026. (See L. 2023, p. 1648.)

25.5-6-209. Establishment of nursing facility provider demonstration of need - criteria - rules.

(1) The state department, in making any medicaid certification determination, shall encourage an appropriate allocation of public health-care resources and the development of alternative or substitute methods of delivering health-care services so that adequate long-term care services are made reasonably available to every qualified member within the state at the appropriate level of care, at the lowest reasonable aggregate cost, and in the least restrictive setting. Medicaid certification determinations shall be made in accordance with *Olmstead v. L.C.*, 527 U.S. 581 (1999).

(2) The state department shall develop, analyze, and enforce a demonstration of need to determine the viability of and required need for each new nursing facility provider seeking medicaid certification. The requirement does not apply to a nursing facility provider certified prior to June 30, 2021.

(3) In order to determine a valid demonstration of need, the state department shall, at a minimum, consider:

(a) State demography office data illustrating the present or impending need within the requesting nursing facility's geographic area;

(b) Quality and performance data of the requesting nursing facility or associated nursing facilities;

(c) Business continuity and solvency information of the requesting nursing facility or associated nursing facilities;

(d) Input from the department of public health and environment; the department of local affairs; the department of regulatory agencies; the department of labor and employment; and any local governments, including cities and counties; and

(e) Measurable innovative practices of the requesting nursing facility.

(4) No later than June 30, 2022, the state board shall promulgate rules pursuant to the "State Administrative Procedure Act", article 4 of title 24, addressing the establishment of criteria to be used in determining a nursing facility provider's medicaid certification. The state board shall publicly consider and gather input on the demonstration of need criteria prior to promulgating rules. The state department shall consider input from, at a minimum:

(a) Disability advocacy organizations;

(b) Urban nursing facility providers;

(c) Rural nursing facility providers;

(d) Aging and older adult advocacy organizations; and

(e) Nursing facility trade organizations.

Source: L. 2021: Entire section added, (HB 21-1227), ch. 192, p. 1014, § 1, effective September 7. **L. 2024:** (1) amended, (SB 24-176), ch. 152, p. 665, § 78, effective August 7.

25.5-6-210. Additional supplemental payments - nursing facilities - funding methodology - reporting requirement - rules - repeal. (Repealed)

Source: L. 2022: Entire section added, (HB 22-1247), ch. 139, p. 926, § 1, effective April 25. **L. 2023:** (1)(a), (1)(b), (6), (7), (8), and (9) repealed, (1)(c) and (1)(d) added, and (10) amended, (HB 23-1228), ch. 278, p. 1648, § 4, effective May 30. **L. 2025:** (4)(b) amended, (SB 25-270), ch. 151, p. 603, § 7, effective May 1.

Editor's note: Subsection (10) provided for the repeal of this section, effective July 1, 2026. (See L. 2023, p. 1648.)

25.5-6-211. Gifts, grants, and donations for enhanced reimbursement model for nursing facilities.

(1) If the executive director receives gifts, grants, and donations for the purpose of providing support for the development and funding of an enhanced reimbursement model for nursing facilities that serve residents with behavioral health needs, the state department shall use the gifts, grants, and donations for that purpose.

(2) Upon request of the joint budget committee, the executive director shall report to the joint budget committee on the use of any gifts, grants, or donations received pursuant to this section.

(3) Any gifts, grants, and donations received pursuant to subsection (1) of this section do not commit the state to an expenditure of general fund money. The general assembly shall not reduce an appropriation made to the state department for the same purpose because of gifts, grants, and donations received pursuant to subsection (1) of this section.

Source: L. 2026: Entire section added, (SB 26-191), ch. 222, p. 1301, § 1, effective August 12.

PART 3

HOME- AND COMMUNITY-BASED SERVICES FOR THE ELDERLY, BLIND, AND DISABLED

25.5-6-301. Short title.

This part 3 shall be known and may be cited as the "Home- and Community-based Services for the Elderly, Blind, and Disabled Act".

Source: L. 2006: Entire article added with relocations, p. 1937, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-601 as it existed prior to 2006.

25.5-6-302. Legislative declaration.

The general assembly hereby finds and declares that it is the purpose of this part 3 to provide, under a federal waiver of statutory requirements, for an array of home- and community-based

services to eligible elderly, blind, and disabled individuals as an alternative to nursing facility placement.

Source: L. 2006: Entire article added with relocations, p. 1937, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-602 as it existed prior to 2006.

25.5-6-303. Definitions.

As used in this part 3, unless the context otherwise requires:

(1) "Adult day care facility" means a facility which meets all applicable state and federal requirements and is certified by the state to provide adult day care services to eligible persons.

(2) "Adult day care services" means health and social services provided on a less than twenty-four-hour basis to eligible persons in state-certified adult day care facilities.

(3) "Alternative care facility" means a residential facility which provides alternative care services and protective oversight to eligible persons, which meets applicable state and federal requirements, and which is state-certified.

(4) "Alternative care services" means a package of personal care and homemaker services provided in a state-certified alternative care facility.

(5) (a) "Case management agency" means agencies providing services on and before July 1, 1995, for home- and community-based programs for the elderly, blind, and disabled shall be terminated July 1, 1995, and case management functions shall thereafter be performed in accordance with this article 6.

(b) "Case management agency" has the same meaning as set forth in section 25.5-6-1702 (2).

(6) "Case management services" has the same meeting as set forth in section 25.5-6-1702 (3).

(7) "Case plan" means a coordinated plan for the provision of long-term-care services in a setting other than a nursing home, developed and managed by a case management agency, in coordination with the member, the member's family or guardian, the member's physician, and other providers of care.

(8) to (11) Repealed.

(12) "Home modification provider" means an entity that meets applicable state, federal, and local requirements and is certified to provide home modification services.

(13) "Home modification services" means home installations or adaptations that are related to the eligible person's physical impairment and enable the person to remain at home.

(14) "Medications administration" means the administration or monitoring of medications provided in a manner consistent with part 3 of article 1.5 of title 25, C.R.S., under the authority and direction of the state department, as part of the "alternative care services", as defined in subsection (4) of this section, as provided in an "alternative care facility", as defined in subsection (3) of this section.

(15) "Nonmedical transportation provider" means an entity that meets applicable state and federal requirements and is certified to provide nonmedical transportation services.

(16) "Nonmedical transportation services" means transportation of eligible persons to services such as, but not limited to, adult day care services, which enable the person to remain at home.

(17) and (18) Repealed.

(19) "Respite care provider" means a facility or agency that meets all applicable state and federal requirements and is state-certified to provide respite care services.

(20) "Respite care services" means services of a short-term nature provided to a member, in the home or in a facility approved by the state department, in order to temporarily relieve the family or other home providers from the care and maintenance of the member, including room and board, maintenance, personal care, and other related services.

(21) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1938, § 7, effective July 1. **L. 2015:** (21) amended, (SB 15-240), ch. 139, p. 423, § 4, effective July 1. **L. 2016:** (21) amended, (SB 16-093), ch. 54, p. 132, § 4, effective July 1. **L. 2018:** IP amended and (21) repealed, (HB 18-1326), ch. 183, p. 1239, § 2, effective July 1; IP and (5)(a) amended, (SB 18-093), ch. 62, p. 610, § 7, effective August 8. **L. 2021:** (9) amended, (SB 21-210), ch. 78, p. 303, § 1, effective April 30; (5), (6), and (7) amended, (HB 21-1187), ch. 83, p. 333, § 30, effective July 1, 2024. **L. 2023:** (8)(b), (9)(b), (10)(b), (11)(b), (17)(b), and (18)(b) added by revision, (SB 23-289), ch. 270, pp. 1606, 1611 §§ 3, 19. **L. 2024:** (7) and (20) amended, (SB 24-176), ch. 152, p. 665, § 79, effective August 7.

Editor's note: (1) This section is similar to former § 26-4-603 as it existed prior to 2006.

(2) The introductory portion to this section was amended in HB 18-1326. Those amendments were superseded by the amendment of the introductory portion to this section in SB 18-093, effective August 8, 2018.

(3) Subsections (8)(b), (9)(b), (10)(b), (11)(b), (17)(b), and (18)(b) provided for the repeal of subsections (8), (9), (10), (11), (17), and (18), respectively, effective July 1, 2025. (See L. 2023, pp. 1606, 1611.)

Cross references: (1) For additional definitions applicable to this part 3, see § 25.5-4-103.

(2) For the legislative declaration in SB 18-093, see section 1 of chapter 62, Session Laws of Colorado 2018.

ANNOTATION

Annotator's note. Since § 25.5-6-303 is similar to § 26-4-603 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-603 is similar to § 26-4.5-103 as it existed prior to the 1991 repeal of article 4.5 of title 26, a relevant case construing that provision has been included in the annotations to this section.

The establishment of procedures and requirements for certification of case management agencies does not result in a plan to provide medical assistance "in effect" statewide, when the state declined to create a management agency in a county or to otherwise fill the void thereby created. Christy v. Ibarra, 826 P.2d 361 (Colo. App. 1991).

The state need not provide all services to all eligible recipients but must provide services to the extent they are available to the general population in the geographic area. Christy v. Ibarra, 826 P.2d 361 (Colo. App. 1991).

25.5-6-304. Administration.

The provisions of this part 3 shall be administered by the state department.

Source: L. 2006: Entire article added with relocations, p. 1940, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-604 as it existed prior to 2006.

25.5-6-305. Provision of services for elderly and blind individuals and individuals with disabilities.

The provision of the services set forth in this part 3 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and costs for the provision of such services.

Source: L. 2006: Entire article added with relocations, p. 1940, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-605 as it existed prior to 2006.

ANNOTATION

Annotator's note. Since § 25.5-6-305 is similar to § 26-4-605 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-605 is similar to § 26-4.5-104.5 as it existed prior to the 1991 repeal of article 4.5 of title 26, a relevant case construing that provision has been included in the annotations to this section.

Once person was initially determined to be eligible for HCBS benefits, his right to continued receipt of the same was similar to "property" right for purposes of the application of the due process clause of the Fourteenth Amendment. Thus, he could be deprived of those continued benefits only by means of a procedure that complied with the tenets of due process of law. Weaver v. Dept. of Soc. Servs., 791 P.2d 1230 (Colo. App. 1990).

The principle that due process prevents a termination of benefits absent a demonstration of a change in circumstances, or other good cause, and that, if the termination of benefits is not to be deemed arbitrary, a showing of some change in circumstances is required applies to the benefits under this section. Weaver v. Dept. of Soc. Servs., 791 P.2d 1230 (Colo. App. 1990).

In the absence of a waiver of any defect in the form of the notice, a notice of adverse action that does not substantially comply with the federal and state requirements cannot provide the basis for a deprivation of benefits. Weaver v. Dept. of Soc. Servs., 791 P.2d 1230 (Colo. App. 1990).

25.5-6-306. Eligible groups.

(1) Home- and community-based services under this part 3 shall be offered only to persons:

(a) Who are elderly, blind, or physically disabled; and

(b) Who are in need of the level of care available in a nursing home; and

(c) Who are categorically eligible for medical assistance, or whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101.

(2) A long-term-care eligible person receiving home- and community-based services shall remain eligible for the services specified in sections 25.5-5-102, 25.5-5-103, 25.5-5-202, and 25.5-5-203, as applicable.

Source: L. 2006: Entire article added with relocations, p. 1940, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-606 as it existed prior to 2006.

ANNOTATION

Annotator's note. Since § 25.5-6-306 is similar to § 26-4-606 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5, a relevant case construing that provision has been included in the annotations to this section.

Department's decision reversing the determination by the administrative law judge (ALJ) that applicant was eligible for home- and community-based services had no reasonable basis in fact or law and district court erred in upholding department's decision. Moczygemba v. Colo. Dept. of Health Care Policy & Fin., 51 P.3d 1083 (Colo. App. 2002).

In determining eligibility, the ALJ is not limited to evidence that the case manager heard on the day of assessment. The ALJ may properly consider any testimony introduced at the hearing concerning the individual's condition as of the date of the level of care assessment. Reiff v. Colo. Dept. of Health Care Policy & Fin., 148 P.3d 355 (Colo. App. 2006).

25.5-6-307. Services for the elderly, blind, and disabled.

(1) Subject to the provisions of this part 3, home- and community-based services for the elderly, blind, and disabled include only the following services:

(a) Adult day care;

(b) Alternative care services;

(c) (Deleted by amendment, L. 2023.)

(d) Home modification services;

(e) (Deleted by amendment, L. 2023.)

(f) Nonmedical transportation services;

(g) (Deleted by amendment, L. 2023.)

(h) Respite care services;

(i) Repealed.

(j) (Deleted by amendment, L. 2023.)

(k) (Deleted by amendment, L. 2023.)

(2) All providers of home- and community-based services for the elderly, blind, and disabled may be separately certified to provide other services, if otherwise qualified.

(3) A case management agency may be certified to provide the services described in subsection (1) of this section, if otherwise qualified as a provider under the state medical assistance program.

(4) (a) The case management agency, in coordination with the eligible person, the person's family or guardian, and the person's physician, shall include in each case plan a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(b) The requirements of this subsection (4) shall not apply if the eligible person is residing in an alternative care facility.

(5) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(I) A reimbursement system with a goal to incentivize and increase transportation provider participation;

(II) How the state department will ensure compliance with applicable federal laws and waiver requirements;

(III) A system of common reporting to ensure a member does not exceed the medicaid benefit in a multi-provider scenario; and

(IV) Best practices based on what other states have done to allow transportation network companies to provide nonmedical transportation services for individuals receiving services, including but not limited to, reimbursement rates; driver compensation; and integration with programs that provide nonmedical transportation services.

(b) In developing the report, the state department shall engage in a stakeholder process that includes individuals with intellectual and developmental disabilities and their families, individuals with disabilities, and transportation network companies. The report may be developed in conjunction with the reporting requirement in sections 25.5-6-409 (6), 25.5-6-606 (9), 25.5-6-704 (8), and 25.5-6-1303 (9).

(c) (I) Upon completion of the report described in subsection (5)(a) of this section, the state department shall analyze and review each operational transportation network company, as defined in section 40-10.1-602 (3). The state department shall verify each transportation network company's viability to ensure the health, safety, welfare, cost effectiveness, and capability in expanding nonmedical transportation services for individuals receiving services pursuant to this section and comply with all rules promulgated pursuant to subsection (5)(e)(I) of this section.

(II) No later than July 1, 2024, the state department shall authorize verified transportation network companies to provide nonmedical transportation services if the state department finds the transportation network company viable under federal requirements and within budgetary constraints.

(III) For the purposes of this subsection (5)(c), "verify" means a transportation network company meets all requirements resulting from the report described in subsection (5)(a) of this section.

(d) The state department may seek any necessary federal authorization for the implementation of this subsection (5).

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid members, transportation network companies, current providers and drivers for nonmedical transportation services, and other parties interested in developing the requirements.

(II) Pursuant to section 40-10.1-105 (1)(l), transportation network companies are not subject to regulation by the public utilities commission when providing nonmedical transportation

services pursuant to this section and are instead subject to rules promulgated by the state department pursuant to this subsection (5)(e).

(f) This subsection (5) does not apply to a provider authorized to provide transportation services pursuant to part 8 of article 1 of title 25.5 prior to August 10, 2022.

Source: L. 2006: Entire article added with relocations, p. 1940, § 7, effective July 1. **L. 2014:** IP(1) amended and (1)(k) added, (HB 14-1357), ch. 254, p. 1015, § 4, effective March 1, 2015. **L. 2018:** (1)(i) repealed, (HB 18-1326), ch. 183, p. 1240, § 3, effective July 1. **L. 2022:** (5) added, (HB 22-1114), ch. 396, p. 2815, § 2, effective August 10. **L. 2023:** (1) amended, (SB 23-289), ch. 270, p. 1607, § 4, effective July 1, 2025. **L. 2024:** (5)(a)(III) and (5)(e)(I) amended, (SB 24-176), ch. 152, p. 666, § 80, effective August 7.

Editor's note: This section is similar to former § 26-4-607 as it existed prior to 2006.

Cross references: For the legislative declaration in HB 22-1114, see section 1 of chapter 396, Session Laws of Colorado 2022.

25.5-6-308. Cost of services.

Home- and community-based services for the elderly, blind, and disabled shall meet aggregate federal waiver budget neutrality requirements.

Source: L. 2006: Entire article added with relocations, p. 1941, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-607.5 as it existed prior to 2006.

25.5-6-309. Special provisions - post-eligibility treatment of income.

Persons who receive services under this part 3 shall pay to the state department, or designated agent or provider, all income remaining after application of federally allowed maintenance and medical deductions or shall pay the cost of home- and community-based services rendered, whichever is less.

Source: L. 2006: Entire article added with relocations, p. 1941, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-608 as it existed prior to 2006.

25.5-6-310. Special provisions - personal care services provided by a family - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1. **L. 2023:** (3) added by revision, (SB 23-289), ch. 270, pp. 1607, 1611 §§ 5, 19. **L. 2024:** (2) amended, (SB 24-176), ch. 152, p. 666, § 81, effective August 7.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-609 as it existed prior to 2006.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2025. (See L. 2023, pp. 1607, 1611.)

25.5-6-311. Duties of state department.

(1) The state department shall:

(a) Seek and utilize any available federal, state, or private funds which are available for carrying out the purposes of this part 3, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended;

(b) Provide a system for reimbursement for services provided pursuant to this part 3, which system shall encourage cost containment.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-610 as it existed prior to 2006.

25.5-6-312. Gifts - grants.

The state department, acting for and on behalf of the state, may receive and accept title to any grant or gift from any source, including the federal government, and all grants, grants-in-aid, and gifts shall be deposited with the state treasurer, who shall credit the same to the general fund, and such moneys shall be appropriated to the state department to carry out the purposes of this article and articles 4 and 5 of this title.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-611 as it existed prior to 2006.

25.5-6-313. Rules - federal authorization.

(1) Pursuant to article 4 of title 24, C.R.S., the state board shall adopt rules for the administration of this part 3.

(1.5) The rules adopted by the state board pursuant to subsection (1) of this section shall include the following provisions concerning adult day care facilities:

(a) A definition of a restricted environment and a restrictive egress alert device;

(b) Parameters governing how the restrictive egress alert device shall be used and tested and the staff roles regarding the use and oversight of the device; and

(c) Parameters governing a restricted environment, including but not limited to staffing and training requirements; appropriateness of placement; assessment; participant's rights; records and reporting requirements; building requirements including grounds and fire safety; restrictive egress alert systems and devices; fencing or other enclosures; and the application process to offer a restricted environment.

(2) The state department is authorized to seek any necessary federal authorization to implement the provisions of this part 3.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1. **L. 2010:** (1.5) added, (HB 10-1053), ch. 276, p. 1267, § 4, effective May 26.

Editor's note: This section is similar to former § 26-4-612 as it existed prior to 2006.

Cross references: For the legislative declaration in the 2010 act adding subsection (1.5), see section 1 of chapter 1267, Session Laws of Colorado 2010.

ANNOTATION

Annotator's note. Since § 25.5-6-313 is similar to § 26-4-612 as it existed prior to the 2006 amendments relocating article 4 of title 26 to title 25.5 and § 26-4-612 is similar to § 26-4.5-115 as it existed prior to the 1991 repeal of article 4.5 of title 26, a relevant case construing that provision has been included in the annotations to this section.

In the absence of a waiver of any defect in the form of the notice, a notice of adverse action that does not substantially comply with the federal and state requirements cannot provide the basis for a deprivation of benefits. Weaver v. Dept. of Soc. Servs., 791 P.2d 1230 (Colo. App. 1990).

Reliance on the numerical point system formulated by the Department of Social Services as the sole criterion upon which to determine petitioner's continuing eligibility for benefits was in error when the system had never been made the subject of a formally adopted rule or regulation nor had claimant been given proper notice of its preeminent significance in determining benefit eligibility. Weaver v. Dept. of Soc. Servs., 791 P.2d 1230 (Colo. App. 1990).

25.5-6-314. Training for staff providing direct-care services to members with dementia - rules - definitions.

(1) As used in this section:

(a) "Covered facility" means a nursing care facility or an assisted living residence licensed by the department of public health and environment pursuant to section 25-1.5-103 (1)(a).

(b) "Dementia diseases and related disabilities" has the same meaning as set forth in section 25-1-502 (2.5).

(c) "Direct-care staff member" means a staff member caring for the physical, emotional, or mental health needs of members of an adult day care facility and whose work involves regular contact with members who are living with dementia diseases and related disabilities.

(d) "Staff member" means an individual, other than a volunteer, who is employed by an adult day care facility.

(2) By July 1, 2024, the state board shall adopt rules requiring all direct-care staff members to obtain dementia training pursuant to curriculum prescribed or approved by the state

department in collaboration with stakeholders that is consistent with the rules adopted pursuant to this subsection (2). The rules must specify the following, at a minimum:

(a) The date on which the dementia training requirement is effective;

(b) The length and frequency of the dementia training, which must be competency-based and must require all direct-care staff to obtain:

(I) At least four hours of initial dementia training, which must be completed as follows:

(A) For all direct-care staff members hired by or who start providing direct-care services at an adult day care facility on or after the effective date of the dementia training requirement specified in the rules, unless an exception established pursuant to subsection (2)(e) of this section applies, the training must be completed within one hundred twenty days after the start of employment or the provision of direct-care services, as applicable; and

(B) For all direct-care staff members hired by or providing direct-care services at an adult day care facility before the effective date of the dementia training requirement specified in the rules, unless an exception established pursuant to subsection (2)(e) of this section applies, the training must be completed within one hundred twenty days after the effective date of the dementia training requirement specified in the rules; and

(II) At least two hours of continuing education on dementia topics every two years. The continuing education must include current information on best practices in the treatment and care of persons living with dementia diseases and related disabilities.

(c) The content of the initial dementia training, which must be culturally competent and include the following topics:

(I) Dementia diseases and related disabilities;

(II) Person-centered care;

(III) Care planning;

(IV) Activities of daily living; and

(V) Dementia-related behaviors and communication;

(d) The method of demonstrating completion of the required dementia training and continuing education and of exempting a direct-care staff member from the required dementia training if the direct-care staff member moves to a different adult day care facility than the adult day care facility through which the direct-care staff member received the training or moves to a covered facility after receiving the training through an adult day care facility;

(e) An exception to the initial dementia training requirements for:

(I) A direct-care staff member hired by or who starts providing direct-care services at an adult day care facility on or after the effective date of the dementia training requirement specified in the rules who has:

(A) Completed an equivalent dementia training program within the twenty-four months immediately preceding the effective date of the dementia training requirement specified in the rules; and

(B) Provided proof of satisfactory completion of the training program; and

(II) A direct-care staff member hired by or providing direct-care services at an adult day care facility before the effective date of the dementia training requirement specified in the rules who has:

(A) Received equivalent training, as defined in the rules, within the twenty-four months immediately preceding the effective date of the dementia training requirement specified in the rules; and

(B) Provided proof of satisfactory completion of the training program;

(f) Minimum requirements for individuals conducting the dementia training;

(g) A process for the state department to verify compliance with this section and the rules adopted by the state board pursuant to this section; and

(h) Any other matters the state board deems necessary to implement this section.

Source: L. 2022: Entire section added, (SB 22-079), ch. 282, p. 2029, § 3, effective August 10. **L. 2024:** (1)(c) amended, (SB 24-176), ch. 152, p. 666, § 82, effective August 7.

Cross references: For the legislative declaration in SB 22-079, see section 1 of chapter 282, Session Laws of Colorado 2022.

PART 4

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

25.5-6-401. Short title.

This part 4 shall be known and may be cited as the "Home- and Community-based Services for Persons with Developmental Disabilities Act".

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-621 as it existed prior to 2006.

25.5-6-402. Legislative declaration - Prader-Willi syndrome.

(1) The general assembly finds and declares that it is the purpose of this part 4 to provide services for persons with intellectual and developmental disabilities that would foster the following goals:

(a) To maintain eligible persons in the most appropriate settings possible and to minimize admissions to institutions;

(b) To recognize the unique services requirements of persons with developmental disabilities;

(c) To provide optimum accessibility to various important social, habilitative, remedial, residential, and health services that are available to assist in maintaining eligible persons in the least restrictive settings;

(d) To provide eligible persons who have the capacity to remain outside an institutional setting access to appropriate social, habilitative, remedial, residential, and health services, without which institutionalization would be necessary;

(e) To provide the most efficient and effective use of funds in the delivery of these social, habilitative, remedial, residential, and health services to eligible persons;

(f) To coordinate, integrate, and link these social, habilitative, remedial, residential, and health services into existing community-based service delivery systems for persons with developmental disabilities, to avoid unnecessary and expensive duplication of services;

(g) To allow the state substantial flexibility in organizing and administering the delivery of social, habilitative, remedial, residential, and health services to eligible citizens.

(2) The general assembly intends that the state department and the department of human services shall cooperate to the maximum extent possible in designing, implementing, and administering the programs authorized under this part 4.

(3) Nothing in this part 4 shall be construed to disqualify persons from receiving any benefits to which they would otherwise be eligible under parts 1 and 2 of article 5 of this title, or under Title XIX of the federal "Social Security Act", as amended, by reason of being designated as a person with developmental disabilities.

(4) The general assembly further finds and declares that:

(a) Repealed.

(b) Because Prader-Willi syndrome is a genetic disorder, individuals either have it or they do not. Further, because there is not currently a cure, individuals who have Prader-Willi syndrome will have it for life.

(c) This disorder affects members of every culture, religion, economic class, race, and social order;

(d) The most critical hallmark of Prader-Willi syndrome is overeating. Individuals with Prader-Willi syndrome cannot tell when they are full and will continue to eat without stopping, leading to a ruptured stomach and even death. Other symptoms include significant developmental and cognitive delays, skin picking, sleep problems, obsessive-compulsive behaviors, hypothyroidism, hypogonadism, and low muscle tone.

(e) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1942, § 7, effective July 1. **L. 2018:** IP(1) amended and (4) added, (SB 18-074), ch. 98, p. 769, § 1, effective August 8. **L. 2023:** (4)(a) and (4)(e) repealed and (4)(d) amended, (HB 23-1040), ch. 41, p. 160, § 1, effective March 31.

Editor's note: This section is similar to former § 26-4-622 as it existed prior to 2006.

25.5-6-403. Definitions.

As used in this part 4, unless the context otherwise requires:

(1) "Case management agency" has the same meaning as set forth in section 25.5-6-1702 (2).

(2) (a) "Eligible person" means a person with developmental disabilities:

(I) Who meets the definition of categorically needy as defined in section 25.5-4-103 (4);

(II) Who is in need of the level of care available in an intermediate care facility for individuals with intellectual disabilities;

(III) Whose gross income does not exceed three hundred percent of the current federal supplemental security income benefits level or other applicable standard provided in federal regulations construing the federal "Social Security Act", as amended, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state

supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101; and

(IV) For whom it is determined that provision of such services is necessary to avoid placement in an intermediate care facility for individuals with intellectual disabilities.

(b) The amount of parental income and resources that shall be attributable to a child's gross income for purposes of eligibility under paragraph (a) of this subsection (2) shall be set forth in rules promulgated by the state board of human services created in section 26-1-107, C.R.S.

(2.5) "Entity" has the same meaning as set forth in section 25.5-6-1702 (8).

(3) "In-home services" means those services described in section 25.5-10-205 provided to support persons living with their family.

(3.3) (a) "Intellectual and developmental disability" means a disability that manifests before the person reaches twenty-two years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when those conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15002 (8) does not apply.

(b) "Person with an intellectual and developmental disability" or "youth with an intellectual and developmental disability" means a person or youth determined by a case management agency to have an intellectual and developmental disability and includes a child with a developmental delay.

(c) "Child with a developmental delay" means:

(I) A person less than five years of age with delayed development as defined by rule of the state board; or

(II) A person less than five years of age who is at risk of having an intellectual and developmental disability as defined by rule of the state board.

(4) "Plan of care" means a coordinated plan of care for provision of services in other than a nursing facility or institutional setting, developed and managed, subject to review and approval pursuant to section 25.5-6-404, by a case management agency for persons with intellectual and developmental disabilities. This plan of care shall fully identify the services to be provided to eligible persons. Prior to the provision of those services, a physician may be required to review an assessment document to ensure that it adequately describes the medical needs of the eligible person.

(5) (a) "Services for persons with intellectual and developmental disabilities" means those services:

(I) Approved for reimbursement by the federal government; and

(II) Necessary to prevent a person, eligible for services under subsection (2) of this section, from being subjected to placement in an intermediate care facility for individuals with intellectual disabilities.

(b) "Services for persons with intellectual and developmental disabilities" includes, but is not limited to, social, habilitative, remedial, residential, health services, and services provided under the consumer-directed care service model, part 11 of this article, which shall include the selection, from a list of qualified entities, of an organization of the eligible person's choice to provide financial management services for the eligible person.

Source: L. 2006: Entire article added with relocations, p. 1943, § 7, effective July 1. **L. 2013:** (2)(a)(II), (2)(a)(IV), and (5)(a)(II) amended, (SB 13-167), ch. 394, p. 2294, § 5, effective June 5; (1), (3), IP(5)(a), (5)(a)(II), and (5)(b) amended, (HB 13-1314), ch. 323, p. 1810, § 47, effective March 1, 2014. **L. 2014:** (3.3) added, (HB 14-1368), ch. 304, p. 1288, § 1, effective May 31. **L. 2018:** (1), (3.3)(a), and (3.3)(c)(II) amended, (SB 18-074), ch. 98, p. 770, § 2, effective August 8; (3.3)(a) amended, (SB 18-096), ch. 44, p. 474, § 15, effective August 8. **L. 2019:** (3.3)(a) amended, (SB 19-241), ch. 390, p. 3473, § 40, effective August 2. **L. 2021:** (1), (3.3)(b), and (4) amended and (2.5) added, (HB 21-1187), ch. 83, p. 334, § 31, effective July 1, 2024.

Editor's note: (1) This section is similar to former § 26-4-623 as it existed prior to 2006.

(2) Amendments to subsection (3.3)(a) by SB 18-074 and SB 18-096 were harmonized.

Cross references: (1) For additional definitions applicable to this part 4, see § 25.5-4-103.

(2) For the legislative declaration in SB 18-096, see section 1 of chapter 44, Session Laws of Colorado 2018.

25.5-6-404. Duties of the department of health care policy and financing and the department of human services.

(1) The state department and the department of human services shall provide a system of reimbursement for services provided pursuant to this part 4 that encourages the most cost-effective provision of services.

(2) The state department and the department of human services shall, subject to appropriation, utilize any available federal, state, local, or private funds, including but not limited to, medicaid funds available under Title XIX of the federal "Social Security Act", as amended, such as medicaid home- and community-based waivers, to carry out the purposes of this part 4.

(3) The state department may contract with the department of human services to certify agencies providing services under this part 4 as eligible medicaid providers, to adopt fiscal and administrative procedures, to review plans of care, to set rates, and to make and implement recommendations regarding the scope, duration, and content of programs and the eligibility of persons for specific services provided pursuant to this part 4, and to fulfill any other responsibilities necessary to implement this part 4 that are consistent with the single state agency designation set out in section 25.5-4-104.

(4) The executive director and the state board shall promulgate rules regarding this part 4 as necessary to fulfill the obligations of the state department as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended. The rules may include, but are not limited to, determination of the level of care requirements for long-term care, patient payment requirements, members' rights, medicaid eligibility, and appeal rights associated with these requirements.

(5) The state board of human services, created in section 26-1-107, C.R.S., shall promulgate such rules as are necessary to implement the provisions of this part 4 and to fulfill the responsibilities and duties set out in article 10.5 of title 27, C.R.S. Such rules shall be promulgated pursuant to section 24-4-103, C.R.S.

(6) In the event that a direct conflict arises between the rules of the state department promulgated pursuant to subsection (4) of this section and the rules of the department of human services promulgated pursuant to subsection (5) of this section, regarding implementation of this part 4, the rules of the state department shall control.

Source: L. 2006: Entire article added with relocations, p. 1944, § 7, effective July 1. **L. 2024:** (4) amended, (SB 24-176), ch. 152, p. 666, § 83, effective August 7.

Editor's note: This section is similar to former § 26-4-624 as it existed prior to 2006.

25.5-6-405. Relationship to other programs.

The provisions of part 3 of this article are separate and distinct from the provisions of this part 4. Therefore, the definitions and restrictions embodied in part 3 of this article shall not apply to services and programs provided pursuant to this part 4.

Source: L. 2006: Entire article added with relocations, p. 1945, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-625 as it existed prior to 2006.

25.5-6-406. Appropriations - reimbursement for services - direct support professionals - legislative declaration - definitions.

(1) To carry out duties and obligations pursuant to this part 4 and for the administration and provision of services to eligible persons, all medicaid funds appropriated pursuant to Title XIX of the federal "Social Security Act", as amended, for the provision of care for persons with developmental disabilities and all other funds otherwise appropriated by the general assembly as additional sources of program funding are available for the placement of eligible persons either in intermediate care facilities for persons with intellectual disabilities or alternatives to such placements.

(2) (a) (I) The general assembly finds and declares that:

(A) Colorado's system of home- and community-based services that supports Coloradans with intellectual and developmental disabilities has grown to serve more than twelve thousand persons and their families;

(B) Costs associated with providing these services continue to rise with growth in demand, inflation, increased regulation, rising minimum wages, rising health-care costs, and other economic factors;

(C) Reimbursement rates have not kept pace with these rising costs, resulting in reduced access to services for Coloradans with intellectual and developmental disabilities;

(D) Colorado needs significant initial investments to address the most urgent issues concerning services for persons with intellectual and developmental disabilities, as well as future long-term planning to address the growing strain on the system;

(E) One of the most urgent issues is the workforce crisis among direct support professionals, characterized by chronically low wages, limited benefits, and lack of career advancement opportunities for these critical workers;

(F) Colorado is experiencing a workforce crisis among direct support professionals because reimbursement rates cannot support the compensation needed to match the high level of responsibility required in these jobs;

(G) Agencies that serve people with intellectual and developmental disabilities increasingly struggle to recruit and retain direct support professionals to meet the demand for services; and

(H) High turnover among direct support professionals results in reduced continuity of services for persons with intellectual and developmental disabilities.

(II) Therefore, as an initial investment, Colorado's reimbursement rates should be increased to allow for direct support professional compensation that better reflects market realities and the high level of responsibility required in these jobs.

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

(I) "Compensation" means any form of monetary payment, including bonuses, employer-paid health and other insurance programs, paid time off, payroll taxes, and all other fixed and variable benefits conferred on or received by a direct support professional.

(II) "Direct support professional" means a worker who assists or supervises a worker to assist a person with intellectual and developmental disabilities to lead a fulfilling life in the community through a diverse range of services, including helping the person get ready in the morning, take medication, go to work or find work, and participate in social activities. "Direct support professional" includes all workers categorized as program direct support professionals and excludes workers categorized as administrative, as defined in standards established by the Financial Accounting Standards Board.

(c) The state department shall immediately seek a six and one-half percent increase in the reimbursement rate for the following services delivered through the home- and community-based services for persons with developmental disabilities, supported living services, and children's extensive supports waivers:

(I) Group residential services and supports;

(II) Individual residential services and supports;

(III) Specialized habilitation;

(IV) Respite;

(V) Repealed.

(VI) Homemaker enhanced;

(VII) Repealed.

(VIII) Prevocational services;

(IX) Behavioral line staff;

(X) Community connector;

(XI) Supported community connections;

(XII) Mentorship;

(XIII) Supported employment - job development; and

(XIV) Supported employment - job coaching.

(d) The state department shall implement a corresponding increase in service plan authorization limits to account for this increase in reimbursement rates.

(e) Service agencies shall use one hundred percent of the funding resulting from the increase in the reimbursement rate pursuant to subsection (2)(c) of this section to increase compensation for direct support professionals above the rate of compensation that direct support professionals are receiving as of June 30, 2018. This requirement applies to funds billed by case management agencies and entities in their role as organized health-care delivery systems, as defined in 42 CFR 447.10 (b). Service agencies shall not use funding resulting from the reimbursement rate increase for general and administrative expenses, such as chief executive officer salaries, human resources, information technology, oversight, business management, general record keeping, budgeting and finance, and other activities not identifiable to a single program.

(f) (I) For the 2018-19 through 2020-21 fiscal years, service agencies shall track how they used the funding resulting from the increase in the reimbursement rate pursuant to subsection (2)(c) of this section using a reporting tool developed by the state department in collaboration with service agencies. On or before December 31, 2019, service agencies shall submit the report to the state department demonstrating how the funding was used to increase direct support professional compensation for the 2018-19 fiscal year. The state department shall have ongoing discretion to request information from service agencies demonstrating how they maintained increases in compensation for direct support professionals beyond the three-year tracking period.

(II) Service agencies shall maintain all books, documents, papers, accounting records, and other evidence required to support the tracking of payroll information for increased compensation to direct support professionals pursuant to subsection (2)(f)(I) of this section for at least three years from the end of each respective fiscal year. Service agencies shall make the information and materials available for inspection by the state department or its designees at all reasonable times.

(g) If a service agency does not use one hundred percent of the funding resulting from the increase in the reimbursement rate pursuant to subsection (2)(c) of this section to increase compensation for direct support professionals, the state department may recoup part or all of the funding resulting from the increase in the reimbursement rate.

(h) If the state department determines that the service agency did not use the funding resulting from the increase in the reimbursement rate pursuant to subsection (2)(c) of this section as required, within one year after the end of each fiscal year described in subsection (2)(f)(I) of this section, the state department shall notify the service agency in writing of the state department's intention to recoup funds pursuant to subsection (2)(g) of this section.

(i) The service agency has forty-five days after receiving notice of the determination under subsection (2)(h) of this section to:

(I) Challenge the determination of the state department;

(II) Provide additional information to the state department demonstrating compliance; or

(III) Submit a plan of correction to the state department.

(j) The state department shall notify the service agency in writing of its final determination after affording the service agency the opportunity to take the actions specified in subsection (2)(i) of this section.

(k) The state department shall recoup from a service agency one hundred percent of the funding resulting from the increase in the reimbursement rate pursuant to subsection (2)(c) of this section that the service agency received but did not use for compensation for direct support professionals if:

(I) The service agency fails to respond to a notice of determination of the state department within the time provided in subsection (2)(i) of this section;

(II) The service agency is unable to provide documentation of compliance; or

(III) The state department does not accept the plan of correction submitted by the service agency pursuant to subsection (2)(i) of this section.

(l) The state department shall participate in the national core indicators staff stability survey.

(m) Once the state department determines that a sufficient quantity and quality of data exists to determine the impact and outcomes, if any, attributed to the increase in the reimbursement rate pursuant to subsection (2)(c) of this section on persons with intellectual and developmental disabilities, the state department shall include in its annual report concerning the waiting list for services and supports for persons with intellectual and developmental disabilities, required pursuant to section 25.5-10-207.5, information from the national core indicators data, or another comparable source, concerning in what ways outcomes for persons with intellectual and

developmental disabilities changed as a result of the increase in reimbursement rates pursuant to subsection (2)(c) of this section. The report must include, if available, multiyear personal outcome data specific to Colorado and comparisons to other states, as appropriate, as well as data from the national core indicators staff stability survey.

Source: L. 2006: Entire article added with relocations, p. 1945, § 7, effective July 1. **L. 2013:** Entire section amended, (SB 13-167), ch. 394, p. 2294, § 6, effective June 5. **L. 2018:** Entire section amended, (HB 18-1407), ch. 248, p. 1527, § 2, effective May 24. **L. 2020:** (2)(f) and (2)(h) amended, (HB 20-1363), ch. 204, p. 1007, § 1, effective June 30. **L. 2021:** (2)(e) amended, (HB 21-1187), ch. 83, p. 334, § 32, effective July 1, 2024. **L. 2023:** (2)(c)(V)(B) and (2)(c)(VII)(B) added by revision, (SB 23-289), ch. 270, pp. 1607, 1611 §§ 6, 19.

Editor's note: (1) This section is similar to former § 26-4-626 as it existed prior to 2006.

(2) Subsections (2)(c)(V)(B) and (2)(c)(VII)(B) provided for the repeal of subsections (2)(c)(V) and (2)(c)(VII), respectively, effective July 1, 2025. (See L. 2023, pp. 1607, 1611.)

Cross references: For the legislative declaration in HB 18-1407, see section 1 of chapter 248, Session Laws of Colorado 2018.

25.5-6-407. Gifts - grants.

The state department and the department of human services, acting on behalf of the state, may receive and accept title to gifts or grants from any source, including the federal government. Both departments shall deposit all grants, grants-in-aid, and gifts with the state treasurer, who shall credit them to the general fund. These moneys shall remain available for appropriation to either department to carry out the purposes of this part 4.

Source: L. 2006: Entire article added with relocations, p. 1946, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-627 as it existed prior to 2006.

25.5-6-408. Eligibility - fees.

(1) Subject to the availability of federal financial participation, services shall be provided to eligible persons pursuant to this part 4.

(2) Any eligible person who accepts and receives services pursuant to this part 4 shall pay to the state department, or to an agent designated by the state department, an amount determined pursuant to federal regulations construing the federal "Social Security Act", as amended, concerning the application of patient income to the cost of services.

Source: L. 2006: Entire article added with relocations, p. 1946, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-628 as it existed prior to 2006.

25.5-6-409. Services for persons with intellectual and developmental disabilities.

(1) A program to provide home- and community-based services to persons with intellectual and developmental disabilities who are in need of the level of care available in an intermediate care facility for individuals with intellectual disabilities is hereby established pursuant to the federal "Social Security Act", as amended. This program shall provide for the social, habilitative, remedial, residential, health, and other needs of persons with intellectual and developmental disabilities to avoid placement in an intermediate care facility for individuals with intellectual disabilities.

(2) Services for persons with intellectual and developmental disabilities provided through this program must be delivered under the provisions of a statewide services plan, in the form of home- and community-based services waivers or model waivers, developed by the state department and the department of human services and approved by the federal centers for medicare and medicaid services, or any successor agency. This plan must include the specific services to be offered, a plan for the delivery of such services through case management agencies or other service agencies approved pursuant to this article 6 or article 10.5 of title 27 utilizing where appropriate the provision of in-home services, the expected costs of such services, the expected benefits of providing those services, and the administrative provisions which shall govern the implementation of the plan. The plan must provide for all necessary safeguards to ensure the health and welfare of any eligible persons. The average per capita expenditure for services under this plan must not exceed the average per capita expenditure the department of human services or the state department would have made for services otherwise available without this plan.

(3) The plan shall utilize existing community-based services programs to the maximum extent possible and shall coordinate all available forms of assistance for the eligible person.

(4) Repealed.

(5) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(I) A reimbursement system with a goal to incentivize and increase transportation provider participation;

(II) How the state department will ensure compliance with applicable federal laws and waiver requirements;

(III) A system of common reporting to ensure a member does not exceed the medicaid benefit in a multi-provider scenario; and

(IV) Best practices based on what other states have done to allow transportation network companies to provide nonmedical transportation services for individuals receiving services, including but not limited to, reimbursement rates; driver compensation; and integration with programs that provide nonmedical transportation services.

(b) In developing the report, the state department shall engage in a stakeholder process that includes individuals with intellectual and developmental disabilities and their families, individuals with disabilities, and transportation network companies. The report may be developed in conjunction with the reporting requirement in sections 25.5-6-307 (6), 25.5-6-606 (9), 25.5-6-704 (8), and 25.5-6-1303 (9).

(c) (I) Upon completion of the report described in subsection (5)(a) of this section, the state department shall analyze and review each operational transportation network company, as defined in section 40-10.1-602 (3). The state department shall verify each transportation network company's viability to ensure the health, safety, welfare, cost effectiveness, and capability in expanding nonmedical transportation services for individuals receiving services pursuant to this section and comply with all rules promulgated pursuant to subsection (5)(e)(I) of this section.

(II) No later than July 1, 2024, the state department shall authorize verified transportation network companies to provide nonmedical transportation services if the state department finds the transportation network company viable under federal requirements and within budgetary constraints.

(III) For the purposes of this subsection (5)(c), "verify" means a transportation network company meets all requirements resulting from the report described in subsection (5)(a) of this section.

(d) The state department may seek any necessary federal authorization for the implementation of this subsection (5).

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid members, transportation network companies, current providers and drivers for nonmedical transportation services, and other parties interested in developing the requirements.

(II) Pursuant to section 40-10.1-105 (1)(l), transportation network companies are not subject to regulation by the public utilities commission when providing nonmedical transportation services pursuant to this section and are instead subject to rules promulgated by the state department pursuant to this subsection (5)(e).

(f) This subsection (5) does not apply to a provider authorized to provide transportation services pursuant to part 8 of article 1 of title 25.5 prior to August 10, 2022.

Source: L. 2006: Entire article added with relocations, p. 1946, § 7, effective July 1. **L. 2013:** (1) amended, (SB 13-167), ch. 394, p. 2294, § 7, effective June 5; (1) and IP(4) amended, (HB 13-1314), ch. 323, p. 1811, § 48, effective March 1, 2014. **L. 2021:** (2) amended, (HB 21-1187), ch. 83, p. 335, § 33, effective July 1, 2024; (4)(d) added by revision, (HB 21-1187), ch. 83, pp. 335, 354, §§ 33, 70. **L. 2022:** (5) added, (HB 22-1114), ch. 396, p. 2817, § 3, effective August 10. **L. 2024:** (5)(a)(III) and (5)(e)(I) amended, (SB 24-176), ch. 152, p. 667, § 84, effective August 7.

Editor's note: (1) This section is similar to former § 26-4-629 as it existed prior to 2006.

(2) Amendments to subsection (1) by Senate Bill 13-167 and House Bill 13-1314 were harmonized.

(3) Subsection (4)(d) provided for the repeal of subsection (4), effective July 1, 2024. (See L. 2021, pp. 335, 354.)

Cross references: For the legislative declaration in HB 22-1114, see section 1 of chapter 396, Session Laws of Colorado 2022.

25.5-6-409.3. Consolidated waiver - intellectual and developmental disabilities - conflict-free case management - legislative declaration - repeal. (Repealed)

Source: L. 2015: Entire section added, (HB 15-1318), ch. 304, p. 1248, § 1, effective August 5. **L. 2021:** (6) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2023:** (2) and (4) amended, (HB 23-1301), ch. 303, p. 1832, § 52, effective August 7. **L. 2024:** IP(3.3)(a), (3.3)(a)(I), and (3.3)(a)(III) amended, (SB 24-176), ch. 152, p. 667, § 85, effective August 7.

Editor's note: (1) SB 24-176 amended subsections IP(3.3)(a), (3.3)(a)(I), and (3.3)(a)(III), effective August 7, 2024, but those amendments did not take effect due to the repeal of this section, effective July 1, 2024.

(2) Subsection (6) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-6-409.5. Transition plan for youth with intellectual and developmental disabilities to adult services - rules - cash fund - legislative declaration.

(1) The general assembly finds and declares that:

(a) Youth with intellectual and developmental disabilities who are eighteen to twenty years of age are currently served through the county child welfare system; and

(b) The home- and community-based services program for persons with intellectual and developmental disabilities is better designed to meet the complex needs of these youth.

(2) Therefore, the general assembly declares that, in order to have a person-centered system, youth with intellectual and developmental disabilities who are eighteen years of age and older who are currently being served through child welfare services must be transitioned to the home- and community-based services program for persons with intellectual and developmental disabilities and a plan developed for the ongoing transition of such youth when they turn eighteen years of age, except in extenuating circumstances when the court or interdisciplinary team determines that it is not in the best interest of the youth to transition.

(3) (a) On or before June 30, 2014, each county department of human or social services shall identify youth with intellectual and developmental disabilities who are receiving services through the child welfare system in that county and who:

(I) Are twenty years of age or older as of June 30, 2014;

(II) Are nineteen years of age or older but younger than twenty-one years of age as of June 30, 2014;

(III) Are eighteen years of age or older but younger than twenty years of age as of June 30, 2014; and

(IV) Will become eighteen years of age on or after June 30, 2014, and before January 1, 2015.

(b) On or before October 1, 2014, and as necessary thereafter, each county department of human or social services shall identify youth with intellectual and developmental disabilities who are receiving services through the child welfare system in that county and who will become eighteen years of age within the following six months.

(c) Each county department of human or social services shall develop a plan to transition youth identified pursuant to paragraphs (a) and (b) of this subsection (3) to adult services for persons with intellectual and developmental disabilities. The transition plan must meet the criteria set forth in subsection (4) of this section and any rules promulgated by the state board to implement this section. Each county's plan must provide for:

(I) Youth described in paragraph (a) of this subsection (3) to be transitioned as soon as possible but in no case later than January 1, 2016; and

(II) Youth described in subparagraph (IV) of paragraph (a) of this subsection (3) or paragraph (b) of this subsection (3) to be transitioned as soon as possible based on individual needs but in no case earlier than their eighteenth birthday.

(d) The requirement to transition youth as set forth in subsection (3)(c) of this section does not apply to youth currently serving a sentence in the division of youth services or to youth under a court order in a juvenile delinquency case, unless the court approves the transition by written court order.

(4) For each youth with intellectual and developmental disabilities who is going to be transitioned to adult services for persons with intellectual and developmental disabilities pursuant to subsection (3) of this section, the county department of human or social services that is currently providing services to the youth through its child welfare system shall develop a transition plan for that youth. The transition plan must, at a minimum:

(a) Include the department-prescribed assessment provided by the case management agency, as defined in section 25.5-6-1702 that is performed as soon as possible for those youth who are being transitioned pursuant to subsection (3) of this section and at seventeen and a half years of age for those youth who are being transitioned pursuant to subsection (3)(a)(IV) or (3)(b) of this section. In all instances, the assessment must be completed within six months of a youth's transition to adult services.

(b) Provide for the social, habilitative, remedial, residential, educational, health, and other needs of the youth who is being transitioned; and

(c) Address any legal needs concerning guardianship of the youth who is being transitioned.

(5) In all instances, the involved parties and the county department of human or social services shall consider and place precedence on the best interest of the youth prior to the transition process, as set forth in sections 19-3-205 and 19-3-213, C.R.S.

(6) It is the intent of the general assembly that county child welfare systems and case management agencies, as defined in section 25.5-6-1702, collaborate to ensure minimal disruption for youth during the transition process.

(7) The medical services board and the state board of human services may promulgate rules as necessary and appropriate for the implementation of this section.

(8) and (9) Repealed.

Source: L. 2014: Entire section added, (HB 14-1368), ch. 304, p. 1289, § 2, effective May 31. **L. 2017:** (3)(d) amended, (HB 17-1329), ch. 381, p. 1983, § 60, effective June 6. **L. 2021:** (4)(a) and (6) amended, (HB 21-1187), ch. 83, p. 336, § 34, effective July 1, 2024. **L. 2026:** (8) repealed, (HB 26-1295), ch. 121, p. 524, § 20, effective August 12.

Editor's note: Subsection (9)(b) provided for the repeal of subsection (9), effective July 1, 2016. (See L. 2014, p. 1289.)

25.5-6-410. Qualification for federal funding.

Nothing in this part 4 shall prevent the state department or the department of human services from complying with federal requirements in order for the state of Colorado to qualify for federal funds under Title XIX of the federal "Social Security Act", as amended.

Source: L. 2006: Entire article added with relocations, p. 1947, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-630 as it existed prior to 2006.

25.5-6-411. Personal needs trust fund required.

All personal needs funds must be held in trust by a residential facility authorized to provide services pursuant to this part 4, or the residential facility's designated trustee, separate and apart from any other funds of the facility, in a checking account or savings account or any combination established to protect and separate the personal needs funds of the members. At all times, the principal and all income derived from the principal in the personal needs trust fund must remain the property of the participating members, and the residential facility or the facility's designated trustee is bound by all of the duties imposed by law upon fiduciaries in handling the fund including accounting for all expenditures from the fund.

Source: L. 2006: Entire article added with relocations, p. 1947, § 7, effective July 1. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 667, § 86, effective August 7.

Editor's note: This section is similar to former § 26-4-631 as it existed prior to 2006.

25.5-6-412. Cross-system response for behavioral health crises pilot program - legislative declaration - creation - criteria - recommendations - fund - repeal. (Repealed)

Source: L. 2015: Entire section added, (HB 15-1368), ch. 308, p. 1258, § 1, effective June 5. **L. 2017:** IP(3) and (3)(e) amended, (SB 17-242), ch. 263, p. 1329, § 208, effective May 25.

Editor's note: Subsection (9) provided for the repeal of this section, effective July 1, 2019. (See L. 2015, p. 1258.)

25.5-6-413. Elimination of subminimum wage - transition plan for individuals with disabilities - waiver - legislative declaration - definition.

(1) The general assembly finds and declares that:

(a) The payment of subminimum wages is an economic justice issue for individuals with disabilities, impacting their ability to earn wages equal to their peers without disabilities and devaluing their contributions based on their disabilities;

(b) Service enhancements and public policy changes are needed to address these systemic barriers and assist individuals in subminimum wage jobs to pursue competitive integrated employment; and

(c) The elimination of subminimum wage employment, along with the implementation of critical service enhancements and policy changes, is essential to promoting economic justice for, and the enhanced self-sufficiency of, individuals with disabilities while ensuring that individuals currently working in subminimum wage jobs can successfully transition to competitive integrated employment, supported employment, or integrated community activities related to each individual's employment goals.

(2) (a) The state department shall seek federal approval, with an effective date on or before July 1, 2023, to add the following medicaid waiver services for adults with intellectual and developmental disabilities to assist them with pursuing competitive integrated employment:

(I) Support to provide line-of-sight supervision on the job as a less intensive and less expensive alternative to individual job coaching, when appropriate; and

(II) Ongoing benefits counseling to assist such adults in earning higher incomes while retaining necessary supports.

(b) The state department shall collaborate with stakeholders to develop service coverage standards, reimbursement rates, and limitations on the services described in subsection (2)(a) of this section.

(3) The state department shall seek federal approval, with an effective date on or before July 1, 2023, to remove the following services from the service plan authorization limits to ensure access to employment supports:

(a) Job coaching, individual; and

(b) Job development, individual.

(4) The state department shall collaborate with stakeholders to publish clarifying guidance regarding allowable activities under services described in subsection (3) of this section.

(5) As used in this section, "competitive integrated employment" has the same meaning as set forth in section 8-84-301 (3).

Source: L. 2021: Entire section added, (SB 21-039), ch. 380, p. 2548, § 6, effective July 1.

25.5-6-414. Delivery of services for individuals with serious mental illness - rules.

(1) The state department is committed to improving access to, and the quality of services for, individuals with serious mental illness who are enrolled in the state medical assistance program.

(2) The state department shall, in collaboration with the behavioral health administration, service providers, stakeholders, and individuals with lived experience, continuously evaluate and explore options to enhance the delivery of services for individuals with serious mental illness, which efforts may include, but are not limited to:

(a) Expanding community-based service capacity and care coordination;

(b) Improving transitions of care across settings;

(c) Leveraging federal authorities, waivers, and financing mechanisms;

(d) Advancing innovative service delivery models and value-based payment approaches; and

(e) Identifying and addressing gaps in access, quality, and outcomes.

(3) The state department shall consider opportunities to align financing, benefits, and service delivery systems to better meet the needs of individuals with serious mental illness, with the goals of improving health outcomes, reducing avoidable utilization of high-cost services, and supporting individuals to live in the least restrictive setting appropriate to meet the individual's needs.

(4) The state department may adopt rules as necessary to implement this section.

(5) This section does not create an entitlement to a specific service or level of care.

Source: L. 2026: Entire section added, (SB 26-149), ch. 142, p. 786, § 23, effective May 21.

25.5-6-415. Individual residential services and supports settings for persons with intellectual and developmental disabilities - statewide database - risk criteria - complaint process - rules - definitions.

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

(a) "Individual residential services and supports" means the residential services provided by a service provider agency to no more than three individuals within one residence.

(b) "Individual residential services and supports setting" means a community living residential setting in which individual residential services and supports are provided to no more than three persons with intellectual and developmental disabilities and for which a state license is not required.

(c) "Service provider agency" means an organization approved by the state department to provide oversight and support to an individual residential services and supports setting to ensure that the caregivers meet state standards for health, safety, and quality of care.

(2) (a) The state department shall establish a statewide database to enhance the transparency of Colorado's individual residential services and supports network. The purpose of the statewide database is to provide accurate information about certain individual residential services and supports settings and their associated service provider agencies.

(b) The database is for use by the state department, the department of public health and environment, and service provider agencies.

(c) The database must include information on individual residential services and supports settings. The state department shall determine what information must be collected on each individual residential services and supports setting type for inclusion in the database. At a minimum, each service provider agency must submit the following information for each covered individual residential services and supports setting that the service provider agency oversees:

(I) The name and contact information of the individual residential services and supports setting, if applicable;

(II) The address and location of the individual residential services and supports setting;

(III) The name of each service provider agency that the individual residential services and supports setting is currently associated with and the service provider agency's contact information; and

(IV) When applicable, the name of each service provider agency that the individual residential services and supports setting contracted with in the previous five years and each service provider agency's contact information.

(d) Beginning July 1, 2026, and quarterly thereafter, a service provider agency shall submit the information detailed in subsection (2)(c) of this section to the state department.

(e) Beginning August 1, 2026, and quarterly thereafter, the state department shall update the database to accurately reflect the information submitted by a service provider agency, as required by subsection (2)(d) of this section. The state department shall update the database within one month after receiving the information detailed in subsection (2)(c) of this section.

(f) The state department shall determine the circumstances in which information from the database may be shared with members of the public, consistent with all applicable state and federal privacy and confidentiality laws.

(g) Identifying information from residential homes where residing individuals receive residential services and supports from a family member shall not be shared with the public.

(h) Information from the database may be provided to appropriate and authorized parties by the service provider agency when considering potential placement.

(5) The state department may adopt rules, as necessary, to carry out the requirements of this section.

(6) Nothing in this section shall be construed to reduce, limit, or otherwise diminish the rights of individuals receiving intellectual and developmental disability services, including the right to informed choice of setting consistent with federal home- and community-based services requirements.

Source: L. 2026: Entire section added, (HB 26-1147), ch. 352, p. 2129, § 2, effective June 3.

Cross references: For the legislative declaration in HB 26-1147, see section 1 of chapter 352, Session Laws of Colorado 2026.

PART 5

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH HEALTH COMPLEXES RELATED TO ACQUIRED IMMUNE DEFICIENCY SYNDROME

25.5-6-501 to 25.5-6-508. (Repealed)

Source: L. 2018: Entire part repealed, (SB 18-093), ch. 62, p. 610, § 2, effective August 8.

Editor's note: This part 5 was added in 2006. For amendments to this part 5 prior to its repeal in 2018, consult the 2017 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

Cross references: For the legislative declaration in SB 18-093, see section 1 of chapter 62, Session Laws of Colorado 2018.

PART 6

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH MAJOR MENTAL HEALTH DISORDERS

25.5-6-601. Short title.

The short title of this part 6 is the "Home- and Community-based Services for Persons with Major Mental Health Disorders Act".

Source: L. 2006: Entire article added with relocations, p. 1951, § 7, effective July 1. **L. 2018:** Entire section amended, (SB 18-091), ch. 35, p. 388, § 27, effective August 8.

Editor's note: This section is similar to former § 26-4-671 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018.

25.5-6-602. Legislative declaration - no entitlement created.

(1) The general assembly finds and declares that the purpose of this part 6 is to provide, under federal authorization and subject to available appropriations, home- and community-based services for persons with major mental health disorders.

(2) Nothing in this part 6 shall be construed to establish that eligible persons as defined in section 25.5-6-603 (1) are entitled to receive services from the state department or the department of human services. The provision of any services pursuant to this part 6 shall be subject to federal waiver authorization and available appropriations.

Source: L. 2006: Entire article added with relocations, p. 1951, § 7, effective July 1. **L. 2018:** (1) amended, (SB 18-091), ch. 35, p. 388, § 28, effective August 8.

Editor's note: This section is similar to former § 26-4-672 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018.

25.5-6-603. Definitions.

As used in this part 6, unless the context otherwise requires:

(1) "Eligible person" means a person:

(a) Who has a primary diagnosis of a major mental health disorder, as such term is defined in the diagnostic and statistical manual of mental disorders used by the mental health profession, and includes schizophrenic, paranoid, major affective, and schizoaffective disorders, and atypical psychosis, but does not include dementia diseases and related disabilities;

(b) Who is in need of the level of care available in a nursing facility;

(c) Who is categorically eligible for medical assistance, or whose gross income does not exceed three hundred percent of the current federal supplemental security income benefit level, and whose resources do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101.

Source: L. 2006: Entire article added with relocations, p. 1951, § 7, effective July 1. **L. 2017:** (1)(a) amended, (SB 17-242), ch. 263, p. 1330, § 209, effective May 25. **L. 2018:** (1)(a) amended, (HB 18-1091), ch. 74, p. 644, § 7, effective August 8.

Editor's note: This section is similar to former § 26-4-673 as it existed prior to 2006.

Cross references: (1) For additional definitions applicable to this part 6, see § 25.5-4-103.

(2) For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017.

25.5-6-604. Cost of services.

Home- and community-based services for persons with major mental health disorders must meet aggregate federal waiver budget neutrality requirements.

Source: L. 2006: Entire article added with relocations, p. 1952, § 7, effective July 1. **L. 2018:** Entire section amended, (SB 18-091), ch. 35, p. 389, § 29, effective August 8.

Editor's note: This section is similar to former § 26-4-673.5 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018.

25.5-6-605. Relationship to single entry point for long-term care - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1952, § 7, effective July 1. **L. 2018:** Entire section amended, (SB 18-091), ch. 35, p. 389, § 30, effective August 8. **L. 2021:** (2) added by revision, (HB 21-1187), ch. 83, pp. 353, 354 §§ 69, 70.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-674 as it existed prior to 2006.

(2) Subsection (2) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

Cross references: For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018.

25.5-6-606. Implementation of program for persons with mental health disorders authorized - federal waiver - duties of the department of health care policy and financing and the department of human services - rules.

(1) The state department is authorized to seek any necessary waiver from the federal government to develop and implement a home- and community-based services program for persons with major mental health disorders. The program must be designed to provide home- and community-based services to eligible persons. Eligibility may be limited to persons who meet the level of services provided in a nursing facility, and services for eligible persons may be established in state board rules to the extent such eligibility criteria and services are authorized or required by federal waiver.

(2) The state department and the department of human services shall provide a system of reimbursement for services provided pursuant to this part 6 that encourages the most cost-effective provision of services.

(3) The state department and the department of human services shall, subject to appropriation, use available federal, state, local, or private funds, including but not limited to medicaid funds available under Title XIX of the federal "Social Security Act", as amended, to carry out the purposes of this part 6.

(4) The state department may include in the memorandum of understanding with the department of human services provisions that allow the department of human services to certify agencies as medicaid providers for the purposes of this part 6, to adopt fiscal and administrative procedures, to review plans of care, to recommend reimbursement rates, to make recommendations regarding the scope, duration, and content of programs and the eligibility of persons for specific services provided pursuant to this part 6, and to fulfill any other responsibilities necessary to implement this part 6. However, the provisions shall be consistent with the designation of the state department as the single state agency in section 25.5-4-104.

(5) The executive director and the state board shall promulgate such rules regarding this part 6 as are necessary to fulfill the obligations of the state department as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended.

(6) The department of human services shall promulgate such rules as are necessary to perform its function pursuant to this part 6. Such rules shall be promulgated in accordance with section 24-4-103, C.R.S., and shall be consistent with the rules of the executive director and the state board.

(7) In the event a direct conflict arises between the rules of the state department promulgated pursuant to subsection (5) of this section and the rules of the department of human services promulgated pursuant to subsection (6) of this section, regarding implementation of this part 6, the rules of the state department shall control.

(8) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(I) A reimbursement system with a goal to incentivize and increase transportation provider participation;

(II) How the state department will ensure compliance with applicable federal laws and waiver requirements;

(III) A system of common reporting to ensure a member does not exceed the medicaid benefit in a multi-provider scenario; and

(IV) Best practices based on what other states have done to allow transportation network companies to provide nonmedical transportation services for individuals receiving services, including but not limited to, reimbursement rates; driver compensation; and integration with programs that provide nonmedical transportation services.

(b) In developing the report, the state department shall engage in a stakeholder process that includes individuals with intellectual and developmental disabilities and their families, individuals with disabilities, and transportation network companies. The report may be developed in conjunction with the reporting requirement in sections 25.5-6-307(6), 25.5-6-409 (6), 25.5-6-704 (8), and 25.5-6-1303 (9).

(c) (I) Upon completion of the report described in subsection (8)(a) of this section, the state department shall analyze and review each operational transportation network company, as defined in section 40-10.1-602 (3). The state department shall verify each transportation network company's viability to ensure the health, safety, welfare, cost effectiveness, and capability in expanding nonmedical transportation services for individuals receiving services pursuant to this section and comply with all rules promulgated pursuant to subsection (8)(e)(I) of this section.

(II) No later than July 1, 2024, the state department shall authorize verified transportation network companies to provide nonmedical transportation services if the state department finds the transportation network company viable under federal requirements and within budgetary constraints.

(III) For the purposes of this subsection (8)(c), "verify" means a transportation network company meets all requirements resulting from the report described in subsection (8)(a) of this section.

(d) The state department may seek any necessary federal authorization for the implementation of this subsection (8).

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid members, transportation network companies, current providers and drivers for nonmedical transportation services, and other parties interested in developing the requirements.

(II) Pursuant to section 40-10.1-105 (1)(l), transportation network companies are not subject to regulation by the public utilities commission when providing nonmedical transportation

services pursuant to this section and are instead subject to rules promulgated by the state department pursuant to this subsection (8)(e).

(f) This subsection (8) does not apply to a provider authorized to provide transportation services pursuant to part 8 of article 1 of title 25.5 prior to August 10, 2022.

Source: L. 2006: Entire article added with relocations, p. 1952, § 7, effective July 1. **L. 2018:** (1) amended, (SB 18-091), ch. 35, p. 389, § 31, effective August 8. **L. 2022:** (8) added, (HB 22-1114), ch. 396, p. 2818, § 4, effective August 10. **L. 2023:** (1) amended, (SB 23-289), ch. 270, p. 1608, § 7, effective July 1, 2025. **L. 2024:** (8)(a)(III) and (8)(e)(I) amended, (SB 24-176), ch. 152, p. 668, § 87, effective August 7.

Editor's note: This section is similar to former § 26-4-675 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018. For the legislative declaration in HB 22-1114, see section 1 of chapter 396, Session Laws of Colorado 2022.

25.5-6-607. Implementation of part contingent upon receipt of federal waiver - repeal of part.

(1) The implementation of this part 6 is conditioned upon the issuance of necessary waivers by the federal government and available appropriations. The provisions of this part 6 shall be implemented to the extent authorized by federal waiver. The state department shall propose legislation that conforms with the waiver provisions no later than the next regular legislative session following the issuance of the waiver.

(2) Provisions of this part 6 that are approved by the federal government and are authorized by federal waiver shall remain in effect only for so long as specified in the federal waiver, unless otherwise extended by the federal government. The state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this part 6 shall be repealed, effective July 1 of the year in which the waiver is terminated.

Source: L. 2006: Entire article added with relocations, p. 1953, § 7, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-676 as it existed prior to 2006.

(2) As of publication date, the revisor of statutes has not received the notice referred to in subsection (2).

PART 7

HOME- AND COMMUNITY-BASED SERVICES FOR PERSONS WITH BRAIN INJURY

25.5-6-701. Short title.

This part 7 shall be known and may be cited as the "Home- and Community-based Services for Persons with Brain Injury Act".

Source: L. 2006: Entire article added with relocations, p. 1953, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-681 as it existed prior to 2006.

25.5-6-702. Legislative declaration - no entitlement created.

(1) The general assembly hereby finds and declares that the purpose of this part 7 is to provide, under federal authorization and subject to available appropriations, home- and community-based services for persons with brain injury.

(2) Nothing in this part 7 shall be construed to establish that eligible persons as defined in section 25.5-6-703 (4) are entitled to receive services from the state department. The provision of any services pursuant to this part 7 shall be subject to federal waiver authorization and available appropriations.

Source: L. 2006: Entire article added with relocations, p. 1953, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-682 as it existed prior to 2006.

25.5-6-703. Definitions.

As used in this part 7, unless the context otherwise requires:

(1) "Adult day care" means health and social services furnished two or more hours per day on a regularly scheduled basis for one or more days per week in an outpatient setting and for the purpose of ensuring the optimal functioning of the member.

(2) "Behavioral programming" means an individualized plan that sets forth strategies to decrease a member's maladaptive behaviors that interfere with the member's ability to remain in the community. Behavioral programming includes a complete assessment of maladaptive behaviors of the member, the development and implementation of a structured behavioral intervention plan, continuous training and supervision of caregivers and behavioral aides, and periodic reassessment of the individualized plan.

(3) "Brain injury" means an injury to the brain arising from external forces including, but not limited to, toxic chemical reactions, anoxia, near drownings, closed or open head injuries, and focal brain injuries.

(4) "Eligible person" means a person:

(a) Who has a diagnosis of brain injury, as such term is defined in subsection (3) of this section;

(b) Who is in need of the level of care available in a hospital, rehabilitation hospital, hospital in lieu of a nursing facility, or is in need of specialized care provided in a nursing facility in lieu of a hospital;

(c) Who is categorically eligible for medical assistance, or has a gross income that does not exceed three hundred percent of the current federal supplemental security income benefit level and resources that do not exceed the limit established for individuals receiving a mandatory minimum state supplementation of supplemental security income benefits or, in the case of a person who is married, do not exceed the amount authorized in section 25.5-6-101; and

(d) For whom the cost of services would not exceed the average cost of hospital care.

(5) "Independent living skills training" means skills and therapies that are directed at the development and maintenance of community living skills and community integration. Independent living skills include supervision or training with respect to or assistance with self-care, communication skills, socialization, sensory and motor development, reducing maladaptive behavior, community living and mobility, and therapeutic recreation.

(6) Repealed.

(7) "Structured day treatment" means structured, nonresidential therapeutic treatment services that are directed at the development and maintenance of community living skills and are provided two or more hours per day on a regularly scheduled basis for one or more days per week. Day treatment services include supervision and specific training that allows a member to function at the member's maximum potential. The services include, but are not limited to, social

skills training that allows for reintegration into the community, sensory and motor development services, and services aimed at reducing maladaptive behavior.

(8) "Supported living" means assistance or support designed to maximize or maintain independence and self-direction on a supportive care campus. Supported living services consist of structured interventions designed to provide:

(a) Protective oversight and supervision;

(b) Behavioral management and cognitive supports;

(c) Interpersonal and social skills development;

(d) Improved household management skills to support independence and community integration; and

(e) Medical management.

(9) "Supportive care campus" means a residential campus that provides supported living services.

(10) "Transitional living" means a nonmedical residential program that provides training and twenty-four-hour supervision to a member that will enhance the member's ability to live more independently.

Source: L. 2006: Entire article added with relocations, p. 1954, § 7, effective July 1. **L. 2014:** (10) amended, (SB 14-160), ch. 153, p. 531, § 1, effective May 9. **L. 2023:** (6)(b) added by revision, (SB 23-289), ch. 270, pp. 1608, 1611 §§ 8, 19. **L. 2024:** (1), (2), (6)(a), (7), and (10) amended, (SB 24-176), ch. 152, p. 668, § 88, effective August 7.

Editor's note: (1) This section is similar to former § 26-4-683 as it existed prior to 2006.

(2) Subsection (6)(b) provided for the repeal of subsection (6), effective July 1, 2025. (See L. 2023, pp. 1608, 1611.)

Cross references: For additional definitions applicable to this part 7, see § 25.5-4-103.

25.5-6-704. Implementation of home- and community-based services program for persons with brain injury authorized - federal waiver - duties of the department - rules.

(1) (a) The state department is hereby authorized to seek any necessary waiver from the federal government to develop and implement a home- and community-based services program for persons with brain injury. The state department shall design the program to provide home- and community-based services to eligible persons. Eligibility shall be limited to persons who meet the level of services provided in a hospital, rehabilitation hospital, hospital in lieu of nursing facility care, or who are in need of specialized care provided in a nursing facility in lieu of a hospital.

(b) The state department shall seek any necessary amendments to the current federal waiver for the home- and community-based services program for persons with brain injury to allow supported living, as defined in section 25.5-6-703 (8), to be provided to eligible persons on a supportive care campus.

(2) Services for eligible persons may be established in department rules to the extent authorized or required by federal waiver, but must include at least the following:

(a) Independent living skills training, as indicated in the eligible person's plan of care, and provided by local agencies determined by the department to be qualified to provide the services;

(b) Residential care including, but not limited to:

(I) Transitional living;

(II) Respite care;

(III) Supported living;

(c) Repealed.

(d) Assisted transportation;

(e) Counseling and training including treatment for substance use disorders and family counseling;

(f) Environmental modification services;

(g) Day care, which may include physical, occupational, and speech therapies as indicated in the eligible person's plan of care;

(h) Structured day treatment, which may include physical, occupational, speech, and cognitive therapies if deemed necessary by the eligible person's case manager and as indicated in the person's plan of care. Structured day treatment services are for individuals who may benefit from continued rehabilitation and reintegration into the community.

(i) Behavioral programming that may be provided in or outside an eligible person's residence;

(j) Assistive technology;

(k) Repealed.

(3) The case manager, in coordination with the eligible person and the person's family or guardian, shall include in each plan of care a process by which the eligible person may receive necessary care, which may include respite care, if the eligible person's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible person and the person's family or guardian shall be duly informed by the case manager of these alternative care provisions at the time the plan of care is initiated.

(4) (a) The department shall provide a system of reimbursement for services provided pursuant to this part 7 that encourages the most cost-effective provision of services.

(b) A member of an eligible person's family, other than the person's spouse or a parent of a minor, may be employed to provide personal care services to such person. The maximum reimbursement for the services provided by a member of the person's family per year for an eligible person shall not exceed the equivalent of four hundred forty-four service units per year for a member of the eligible person's family. Standards that apply to other providers who provide personal care services apply to a family member who provides these services. In addition, a registered nurse shall supervise a family member in providing services to the extent indicated in the eligible person's plan of care.

(5) The state department shall, subject to appropriation, use available federal, state, local, or private funds including, but not limited to, medicaid funds available under Title XIX of the federal "Social Security Act", as amended, to carry out the purposes of this part 7.

(6) The state board shall adopt rules concerning the certification of agencies as medicaid providers for the purposes of this part 7, fiscal and administrative procedures, procedures for reviewing plans of care, reimbursement rates, and the scope, duration, and content of programs and the eligibility for specific services provided pursuant to this part 7. The state board shall adopt such rules as are necessary to fulfill the obligations of the state department as the single state agency to administer medical assistance programs in accordance with Title XIX of the federal "Social Security Act", as amended.

(7) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(I) A reimbursement system with a goal to incentivize and increase transportation provider participation;

(II) How the state department will ensure compliance with applicable federal laws and waiver requirements;

(III) A system of common reporting to ensure a member does not exceed the medicaid benefit in a multi-provider scenario; and

(IV) Best practices based on what other states have done to allow transportation network companies to provide nonmedical transportation services for individuals receiving services, including but not limited to, reimbursement rates; driver compensation; and integration with programs that provide nonmedical transportation services.

(b) In developing the report, the state department shall engage in a stakeholder process that includes individuals with intellectual and developmental disabilities and their families, individuals with disabilities, and transportation network companies. The report may be developed in conjunction with the reporting requirement in sections 25.5-6-307 (6), 25.5-6-409 (6), 25.5-6-606 (9), and 25.5-6-1303 (9).

(c) (I) Upon completion of the report described in subsection (7)(a) of this section, the state department shall analyze and review each operational transportation network company, as defined in section 40-10.1-602 (3). The state department shall verify each transportation network company's viability to ensure the health, safety, welfare, cost effectiveness, and capability in expanding nonmedical transportation services for individuals receiving services pursuant to this section and comply with all rules promulgated pursuant to subsection (7)(e)(I) of this section.

(II) No later than July 1, 2024, the state department shall authorize verified transportation network companies to provide nonmedical transportation services if the state department finds the transportation network company viable under federal requirements and within budgetary constraints.

(III) For the purposes of this subsection (7)(c), "verify" means a transportation network company meets all requirements resulting from the report described in subsection (7)(a) of this section.

(d) The state department may seek any necessary federal authorization for the implementation of this subsection (7).

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid members, transportation network companies, current providers and drivers for nonmedical transportation services, and other parties interested in developing the requirements.

(II) Pursuant to section 40-10.1-105 (1)(l), transportation network companies are not subject to regulation by the public utilities commission when providing nonmedical transportation services pursuant to this section and are instead subject to rules promulgated by the state department pursuant to this subsection (7)(e).

(f) This subsection (7) does not apply to a provider authorized to provide transportation services pursuant to part 8 of article 1 of title 25.5 prior to August 10, 2022.

Source: L. 2006: Entire article added with relocations, p. 1955, § 7, effective July 1. **L. 2017:** IP(2) and (2)(e) amended, (SB 17-242), ch. 263, p. 1330, § 210, effective May 25. **L. 2022:** (7) added, (HB 22-1114), ch. 396, p. 2820, § 5, effective August 10. **L. 2023:** (2)(c)(II) and (2)(k)(II) added by revision, (SB 23-289), ch. 270, pp. 1608, 1611 §§ 9, 19. **L. 2024:** (7)(a)(III) and (7)(e)(I) amended, (SB 24-176), ch. 152, p. 669, § 89, effective August 7.

Editor's note: (1) This section is similar to former § 26-4-684 as it existed prior to 2006.

(2) Subsections (2)(c)(II) and (2)(k)(II) provided for the repeal of subsections (2)(c) and (2)(k), respectively, effective July 1, 2025. (See L. 2023, pp. 1608, 1611.)

Cross references: For the legislative declaration in SB 17-242, see section 1 of chapter 263, Session Laws of Colorado 2017. For the legislative declaration in HB 22-1114, see section 1 of chapter 396, Session Laws of Colorado 2022.

25.5-6-705. Implementation of part contingent upon receipt of federal waiver - repeal of part.

(1) (a) The implementation of this part 7 is conditioned upon the issuance of necessary waivers by the federal government and available appropriations. The provisions of this part 7 shall be implemented to the extent authorized by federal waiver. The state department shall propose legislation that conforms with the waiver provisions no later than the next regular legislative session following the issuance of the waiver.

(b) The implementation of the provisions of this part 7 relating to services provided on a supportive care campus are conditioned upon the approval of necessary waiver amendments by the federal government. The provisions of this part 7 relating to supported living shall be implemented to the extent authorized by federal waiver and in accordance with applicable federal requirements.

(2) Provisions of this part 7 that are approved by the federal government and are authorized by federal waiver shall remain in effect only for so long as specified in the federal waiver, unless otherwise extended by the federal government. The state department shall provide written notice to the revisor of statutes of the final termination date of the waiver, and this part 7 shall be repealed, effective July 1 of the year in which the waiver is terminated.

Source: L. 2006: Entire article added with relocations, p. 1957, § 7, effective July 1.

Editor's note: (1) This section is similar to former § 26-4-685 as it existed prior to 2006.

(2) As of publication date, the revisor of statutes has not received the notice referred to in subsection (2).

25.5-6-706. Rate structure - rules - quality assurance.

(1) (a) The state board, by rule, shall set tiered per diem rates for services provided on a supportive care campus under this part 7. When structuring the tiered per diem rates, the state board shall consider the medical and cognitive needs of eligible persons being served on the supportive care campus.

(b) The maximum per diem rate for the services provided on a supportive care campus shall not exceed the total per diem cost of comparable populations either in institutions or in other community-based settings.

(2) The state board shall adopt rules necessary for quality assurance, which shall include certification of supportive care campuses.

Source: L. 2006: Entire article added with relocations, p. 1958, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-686 as it existed prior to 2006.

PART 8

HOME- AND COMMUNITY-BASED SERVICES FOR CHILDREN WITH AUTISM

25.5-6-801 to 25.5-6-806. (Repealed)

Source: L. 2023: Entire part repealed, (SB 23-289), ch. 270, p. 1611, § 18, effective May 25.

Editor's note: This part 8 was added in 2006. For amendments to this part 8 prior to its repeal in 2023, consult the 2022 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

PART 9

HOME- AND COMMUNITY-BASED SERVICE PROGRAMS FOR CHILDREN

25.5-6-901. Disabled children care program - eligibility criteria - documentation requirements - report to the general assembly - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1960, § 7, effective July 1. **L. 2025:** (5) added by revision, (HB 25-1003), ch. 50, p. 223, §§ 6, 7.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-509 as it existed prior to 2006.

(2) Subsection (5) provided for the repeal of this section, effective July 1, 2026. (See L. 2025, p. 223.)

25.5-6-902. Children's personal assistance services and family support program.

(1) The general assembly finds that many families who attempt to care for severely disabled or terminally ill children at home often are burdened with the excessive financial and personal costs of providing continuous care. Private insurance companies rarely support essential, long-term custodial services and often establish monetary limits that are well below the levels required by these disabled children. When coverage is available, care is frequently provided in a medical

model that is marginally appropriate to the needs of the children and the family and usually more expensive to the payer. The resulting pressures often contribute to family disintegration and increased dependency on public programs. The general assembly finds that it is in the best interests of the citizens of the state to encourage the preservation of families with children with disabilities.

(2) As used in this section, unless the context otherwise requires, "eligible disabled children" means children eighteen years of age or younger:

(a) Who have medical needs that, pursuant to state department rules, would qualify them for institutionalization or place them at risk of institutionalization in an acute care hospital or nursing facility;

(b) Who have gross incomes, including the amount of parental income and resources to be attributed to the child's gross income according to rules to be promulgated by the state board, that do not exceed three hundred percent of the current federal supplemental security income benefit level;

(c) Who are not receiving long-term services from any alternative waiver program established under this title;

(d) For whom a licensed physician or an advanced practice registered nurse has certified that in-home care is an appropriate way to meet the child's needs; and

(e) For whom the cost of care outside of the institution is no higher than the estimated medicaid cost of appropriate institutional care.

(3) There is hereby established in the state department the children's personal assistance services and family support waiver program, referred to in this section as the "program", to provide services to eligible disabled children in their homes rather than in the confines of an acute care hospital or nursing facility. The number of children enrolled in this program or any other model 200 program shall not exceed the state department's ability to cover the costs of the programs within the annual appropriations for this program and any other model 200 program.

(4) Priority for participation in the program shall be given first to children who are on the waiting list for other model 200 programs and secondly to children whose parents will return to work if appropriate care for their disabled child is provided under the program. Spaces in the program shall also be available to children who were already covered by medicaid but who were rendered temporarily ineligible for a period of not more than three months due to a periodic or cyclical peak in their parents' income.

(5) The state board shall adopt rules to govern the program consistent with any federal waivers including, but not limited to, rules concerning:

(a) Services that are reimbursable under this section including, but not limited to:

(I) Respite care, to the degree its additional cost is offset by collection of a parental copayment;

(II) Case management; and

(III) Medically necessary professional or community services beyond those specified in section 25.5-5-102 or 25.5-5-202, to the degree that they provide a cost-effective and medically appropriate alternative to covered services;

(b) Provider selection and certification;

(c) Documentation for assessment and recertification;

(d) Repealed.

(e) Reimbursement.

(6) The case management agency, in coordination with the eligible disabled child's family and the child's physician, shall include in each case plan a process by which the eligible disabled child may receive necessary care, which may include respite care, if the eligible disabled child's family or care provider is unavailable due to an emergency situation or to unforeseen circumstances. The eligible disabled child's family shall be duly informed by the case management agency of these alternative care provisions at the time the case plan is initiated.

(7) If the state department finds it cost-effective and all necessary federal waivers are obtained, parents of eligible disabled children may be authorized to hire and manage care providers from certified medicaid agencies. Case management agencies shall work with parents to develop the skills necessary for ongoing care management.

(8) The state department is authorized to seek waivers from the federal government to qualify for federal financial participation in the program.

(9) The state department is authorized to charge and collect copayments from parents for services rendered.

(10) The state department is directed to study the advisability of setting an upper limit on parental income for participation in this program and other children's medicaid waiver programs.

Source: L. 2006: Entire article added with relocations, p. 1962, § 7, effective July 1. **L. 2008:** (2)(d) amended, p. 134, § 22, effective January 1, 2009. **L. 2021:** (5)(d)(II) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70.

Editor's note: (1) This section is similar to former § 26-4-509.2 as it existed prior to 2006.

(2) Subsection (5)(d)(II) provided for the repeal of subsection (5)(d), effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-6-903. Residential child health-care program - waiver - home- and community-based services - rules.

(1) Subject to federal authorization, the state department shall implement a program for medicaid-eligible children with intellectual and developmental disabilities, as defined in section 25.5-10-202, with significant behavioral support needs who are at risk of institutionalization. The state board shall establish, by rule, the type of services provided pursuant to the program, to the extent the services are cost-efficient, and the member eligibility criteria that may include, but are not limited to, a medical necessity determination and a financial eligibility determination.

(2) The state department may limit the number of participants in the program in accordance with any federal waiver obtained by the state department to implement this section.

(3) The state board shall promulgate rules as necessary for the implementation and administration of the program, including but not limited to rules regarding program services; eligibility criteria, including financial eligibility criteria; and reimbursement of providers.

(4) This section will take effect if the federal department of health and human services approves a redesigned children's habilitation residential program waiver for medicaid-eligible children with intellectual and developmental disabilities, as defined in section 25.5-10-202, who have complex behavioral support needs, pursuant to House Bill 18-1328, as enacted in 2018. The executive director of the state department shall notify the revisor of statutes in writing of the date on which the condition specified in this section has occurred by emailing the notice to revisorofstatutes.ga@coleg.gov. This section takes effect, effective upon the date identified in the notice that the federal department of health and human services approved the waiver or, if the notice does not specify that date, upon the date of the notice to the revisor of statutes.

Source: L. 2018: Entire section added, (HB 18-1328), ch. 184, p. 1243, § 3, effective June 7, 2019. **L. 2024:** (1) amended, (SB 24-176), ch. 152, p. 669, § 90, effective August 7.

Editor's note: Section 10 of chapter 184 (HB 18-1328), Session Laws of Colorado 2018, provides that section 3 of the act adding this section takes effect upon notice to the revisor of statutes pursuant to § 25.5-5-306 (6) as enacted in section 2 of the act. For more information, see HB 18-1328. (L. 2018, p. 1247.) On August 14, 2019, the revisor of statutes received the notice referred to in subsection (4) and § 25.5-5-306 (6) that the federal department of health and human services approved the waiver on June 7, 2019.

Cross references: For the legislative declaration in HB 18-1328, see section 1 of chapter 184, Session Laws of Colorado 2018.

25.5-6-904. Children with complex health needs waiver program - federal authorization - rules - legislative declaration - definitions.

(1) The general assembly finds and declares that:

(a) Due to changes in the state's medical assistance program, it is necessary to merge the current disabled children care program established pursuant to section 25.5-6-901 and the pediatric hospice care program established pursuant to section 25.5-5-305 into a children with complex health needs waiver program; and

(b) Combining the programs will allow the state department to streamline home- and community-based services for children, expand access to services, and ensure eligible children continued access to necessary services.

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

(a) "Bereavement services" means counseling provided to eligible children or their family members to guide and help children and families cope with an eligible child's complex health needs and the stress that accompanies the continuous care for a child with complex health needs.

(b) "Palliative care" means a specific program of specialized medical care, including care coordination and pain and symptom management, for eligible children that is offered by a licensed health-care facility or provider and that is specifically focused on the provision of services in order to:

(I) Provide eligible children with relief from the symptoms, pain, and stress of complex health needs, whatever the diagnosis; and

(II) Improve the quality of life for both the eligible child and the child's family.

(c) "Respite care services" means short-term services provided to an eligible child in the child's home or in a facility approved by the state department in order to temporarily relieve the child's family or other home care providers from the care and maintenance of the eligible child, including room and board, personal care, and other related services.

(3) (a) The state department shall seek any federal authorization necessary to implement a waiver program for children with complex health needs. The state board shall establish, by rule, to the extent authorized or required by the federal waiver, the types of services provided by the waiver program, which must include respite care services, palliative care, and bereavement services.

(b) A child is eligible for the waiver program if the child is under nineteen years of age, is eligible for the state medical assistance program pursuant to this article 6 and articles 4 and 5 of this title 25.5, and has a life-limiting illness or qualifies for nursing facility or hospital level of care.

(4) The children with complex health needs waiver program, as authorized pursuant to this section, must meet aggregate federal waiver budget neutrality requirements.

Source: L. 2025: Entire section added, (HB 25-1003), ch. 50, p. 221, § 1, effective July 1.

PART 10

CONSUMER-DIRECTED ATTENDANT SUPPORT FOR PERSONS WITH DISABILITIES

25.5-6-1001 to 25.5-6-1004. (Repealed)

Editor's note: (1) This article was added with relocations in 2006, and this part 10 was subsequently repealed in 2009. For amendments to this part 10 prior to its repeal in 2009, consult the Colorado statutory research explanatory note beginning on page vii in the front of this volume and the editor's note following the article heading.

(2) Section 25.5-6-1004 provided for the repeal of this part 10, effective July 1, 2009. (See L. 2006, p. 1967.)

PART 11

CONSUMER-DIRECTED CARE

25.5-6-1101. Definitions.

As used in this part 11, unless the context otherwise requires:

(1) "Attendant support" means any action to assist an eligible person in accomplishing activities of daily living, instrumental activities of daily living, and habilitative and health-related tasks. Such activities include, but are not limited to, personal care services, household services, cognitive services, mobility services, and health-related tasks.

(2) "Authorized representative" means an individual designated by the eligible person, by the parent of a minor, or by the legal guardian of the eligible person if the eligible person cannot

demonstrate sound judgment to his or her primary care physician, who has the judgment and ability to assist the eligible person in acquiring and utilizing services under this part 11. The extent of the authorized representative's involvement shall be determined upon designation.

(3) "Consumer-directed" means that an eligible person receives a direct payment through a voucher and employs, trains, and in other ways manages the person who provides his or her attendant support. The direct payment through a voucher that is received by an eligible person to pay for attendant support shall not be counted as income for purposes of determining eligibility for medicaid and other state programs that use income to determine eligibility.

(4) "Eligible person" means a person who is eligible to receive services pursuant to part 19 of this article 6.

(5) "Primary care physician" means a physician who is the primary provider of physician services to the eligible person or who is familiar with the eligible person's needs and capabilities.

(6) "Qualified services" means services provided under the eligible person's community first choice option.

Source: L. 2006: Entire article added with relocations, p. 1967, § 7, effective July 1. **L. 2023:** (4) and (6) amended, (SB 23-289), ch. 270, p. 1608, § 10, effective July 1, 2025.

Editor's note: This section is similar to former § 26-4-1301 as it existed prior to 2006.

Cross references: For additional definitions applicable to this part 11, see § 25.5-4-103.

25.5-6-1102. Service model - consumer-directed care.

(1) The state department shall implement a consumer-directed care service model that allows eligible persons to receive a direct payment through a voucher to purchase qualified services. The state department is authorized to seek any federal waivers or waiver amendments that may be necessary to implement this part 11. The state department shall design and implement the consumer-directed care service model with input from consumers of home- and community-based services or their authorized representatives. An eligible person shall not be required to disenroll from the person's waiver program in order to receive qualified services through the consumer-directed care service model.

(2) In order to qualify and to remain eligible for the consumer-directed care service model authorized by this section, a person shall:

(a) Be eligible for community first choice services pursuant to part 19 of this article 6;

(b) Be willing to participate;

(c) Obtain a statement from his or her primary care physician or advanced practice registered nurse indicating that the person has sound judgment and the ability to direct his or her care or has an authorized representative;

(d) Demonstrate the ability to handle the financial aspects of self-directed care or has an authorized representative who is able to handle the financial aspects of the eligible person's care; and

(e) Meet any other qualifications established by the state board by rule.

(3) The allocation issued to the eligible person pursuant to this part 11 must be based on the eligible person's historical utilization of home- and community-based services pursuant to parts 3 to 12 of this article 6, the case management agency's care plan, or any approved resource allocation process as determined by the state department and the department of human services for the eligible person.

(4) While an eligible person is participating in the consumer-directed care service model established in this part 11, that person shall be ineligible to receive a home care allowance as provided in section 26-2-122.3 (1)(b), C.R.S.

(5) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars, to promote effective and efficient delivery of services, and to monitor the safety and welfare of eligible persons under this part 11.

(6) The state board shall adopt rules as necessary for the implementation and administration of the consumer-directed care service model authorized by this part 11. Such rules shall include a provision allowing an eligible person to designate a family member or authorized representative to be responsible for managing the financial matters associated with the consumer-directed care or to direct the eligible person's care. The designee shall not receive reimbursement for managing the financial matters associated with the eligible person's care or for directing the eligible person's care.

(7) Sections 12-255-104 (7), (8.5), and (11), 12-255-125 (1), and 12-255-214 (1)(b) shall not apply to a person who is directly employed by an individual participating in the consumer-directed care service model pursuant to this section and who is acting within the scope and course of such employment. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(8) Repealed.

(9) A person who has been designated as an authorized representative under this part 11 shall submit an affidavit, which shall become part of the eligible person's file, stating that:

(a) He or she is at least eighteen years of age;

(b) He or she has known the eligible person for at least two years;

(c) He or she has not been convicted of any crime involving exploitation, abuse, or assault on another person; and

(d) He or she does not have a mental, emotional, or physical condition that could result in harm to the eligible person.

Source: L. 2006: Entire article added with relocations, p. 1968, § 7, effective July 1. **L. 2008:** (2)(c) amended, p. 134, § 24, effective January 1, 2009. **L. 2019:** (7) amended, (HB 19-1172), ch. 136, p. 1710, § 189, effective October 1. **L. 2020:** (7) amended, (HB 20-1183), ch. 157, p. 703, § 61, effective July 1. **L. 2021:** (3) amended, (HB 21-1187), ch. 83, p. 336, § 36, effective July 1, 2024. **L. 2023:** (2)(a) and (3) amended, (SB 23-289), ch. 270, p. 1609, § 11, effective July 1, 2025; (8)(b) added by revision, (SB 23-289), ch. 270, pp. 1609, 1611, §§ 11, 19.

Editor's note: (1) This section is similar to former § 26-4-1302 as it existed prior to 2006.

(2) Senate Bill 23-289 amended subsection (3) as it will become effective July 1, 2024. (See L. 2021, p. 336.). Senate Bill 23-289 takes effect July 1, 2025.

(3) Subsection (8)(b) provided for the repeal of subsection (8), effective July 1, 2025. (See L. 2023, pp. 1609, 1611.)

25.5-6-1103. Reporting.

(1) The state department shall provide a report to the joint budget committee of the general assembly and the health and human services committees of the house of representatives and the senate, or any successor committees, by October 1, 2006, that includes, but is not limited to, the following:

(a) The number of elderly persons participating in the consumer-directed care program;

(b) The cost-effectiveness of the consumer-directed care program;

(c) Feedback from consumers and the state department concerning the progress and success of the consumer-directed care program; and

(d) Any changes to the health status or health outcomes of the program participants.

Source: L. 2006: Entire article added with relocations, p. 1969, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-1303 as it existed prior to 2006.

PART 12

IN-HOME SUPPORT SERVICES

25.5-6-1201. Legislative declaration - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1970, § 7, effective July 1. **L. 2014:** Entire section amended, (HB 14-1358), ch. 255, p. 1017, § 2, effective August 6; entire section amended, (HB 14-1357), ch. 254, p. 1013, § 1, effective March 1, 2015. **L. 2018:** (2) amended, (SB 18-091), ch. 35, p. 389, § 32, effective August 8. **L. 2023:** (3) added by revision, (SB 23-289), ch. 270, pp. 1609, 1611, §§ 12, 19. **L. 2024:** Entire section amended, (SB 24-176), ch. 152, p. 670, § 91, effective August 7. **L. 2025:** (1) amended, (SB 25-226), ch. 219, p. 1006, § 1, effective August 6.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-1401 as it existed prior to 2006.

(2) SB 25-226 amended subsection (1), effective August 6, 2025, but those amendments did not take effect due to the repeal of this section, effective July 1, 2025.

(3) Subsection (3) provided for the repeal of this section, effective July 1, 2025. (See L. 2023, pp. 1609, 1611.)

Cross references: For the legislative declaration in SB 18-091, see section 1 of chapter 35, Session Laws of Colorado 2018.

25.5-6-1202. Definitions.

As used in this part 12, unless the context otherwise requires:

(1) "Attendant" means a person who is directly employed by an in-home support service agency to provide, or a family member, including a spouse, providing, in-home support services to eligible persons.

(2) "Authorized representative" means an individual designated by the eligible person receiving services, or by the parent or guardian of the eligible person receiving services, if appropriate, who has the judgment and ability to assist the eligible person receiving services in acquiring and utilizing services under this part 12. The extent of the authorized representative's involvement shall be determined upon designation. The authorized representative shall not be the eligible person's service provider.

(3) "Eligible person" means any person who:

(a) Is enrolled in community first choice services pursuant to part 19 of this article 6;

(b) Is willing to participate;

(c) Obtains a statement from his or her primary care physician indicating that the person has sound judgment and the ability to direct his or her care, the eligible child's parent or guardian has sound judgment and the ability to direct the eligible child's care, or the person has an authorized representative; and

(d) Meets any other qualifications established by the state board by rule.

(4) "Health maintenance activities" means routine and repetitive health-related tasks furnished to a member in the community or in the member's home that are necessary for the health and normal bodily functioning that a person with a disability is physically unable to carry out. "Health maintenance activities" includes skilled tasks typically performed by a certified nursing assistant or a licensed nurse that do not require the clinical assessment and judgment of a licensed nurse.

(5) "In-home support service agency" means an agency that is certified by the state department and provides independent living core services as defined in section 8-85-102 (6), C.R.S., and in-home support services.

(6) "In-home support services" means services that are provided in the home and in the community by an attendant under the direction of the eligible person or the eligible person's authorized representative including health maintenance activities and support for activities of daily living or instrumental activities of daily living, and personal care services and homemaker services as defined in rules promulgated by the medical services board pursuant to section 24-4-103, C.R.S.

Source: L. 2006: Entire article added with relocations, p. 1970, § 7, effective July 1. **L. 2014:** (3)(a) amended, (HB 14-1358), ch. 255, p. 1018, § 3, effective August 6; (1), (3)(a), and (6)

amended, (HB 14-1357), ch. 254, p. 1014, § 2, effective March 1, 2015. **L. 2015:** (5) amended, (SB 15-240), ch. 139, p. 423, § 5, effective July 1. **L. 2016:** (5) amended, (SB 16-093), ch. 54, p. 132, § 5, effective July 1. **L. 2019:** (3)(a) amended, (SB 19-164), ch. 371, p. 3386, § 3, effective August 2. **L. 2023:** (3)(a) and (4) amended, (SB 23-289), ch. 270, p. 1610, § 13, effective July 1, 2025.

Editor's note: This section is similar to former § 26-4-1402 as it existed prior to 2006.

Cross references: For additional definitions applicable to this part 12, see § 25.5-4-103.

25.5-6-1203. In-home support services - eligibility - licensure exclusion - in-home support service agency responsibilities - rules.

(1) The state department shall offer in-home support services as an option for eligible persons who receive community first choice services. In-home support services must be provided to eligible persons. The state department shall seek any federal authorization that may be necessary to implement this part 12. The state department shall design and implement in-home support services with input from consumers of community first choice services and independent living centers.

(1.5) Repealed.

(2) An eligible person receiving in-home support services or the eligible person's authorized representative or parent or guardian shall be allowed to:

(a) Choose the eligible person's in-home support service agency or the eligible person's attendant; and

(b) Direct the eligible person's care, including directly scheduling, managing, and supervising the attendant, and determine the level of in-home support services agency support.

(3) Sections 12-255-104 (7), (8.5), and (11), 12-255-125 (1), and 12-255-214 (1)(b) shall not apply to a person who is directly employed by an in-home support service agency to provide in-home support services and who is acting within the scope and course of such employment or is a family member providing in-home support services pursuant to this part 12. However, such person may not represent himself or herself to the public as a licensed nurse, a certified nurse aide, a licensed practical or professional nurse, a registered nurse, or a registered professional nurse. This exclusion shall not apply to any person who has had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

(4) (a) In-home support service agencies providing in-home support services shall provide twenty-four-hour back-up services to the agencies' members. In-home support service agencies shall either contract with or have on staff a state licensed health-care professional, as defined by state board by rule, acting within the scope of the person's profession. The state board shall promulgate rules setting forth the training requirements for attendants providing in-home support services and the oversight and monitoring responsibilities of the state licensed health-care professional that is either contracting with or is on staff with the in-home support service agency. The state board rules must allow the eligible person or the eligible person's authorized representative, parent of a minor, or guardian to determine, in conjunction with the in-home support services agency, the amount of oversight needed in connection with the eligible person's in-home support services.

(b) The state board shall promulgate rules that establish how an in-home support service agency can discontinue a member under this part 12. The rules must establish that a member can only be involuntarily discontinued when equivalent care in the community has been secured or that a member can be discontinued after exhibiting documented prohibited behavior involving attendants, including abuse of attendants, and that dispute resolution has failed. The state department shall determine whether an in-home support service agency has made adequate attempts at resolution.

(5) The case management agencies established in section 25.5-6-1703 are responsible for determining a person's eligibility for in-home support services; except that for eligible disabled children, the state department shall designate the entity that will determine the child's eligibility. The state board shall promulgate rules specifying the case management agencies' responsibilities pursuant to this part 12. At a minimum, the rules must require that case managers discuss the option and potential benefits of in-home support services with all eligible long-term care members.

(6) Repealed.

(7) In administering the provision of in-home support services pursuant to this part 12, the state department shall:

(a) Implement a system for the routine and accurate monitoring of the number of persons receiving in-home support services; and

(b) Provide comprehensive, periodic training for all case management agencies in the state, which training shall include, at a minimum:

(I) The current eligibility requirements for the receipt of in-home support services; and

(II) The location of, and contact information for, the in-home support service agencies providing in-home support services in the state.

Source: L. 2006: Entire article added with relocations, p. 1971, § 7, effective July 1. **L. 2011:** (7) added, (SB 11-105), ch. 277, p. 1244, § 1, effective June 2. **L. 2014:** (1.5) added and (2), (4)(a), and (6) amended, (HB 14-1357), ch. 254, p. 1014, § 3, effective March 1, 2015. **L. 2019:** (1.5) repealed, (SB 19-164), ch. 371, p. 3386, § 4, effective August 2; (3) amended, (HB 19-1172), ch. 136, p. 1711, § 190, effective October 1. **L. 2020:** (3) amended, (HB 20-1183), ch. 157, p. 703, § 62, effective July 1. **L. 2021:** (5) and (7)(b) amended, (HB 21-1187), ch. 83, p. 337, § 37, effective July 1, 2024. **L. 2023:** (1) amended, (SB 23-289), ch. 270, p. 1610, § 14, effective July 1, 2025; (6)(b) added by revision, (SB 23-289), ch. 270, pp. 1610, 1611 §§ 14, 19. **L. 2024:** (4) and (5) amended, (SB 24-176), ch. 152, p. 670, § 92, effective August 7.

Editor's note: (1) This section is similar to former § 26-4-1403 as it existed prior to 2006.

(2) Subsection (6)(b) provided for the repeal of subsection (6), effective July 1, 2025. (See L. 2023, pp. 1610, 1611.)

25.5-6-1204. Provision of services - duties of state department - gifts - grants.

(1) The provision of the in-home support services set forth in this part 12 shall be subject to the availability of federal matching medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended, for payment of the costs for administration and the costs for the provision of such services.

(2) The state department shall seek and utilize any available federal, state, or private funds that are available for carrying out the purposes of this part 12, including but not limited to medicaid funds, pursuant to Title XIX of the federal "Social Security Act", as amended.

(3) The executive director of the state department is authorized to accept and expend on behalf of the state any grants or gifts from any public or private source for the purpose of implementing this part 12.

Source: L. 2006: Entire article added with relocations, p. 1972, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-1404 as it existed prior to 2006.

25.5-6-1205. Accountability - rate structure - rules.

(1) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars and to promote effective and efficient service delivery under this part 12.

(2) The state board, by rule, shall set a separate rate structure for in-home support services provided under this part 12.

(3) The state board shall adopt rules as necessary for the implementation and administration of the in-home support services authorized by this part 12. At a minimum, the rules shall include certification of in-home support service agencies and standards of care for the provision of services under this part 12.

Source: L. 2006: Entire article added with relocations, p. 1972, § 7, effective July 1.

Editor's note: This section is similar to former § 26-4-1405 as it existed prior to 2006.

25.5-6-1206. Report - repeal. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1. **L. 2011:** Entire section amended, (SB 11-105), ch. 277, p. 1244, § 2, effective June 2. **L. 2023:** (2) added by revision, (SB 23-289), ch. 270, pp. 1610, 1611 §§ 15, 19.

Editor's note: (1) Prior to its repeal, this section was similar to former § 26-4-1406 as it existed prior to 2006.

(2) Subsection (2) provided for the repeal of this section, effective July 1, 2025. (See L. 2023, pp. 1610, 1611.)

25.5-6-1207. Repeal of part.

This part 12 is repealed, effective September 1, 2028. Prior to such repeal, in-home support services established under this part 12 shall be reviewed as provided for in section 24-34-104.

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1. **L. 2008:** Entire section amended, p. 323, § 3, effective April 7. **L. 2011:** Entire section amended, (SB 11-105), ch. 277, p. 1245, § 3, effective June 2. **L. 2014:** Entire section amended, (HB 14-1358), ch. 255, p. 1018, § 4, effective August 6. **L. 2019:** Entire section amended, (SB 19-164), ch. 371, p. 3385, § 1, effective August 2.

Editor's note: This section is similar to former § 26-4-1407 as it existed prior to 2006.

25.5-6-1208. Conditional repeal of part. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1. **L. 2011:** Entire section repealed, (SB 11-105), ch. 277, p. 1245, § 4, effective June 2; entire section repealed, (HB 11-1303), ch. 264, p. 1169, § 69, effective August 10.

Editor's note: This section is similar to former § 26-4-1408 as it existed prior to 2006.

PART 13

COMPLEMENTARY AND INTEGRATIVE HEALTH FOR A PERSON WITH A SPINAL CORD INJURY

25.5-6-1301. Legislative declaration.

(1) The general assembly finds that:

(a) A person living with a spinal cord injury, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy could benefit from complementary and integrative health such as chiropractic care, massage therapy, or acupuncture; and

(b) Complementary and integrative health could improve the quality of life and help reduce the need for continuous or more expensive procedures, medications, and hospitalizations for an eligible person and could allow an eligible person to be employed.

Source: L. 2009: Entire part added, (HB 09-1047), ch. 395, p. 2128 § 1, effective August 5. **L. 2015:** Entire section amended, (SB 15-011), ch. 333, p. 1354, § 1, effective June 5. **L. 2025:** Entire section amended, (SB 25-226), ch. 219, p. 1006, § 2, effective August 6.

25.5-6-1302. Definitions.

As used in this part 13, unless the context otherwise requires:

(1) "Complementary or integrative health" means a form of diverse health-care services not provided for under this article 6 or article 4 or 5 of this title 25.5 prior to August 5, 2009, but authorized by the rules of the state board adopted pursuant to section 25.5-6-1303 (4). The health is limited to chiropractic care, massage therapy, and acupuncture performed by licensed providers.

(2) "Eligible person with a disability" means a person with a disability who meets the eligibility criteria specified in section 25.5-6-1303 (2)(b).

(3) "Program" means the program authorized pursuant to section 25.5-6-1303 to allow an eligible person with a disability to receive complementary and integrative health.

Source: L. 2009: Entire part added, (HB 09-1047), ch. 395, p. 2128, § 1, effective August 5. **L. 2015:** (1) and (3) amended, (SB 15-011), ch. 333, p. 1354, § 2, effective June 5. **L. 2025:** (1) and (3) amended, (SB 25-226), ch. 219, p. 1007, § 3, effective August 6.

Cross references: For additional definitions applicable to this part 13, see § 25.5-4-103.

25.5-6-1303. Complementary and integrative health - rules.

(1) (a) The general assembly authorizes the state department to continue operations of a program that would allow an eligible person with a disability to receive complementary or integrative health to the extent authorized by federal waiver. The state department may seek any federal waivers that may be necessary to implement this part 13.

(b) Subject to available funds, it is the intent of the general assembly that the state department enroll every eligible person that applies for the waiver and that an eligible person is not placed on a waiting list for services.

(2) (a) The purpose of the program is to expand the choice of therapies available to eligible persons with disabilities and to produce an overall cost savings for the state compared to the estimated expenditures that would have otherwise been spent for the same persons absent the program.

(b) In order to qualify and to remain eligible for the program authorized by this section, a person must:

(I) Be diagnosed with a primary condition of a spinal cord injury, multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy, with the total inability for independent ambulation directly resulting from one of these diagnoses;

(II) Be willing to participate in the program;

(III) Demonstrate a current need, as further defined in rule by the state board, for complementary or integrative health; and

(IV) Be eligible for medicaid, including but not limited to persons who meet the functional level of care and financial criteria described in rules promulgated by the state board relating to long-term care services.

(c) Repealed.

(d) The program is available to all eligible individuals in Colorado.

(3) The state department shall develop the accountability requirements for the program necessary to safeguard the use of public money and to promote effective and efficient service delivery.

(4) The state board shall adopt rules as necessary for the implementation and administration of the program.

(5) to (7) Repealed.

(8) (a) No later than January 2024, the state department shall submit a report to the senate health and human services committee, the house of representatives public and behavioral health and human services committee, and the house of representatives health and insurance committee, or any successor committees, as part of its "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act" presentation required by section 2-7-203. At a minimum, the report must identify:

(I) A reimbursement system with a goal to incentivize and increase transportation provider participation;

(II) How the state department will ensure compliance with applicable federal laws and waiver requirements;

(III) A system of common reporting to ensure a member does not exceed the medicaid benefit in a multi-provider scenario; and

(IV) Best practices based on what other states have done to allow transportation network companies to provide nonmedical transportation services for individuals receiving services, including but not limited to, reimbursement rates; driver compensation; and integration with programs that provide nonmedical transportation services.

(b) In developing the report, the state department shall engage in a stakeholder process that includes individuals with intellectual and developmental disabilities and their families, individuals with disabilities, and transportation network companies. The report may be developed in conjunction with the reporting requirement in sections 25.5-6-307 (6), 25.5-6-409 (6), 25.5-6-606 (9), and 25.5-6-704 (8).

(c) (I) Upon completion of the report described in subsection (8)(a) of this section, the state department shall analyze and review each operational transportation network company, as defined in section 40-10.1-602 (3). The state department shall verify each transportation network company's viability to ensure the health, safety, welfare, cost effectiveness, and capability in expanding nonmedical transportation services for individuals receiving services pursuant to this section and comply with all rules promulgated pursuant to subsection (8)(e)(I) of this section.

(II) No later than July 1, 2024, the state department shall authorize verified transportation network companies to provide nonmedical transportation services if the state department finds the transportation network company viable under federal requirements and within budgetary constraints.

(III) For the purposes of this subsection (8)(c), "verify" means a transportation network company meets all requirements resulting from the report described in subsection (8)(a) of this section.

(d) The state department may seek any necessary federal authorization for the implementation of this subsection (8).

(e) (I) The state department shall promulgate any necessary rules to ensure transportation network companies comply with federal and state oversight requirements and shall include all relevant stakeholders, including medicaid members, transportation network companies, current providers and drivers for nonmedical transportation services, and other parties interested in developing the requirements.

(II) Pursuant to section 40-10.1-105 (1)(l), transportation network companies are not subject to regulation by the public utilities commission when providing nonmedical transportation services pursuant to this section and are instead subject to rules promulgated by the state department pursuant to this subsection (8)(e).

(f) This subsection (8) does not apply to a provider authorized to provide transportation services pursuant to part 8 of article 1 of title 25.5 prior to August 10, 2022.

Source: L. 2009: Entire part added, (HB 09-1047), ch. 395, p. 2129, § 1, effective August 5. **L. 2015:** (1), (2)(a), (2)(b)(III), (5), and (7) amended and (6) repealed, (SB 15-011), ch. 333, p. 1355, § 3, effective June 5. **L. 2019:** IP(5) amended, (SB 19-197), ch. 335, p. 3089, § 1, effective May 29. **L. 2021:** (1)(a) and (2)(b) amended and (2)(c) and (2)(d) added, (SB 21-038), ch. 404,

p. 2684, § 1, effective September 7. **L. 2022:** (8) added, (HB 22-1114), ch. 396, p. 2821, § 6, effective August 10. **L. 2024:** (5)(c), (8)(a)(III), and (8)(e)(I) amended, (SB 24-176), ch. 152, p. 671, § 93, effective August 7. **L. 2025:** (1)(a), (2)(a), IP(2)(b), (2)(b)(II), (2)(b)(III), (2)(d), (3), and (4) amended and (2)(c), (5), and (7) repealed, (SB 25-226), ch. 219, p. 1007, § 4, effective August 6.

Cross references: For the legislative declaration in HB 22-1114, see section 1 of chapter 396, Session Laws of Colorado 2022.

25.5-6-1304. Repeal of part.

This part 13 is repealed, effective September 1, 2030.

Source: L. 2009: Entire part added, (HB 09-1047), ch. 395, p. 2130, § 1, effective August 5. **L. 2015:** Entire section amended, (SB 15-011), ch. 333, p. 1356, § 4, effective June 5. **L. 2019:** Entire section amended, (SB 19-197), ch. 335, p. 3089, § 2, effective May 29. **L. 2025:** Entire section amended, (SB 25-226), ch. 219, p. 1008, § 5, effective August 6.

PART 14

MEDICAID BUY-IN

Cross references: For the "Ticket to Work and Work Incentives Improvement Act of 1999", see Pub.L. 106-170, codified at 42 U.S.C. sec. 1320b-19.

25.5-6-1401. Legislative declaration.

The general assembly hereby declares its support for the full employment of people with disabilities. It is the general assembly's intent to enact this part 14 for the purpose of allowing an individual with disabilities to purchase medicaid coverage that will enable the individual to maintain employment without losing his or her medicaid benefits.

Source: L. 2008: Entire part added, p. 2197, § 1, effective July 1.

25.5-6-1402. Definitions.

As used in this part 14, unless the context otherwise requires:

(1) "Basic coverage group" means the category of eligibility under the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170, that provides an opportunity to buy into medicaid consistent with the federal "Social Security Act", 42 U.S.C. sec. 1396a (a)(10)(A)(ii)(XV), as amended, for each worker with disabilities who is at least sixteen years of age but less than sixty-five years of age and who, except for earnings, would be eligible for the supplemental security income program. A person who is eligible under the basic coverage group may also be a home- and community-based services waiver member.

(2) "Family" means an individual, the individual's spouse, and any dependent child of the individual.

(3) "Health insurance" means surgical, medical, hospital, major medical, or other health service coverage, including a self-insured health plan, but does not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time, or accident benefits.

(4) "Medicaid buy-in program" means a program that gives each person with disabilities the opportunity to buy into medicaid if the person meets the eligibility criteria specified in section 25.5-6-1404.

(5) "Medical improvement group" means the category of eligibility under the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170, that provides an opportunity to buy into medicaid consistent with the federal "Social Security Act", 42 U.S.C. sec. 1496a (a)(10)(A)(ii)(XV), as amended, for each worker with a medically improved disability who is at least sixteen years of age but less than sixty-five years of age and who was previously in the basic coverage group and is no longer eligible for the basic coverage group due to medical improvement. A person who is eligible under the medical improvement group may also be a home- and community-based services waiver member.

(6) "Work incentives eligibility group" means the category of eligibility under the federal "Balanced Budget Act of 1997", Pub.L. 105-33, 111, as amended, for individuals with a disability who, except for assets or income, would be eligible for the supplemental security income program. This eligibility applies to individuals who are sixty-five years of age or older.

Source: L. 2008: Entire part added, p. 2197, § 1, effective July 1. **L. 2020:** (6) added, (SB 20-033), ch. 237, p. 1150, § 1, effective July 6. **L. 2024:** (1) and (5) amended, (SB 24-176), ch. 152, p. 672, § 94, effective August 7.

Cross references: For additional definitions applicable to this part 14, see § 25.5-4-103.

25.5-6-1403. Waivers and amendments.

(1) Repealed.

(2) If approved by the joint budget committee and subject to available appropriations, the state department shall submit to the federal centers for medicare and medicaid services an amendment to the state medical assistance plan, and shall request any necessary waivers from the secretary of the federal department of health and human services, to permit the state department to expand medical assistance eligibility as provided in this part 14 for the purpose of implementing a medicaid buy-in program for people with disabilities who are in the basic coverage group or the medical improvement group. In addition, the state department shall apply to the secretary of the federal department of health and human services for a medicaid infrastructure grant, if available, to develop and implement the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170.

(3) If the state medical assistance plan amendment and all necessary waivers are approved, the state department shall implement the medicaid buy-in program provided in this part 14 not later than three months after receiving full federal approval, whichever is later.

(4) The state department shall seek federal authorization to implement a medicaid buy-in program for adults who are eligible to receive home- and community-based services pursuant to the supported living services waiver; the developmental disabilities waiver or its successor, part 4 of this article 6; the persons with brain injury waiver, part 7 of this article 6; and the complementary and integrative health program, part 13 of this article 6. The state department shall prepare and submit any requests necessary for federal approval not later than January 1, 2023, and shall implement the medicaid buy-in program pursuant to this subsection (4) not later than three months after receiving federal approval.

(5) (a) Except as provided in subsection (5)(b) of this section:

(I) The state department shall seek federal authorization through an amendment to the state medical assistance plan to implement the federal "Balanced Budget Act of 1997", Pub.L. 105-33, 111, as amended, which provides individuals an opportunity to buy into medicaid consistent with the federal "Social Security Act", 42 U.S.C. sec. 1396a (a)(10)(A)(ii)(XIII), as amended, to permit the state department to provide medical assistance eligibility to individuals in the work incentives eligibility group, age sixty-five and older, after they are no longer eligible under the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170.

(II) In addition to submitting an amendment to the state medical assistance plan pursuant to subsection (5)(a)(I) of this section, the state department shall submit a state plan amendment pursuant to section 1902(r)(2) of the federal "Social Security Act" to use less restrictive income

and resource methodologies to match the income, household, and asset levels of the medicaid buy-in program for implementation no later than July 1, 2022.

(b) The state department shall not prepare and submit the amendments to the state medical assistance plan pursuant to this subsection (5) if there are insufficient revenues from the healthcare affordability and sustainability hospital provider fee cash fund, created in section 25.5-4-402.4, for the administrative expenses associated with preparing and submitting the state plan amendments. If there are insufficient revenues from the healthcare affordability and sustainability hospital provider fee cash fund, the state department may accept and expend gifts, grants, or donations for this purpose.

Source: L. 2008: Entire part added, p. 2198, § 1, effective July 1. **L. 2009:** (2) amended, (HB 09-1293), ch. 152, p. 649, § 7, effective July 1. **L. 2016:** (4) added, (HB 16-1321), ch. 344, p. 1398, § 1, effective June 10; (1) repealed and (2) amended, (HB 16-1081), ch. 22, p. 52, § 7, effective August 10. **L. 2020:** (5) added, (SB 20-033), ch. 237, p. 1150, § 2, effective July 6. **L. 2021:** (4) amended, (SB 21-039), ch. 380, p. 2549, § 7, effective July 1. **L. 2025:** (5)(b) amended, (SB 25-270), ch. 151, p. 605, § 15, effective May 1; (4) amended, (SB 25-226), ch. 219, p. 1008, § 6, effective August 6.

25.5-6-1404. Medicaid buy-in program - eligibility - premiums - medicaid buy-in fund - report - rules.

(1) **Eligibility.** An individual is eligible for and shall receive medicaid provided in this part 14 through a medicaid buy-in program without losing eligibility for medicaid if all of the following conditions are met:

(a) The individual meets the requirements for the basic coverage group or the individual was previously in the basic coverage group and now meets the requirements for the medical improvement group or the individual was previously in the basic coverage group and now meets the requirements for the work incentives eligibility group, if a state plan amendment for the work incentives eligibility group has been submitted and approved pursuant to section 25.5-6-1403 (5);

(b) The individual maintains premium payments calculated by the state department in accordance with subsection (3) of this section, unless the individual is exempted from premium payments under rules promulgated by the state board; and

(c) The individual meets all other requirements established by rule of the state board.

(2) There is no income or asset limitation for a participant in the medicaid buy-in program. In addition, there is no income or asset limitation for an individual who participates in the medicaid buy-in program and also receives home- and community-based services.

(3) **Premiums.**

(a) An individual who is eligible for and receives medicaid under subsection (1) of this section shall pay a premium pursuant to a payment schedule established by the state department in consultation with the Colorado healthcare affordability and sustainability enterprise created in section 25.5-4-402.4 (3)(a). The amount of the premium shall be determined from a sliding-fee scale adopted by rule of the state board that is based on a percentage of the individual's income adjusted for family size and on any impairment-related work expenses; except that, consistent with federal law, if the amount of the individual's adjusted gross income exceeds seventy-five thousand dollars, the individual shall be responsible for paying one hundred percent of the premium. The rules shall specify the amount of unearned income the state department shall disregard in calculating the individual's income. Premiums are credited to the healthcare affordability and sustainability medicaid buy-in cash fund created in section 25.5-4-402.4 (5.1) for the purpose of offsetting program costs.

(b) Repealed.

(c) Within three years after implementation of the medicaid buy-in program pursuant to this part 14, the state department shall submit a report on the effectiveness of the program to the health and human services committees of the general assembly, or any successor committees, and the joint budget committee of the general assembly.

(4) Repealed.

(5) **Medicare.** If federal financial participation is available, subject to available appropriations, the state department may pay medicare part A and part B premiums for individuals who are eligible for medicare and for medicaid under subsection (1) of this section.

(6) Repealed.

Source: L. 2008: Entire part added, p. 2199, § 1, effective July 1. **L. 2020:** (1)(a) amended and (4) repealed, (SB 20-033), ch. 237, p. 1151, § 3, effective July 6. **L. 2022:** (3)(a) amended, (SB 22-212), ch. 421, p. 2990, § 105, effective August 10. **L. 2023:** (6) added, (SB 23-182), ch. 118, p. 431, § 4, effective April 27. **L. 2024:** (6)(c) amended, (HB 24-1400), ch. 77, p. 263, § 4, effective April 18. **L. 2025:** (3)(a) and (3)(b) amended, (SB 25-228), ch. 150, p. 574, § 3, effective May 1.

Editor's note: (1) For the amendments to subsection (3)(b) in SB 25-228 in effect from May 1, 2025, to July 1, 2025, see chapter 150, Session Laws of Colorado 2025. (L. 2025, p. 574.)

(2) Subsection (3)(b)(III) provided for the repeal of subsection (3)(b), effective July 1, 2025. (See L. 2025, p. 574.)

(3) Subsection (6)(c) provided for the repeal of subsection (6), effective September 1, 2025. (See L. 2024, p. 263.)

25.5-6-1405. Rule-making authority.

(1) The state board shall promulgate rules necessary to implement and administer the medicaid buy-in program created in this part 14, including, in consultation with the Colorado healthcare affordability and sustainability enterprise created in section 25.5-4-402.4 (3)(a), the establishment of appropriate premium and cost-sharing charges on a sliding-fee scale based on income. The premiums and cost-sharing charges shall be based upon an actuarial study of the disabled population in this state.

(2) Any rules adopted by the state board must be consistent with the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170, and the "Balanced Budget Act of 1997", Pub.L. 105-33, 111, as amended.

Source: L. 2008: Entire part added, p. 2200, § 1, effective July 1. **L. 2020:** (2) amended, (SB 20-033), ch. 237, p. 1152, § 4, effective July 6. **L. 2025:** (1) amended, (SB 25-228), ch. 150, p. 575, § 4, effective May 1.

25.5-6-1406. Availability of federal financial assistance under medical assistance.

Notwithstanding any other provision of law, this part 14 shall be implemented only if, and to the extent that, the state department determines that federal financial participation is available under the medicaid program.

Source: L. 2008: Entire part added, p. 2200, § 1, effective July 1.

PART 15

TRANSITION SERVICES

25.5-6-1501. Community transition services and supports - legislative declaration - rules.

(1) The general assembly finds and declares that:

(a) Federally required assessments indicate that more persons living in institutional settings expressed an interest in transitioning to home- or community-based settings than currently have transitions available to them;

(b) Federally required surveys indicate these persons report a higher quality of life after transitioning to home- and community-based settings, and those successful transitions often result in cost savings to the state;

(c) In order to ensure a successful transition, such persons will need ongoing services and supports after the transition; and

(d) Some persons transitioning out of an institution will need assistance with finding and paying for housing that may be provided by vouchers from the department of local affairs.

(2) (a) The state department shall implement community transition services and supports that allow eligible persons to receive services to support a successful transition from an institutional setting to a home- or community-based setting. The state department may seek any state plan amendments or federal waivers or waiver amendments that may be necessary to implement this part 15.

(b) With input from consumers of home- and community-based services, the state department shall design and implement community transition services and supports for eligible persons who are preparing to transition or have recently transitioned from an institutional setting.

(c) An eligible person is not required to leave an institutional setting if, while exploring the option to transition, the person decides to remain in his or her current living situation. If an eligible person does transition, the person may choose between state plan benefits and waiver services for which he or she is eligible to ensure a successful transition.

(3) In order to qualify and to remain eligible for the community transition services and supports authorized by this part 15, a person shall:

(a) Be eligible for home- and community-based services under parts 3 to 12 of this article 6 or any other home- and community-based service waiver for which the state department has federal waiver authority;

(b) Be willing to participate and have expressed an interest in moving to a home- or community-based setting;

(c) Reside in a nursing home or other institutional setting;

(d) Obtain medicaid eligibility prior to discharging from the institutional setting and prior to accessing community transition services needed to assist the person with planning and preparing for the transition;

(e) Work with a case management agency to determine and enroll in the additional home- and community-based services needed for a successful transition;

(f) Transition to a home- or community-based setting that complies with federal and state rules; and

(g) Meet any other qualifications established by the state board by rule.

(4) The services provided to the eligible person under this part 15 must be based on the eligible person's community living goals, assessed needs, and support plan, or any approved resource allocation process as determined by the state department for the eligible person.

(5) The state department shall develop the accountability requirements necessary to safeguard the use of public dollars, to promote effective and efficient delivery of services, and to monitor the safety and welfare of persons receiving services pursuant to this part 15.

(6) The state board shall adopt rules as necessary for the implementation and administration of the community transition services and supports authorized by this part 15, including establishing limits on the units of service per eligible person to fit within available appropriations.

(7) A person who has been designated as a legal guardian must be involved in the decision-making related to the feasibility of a transition to a home- or community-based setting and the choice of services and supports that may be needed to support a successful transition.

(8) Repealed.

Source: L. 2018: Entire part added, (HB 18-1326), ch. 183, p. 1237, § 1, effective July 1. **L. 2024:** (8) repealed, (SB 24-135), ch. 34, p. 116, § 27, effective March 22.

PART 16

HOME CARE EMPLOYEES' COMPENSATION AND TRAINING

25.5-6-1601. Definitions.

As used in this part 16, unless the context otherwise requires:

(1) "Compensation" has the meaning set forth in section 25.5-6-406 (2)(b)(I).

(2) "Health maintenance activities" has the meaning set forth in section 25.5-6-1901 (2).

(3) "Home care agency" has the meaning set forth in section 25-27.5-102 (3).

(4) "Homemaker services" has the meaning as set forth in section 25.5-6-1901 (3).

(5) "In-home support service agency" has the meaning set forth in section 25.5-6-1202 (5).

(6) "In-home support services" has the meaning set forth in section 25.5-6-1202 (6); except that the term does not include health maintenance activities.

(7) "Personal care services" has the meaning set forth in section 25-27.5-102 (6).

Source: L. 2019: Entire part added, (SB 19-238), ch. 319, p. 2964, § 1, effective May 28. **L. 2023:** (2) and (4) amended, (SB 23-289), ch. 270, p. 1611, § 16, effective July 1, 2025.

Cross references: For additional definitions applicable to this part 16, see § 25.5-4-103.

25.5-6-1602. State department to request increase in reimbursement rate for certain services.

(1) Not more than ninety days after May 28, 2019, the state department shall request from the federal government an increase of eight and one-tenth percent in the reimbursement rate for the following services delivered to members through the home- and community-based services waivers:

(a) Homemaker;

(b) Homemaker enhanced; and

(c) Personal care.

(2) For the 2019-20 fiscal year, each home care agency shall pay one hundred percent of the funding that results from the rate increase described in subsection (1) of this section as

compensation for employees who provide personal care services, homemaker services, and in-home support services to members. This compensation is provided in addition to the rate of compensation that the employee was receiving as of June 30, 2019. For an employee who was hired after June 30, 2019, the home care agency shall use the lowest compensation paid to an employee of similar functions and duties as of June 30, 2019, as the base compensation to which the increase is applied.

(3) Within sixty days after the request described in subsection (1) of this section is approved, each home care agency shall provide written notification to each nonadministrative employee of the agency who provides personal care services, homemaker services, or in-home support services of the compensation they are entitled to pursuant to subsection (2) of this section.

Source: L. 2019: Entire part added, (SB 19-238), ch. 319, p. 2965, § 1, effective May 28. **L. 2024:** IP(1) and (2) amended, (SB 24-176), ch. 152, p. 672, § 95, effective August 7.

25.5-6-1603. Minimum wage - wage pass-through requirement for certain home care agencies - applicability - reports - recovery.

(1) This section applies to each home care agency that receives reimbursement pursuant to the "Colorado Medical Assistance Act" for the provision of personal care services, homemaker services, or in-home support services.

(2) (a) On and after July 1, 2025, the hourly minimum wage rate for individuals who provide direct care services, including personal care services, homemaker services, or in-home support services for which a home care agency may receive reimbursement pursuant to the "Colorado Medical Assistance Act", is seventeen dollars per hour.

(b) The state department shall enforce the minimum direct care worker base wage that is required by this subsection (2).

(3) For any increase to the reimbursement rates for personal care services, homemaker services, or in-home support services that takes effect during the 2020-21 fiscal year, home care agencies shall use eighty-five percent of the funding resulting from the increase to increase compensation for nonadministrative employees above the rate of compensation that nonadministrative employees are receiving as of June 30, 2020. Home care agencies may use any remaining funding resulting from the reimbursement rate increase for general and administrative expenses, such as chief executive officer salaries, human resources, information technology, oversight, business management, general record keeping, budgeting and finance, and other activities not identifiable to a single program.

(4) (a) Each home care agency shall track and report how it used any funding resulting from the increase in the reimbursement rate pursuant to this section or section 25.5-6-1602 using a reporting tool developed by the state department. On or before December 31, 2020, each home care agency shall submit the report to the state department demonstrating how the funding was used to increase compensation for the 2019-20 fiscal year. On or before December 31, 2021, each home care agency shall report to the state department how the funding was used to increase or, in the event that there is no reimbursement rate increase, maintain each employee's compensation for the 2020-21 fiscal year. The state department has ongoing discretion to request information from a home care agency demonstrating how it maintained increases in compensation for nonadministrative employees beyond the reporting period.

(b) Each home care agency shall maintain all books, documents, papers, accounting records, and other evidence required to support the reporting of payroll information for increased compensation to nonadministrative employees pursuant to subsection (4)(a) of this section for at least three years from the reporting deadlines described in subsection (4)(a) of this section for each respective fiscal year. Each home care agency shall make the information and materials available for inspection by the state department or its designees at all reasonable times.

(5) (a) The state department may recoup part or all of the funding resulting from the increase in the reimbursement rate described in this section or section 25.5-6-1602 if the state department determines that a home care agency:

(I) Did not use one hundred percent of any funding resulting from the rate increase to increase compensation for nonadministrative employees, as required by section 25.5-6-1602 (2);

(II) Did not use eighty-five percent of the funding resulting from the rate increase to increase compensation for nonadministrative employees, as required by subsection (3) of this section; or

(III) Failed to track and report how it used any funds resulting from the increase in the reimbursement rate as required by subsection (4) of this section.

(b) If the state department makes a determination described in subsection (5)(a) of this section, the state department shall notify the home care agency in writing of the state department's intention to recoup funds pursuant to subsection (5)(a) of this section. A home care agency has forty-five days after receiving such notice to:

(I) Challenge the determination of the state department;

(II) Provide additional information to the state department demonstrating compliance; or

(III) Submit a plan of correction to the state department.

(c) The state department shall notify a home care agency in writing of its final determination after affording the home care agency the opportunity to take one of the actions specified in subsection (5)(b) of this section.

(d) The state department shall recoup from a home care agency any funding resulting from the increase in the reimbursement rate pursuant to this section or section 25.5-6-1602 that the home care agency received but did not use for compensation for nonadministrative employees if:

(I) The home care agency fails to respond to a notice of determination of the state department within the time provided in subsection (5)(b) of this section;

(II) The home care agency is unable to provide documentation of compliance; or

(III) The state department does not accept the plan of correction submitted by the home care agency pursuant to subsection (5)(b)(III) of this section.

Source: L. 2019: Entire part added, (SB 19-238), ch. 319, p. 2965, § 1, effective May 28. **L. 2025:** (2) amended, (HB 25-1328), ch. 263, p. 1352, § 5, effective August 6.

Cross references: For the legislative declaration in HB 25-1328, see section 1 chapter 263, Session Laws of Colorado 2025.

25.5-6-1604. Training for home care agency employees - process for reviewing and enforcing training requirements.

(1) On or before January 1, 2020, the state department and the department of public health and environment, in consultation with stakeholders, shall establish a process for reviewing and enforcing initial and ongoing training requirements for persons who provide personal care services, homemaker services, and in-home support services for which a home care agency may receive reimbursement pursuant to the "Colorado Medical Assistance Act", as such requirements are set forth in this section and in rules promulgated by the state board. The stakeholders must include, but are not limited to:

(a) One or more consumer advocacy organizations;

(b) One or more personal care workers;

(c) One or more worker organizations;

(d) One or more home care agencies;

(e) One or more disability advocacy organizations;

(f) One or more senior advocacy organizations; and

(g) One or more children's advocacy organizations.

(2) The stakeholders with whom the departments consult pursuant to subsection (1) of this section shall discuss and advise the departments concerning the manner in which nonadministrative employees will be notified of the compensation increases and minimum wage described in sections 25.5-6-1602 and 25.5-6-1603.

Source: L. 2019: Entire part added, (SB 19-238), ch. 319, p. 2967, § 1, effective May 28.

25.5-6-1605. Exemptions.

(1) Notwithstanding any provision of this part 16 to the contrary, this part 16 does not apply to services provided under:

(a) The consumer-directed attendant support services model; or

(b) The pediatric personal care benefit.

Source: L. 2019: Entire part added, (SB 19-238), ch. 319, p. 2968, § 1, effective May 28.

PART 17

CASE MANAGEMENT SERVICES FOR LONG-TERM SERVICES AND SUPPORTS

25.5-6-1701. Legislative declaration.

The general assembly finds and declares that there is a need to ensure a high-performing statewide case management system exists that serves all populations of people who qualify for long-term services and supports. The case management system includes, but is not limited to, intake and eligibility screening and determination, outreach, and other administrative activities and case management services. The five key outcomes of the statewide case management system must include federal compliance, quality, simplicity, stability, and accountability.

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 313, § 1, effective September 7.

25.5-6-1702. Definitions.

As used in this part 17, unless the context otherwise requires:

(1) "Authorized representative" means a person designated by the member receiving services, or by the parent or guardian of the member receiving services, if appropriate, to assist the member in acquiring or utilizing long-term services and supports pursuant to this article 6 and article 10 of this title 25.5. The extent of the authorized representative's involvement must be determined upon designation.

(2) "Case management agency" means a public or private not-for-profit or for-profit organization contracted with the state of Colorado to provide case management services and activities.

(3) "Case management services" means the assessment of an individual's need for long-term services and supports; the development and implementation of a person-centered support plan for the member; the coordination, monitoring, and delivery of long-term services and supports; the evaluation of service effectiveness; and the reassessment of the member's needs, all of which must be performed by a case management agency or an entity.

(4) "Case manager" means a person who provides case management services and activities pursuant to this article 6 and article 10 of this title 25.5 for members receiving long-term services and supports.

(5) "Community-centered board" means a private for-profit or not-for-profit organization that is an administrator of locally generated funding pursuant to section 25.5-10-206 (6) and acts as a resource for persons with an intellectual and developmental disability or a child with a developmental delay.

(6) "Conflict-free case management" means case management services and activities provided to a member enrolled in a home- and community-based services waiver by an entity other than the entity providing direct long-term services and supports, except as otherwise allowed pursuant to 42 CFR 441.301 (c)(1)(vi). Service providers, case management agencies, and entities are responsible for ensuring employees meet the requirements of this article 6.

(7) "Defined service area" means the geographical area determined by the state department to be served by a case management agency.

(8) "Entity" means a public or private not-for-profit or for-profit organization, which may include a community-centered board, that has a contract or agreement with the state of Colorado to perform specific functions.

(9) "Intellectual and developmental disability" has the same meaning as set forth in section 25.5-6-403 (3.3)(a).

(10) "Long-term services and supports" means the services and supports used by members of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

(11) "Member" means any person enrolled in the state medical assistance program, articles 4, 5, and 6 of this title 25.5, or the children's basic health plan, article 8 of this title 25.5.

(12) "Person-centered support plan" means a long-term services and supports plan that is directed by the member, or the member's legal guardian, and prepared by the case manager to identify the supports needed for the member to achieve personally identified goals and is based on respecting and valuing member preferences, strengths, and contributions.

(13) "Person with an intellectual and developmental disability" has the same meaning as set forth in section 25.5-6-403 (3.3)(b).

(14) "Service provider" means an agency or individual certified by the state department and enrolled to provide one or more long-term services and supports.

(15) "Waiting list" has the same meaning as set forth in section 25.5-10-202 (38).

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 313, § 1, effective September 7.

25.5-6-1703. Case management system - defined service areas - case management services - only willing and qualified provider exemption - rules.

(1) No later than July 1, 2024, the state board shall adopt rules providing for the establishment of a case management system that consists of case management agencies throughout the state for the purpose of enabling individuals in need of long-term care to access appropriate long-term services and supports. Members in need of specialized assistance may be referred to other services outside of long-term services and supports, as necessary for additional care coordination.

(2) No later than December 31, 2021, the state department shall work with stakeholders to develop a timeline for the implementation of this part 17.

(3) (a) No later than December 31, 2022, the state department shall issue a competitive solicitation in order to select case management agencies pursuant to subsection (1) of this section. The competitive solicitation must include a reimbursement structure developed through a fiscal analysis.

(b) No later than January 31, 2023, the state department shall provide an update on the status of the implementation of this part 17 to the joint budget committee of the general assembly as part of its annual presentation to that committee.

(4) The state department shall utilize a stakeholder process to identify defined service areas for case management agencies across the state.

(5) A case management agency may provide case management services to private paying individuals on a fee-for-service basis and shall provide case management services to members of publicly funded long-term services and supports programs, including but not limited to programs created pursuant to this article 6 and article 10 of this title 25.5.

(6) Where applicable, the state department is authorized to seek a federal exemption from conflict-free case management requirements for defined service areas within the state where the only willing and qualified entity to provide case management services is also the only willing and qualified entity to provide home- and community-based services in that defined service area.

(7) The state board shall utilize a stakeholder process when promulgating rules to implement this section.

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 315, § 1, effective September 7.

25.5-6-1704. Intellectual and developmental disability determination - functional eligibility determination - rules.

(1) **Intellectual and developmental disability determination.** Any person may request an evaluation to determine whether the person has a developmental delay or an intellectual and developmental disability and is eligible to receive long-term services and supports pursuant to this article 6 and article 10 of this title 25.5. The person must request a developmental delay determination or intellectual and developmental disabilities determination from the case management agency or the entity in the defined service area where the person resides.

(2) **Functional eligibility determination.** Pursuant to the contract with the state department, a case management agency shall determine whether a person is eligible to receive long-term services and supports pursuant to this article 6 and article 10 of this title 25.5. A case management agency or an entity shall develop a person-centered support plan for persons eligible for long-term services and supports for home- and community-based services and state general-funded programs.

(3) The state board shall promulgate rules pursuant to article 4 of title 24 setting forth the procedure and criteria for determination of eligibility and person-centered support plan development. The procedure and criteria must be uniform in nature and applied throughout the state in a consistent manner.

(4) Subject to available appropriations pursuant to section 25.5-10-206 and to the capacity of a service provider, the person must be provided options for long-term services and supports within the defined service area that can appropriately meet the person's identified needs, pursuant to this section.

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 316, § 1, effective September 7.

25.5-6-1705. Person-centered support plan.

(1) Each member receiving services shall have a person-centered support plan, or a similar plan specified by the state department, developed and managed by a case management agency or an entity, and subject to review and approval pursuant to section 25.5-6-404. The person-centered support plan shall:

(a) Be based on the particular service needs of the member receiving services;

(b) Describe the services necessary to avoid institutionalization;

(c) Ensure the member receives services in the setting of the member's choice; and

(d) Identify the supports needed for the member to achieve personally identified goals.

(2) Pursuant to this section, the person-centered support plan for each member receiving services must be reviewed at least annually and modified as necessary or appropriate.

(3) A person-centered support plan is not required for a person with an intellectual and developmental disability or a developmental delay who is eligible for long-term services and supports and who is on a waiting list for enrollment into a program funded pursuant to article 10 of this title 25.5. Each case management agency shall provide information and referral services to each member on the waiting list for enrollment in a program at the time of the member's eligibility and annually thereafter, regarding long-term services and supports that are relevant to persons and are commonly used by persons with intellectual and developmental disabilities and a developmental delay as provided by rules promulgated by the state board. The criteria for information and referral must be uniform in nature and applied throughout the state in a consistent manner.

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 316, § 1, effective September 7.

25.5-6-1706. Termination of long-term services and supports for member receiving services.

(1) A member receiving long-term services and supports pursuant to this article 6 or article 10 of this title 25.5 must be terminated from long-term services and supports upon a determination, made pursuant to the person-centered support planning process, that the long-term services and supports are no longer necessary. Prior to the effective date of the termination,

notification of termination must be given to the member receiving services, the parents or guardian of a minor receiving services, and the person's legal guardian or other legal representative when applicable. A member terminated from services pursuant to this subsection (1) has a right to challenge the termination in accordance with state department rules.

(2) When a member receiving services notifies the case management agency that the member no longer wishes to receive long-term services and supports, the member must be terminated from long-term services and supports unless the member is subject to a petition to impose a legal disability or to remove a legal right, filed pursuant to section 25.5-10-216, or the member has a legal guardian or other legal representative appointed affecting the member's ability to voluntarily terminate long-term services and supports. The parents of a minor who is receiving long-term services and supports and the minor's guardian must be notified of the minor's wish to terminate long-term services and supports, but no minor's long-term services and supports will be terminated without the consent of the minor's parent or legal guardian.

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 317, § 1, effective September 7.

25.5-6-1707. Records and confidentiality of information.

(1) A record for each member receiving services must be diligently maintained by the case management agency or the entity. The record must include, but not be limited to, information pertaining to the determination of eligibility for services and the person-centered support plan. The record is not a public record for purposes of the "Colorado Open Records Act", part 2 of article 72 of title 24.

(2) Except as otherwise provided by law, all information obtained and any records prepared in the course of determining eligibility or providing long-term services and supports pursuant to this article 6 or article 10 of this title 25.5 are confidential and subject to the evidentiary privileges established by law. The disclosure of this information and these records in any manner is permitted only:

(a) To the applicant or member receiving services, to the parents of a minor receiving services, to the member's legal guardian, or to any person authorized by the member receiving services;

(b) In communications between qualified professional personnel, including the board of directors or governing body of the case management agency and service agencies providing services to the member, to the extent necessary for the acquisition, provision, oversight, or referral of long-term services and supports;

(c) To the extent necessary to make claims for aid, insurance, or medical assistance to which a member receiving services may be entitled, or to access long-term services and supports pursuant to the person-centered support plan;

(d) For the purposes of evaluation, gathering statistics, or research when no identifying information concerning a person or family is disclosed. Identifying information is information which could reasonably be expected to identify a specific person and includes, but is not limited to, name, address, telephone number, social security number, medicaid number, household number, and photograph.

(e) To the court when necessary to implement the provisions of this article 6 or article 10 of this title 25.5;

(f) To persons authorized by a court order issued after a hearing, notice of which was given to the member, parents or legal guardian, where appropriate, and the custodian of the information;

(g) To safeguard the health and safety of an at-risk member by coordinating appropriate services and medical supports;

(h) To the agency designated pursuant to 45 CFR 1326.20 as the protection and advocacy system for Colorado when:

(I) The protection and advocacy system receives a complaint from or on behalf of a member receiving services; and

(II) The person does not have a legal guardian or the state or the designee of the state is the legal guardian of the person; and

(i) To the state department or the state department's designees as deemed necessary by the executive director to fulfill the duties prescribed by this article 6 or article 10 of this title 25.5.

(3) Nothing in this section limits a member receiving services access to the member's records.

(4) Nothing in this section interferes with the protections afforded to a person under the federal "Health Insurance Portability and Accountability Act of 1996", 42 U.S.C. sec. 1320d, and the federal "Family Educational Rights and Privacy Act of 1974", 20 U.S.C. sec. 1232g.

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 318, § 1, effective September 7.

25.5-6-1708. Performance audits - Colorado local government audit law - public disclosure of board administration and operations.

(1) The state auditor may conduct or cause to be conducted a performance audit that includes each case management agency or each entity that receives more than seventy-five percent of its funding on an annual basis from the federal, the state, or a local government or from any combination of governmental entities to determine whether the board of directors or the governing body is effectively and efficiently fulfilling its statutory obligations. A case management agency or an entity becomes subject to the audit requirement under this subsection (1) at the time the case management agency or the entity initially satisfies the seventy-five percent funding requirement for any one year regardless of whether or not the funding level decreases below seventy-five percent in any subsequent year. The state auditor shall submit a written report and recommendations on each audit conducted pursuant to this subsection (1) and shall present the report and recommendations to the legislative audit committee created in section 2-3-101 (1). The state auditor shall pay the costs of any performance audit conducted pursuant to this section.

(2) Each case management agency and each entity is subject to the requirements of the "Colorado Local Government Audit Law", part 6 of article 1 of title 29.

(3) In connection with the board of directors or the governing body of each case management agency or each entity, in addition to any other requirements applicable to the operation of the board of directors or the governing body pursuant to this section or as required elsewhere by law:

(a) The case management agency or the entity shall post the date, time, and location of each regularly scheduled meeting of the board of directors or the governing body on the website of the case management agency or the entity not less than fourteen business days before the meeting. The case management agency or the entity shall post the date, time, and location of any special or emergency meeting of the board of directors or the governing body on the website of the case management agency or the entity not less than twenty-four hours before the meeting.

(b) Each case management agency or each entity shall post the agenda for each meeting of the board of directors or the governing body on the website of the case management agency or the entity not less than seven business days before the meeting. The case management agency or the entity shall post the agenda of any special or emergency meeting of the board of directors or the governing body on the website of the case management agency or the entity not less than twenty-four hours before the meeting. Each meeting of the board of directors or the governing body must allow for public comment, and the agenda must reflect this requirement. Public comment must be reasonably permitted during the board's or the governing body's meeting to accommodate community needs. Any documents related to functions of the case management agency or the entity to be distributed at a meeting of the board of directors or the governing body that are available for public dissemination at the time the agenda is posted must also be posted on the website of the case management agency or the entity at the time the agenda is posted. Written

copies of the documents must be made available for public dissemination at the board of directors' or the governing body's meeting; except that the posting requirement specified in this subsection (3)(b) does not apply to any document, or any portion of a document, the disclosure of which requires the approval of the board of directors or the governing body and which approval has not been obtained at the time the agenda is posted or any other document, or any portion of a document, containing any information that is legally prohibited from being disclosed to the public pursuant to the privacy requirements specified in the federal "Health Insurance Portability and Accountability Act of 1996", 42 U.S.C. sec. 1320d, any document that has been or will be discussed by the board of directors or the governing body meeting in executive session, or any other document the disclosure of which is otherwise prohibited by law.

(c) Each case management agency and each entity shall provide a direct email address to each member of the board of directors or the governing body on the website of the case management agency or the entity. The email address selected must specify the name of the individual board or governing body member and make reference to the particular case management agency or entity for which the board or governing body member serves as a member of the board of directors or the governing body. An email that is sent to a member of the board of directors or the governing body of a case management agency or an entity must not be filtered by the case management agency or the entity through an employee of the case management agency or the entity before it is sent to the board or governing body member.

(d) The board of directors or the governing body of each case management agency or each entity shall present the financial statements of the organization for the approval of the board of directors or the governing body at each regularly scheduled meeting of the board of directors or the governing body. The financial statements must reflect accurate and current financial information and be prepared using generally accepted accounting principles. Where exigent circumstances are present that materially affect the preparation of the financial statements on a monthly basis, the statements may be presented for the approval of the board of directors or the governing body at the next regularly scheduled meeting of the board of directors or the governing body but not less than at least once each quarter of the calendar year.

(e) Each case management agency and each entity shall require the person or organization that performs financial audits of the case management agency or the entity to present and discuss the results of the audit to the board of directors or the governing body not less than once each year at a regularly scheduled meeting of the board of directors or the governing body;

(f) Each case management agency and each entity shall provide to the incoming members of the board of directors or the governing body training in such topics as the duties of a board or governing body member, the financial and fiduciary responsibilities assumed by board or governing body members, the intellectual and developmental disability and long-term services and supports system in the state, the overall business functions of the case management agency or the entity, and any other matters that will, in the determination of the case management agency

or the entity, allow the board or governing body member to better understand and fulfill the board or governing body member's obligations to the board of directors or the governing body and the case management agency or the entity and the role played by the case management agency or the entity in the state in connection with the delivery of services for members receiving services pursuant to this article 6 and article 10 of this title 25.5; and

(g) Each case management agency and each entity shall post on the website of the case management agency or the entity the minutes of each meeting of its board of directors or its governing body as the minutes are approved by the board of directors or the governing body. Each case management agency and each entity shall also post on the website of the case management agency or the entity any additional documents that were distributed to the board or governing body at the meeting that were not, as of that date, already posted on the website of the case management agency or the entity unless the public distribution of the documents, or any portion of the documents, is otherwise prohibited pursuant to the privacy requirements specified in the federal "Health Insurance Portability and Accountability Act of 1996", 42 U.S.C. sec. 1320d, or as otherwise prohibited by law. Minutes of special meetings of the board of directors or the governing body must be posted on the website of the case management agency or the entity after approval by the board of directors or the governing body at the board's or governing body's next regular meeting.

(4) With respect to financial information concerning the case management agency or the entity, each case management agency or each entity shall:

(a) Post the following on the website of the case management agency or the entity in a place that allows access to the public in a clear, accessible, easily operated, and uncomplicated manner:

(I) Each completed financial audit undertaken of the case management agency or the entity not later than thirty days following acceptance by the organization's board of directors or governing body of the audit. Any case management agency or any entity that is not required to have an annual audit of financial statements shall post a detailed account of the agency's or entity's assets, liabilities, revenue, losses and gains, expenses, investing activities, property and equipment, and any other relevant financial disclosures required by the state department.

(II) The most current form 990 the case management agency or the entity has filed with the federal internal revenue service not later than thirty days following filing of the form with the federal internal revenue service. Any case management agency or any entity that is not required to prepare and file a form 990 shall disclose and post the for-profit equivalent federal internal revenue services tax form that includes the total number of individuals employed, all executive-level employee salaries and other compensation, and employee benefits, as required by the state department.

(b) Make the following information available upon reasonable request not later than five business days after the request is made:

(I) The annual budget of the case management agency or the entity for each calendar or fiscal year, as applicable, not later than thirty days after final approval of the budget by the board of directors or the governing body of the case management agency or the entity;

(II) An annual summary of all revenues and expenditures of the case management agency or the entity that have been appropriated by the state department that is calculated by September 30 of each year for the prior year, as applicable; and

(III) A description of the policies and procedures the case management agency or the entity follows to track, manage, and report its financial resources and transactions, which policies and procedures are also known and may be referred to as its "financial controls".

(5) Any contract that each case management agency or each entity enters into with either the state department or the department of human services, created in section 26-1-105, must be posted on the website of the case management agency or the entity in a place that allows access to the public in a clear, accessible, easily operated, and uncomplicated manner not later than thirty days following approval of the contract by the board of directors or the governing body of the case management agency or the entity.

(6) This section does not apply to a county agency, including a county department of human or social services, a county nursing service, an area agency on aging, or a multicounty agency acting as a case management agency that already has existing or duplicative audit and transparency requirements.

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 319, § 1, effective September 7.

25.5-6-1709. Community-centered board designation - rules.

The state department shall develop a process to designate local or regional organizations as community-centered boards. The state department shall promulgate rules outlining the designation process no later than July 1, 2024. Any contracts or agreements entered into pursuant to this section are exempt from the "Procurement Code", articles 101 to 112 of title 24.

Source: L. 2021: Entire part added, (HB 21-1187), ch. 83, p. 323, § 1, effective September 7.

PART 18

COLORADO MEDICAL ASSISTANCE PROGRAM REQUIREMENTS FOR DISBURSEMENT OF FEDERAL FUNDS UNDER THE FEDERAL "AMERICAN RESCUE PLAN ACT OF 2021"

Editor's note: (1) Section 25.5-6-1806 provided for the repeal of this part 18, effective July 1, 2025. (See L. 2021, p. 2626.)

(2) This part 18 was added in 2021. For amendments to this part 18 prior to its repeal in 2025, consult the 2024 Colorado Revised Statutes and the Colorado statutory research explanatory note beginning on page vii in the front of this volume.

25.5-6-1801 to 25.5-6-1806. (Repealed)

PART 19

COMMUNITY FIRST CHOICE

25.5-6-1901. Definitions.

As used in this part 19, unless the context otherwise requires:

(1) "Electronic monitoring" means the installation, purchase, or rental of electronic monitoring devices that enable an individual to secure help in the event of an emergency; provide the individual reminders about medical appointments, treatment, or medication schedules; are required because of the individual's illness, impairment, or disability; and include personal emergency response systems and medication reminders through an automated medication dispensing system.

(2) "Health maintenance activities" means routine and repetitive health-related tasks furnished to a member in the community or in the member's home that are necessary for the health and normal bodily functioning that a person with a disability is physically unable to carry out. "Health maintenance activities" includes skilled tasks typically performed by a certified nursing assistant or a licensed nurse that do not require the clinical assessment and judgment of a licensed nurse.

(3) "Homemaker services" means general household activities provided by an attendant in a member's home to maintain a healthy and safe environment for the member through hands-on assistance, supervision, or cueing. "Homemaker services" must only be provided in the member's primary living space and multiple attendants shall not be reimbursed for duplicating such services.

(4) "Personal care services" means services that are furnished to a member to meet the member's physical, maintenance, and supportive needs through hands-on assistance, supervision, or cueing that do not require a nurse's supervision or physician's order.

Source: L. 2023: Entire part added, (SB 23-289), ch. 270, p. 1603, § 1, effective May 25.

25.5-6-1902. Community first choice option - covered services - state plan amendment.

(1) No later than July 1, 2025, the state department shall seek federal authorization through an amendment to the state medical assistance plan to implement the community first choice option.

(2) At a minimum, the state plan amendment must provide for, but is not limited to:

(a) The following services:

(I) Personal care services;

(II) Homemaker services;

(III) Health maintenance activities;

(IV) Electronic monitoring services; and

(V) Voluntary training on how to select, manage, and dismiss an attendant; and

(b) The delivery of covered services, if applicable, through:

(I) In-home support services;

(II) Consumer-directed services and supports; and

(III) Licensed home care services.

Source: L. 2023: Entire part added, (SB 23-289), ch. 270, p. 1604, § 1, effective May 25.

25.5-6-1903. Permissible services and supports.

(1) The state department may provide permissible services and supports that are linked to an assessed need or goal in the individual's person-centered service plan. Permissible services and supports may include, but are not limited to, the following:

(a) Expenditures for transition costs, such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities linked to an assessed need for an individual to transition from a nursing facility, institution for behavioral or mental health disorders, or intermediate care facility for individuals with intellectual disabilities, to a home- and community-based setting where the individual resides; and

(b) Expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that would otherwise be made for human assistance.

Source: L. 2023: Entire part added, (SB 23-289), ch. 270, p. 1604, § 1, effective May 25.

25.5-6-1904. Maintenance of effort.

In implementing the community first choice option, the state department shall ensure continuity of support for eligible individuals who were receiving services as of July 1, 2025, and who have maintained eligibility in the state medical assistance program since that date.

Source: L. 2023: Entire part added, (SB 23-289), ch. 270, p. 1605, § 1, effective May 25.

25.5-6-1905. Eligibility.

(1) To be eligible for the community first choice option, an individual must:

(a) Be eligible for the state medical assistance program;

(b) Be in an eligibility group under the state medical assistance program that includes nursing facility services, or if in an eligibility group that does not include nursing facility services, have an income that is at or below one hundred fifty percent of the federal poverty level. The state department shall determine whether an individual is at or below one hundred fifty percent of the federal poverty level on an annual basis by applying the same methodologies that apply under the state medical assistance program, including the same less restrictive resource methodologies described in the federal "Social Security Act", 42 U.S.C. sec. 1902 (r)(2).

(c) (I) Receive an annual determination that in the absence of the home- and community-based attendant services and supports provided pursuant to the community first choice option, the individual would require the level of care furnished in a hospital, a nursing facility, an intermediate care facility to an individual with intellectual disabilities, an institution providing

inpatient psychiatric services to an individual under twenty-one years of age, or an institution for behavioral or mental health disorders for an individual sixty-five years of age or older if the cost could be reimbursed under the state medical assistance program.

(II) The state department may, at its discretion, permanently waive the annual determination for an individual if the state department:

(A) Determines there is no reasonable expectation of improvement or significant change in the individual's condition because of the severity of a chronic condition or the degree of impairment of functional capacity; and

(B) Retains documentation of the reason for waiving the individual's annual determination requirement.

(2) For the purposes of meeting the requirements of subsection (1)(b) of this section, an individual who qualifies for medical assistance pursuant to the special home- and community-based waiver eligibility group defined in the federal "Social Security Act", 42 U.S.C. sec. 1902 (a)(10)(A)(ii)(VI), shall meet all the requirements in 42 U.S.C. sec. 1915(c) and receive at least one home- and community-based waiver service per month.

(3) Individuals receiving services through the community first choice option must not be precluded from receiving other home- and community-based long-term care services and supports through other state medical assistance program waivers, grants, or demonstration authorities.

Source: L. 2023: Entire part added, (SB 23-289), ch. 270, p. 1605, § 1, effective May 25.

PART 20

SYSTEM OF CARE FOR CHILDREN AND YOUTH WITH COMPLEX BEHAVIORAL HEALTH NEEDS

25.5-6-2001. System of care for children and youth - federal authorization - leadership and implementation team - workforce capacity center - report - rules - definition - repeal.

(1) No later than July 1, 2024, the state department, in collaboration with the behavioral health administration, and the department of human services pursuant to article 64.5 of title 27, shall begin developing a system of care for children and youth who have complex behavioral health needs. At a minimum, the system of care must include:

(a) Implementation of a standardized assessment tool that:

(I) Expands upon and modifies the assessment tool described in section 19-1-115 (4)(e)(I);

(II) Makes recommendations regarding the appropriate level of care necessary to meet the child's or youth's treatment needs;

(III) Informs the child's or youth's treatment planning, including behavioral health programming and medical needs; and

(IV) Is administered to children and youth who are enrolled in the medical assistance program or any child or youth who meets the referral requirements established by the behavioral health administration pursuant to article 64.5 of title 27;

(b) Intensive-care coordination for children and youth enrolled in the medical assistance program;

(c) Expanded supportive services for children and youth pursuant to subsection (4) of this section; and

(d) Expanded access to treatment foster care, as defined in section 26-6-903, pursuant to subsection (5) of this section.

(2) (a) The state department shall convene a leadership team that is responsible for advising and reviewing the development and operation of the system of care for children and youth who have complex behavioral health needs.

(b) The leadership team consists of the following members:

(I) The executive director of the state department, or the executive director's designee;

(II) The executive director of the department of human services, or the executive director's designee;

(III) The commissioner of the behavioral health administration in the department of human services, or the commissioner's designee;

(IV) The executive director of the department of public health and environment, or the executive director's designee;

(V) The commissioner of the department of education, or the commissioner's designee;

(VI) The executive director of the department of early childhood, or the executive director's designee;

(VII) The commissioner of the division of insurance in the department of regulatory agencies, or the commissioner's designee;

(VIII) One county commissioner, or the county commissioner's designee, from the eastern region, the front range region, the mountain region, the southern region, and the western region, as designated by the statewide organization that represents county commissioners;

(IX) One county commissioner at large, or a county commissioner's designee;

(X) One director of a county department of human or social services at large, or the director's designee, as designated by the statewide organization that represents county department of human or social services directors;

(XI) One or more families or individuals with lived experience using children's or youth's behavioral health services, appointed by the commissioner of the behavioral health administration; and

(XII) One or more representatives from a consumer advocacy organization, appointed by the commissioner of the behavioral health administration.

(c) The leadership team has the following duties and responsibilities:

(I) To evaluate the performance and effectiveness of the state department in the development of the system of care for children and youth with complex behavioral health needs;

(II) To review and advise on the strategic direction of the development of the system of care; and

(III) To review and comment on the state department's fiscal development and oversight of the system of care.

(3) (a) The state department shall convene an implementation team that shall create a plan utilizing the recommendations from the leadership team, as appropriate, to implement the system of care for children and youth who have complex behavioral health needs.

(b) The implementation team consists of the following members:

(I) The executive director of the state department, or the executive director's designee;

(II) The executive director of the department of human services, or the executive director's designee;

(III) The commissioner of the behavioral health administration in the department of human services, or the commissioner's designee;

(IV) The executive director of the department of public health and environment, or the executive director's designee;

(V) The commissioner of the department of education, or the commissioner's designee;

(VI) The executive director of the department of early childhood, or the executive director's designee;

(VII) The commissioner of the division of insurance in the department of regulatory agencies, or the commissioner's designee;

(VIII) One or more county commissioners, as designated by the statewide organization that represents county commissioners;

(IX) One or more directors of a county department of human or social services, or the director's designee, as designated by the statewide organization that represents county department of human or social services directors;

(X) One or more families or individuals with lived experience using children's or youth's behavioral health services, appointed by the commissioner of the behavioral health administration;

(XI) One or more representatives from a consumer advocacy organization, appointed by the commissioner of the behavioral health administration;

(XII) A representative of the statewide association that represents child welfare agencies, appointed by the director of the association;

(XIII) A representative of the statewide association that represents hospitals, appointed by the director of the association; and

(XIV) A representative of the statewide association that represents comprehensive behavioral health providers, appointed by the director of the association.

(4) No later than January 1, 2025, the state department shall seek federal authorization to expand the residential child health-care program established pursuant to section 25.5-6-903 to include children and youth who have a serious emotional disturbance that puts the child or youth at risk or in need of out-of-home placement.

(5) No later than January 1, 2025, the state department shall develop and implement a plan to increase access to treatment foster care, as defined in section 26-6-903, under the state medical assistance program.

(6) The state department may promulgate rules in consultation with the behavioral health administration and the department of human services for the administration and implementation of the system of care for children and youth.

(7) (a) No later than January 1, 2025, the department of health care policy and financing shall contract with a third-party vendor to complete an actuarial analysis in order to determine the appropriate medicaid reimbursement rate for psychiatric residential treatment facilities, as defined in section 25.5-4-103.

(b) Beginning January 2025, and each quarter thereafter, the state department shall report progress on the development and implementation of the system of care developed pursuant to this section to the joint budget committee, the implementation team, the leadership team, the senate health and human services committee, and the house of representatives health and human

services committee. The report required by this subsection (7)(b) must include the rationale for any recommendation from the leadership team that the department elects not to implement.

(7.5) (a) The state department, in collaboration with the behavioral health administration established in section 27-50-102, shall establish the workforce capacity center to train providers in evidence-based or supported models as part of the system of care for children and youth described in subsection (1) of this section, including training on high-fidelity wraparound for children and youth pursuant to part 1 of article 62 of title 27, intensive in-home treatment models, and other interventions.

(b) The workforce capacity center must assist providers in maintaining ongoing training to ensure interventions are applied accurately.

(c) The workforce capacity center is responsible for:

(I) Developing the trainings for providers;

(II) Conducting the trainings;

(III) Covering the costs incurred by providers completing the trainings; and

(IV) Providing ongoing technical assistance for providers across the state of Colorado while participating in training.

(d) (I) In the quarterly report to the joint budget committee required pursuant to subsection (7)(b) of this section, the state department shall include updates on the work of the workforce capacity center. The report must include key milestones for startup activities, what trainings are offered, the number of trainings being provided each month, the number and type of certifications earned by providers as a result of the trainings, the number of certified providers enrolled as medicaid providers, and the locations where those certified providers practice.

(II) In the quarterly report submitted to the joint budget committee in January 2027, the state department shall include an analysis of the workforce capacity center's work that includes an overview of the impact of the workforce capacity center and a recommendation on the continuation, reduction, or closure of the center.

(e) This subsection (7.5) is repealed, effective July 1, 2027.

(8) As used in this section, "child or youth" means an individual who is less than twenty-one years of age.

Source: L. 2024: Entire part added, (HB 24-1038), ch. 459, p. 3174, § 1, effective June 6. **L. 2025:** (7.5) added, (SB 25-292), ch. 297, p. 1520, § 1, effective May 30; (2)(a), (2)(c)(II), (2)(c)(III), (3)(a), and (7)(b) amended, (HB 25-1213), ch. 276, p. 1439, § 9, effective August 6.

CHILDREN'S BASIC HEALTH PLAN

ARTICLE 8

Children's Basic Health Plan

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25.5-8-101. Short title.

This article shall be known and may be cited as the "Children's Basic Health Plan Act".

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1.

Editor's note: This section is similar to former § 26-19-101 as it existed prior to 2006.

25.5-8-102. Legislative declaration.

(1) The general assembly hereby finds and declares that a significant percentage of children are uninsured. This lack of health insurance coverage decreases children's access to preventive health-care services, compromises the productivity of the state's future workforce, and results in avoidable expenditures for emergency and remedial health care. Health-care providers, health-care facilities, and all purchasers of health care, including the state, bear the costs of this uncompensated care.

(2) The general assembly further finds and declares that the coordination and consolidation of funding sources currently available to provide services to uninsured children such as the children's basic health plan, and other children's health programs would efficiently and effectively meet the health-care needs of uninsured children and would help to reduce the volume of uncompensated care in the state.

(3) (a) It is the intent of the general assembly to make health insurance coverage available and affordable and to support employers in their efforts to provide their employees and their dependents with health insurance coverage and to support increased availability of affordable health insurance in the individual market.

(b) It is the intent of the general assembly that the savings and efficiencies realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and achieved in consolidating other health-care programs should be identified.

(4) It is not the intent of the general assembly to create an entitlement for health insurance coverage.

(5) The general assembly hereby declares that the following principles shall be used in implementing the children's basic health plan set forth in this article:

(a) The department shall establish and maintain a goal of inter-program communication in order to maximize existing state appropriations for the population served in the program;

(b) There shall be efficient program utilization through inter-program coordination and program consolidation and, where appropriate, through contracting with the private sector and with essential community providers;

(c) The policies enacted in House Bill 97-1304 regarding a strong managed care direction shall be emphasized;

(d) The private sector shall be involved to the greatest possible degree with respect to contracting for managed care;

(e) There shall be maximum emphasis on coordination with local and state public health programs and initiatives for children.

(6) The general assembly hereby finds and declares:

(a) That the goal of the "Children's Basic Health Plan Act" is to support low-income, working parents and families in overcoming barriers in obtaining good quality, affordable health-care services for their children;

(b) That the health services that low-income children receive through the children's basic health plan should be cost-effective, of high quality, and promote positive health outcomes for enrolled children;

(c) That the children's basic health plan was designed as, and should continue to be, a private-public partnership that encourages enrollment and seeks every opportunity to operate with the efficiency and creativity that is found in utilizing private sector systems and business practices while maintaining the highest level of accountability to the general assembly, the executive branch, and the public through administration of the plan by the department;

(d) That the children's basic health plan was designed as, and should continue to be, a community-based program that encourages local participation in enrolling children in and supporting its goals.

Source: L. 2006: Entire article added with relocations, p. 1973, § 7, effective July 1. **L. 2024:** (2) amended, (HB 24-1399), ch. 76, p. 259, § 29, effective July 1, 2025.

Editor's note: This section is similar to former § 26-19-102 as it existed prior to 2006.

25.5-8-103. Definitions - rules.

As used in this article 8, unless the context otherwise requires:

(1) "Child" means a person who is less than nineteen years of age.

(2) "Children's basic health plan" or "plan" means the subsidized health insurance product designed by the department of health care policy and financing and provided to enrollees, as defined in this section.

(3) "Department" means the department of health care policy and financing created in section 25.5-1-104.

(4) "Eligible person" means:

(a) (I) A person who is less than nineteen years of age, who is a citizen or meets the immigration status requirements set forth in section 25.5-8-109 (6) or 25.5-8-109 (7), whose

family income does not exceed two hundred sixty percent of the federal poverty line, adjusted for family size, and who is not eligible for medical assistance pursuant to articles 4, 5, and 6 of this title 25.5.

(II) Notwithstanding the provisions of subsection (4)(a)(I) of this section, if the money in the healthcare affordability and sustainability hospital provider fee cash fund established pursuant to section 25.5-4-402.4 (5), together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for persons less than nineteen years of age, the state board may by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) reduce the percentage of the federal poverty line to below two hundred sixty percent, but the percentage shall not be reduced to below two hundred thirteen percent.

(III) Repealed.

(b) (I) A pregnant person who is a citizen or meets the immigration status requirements set forth in section 25.5-8-109 (6) or 25.5-8-109 (7), whose family income does not exceed two hundred sixty percent of the federal poverty line, adjusted for family size, and who is not eligible for medical assistance pursuant to articles 4, 5, and 6 of this title 25.5.

(II) Notwithstanding the provisions of subsection (4)(b)(I) of this section, if the money in the healthcare affordability and sustainability hospital provider fee cash fund established pursuant to section 25.5-4-402.4 (5), together with the corresponding federal matching funds, is insufficient to fully fund all of the purposes described in section 25.5-4-402.4 (5)(b), after receiving recommendations from the Colorado healthcare affordability and sustainability enterprise established pursuant to section 25.5-4-402.4 (3), for pregnant women, the state board by rule adopted pursuant to the provisions of section 25.5-4-402.4 (6)(b)(III) may reduce the percentage of the federal poverty line to below two hundred sixty percent, but the percentage shall not be reduced to below two hundred thirteen percent.

(III) Repealed.

(5) "Enrollee" means any eligible person that has enrolled in the plan.

(6) "Essential community provider" means a health-care provider that:

(a) Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves the medically indigent patients within its medical capability; and

(b) Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a member's financial limitations.

(7) "Health-care program" means any health-care program in the state that is supported with state general fund or federal dollars.

(8) "Master settlement agreement" means the master settlement agreement, the smokeless tobacco master settlement agreement, and the consent decree approved and entered by the court in the case denominated *State of Colorado, ex rel. Gale A. Norton, Attorney General v. R.J. Reynolds Tobacco Co.; American Tobacco Co., Inc.; Brown & Williamson Tobacco Corp.; Liggett & Myers, Inc.; Lorillard Tobacco Co., Inc.; Philip Morris, Inc.; United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council For Tobacco Research--U.S.A., Inc.; and Tobacco Institute, Inc.*, Case No. 97 CV 3432, in the district court for the city and county of Denver.

(9) "Medical services board" means the medical services board created in section 25.5-1-301.

(10) "Subsidized enrollee" means an eligible person who receives a subsidy from the department to purchase coverage under the plan or a comparable health insurance.

(11) "Subsidy" means the amount paid by the department to assist an eligible person in purchasing coverage under the plan or a comparable health insurance product available to the eligible person through another coverage entity.

(12) "Trust" means the children's basic health plan trust created in section 25.5-8-105.

Source: L. 2006: Entire article added with relocations, p. 1975, § 7, effective July 1. **L. 2007:** (4) amended, p. 149, § 10, effective March 22. **L. 2008:** (4)(a) amended, p. 2019, § 1, effective March 1, 2009; (4)(b) amended, p. 2019, § 2, effective October 1, 2009. **L. 2009:** (4)(a) and (4)(b) amended, (SB 09-211), ch. 2, pp. 3, 4, § § 1, 2, 3, effective February 26; (4) amended, (HB 09-1293), ch. 152, p. 650, § 8, effective July 1; (4)(b) amended, (SB 09-292), ch. 369, p. 1985, § 130, effective August 5. **L. 2010:** (4)(a)(I), (4)(a)(II), (4)(a)(III)(A), (4)(a)(III)(B), (4)(b)(I), (4)(b)(II), (4)(b)(III)(A), and (4)(b)(III)(B) amended, (HB 10-1422), ch. 419, p. 2114, § 150, effective August 11. **L. 2017:** IP, (4)(a)(II), and (4)(b)(II) amended, (SB 17-267), ch. 267, p. 1466, § 22, effective July 1. **L. 2022:** (4)(a)(I), (4)(a)(II), (4)(b)(I), and (4)(b)(II) amended, (SB 22-052), ch. 43, p. 217, § 4, effective March 24; (4)(a)(I) and (4)(b)(I) amended, (HB 22-1289), ch. 399, p. 2844, § 20, effective June 7. **L. 2024:** (6)(b) amended, (SB 24-176), ch. 152, p. 673, § 97, effective August 7. **L. 2025:** (4)(a)(II) and (4)(b)(II) amended, (SB 25-270), ch. 151, p. 606, § 16, effective May 1.

Editor's note: (1) This section is similar to former § 26-19-103 as it existed prior to 2006.

(2) Subsection (4)(a)(III)(C) and (4)(b)(III)(C) provided for the repeal of subsection (4)(a)(III) and (4)(b)(III), respectively, effective the July 1 following the revisor of statutes' receipt of the

notice required pursuant to subsection (4)(a)(III)(B) and (4)(b)(III)(B). (See L. 2010, p. 2114.) The revisor of statutes received said notice dated February 17, 2017.

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

(4) Amendments to subsections (4)(a)(I) and (4)(b)(I) by HB 22-1289 and SB 22-052 were harmonized.

Cross references: For the legislative declaration in SB 17-267, see section 1 of chapter 267, Session Laws of Colorado 2017. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-8-104. Children's basic health plan - rules.

The medical services board is authorized to adopt rules to implement the children's basic health plan to provide health insurance coverage to eligible persons on a statewide basis pursuant to the provisions of this article. Any rules adopted by the children's basic health plan policy board in accordance with the requirements of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., shall be enforceable and shall be valid until amended or repealed by the medical services board.

Source: L. 2006: Entire article added with relocations, p. 1976, § 7, effective July 1.

Editor's note: This section is similar to former § 26-19-104 as it existed prior to 2006.

25.5-8-105. Trust - created.

(1) A fund to be known as the children's basic health plan trust is hereby created and established in the state treasury. Except as provided for in subsection (8) of this section, all moneys deposited in the trust and all interest earned on moneys in the trust shall remain in the trust for the purposes set forth in this article, and no part thereof shall be expended or

appropriated for any other purpose. The principal of the trust shall be expended, subject to annual appropriation by the general assembly, solely for the purposes set forth in this article.

(2) (a) Except as provided for in subsection (8) of this section, all or a portion of the moneys in the trust shall be annually appropriated by the general assembly for the purposes of this article and shall not be transferred to or revert to the general fund of the state at the end of any fiscal year.

(b) Notwithstanding the provisions of paragraph (a) of this subsection (2), moneys in the trust may be used to pay the state's portion of any computer system changes necessary to expand eligibility in the plan.

(3) (a) Pursuant to section 24-75-1104.5 (1.7)(b), C.R.S., and except as otherwise provided in section 24-75-1104.5 (5), C.R.S., beginning in the 2016-17 fiscal year and in each fiscal year thereafter so long as the state receives moneys pursuant to the master settlement agreement, the state treasurer shall transfer to the trust eighteen percent of the total amount of the moneys annually received by the state pursuant to the master settlement agreement, not including attorney fees and costs, during the preceding fiscal year. The state treasurer shall transfer the amount specified in this subsection (3) from moneys credited to the tobacco litigation settlement cash fund created in section 24-22-115, C.R.S. The amount transferred pursuant to this subsection (3) is in addition to and not in replacement of any general fund moneys appropriated to the trust.

(b) Repealed.

(4) Repealed.

(5) (a) Beginning in fiscal year 1998, appropriations to the trust may be made by the general assembly based on the savings achieved through reforms, consolidations, and streamlining of health-care programs realized through actual reductions in administrative and programmatic costs associated with the implementation of this article and not decreases in the number of caseloads of such programs. Beginning with and subsequent to fiscal year 2000-01, the general assembly may make annual appropriations to the trust.

(b) and (c) Repealed.

(6) As part of its annual savings report to the general assembly on November 1 of each year, the department may identify efficiencies and consolidations that produce savings in the department's annual budget request that result in actual reductions in administrative and programmatic costs associated with the implementation of this article and not decreases in the number of caseloads of such programs.

(7) The department may receive payment for coverage offered and may receive or contract for donations, gifts, and grants from any source. Such funds shall be transmitted to the state

treasurer who shall credit the same to the trust. The department may expend such funds from the trust for the purposes of this article.

(8) (a) Beginning in the 2011-2012 fiscal year and for each fiscal year thereafter, moneys in the trust may be used for costs associated with children enrolled in the medical assistance program, articles 4, 5, and 6 of this title, whose family income is more than one hundred percent but does not exceed one hundred thirty-three percent of the federal poverty line and who would have been eligible for enrollment in the children's basic health plan prior to September 1, 2011.

(b) On July 1, 2016, the state treasurer shall transfer twenty million dollars from the children's basic health plan trust to the primary care provider sustainability fund created in section 25.5-5-418.

Source: L. 2006: (3) amended, p. 1040, § 10, effective May 25; entire article added with relocations, p. 1976, § 7, effective July 1. **L. 2007:** (1), (2), and (3) amended, p. 150, § 11, effective March 22; (3)(b) amended, p. 892, § 5, effective July 1. **L. 2008:** (2) amended, p. 2020, § 3, effective June 3. **L. 2009:** (1), (2), and (3) amended, (SB 09-210), ch. 124, p. 531, § 5, effective April 16; (3) amended, (SB 09-269), ch. 333, p. 1768, § 9, effective June 1. **L. 2011:** (1) and (2)(a) amended and (8) added, (SB 11-008), ch. 100, p. 293, § 3, effective September 1. **L. 2012:** (3)(b) amended, (HB 12-1247), ch. 53, p. 197, § 7, effective March 22. **L. 2015:** (1) and (2)(a) amended and (4), (5)(b), and (5)(c) repealed, (SB 15-264), ch. 259, p. 962, § 79, effective August 5. **L. 2016:** (3)(a) and (8) amended and (3)(b) repealed, (HB 16-1408), ch. 153, pp. 469, 472, § § 20, 26, effective July 1; (6) amended, (HB 16-1081), ch. 22, p. 53, § 10, effective August 10.

Editor's note: (1) This section is similar to former § 26-19-105 as it existed prior to 2006.

(2) Subsection (3) was originally numbered as § 26-19-105 (2.5), and the amendments to it in House Bill 06-1310 were harmonized with subsection (3) as it appeared in Senate Bill 06-219.

(3) Amendments to subsection (3) by Senate Bill 09-210 and Senate Bill 09-269 were harmonized.

25.5-8-106. Annual savings report. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1977, § 7, effective July 1. **L. 2016:** Entire section repealed, (HB 16-1081), ch. 22, p. 52, § 8, effective August 10.

Editor's note: This section was similar to former § 26-19-106 as it existed prior to 2006.

25.5-8-107. Duties of the department - schedule of services - premiums - copayments - subsidies - purchase of childhood immunizations.

(1) In addition to any other duties pursuant to this article 8, the department has the following duties:

(a) (I) To design, and from time to time revise, a schedule of health-care services included in the plan and to propose said schedule to the medical services board for approval or modification. The schedule of health-care services as proposed by the department and approved by the medical services board shall include, but shall not be limited to, preventive care, physician services, prenatal care and postpartum care, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be medically necessary for the health of enrollees; except that the department may modify the schedule of health-care services to meet specific federal requirements or to accommodate those changes necessary for a program designed specifically for children.

(II) In addition to the items specified in subsection (1)(a)(I) of this section and any additional items approved by the medical services board, on and after January 1, 2001, the medical services board shall include dental services for all enrolled children, and on and after October 1, 2019, for all enrolled pregnant women, in the schedule of health-care services.

(III) In addition to the items specified in subsections (1)(a)(I) and (1)(a)(II) of this section and any additional items approved by the medical services board, the medical services board shall include mental health services that are at least as comprehensive as the mental health services provided to medicaid members in the schedule of health-care services.

(IV) The schedule of health-care services included in the plan shall not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 (1.4), C.R.S.

(V) In addition to the items specified in subsections (1)(a)(I), (1)(a)(II), and (1)(a)(III) of this section, and any additional items approved by the medical services board, the medical services board shall include, for all perinatal people, comprehensive lactation support services, lactation supplies and equipment, and maintenance of multi-user loaned equipment. An individual trained in advanced lactation support shall provide the lactation support services. Lactation equipment must include a single-user double electric breast pump, pump parts and pump collection kit, and access to a loaned multi-user hospital grade electric breast pump along with a compatible individual collection kit. Individuals must have access to single-user lactation supplies and equipment prior to delivery. Access to multi-user loaned breast pumps shall be authorized by a health-care provider. Access to multi-user loaned breast pumps is prioritized for individuals with premature, medically fragile, low birth weight infants, and with lactation complications.

Individuals cannot be required to enroll in separate or additional programs in order to receive covered lactation equipment or lactation support services.

(VI) In addition to the items specified in subsections (1)(a)(I), (1)(a)(II), (1)(a)(III), and (1)(a)(V) of this section, and any additional items approved by the medical services board, on and after January 1, 2026, the medical services board shall include abortion care in the schedule of health-care services for all enrolled pregnant persons.

(VII) **[*Editor's note: Subsection (1)(a)(VII) is effective January 1, 2027.*]** The schedule of health-care services included in the plan must not include coverage pursuant to the mandatory coverage provisions of section 10-16-104 (29).

(b) Repealed.

(c) To design and implement a structure of copayments due to providers of managed health-care plans from enrollees. Enrollees in the plan may use funds from a medical savings account to pay copayments.

(d) To design and propose to the medical services board for adoption detailed rules of eligibility and enrollment processes for the plan;

(e) To design a procedure whereby a financial sponsor may pay the annual enrollment fee or some portion thereof on behalf of a subsidized or nonsubsidized enrollee; except that the payment made on behalf of said enrollee shall not exceed the total enrollment fee due from the enrollee;

(f) To design a procedure whereby the plan may pay subsidies for eligible persons to purchase coverage under the plan or a comparable health insurance product;

(g) To establish criteria to allow a managed care plan, the department, or some other entity to verify eligibility pursuant to section 25.5-8-109;

(h) To conduct pilot projects including, but not limited to, testing models of marketing, enrollment, eligibility determination, and premium structures, to be implemented where appropriate and as approved by the joint budget committee.

(i) Repealed.

(2) The department is authorized to institute a program for competitive bidding pursuant to section 24-103-202 or 24-103-203, C.R.S., for providing medical services on a managed care basis for children under this article. The department shall select more than one managed care contractor to serve counties in which there are providers contracting with more than one managed care plan. In counties where there is only one operational managed care plan, the department may contract with that managed care plan to serve children enrolled in the plan. The department shall assure the utilization of essential community providers for the provision of services including eligibility determination, enrollment, and outreach when reasonable. The

department shall contract with managed care organizations for the delivery of health services pursuant to this article. The department may contract with essential community providers for health-care services in areas of the state that are not adequately served by managed care organizations.

(3) The department may contract for billing and premium collection functions for the children's basic health plan with vendors who provide billing and premium collection functions for other state insurance programs in order to consolidate billing and premium collection functions among multiple state programs. Such contracts may be entered into if the department determines that the scope of work provided by the vendor is similar to the work requirements for the children's basic health plan and that it would be more efficient and cost-effective to contract with the same vendor on multiple programs.

(4) Commencing with fiscal year 2001-02, the annual administrative costs for the children's basic health plan shall not exceed ten percent of the total annual program costs.

(5) The department may purchase vaccines recommended by the advisory committee on immunization practices to the centers for disease control and prevention in the federal department of health and human services, or its successor entity, the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, or the American College of Physicians through a vaccine purchasing system, if such a system is developed pursuant to section 25-4-2403 (1), for children enrolled in the children's basic health plan.

Source: L. 2006: (1)(a)(I) amended, p. 1505, § 51, effective June 1; entire article added with relocations, p. 1978, § 7, effective July 1; (1)(a)(I) amended, p. 1078, § 6, effective January 1, 2007. **L. 2008:** (2)(a)(III) added, p. 2020, § 4, effective January 1, 2009. **L. 2009:** (1)(a)(IV) added, (SB 09-244), ch. 391, p. 2118, § 5, effective July 1, 2010. **L. 2010:** (1)(b) amended, (HB 10-1422), ch. 419, p. 2115, § 151, effective August 11. **L. 2013:** (1)(a)(I) amended, (HB 13-1266), ch. 217, p. 993, § 64, effective May 13; (5) amended, (SB 13-222), ch. 350, p. 2033, § 5, effective May 28. **L. 2019:** IP(1) and (1)(a)(II) amended, (HB 19-1038), ch. 116, p. 491, § 2, effective April 16. **L. 2022:** (1)(a)(V) and (1)(i) added and (1)(b) repealed, (HB 22-1289), ch. 399, p. 2845, § 21, effective June 7. **L. 2024:** (1)(a)(III) amended, (SB 24-176), ch. 152, p. 673, § 98, effective August 7. **L. 2025:** (1)(a)(VI) added, (SB 25-183), ch. 97, p. 444, § 5, effective January 1, 2026; (1)(a)(VII) added, (SB 25-048), ch. 365, p. 1981, § 4, effective January 1, 2027. **L. 2026:** (5) amended, (SB 26-032), ch. 24, p. 117, § 16, effective March 27; (1)(i) repealed, (HB 26-1411), ch. 398, p. 2492, § 3, effective June 4.

Editor's note: (1) This section is similar to former § 26-19-107 as it existed prior to 2006.

(2) Amendments to section 26-19-107 (1)(a)(I) by House Bill 06-1391 were harmonized with subsection (1)(a)(I) as it appeared in Senate Bill 06-219. Amendments to section 26-19-107 (1)(a)(I) by Senate Bill 06-036 were further harmonized with subsection (1)(a)(I), effective January 1, 2007.

(3) Section 5(2) of chapter 365 (SB 25-048), Session Laws of Colorado 2025, provides that the act changing this section applies to large group health benefit plans issued or renewed on or after January 1, 2027.

Cross references: (1) For the legislative declaration contained in the 2006 act amending subsection (1)(a)(I), see § 1 of chapter 236, Session Laws of Colorado 2006. For the legislative declaration contained in the 2009 act adding subsection (1)(a)(IV), see § 1 of chapter 391, Session Laws of Colorado 2009. For the legislative declaration in the 2013 act amending subsection (5), see section 1 of chapter 350, Session Laws of Colorado 2013. For the legislative declaration in HB 19-1038, see section 1 of chapter 116, Session Laws of Colorado 2019. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

(2) For the short title ("Diabetes Prevention and Obesity Treatment Act") and the legislative declaration in SB 25-048, see sections 1 and 2 of chapter 365, Session Laws of Colorado 2025.

(3) For the short title ("Ensuring Immunization Access for Coloradans Act") and the legislative declaration in SB 26-032, see sections 1 and 2 of chapter 24, Session Laws of Colorado 2026.

25.5-8-108. Financial management - cash system of accounting.

(1) The department shall propose rules for approval by the medical services board to implement financial management of the plan. Pursuant to such rules, the department shall adjust benefit levels, eligibility guidelines, and any other measure to ensure that sufficient funds are present to implement the provisions of this article. The department shall develop and use quality assurance measures, such as the health employer data information set (HEDIS) reports regarding provider compensation, adapted to children's needs, to ensure that appropriate health-care outcomes are met and to justify the continued use of taxpayer dollars for the plan. The department shall implement performance-based contracting based on such quality assurance measures.

(2) The department shall make a quarterly assessment of the expected expenditures for the plan for the remainder of the current biennium and for the following biennium. The estimated expenditures, including minimum reserve requirements, shall be compared to an estimate of the revenues that will be deposited in the trust fund. Based on this comparison, the department shall

make adjustments as necessary to ensure that expenditures remain within the limits of available revenues for the remainder of the current biennium and the following biennium.

(3) The department may, in addition to any other measure it determines to be necessary, decrease subsidies for annual enrollment fees or limit enrollment in the plan to ensure that the trust retains sufficient funds pursuant to subsection (1) of this section.

(4) (a) Nothing in this article or any rules promulgated pursuant to the plan shall be interpreted to create a legal entitlement in any person to coverage under the plan. If enrollment in the plan is limited, the department shall give priority to children with family incomes under one hundred thirty-three percent of the federal poverty line.

(b) The department shall report quarterly to the joint budget committee on any enrollment caps that have been instituted for the plan and the number of children who are on waiting lists.

(5) The department shall utilize the cash system of accounting, as enunciated by the governmental accounting standards board, regardless of the source of revenues involved, for all activities of the department relating to the financial administration of any nonadministrative expenditure for the plan.

Source: L. 2006: Entire article added with relocations, p. 1980, § 7, effective July 1. **L. 2007:** (5) added, p. 465, § 3, effective July 1. **L. 2008:** (4)(a) amended, p. 459, § 2, effective April 14. **L. 2010:** (4)(a) amended, (HB 10-1422), ch. 419, p. 2115, § 152, effective August 11.

Editor's note: This section is similar to former § 26-19-108 as it existed prior to 2006.

25.5-8-109. Eligibility - children - pregnant women - rules.

(1) To be eligible for a subsidy, a child must not be insured by a comparable health plan through an employer.

(2) If one child from a family is enrolled in the plan, all children must be enrolled, unless the other children have alternative health insurance coverage.

(3) The department may establish procedures such that children with family incomes that exceed the percent of the federal poverty guidelines specified in section 25.5-8-103 (4)(a) may enroll in the plan, but are not eligible for subsidies from the department.

(4) A child whose family income does not exceed the applicable level specified in section 25.5-8-103 (4)(a) shall be presumptively eligible for the plan. Children who are determined to be eligible for the plan shall remain eligible for twelve months subsequent to the last day of the

month in which they were enrolled; except that a child shall no longer be eligible for the plan and shall be disenrolled from the plan if the department becomes aware of or is notified that any of the following has occurred:

(a) The child has moved out of the state; or

(b) Repealed.

(c) The child has been enrolled in a commercial health insurance plan during the twelve-month period following enrollment in the plan under this article.

(4.5) (a) (I) To the extent authorized by federal law, the department shall require an applicant to state only the applicant's family income and shall notify the applicant that the applicant's family income will be verified by federally approved electronic data sources. The department shall allow an applicant to provide income information more recent than the records of the federally approved electronic data sources.

(II) The department shall annually verify the member's income eligibility at reenrollment through federally approved electronic data sources. If a member meets all eligibility requirements, a member remains enrolled in the plan. The department shall also allow a member to provide income information more recent than the records of federally approved electronic data sources.

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

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

(V) The county department, state department, or other entity designated by the state department to make the eligibility determination shall automatically transfer to the state insurance marketplace through a system interface the application data and verifications of a child or pregnant woman who is determined ineligible for medical assistance benefits pursuant to this section.

(VI) The state department may seek federal authorization to not require additional verification during a member's eligibility reenrollment process if information about the member's income is not verified through a federally approved electronic data source. The state department may use the information on file or the information that was originally collected during the

application process to determine whether the member is eligible for reenrollment. Notwithstanding this subsection (4.5)(a)(VI) to the contrary, the state department shall require additional income verification if information about a member's income is not verified through a federally approved electronic data source for two or more consecutive years or as specified through federal authorization.

(VII) The state department may seek federal authorization to not require additional verification during a member's eligibility reenrollment process if information about the member's assets is not verified through a federally approved electronic data source in a reasonable time, as determined by the state department. The state department may complete the member's eligibility reenrollment process without any additional verification of the member's assets if there has been no change in the member's assets since the initial verification during the application process or as specified through federal authorization.

(VIII) The state department may seek federal authorization to delay a member's procedural termination during the reenrollment process to allow the member to continue receiving necessary services during the reenrollment process. The state department may apply this delay in procedural termination to a specific population or as specified through federal authorization.

(IX) The state department may seek federal authorization to allow an applicant's or member's eligibility for reenrollment to be based on financial findings from the supplemental nutrition assistance program established pursuant to part 3 of article 2 of title 26, the temporary assistance for needy families program established pursuant to part 7 of article 2 of title 26, and other means-tested benefit programs administered through the Colorado benefits management system. The state department may apply financial eligibility for medicaid to individuals whose gross income program and assets for applicable means-tested benefit programs are below applicable medicaid limits, regardless of differences in household composition and income-counting rules between programs or as specified through federal authorization.

(X) Subject to available appropriations and upon receiving necessary federal authorization, the state department may implement subsections (4.5)(a)(VI), (4.5)(a)(VII), (4.5)(a)(VIII), and (4.5)(a)(IX) of this section.

(b) Repealed.

(c) Subject to the provisions and requirements of section 25.5-4-205 (3)(e), the department shall establish a process so that an enrollee or the parent or guardian of an enrollee may apply for reenrollment either over the telephone or through the internet.

(5) (a) (I) A pregnant woman whose family income does not exceed the applicable level specified in section 25.5-8-103 (4)(b) shall be presumptively eligible for the plan. Once determined eligible for the plan, a pregnant woman shall be considered to be continuously eligible throughout the pregnancy and for the sixty days following the pregnancy, even if the woman's eligibility would otherwise terminate during such period due to an increase in income.

Upon birth, a child born to a woman eligible for the plan shall be eligible for the plan and shall be automatically enrolled in the plan in accordance with the eligibility requirements for children specified in subsection (4) of this section.

(II) Repealed.

(b) (I) Under the plan, prenatal and postpartum primary health-care providers shall implement policies regarding the integration of evidence-based tobacco use treatments into the regular health-care delivery system, including, but not limited to:

(A) Assessment of tobacco use and exposure to second-hand smoke;

(B) Education on the dangers of tobacco use during pregnancy and postpartum;

(C) Referrals to appropriate cessation services.

(II) Health-care providers may coordinate the implementation of such policies with the tobacco education, prevention, and cessation programs established in section 25-3.5-804, C.R.S.

(c) The addition of coverage under the plan for pregnant women shall only be implemented if the department obtains a waiver from the federal department of health and human services.

(d) Enrollment of a pregnant woman in the plan shall be limited based upon annual appropriations made out of the trust by the general assembly as described in section 25.5-8-105 and any grants and donations. The general assembly shall annually establish maximum enrollment figures for pregnant women in the plan. The department shall not exceed the enrollment caps regardless of whether the funding comes from annual appropriations or grants and donations.

(5.5) (a) Subject to the receipt of federal financial participation, to the maximum extent allowed under federal law, a person who was eligible for the plan while pregnant and who remains eligible for the plan for the sixty days following the pregnancy remains continuously eligible for all services under the plan for the twelve-month postpartum period.

(b) The department shall seek any plan amendment necessary to implement a twelve-month postpartum benefit pursuant to this subsection (5.5) and shall implement the benefit only upon receipt of federal authorization and financial participation, and no later than July 1, 2022.

(c) If permissible under federal law, an eligible individual within the postpartum period may resume coverage under the plan upon implementation of this section.

(6) (a) Notwithstanding any other provision of law, but subject to the receipt of federal financial participation, the department shall provide benefits pursuant to this article 8 to a pregnant person who is lawfully residing, as defined in section 25.5-4-103 (10), and a child less than nineteen years of age, who is lawfully residing, so long as such pregnant person or child meets eligibility criteria other than those related to citizenship or immigration status.

(7) (a) Beginning no later than January 1, 2025, notwithstanding any other provision of law, the department shall provide benefits pursuant to this article 8 to a pregnant person who is not a citizen and is not eligible pursuant to subsection (6) of this section, so long as the pregnant person meets the eligibility criteria other than those related to citizenship or immigration status. Eligibility pursuant to this section extends continuously through the twelve-month postpartum period, so long as eligibility remains in effect pursuant to subsection (5.5)(a) of this section.

(b) The department shall seek any necessary federal approvals to maximize any available federal financial participation in implementing this subsection (7).

(c) (I) During its 2024 presentation to the joint budget committee of the general assembly and in its presentation to the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees, at the hearing held pursuant to section 2-7-203 (2)(a) of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", the state department shall report on its plans and progress in implementing the coverage expansion created pursuant to this subsection (7).

(II) Beginning January 1, 2026, and continuing every January thereafter, the state department, in its presentation to the joint budget committee of the general assembly and in its presentation to the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees, at the hearing held pursuant to section 2-7-203 (2)(a) of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act", shall report on the cost savings and health improvements associated with the coverage expansion created pursuant to this subsection (7).

(d) This subsection (7) constitutes state authority within the meaning of 8 U.S.C. sec. 1621 (d), as that law existed on January 1, 2022.

(8) Repealed.

Source: L. 2006: (5)(a) amended, p. 1121, § 1, effective May 25; entire article added with relocations, p. 1981, § 7, effective July 1. **L. 2007:** (5)(a)(I) and (5)(a)(II)(A) amended, p. 151, § 12, effective March 22; (3), IP(4), and (4)(b) amended, p. 1493, § 6, effective January 1, 2008. **L. 2008:** (4.5) added, p. 2026, § 2, effective June 3; (5)(a)(I) amended, p. 2020, § 5, effective October 1, 2009. **L. 2009:** (4.5)(c) added, (HB 09-1020), ch. 298, p. 1596, § 2, effective May 21; (6) added, (HB 09-1353), ch. 360, p. 1870, § 3, effective July 1, 2010. **L. 2012:** (4.5)(a)(I), (4.5)(a)(II), and (4.5)(a)(III) amended, (HB 12-1120), ch. 27, p. 109, § 26, effective June 1. **L. 2013:** (1) amended, (SB 13-008), ch. 78, p. 251, § 1, effective March 29. **L. 2014:** (4)(a) and (4.5)(a) amended and (4)(b) repealed, (SB 14-067), ch. 12, p. 114, § 8, effective February 27. **L. 2021:** (5.5) added, (SB 21-194), ch. 434, p. 2871, § 8, effective September 7. **L. 2022:** (5.5)(a) and (6) amended and (7) added, (HB 22-1289), ch. 399, p. 2846, § 22, effective June 7. **L. 2023:**

(8) added, (SB 23-182), ch. 118, p. 432, § 5, effective April 27. **L. 2024:** (4.5)(a)(VI), (4.5)(a)(VII), (4.5)(a)(VIII), (4.5)(a)(IX), and (4.5)(X) added and (8) amended, (HB 24-1400), ch. 77, p. 264, § 5, effective April 18; (4.5)(a)(II) and (4.5)(a)(III) amended, (SB 24-176), ch. 152, p. 673, § 99, effective August 7.

Editor's note: (1) This section is similar to former § 26-19-109 as it existed prior to 2006.

(2) Amendments to section 26-19-109 (5)(a) by Senate Bill 06-135 were harmonized with subsection (5)(a) as it appeared in Senate Bill 06-219.

(3) Subsection (5)(a)(II)(B) provided for the repeal of subsection (5)(a)(II), effective July 1, 2007. (See L. 2006, pp. 1121, 1981.)

(4) Subsection (4.5)(b)(II) provided for the repeal of subsection (4.5)(b), effective July 1, 2009. (See L. 2008, p. 2026.)

(5) The effective date for amendments to subsections (4.5)(a)(I), (4.5)(a)(II), and (4.5)(a)(III) by House Bill 12-1120 (chapter 27, Session Laws of Colorado 2012) was changed from August 8, 2012, to June 1, 2012, by House Bill 12S-1002 (First Extraordinary Session, chapter 2, p. 2432, Session Laws of Colorado 2012.)

(6) Subsection (8)(c) provided for the repeal of subsection (8), effective January 1, 2025. (See L. 2024, p. 264.)

Cross references: For the legislative declaration contained in the 2007 act amending subsections (3) and (4)(b) and the introductory portion to subsection (4), see section 1 of chapter 347, Session Laws of Colorado 2007. For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-8-109.3. Health services initiatives.

(1) To the extent federal financial participation is available, the department shall design and implement health service initiatives pursuant to section 2105(a)(1)(D)(ii) of the federal "Social Security Act", as amended, to provide funding for continuous enrollment for the twelve-month postpartum period for a person who is enrolled in health-care coverage pursuant to section 25.5-5-201 (6) or 25.5-8-109 (7).

(2) To the extent additional federal financial participation is available, the department shall establish a stakeholder process in collaboration with department staff to determine additional priorities and budget allocations that draw down at least fifty percent of the remaining health services initiative funds to expand access to perinatal and postpartum supports. The department

shall report on the established priorities and budget allocations and the ways in which they are inclusive of stakeholder input during the department's 2024 presentation to the joint budget committee of the general assembly and in the department's presentation to the health and human services committee of the senate and the health and insurance committee of the house of representatives, or any successor committees, at the hearing held pursuant to section 2-7-203 (2)(a) of the "State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act". In conducting the stakeholder process, the department shall:

(a) Engage directly with impacted individuals, service providers, advocacy organizations, and individuals working in or representing communities who are diverse with regard to race, ethnicity, immigration status, age, ability, sexual orientation, gender identity, or geographic region of the state and who are affected by higher rates of health disparities and inequities;

(b) Publicize, conduct, and report outcomes of stakeholder meetings in, at a minimum, English and Spanish;

(c) Include opportunities for participation in the stakeholder process outside of regular work hours;

(d) Conduct a minimum of five stakeholder meetings and conduct additional meetings focused on hearing input from individual constituencies listed in subsection (2)(a) of this section;

(e) Take into consideration research and information from reports issued by the maternal mortality review committee, as required by section 25-52-104 (6);

(f) Take into consideration data from the health survey for birthing parents to inform stakeholder decision-making; and

(g) Consider initiatives to reduce diaper need, expand access to group-based prenatal and pediatric care models, and expand home visitation programs, including voluntary newborn nurse visitation programs that are universally offered to all families in a given community and provide at least one nurse visit within the first three months of life.

(3) (a) The department shall seek any necessary federal approvals to obtain federal financial participation in implementing subsection (1) of this section.

(b) To the extent allowable, the department shall maximize federal financial participation in implementing this section.

Source: L. 2022: Entire section added, (HB 22-1289), ch. 399, p. 2847, § 23, effective June 7.

Cross references: For the legislative declaration in HB 22-1289, see section 1 of chapter 399, Session Laws of Colorado 2022.

25.5-8-109.5. Telehealth - interim therapeutic restorations - reimbursement - definitions.

(1) Subject to federal authorization and financial participation, on or after July 1, 2016, in-person contact between a health-care provider and an enrollee is not required under the children's basic health plan for the diagnosis, development of a treatment plan, instruction to perform an interim therapeutic restoration procedure, or supervision of a dental hygienist performing an interim therapeutic restoration procedure. A health-care provider may provide these services through telehealth, including store-and-forward transfer, and is entitled to reimbursement for the delivery of those services via telehealth to the extent the services are otherwise eligible for reimbursement under the plan. The services are subject to the reimbursement policies developed pursuant to the children's basic health plan.

(2) As used in this section:

(a) "Interim therapeutic restoration" has the same meaning as set forth in section 12-220-104 (10).

(b) "Store-and-forward transfer" means the asynchronous transmission of medical or dental information to be reviewed by a dentist at a later time at a distant site without the patient present in real time.

Source: L. 2015: Entire section added, (HB 15-1309), ch. 326, p. 1335, § 9, effective August 5. **L. 2019:** (2) amended, (HB 19-1172), ch. 136, p. 1711, § 191, effective October 1. **L. 2021:** (2)(b) amended, (SB 21-102), ch. 31, p. 130, § 11, effective September 1.

25.5-8-110. Participation by managed care plans.

(1) Managed care plans, as defined in section 10-16-102 (43), C.R.S., that participate in the plan shall do so by contract with the department and shall provide the health-care services covered by the plan to each enrollee.

(2) Managed care plans participating in the plan shall not discriminate against any potential or current enrollee based upon health status, disability, sex, sexual orientation, gender identity, gender expression, marital status, race, creed, color, national origin, ancestry, ethnicity, or religion.

(3) Managed care plans that contract with the department to provide the plan to enrollees shall also be willing to contract with the medicaid managed care program, as administered by the department.

(4) (a) Managed care plans shall be selected by the department to participate in the children's basic health plan based upon the managed care plans' assurances and the department's verification that the managed care plan is utilizing within its network essential community providers to the extent that this action does not result in a net increase in the cost for providing services to the managed care plan.

(b) The managed care organization shall seek proposals from each essential community provider in a county in which the managed care organization is enrolling members for those services that the managed care organization provides or intends to provide and that an essential community provider provides or is capable of providing. To assist managed care organizations in seeking proposals, the department shall provide managed care organizations with a list of essential community providers in each county. The managed care organization shall consider the proposals in good faith and shall, when deemed reasonable by the managed care organization based on the needs of its members, contract with essential community providers. Each essential community provider must be willing to negotiate on reasonably equitable terms with each managed care organization. Essential community providers making proposals pursuant to this subsection (4) must be able to meet the contractual requirements of the managed care organization. The requirement of this subsection (4) does not apply to a managed care organization in areas in which the managed care organization operates entirely as a group model health maintenance organization.

(c) Any disputes between a managed care organization and an essential community provider that cannot be resolved through good faith negotiations may be resolved through an informal review by the department at the request of one of the parties, or through the department's aggrieved provider appeal process in accordance with section 25.5-1-107 (2), if requested by one of the parties.

(d) In selecting managed care organizations through competitive bidding, the department shall give preference to those managed care organizations that have executed contracts for services with one or more essential community providers. In selecting managed care organizations, the department shall not penalize a managed care organization for paying cost-based reimbursement to federally qualified health centers as defined in the federal "Social Security Act".

(5) The department may receive and act upon complaints from members regarding failure to provide covered services or efforts to obtain payment, other than authorized copayments, for covered services directly from eligible members.

(6) Parents or guardians of children shall choose a participating health maintenance organization before enrolling in the plan in areas of the state where a participating health maintenance organization is available. The department will assign children who are currently enrolled in the plan and whose parents or guardians have not selected a health maintenance organization within a time period determined by the department to a participating health

maintenance organization with the child's primary care physician in the network. The department shall seek to maintain continuity of the health plan between medicaid and the children's basic health plan.

(7) In areas of the state in which a participating managed care plan does not have providers, the department may contract with essential community providers and other health-care providers to provide health-care services under the children's basic health plan using a managed care model.

(8) The department may contract with essential community providers or other providers or develop other administrative arrangements to provide health-care services under the children's basic health plan to enrollees prior to the effective date of enrollment in the selected managed care plan.

(9) The department shall allow, at least annually, an opportunity for members to transfer among participating managed care plans serving their respective geographic regions. The department shall establish a period of at least twenty days annually when the opportunity to transfer is afforded to eligible members. In geographic regions served by more than one participating managed care plan, the department shall endeavor to establish a uniform period for the opportunity to transfer.

(10) (a) The department shall make a capitation payment to managed care plans based upon a defined scope of services at an agreed upon rate. The department shall only use market rate bids that do not discriminate and are adequate to assure quality, network sufficiency, and long-term competitiveness in the children's basic health plan managed care market. The department shall retain a qualified actuary to establish a lower limit for such bids. A certification by such actuary to the appropriate lower limit shall be conclusive evidence of the department's compliance with the requirements of this subsection (10). For the purposes of this subsection (10), a "qualified actuary" shall be a person deemed as such under rules promulgated by the commissioner of insurance.

(b) Repealed.

(11) All managed care plans participating in the plan shall meet standards regarding the quality of services to be provided, financial integrity, and responsiveness to the unmet health-care needs of eligible persons that may be served.

Source: L. 2006: Entire article added with relocations, p. 1982, § 7, effective July 1. **L. 2008:** (2) amended, p. 1603, § 32, effective May 29. **L. 2009:** (10) amended, (SB 09-265), ch. 205, p. 936, § 7, effective May 1. **L. 2010:** (10)(b) repealed, (HB 10-1382), ch. 217, p. 940, § 6, effective May 6. **L. 2013:** (1) amended, (HB 13-1266), ch. 217, p. 993, § 65, effective May 13.

L. 2021: (2) amended, (HB 21-1108), ch. 156, p. 897, § 41, effective September 7. **L. 2024:** (4)(b), (5), and (9) amended, (SB 24-176), ch. 152, p. 674, § 100, effective August 7.

Editor's note: This section is similar to former § 26-19-110 as it existed prior to 2006.

Cross references: (1) For the legislative declaration contained in the 2008 act amending subsection (2), see section 1 of chapter 341, Session Laws of Colorado 2008.

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

(3) For the legislative declaration in HB 21-1108, see section 1 of chapter 156, Session Laws of Colorado 2021.

25.5-8-111. Department - administration - outsourcing.

(1) (a) The department may:

(I) Pursuant to section 24-50-504 (2)(a), C.R.S., enter into personal services contracts for the administration of the children's basic health plan. Any contracts established pursuant to this section shall contain performance measures that shall be monitored by the department.

(II) Use county departments of human or social services to perform functions relating to the administration of the children's basic health plan;

(III) Perform administrative functions at the department, including consolidation of functions with other administrative functions handled by the department.

(b) In deciding how to allocate functions relating to the administration of the children's basic health plan as allowed under paragraph (a) of this subsection (1), the department shall determine and base its decisions upon what is the most cost-effective method to handle the particular function and to deliver the services.

(2) The implementation of subparagraph (I) of paragraph (a) of subsection (1) of this section is contingent upon a finding by the state personnel director that any of the conditions of section 24-50-504 (2), C.R.S., have been met or that the conditions of section 24-50-503 (1), C.R.S., have been met.

(3) Repealed.

Source: L. 2006: Entire article added with relocations, p. 1984, § 7, effective July 1. **L. 2018:** (1)(a)(II) amended, (SB 18-092), ch. 38, p. 446, § 113, effective August 8. **L. 2022:** (3) added, (SB 22-235), ch. 409, p. 2895, § 4, effective June 7. **L. 2026:** (3) repealed, (HB 26-1375), ch. 243, p. 1386, § 2, effective May 29.

Editor's note: This section is similar to former § 26-19-111 as it existed prior to 2006.

Cross references: For the legislative declaration in SB 18-092, see section 1 of chapter 38, Session Laws of Colorado 2018.

25.5-8-112. Authority to the department to apply for federal waivers.

The department is hereby authorized and required to apply for any federal waivers necessary to implement the purposes of this article.

Source: L. 2006: Entire article added with relocations, p. 1985, § 7, effective July 1.

Editor's note: This section is similar to former § 26-19-112 as it existed prior to 2006.

25.5-8-113. Reports by contractors to medical services board. (Repealed)

Source: L. 2006: Entire article added with relocations, p. 1985, § 7, effective July 1. **L. 2016:** Entire section repealed, (HB 16-1081), ch. 22, p. 52, § 5, effective August 10.

Editor's note: This section was similar to former § 26-19-113 as it existed prior to 2006.

COMMUNITY LIVING

ARTICLE 10

Community Living

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PART 1

OFFICE OF COMMUNITY LIVING

25.5-10-100.3. Definitions.

As used in this article 10, unless the context otherwise requires:

(1) "Office" means the office of community living created in section 25.5-10-101 (1).

Source: L. 2025: Entire section added, (SB 25-275), ch. 377, p. 2081, § 225, effective August 6.

25.5-10-101. Office of community living - creation - transfer of duties and functions - rules - legislative declaration.

(1) There is created in the state department the office of community living. The office is a **type 2** entity, as defined in section 24-1-105. The head of the office is the director of community living appointed by the executive director in accordance with section 13 of article XII of the state constitution. The director of community living reports directly to the executive director.

(2) (a) On and after March 1, 2014, the powers, duties, and functions of the department of health care policy and financing include the powers, duties, and functions relating to the programs, services, and supports contained in this article 10 that were formerly vested in the department of human services. Such powers, duties, and functions are allocated to the division of intellectual and developmental disabilities of the office, which division is created in part 2 of this article 10.

(b) (I) By March 1, 2014, all positions of employment in the department of human services related to the administration of community-based long-term services and supports are transferred to the division of intellectual and developmental disabilities of the office and become employment positions therein.

(II) All employees in positions transferred to the division of intellectual and developmental disabilities are considered employees of the division of intellectual and developmental disabilities of the office. Such employees retain all rights under the state personnel system and to retirement benefits pursuant to the laws of this state, and their services shall be deemed to have been continuous.

(c) By March 1, 2014, all items of property, real and personal, including office furniture and fixtures, books, documents, and records of the department of human services related to the administration of community-based long-term services and supports are transferred to the division of intellectual and developmental disabilities of the office and become the property thereof.

(d) On and after March 1, 2014, whenever the executive director of the department of human services or the department of human services is referred to or designated by any contract or other document in connection with the powers, duties, and functions transferred to the department of health care policy and financing, the reference or designation shall be deemed to apply to the department of health care policy and financing. All contracts entered into by the executive director of the department of human services prior to March 1, 2014, in connection with the powers, duties, and functions transferred to the department of health care policy and financing are hereby validated, with the executive director of the department of health care policy and financing succeeding to all the rights and obligations of such contracts.

(3) All rules and orders of the department of human services, the executive director of the department of human services, and the state board of human services in connection with the programs transferred to the department of health care policy and financing shall continue to be effective until revised, amended, repealed, or nullified pursuant to law.

(4) Repealed.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1742, § 1, effective July 1. **L. 2022:** (1) and (2)(a) amended, (SB 22-162), ch. 469, p. 3372, § 61, effective August 10. **L. 2025:** (1) amended, (SB 25-275), ch. 377, p. 2081, § 226, effective August 6.

Editor's note: Subsection (4)(b) provided for the repeal of subsection (4), effective July 1, 2014. (See L. 2013, p. 1742.)

Cross references: For the short title ("Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

25.5-10-102. Transition planning - task force - legislative declaration - report - definitions - repeal. (Repealed)

Source: L. 2018: Entire section added, (SB 18-231), ch. 331, p. 1990, § 1, effective May 30.

Editor's note: Subsection (5) provided for the repeal of this section, effective September 1, 2019. (See L. 2018, p. 1990.)

PART 2

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

25.5-10-201. Legislative declaration.

(1) In recognition of the varied, extensive, and substantial needs of persons with intellectual and developmental disabilities, including the urgent need to enhance the development of children with intellectual and developmental disabilities, the general assembly, subject to available appropriations and subject to the existence of appropriate services and supports with available resources, hereby declares that the purposes of this article are:

(a) To provide appropriate services and supports to persons with intellectual and developmental disabilities throughout their lifetimes regardless of their age or degree of disability;

(b) To prohibit deprivation of liberty of persons with intellectual and developmental disabilities, except when such deprivation is for the purpose of providing services and supports which constitute the least restrictive available alternative adequate to meet the person's needs, and to ensure that these services and supports afford due process protections;

(c) To ensure the fullest measure of privacy, dignity, rights, and privileges to persons with intellectual and developmental disabilities;

(d) To ensure the provision of services and supports to all persons with intellectual and developmental disabilities on a statewide basis;

(e) To enable persons with intellectual and developmental disabilities to remain with their families and in the community of their choice, to minimize the likelihood of out-of-home placement, and to enhance the capacity of families to meet the needs of children with intellectual and developmental disabilities;

(f) To provide community services and supports for persons with intellectual and developmental disabilities which reflect typical patterns of everyday living;

(g) To encourage state and local agencies to provide a wide array of innovative and cost-effective services and supports for persons with intellectual and developmental disabilities;

(h) To ensure that persons with intellectual and developmental disabilities receive services and supports which encourage and build on existing social networks and natural sources of support, and result in increased interdependence, contribution to, and inclusion in community life; and

(i) To recognize the efficacy of early intervention services and supports in minimizing developmental delays and reducing the future education costs to our society.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1744, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-101 as it existed prior to 2013.

ANNOTATION

Annotator's note. Since § 25.5-10-201 is similar to § 27-10.5-101 as it existed prior to the 2013 amendment to parts 1, 4, and 5 of article 10.5 of title 27, which resulted in the relocation of provisions, relevant cases construing that provision have been included in the annotations to this section.

The state has authority to enact legislation for the welfare of developmentally disabled citizens under its police powers. Glennon Heights, Inc. v. Central Bank & Trust, 658 P.2d 872 (Colo. 1983).

Applied in Adams County Ass'n for Retarded Citizens, Inc. v. City of Westminster, 196 Colo. 79, 580 P.2d 1246 (1978).

25.5-10-202. Definitions.

As used in this article 10, unless the context otherwise requires:

(1) "Abuse" means any of the following acts or omissions committed against a person with an intellectual and developmental disability:

(a) The nonaccidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;

(b) Confinement or restraint that is unreasonable under generally accepted caretaking standards; or

(c) Unlawful sexual behavior as defined in section 16-22-102 (9).

(1.3) "Authorized representative" means a person designated by the person receiving services, or by the parent or guardian of the person receiving services, if appropriate, to assist the person receiving services in acquiring or utilizing services or supports pursuant to this article. The extent of the authorized representative's involvement shall be determined upon designation.

(1.6) "Caretaker" means a person who:

(a) Is responsible for the care of a person with an intellectual and developmental disability as a result of a family or legal relationship;

(b) Has assumed responsibility for the care of a person with an intellectual and developmental disability; or

(c) Is paid to provide care, services, or oversight of services to a person with an intellectual and developmental disability.

(1.8) (a) "Caretaker neglect" means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health and safety of a person with an intellectual and developmental disability is not secured for a person with an intellectual and developmental disability or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult with an intellectual and developmental disability.

(b) Notwithstanding the provisions of paragraph (a) of this subsection (1.8), the withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation, dialysis, artificial nutrition and hydration, any medication or medical procedure or device, in accordance with any valid medical directive or order, or as described in a palliative plan of care, shall not be deemed caretaker neglect.

(c) As used in this subsection (1.8), "medical directive or order" includes a medical durable power of attorney, a declaration as to medical treatment executed pursuant to section 15-18-104, C.R.S., a medical order for scope of treatment form executed pursuant to article 18.7 of title 15, C.R.S., and a CPR directive executed pursuant to article 18.6 of title 15, C.R.S.

(1.9) "Case management agency" has the same meaning as set forth in section 25.5-6-1702 (2).

(2) "Case management services" has the same meaning as set forth in section 25.5-6-1702 (3).

(3) "Case manager" has the same meaning as set forth in section 25.5-6-1702 (4).

(4) Repealed.

(5) "Community residential home" means a group living situation accommodating at least four but no more than eight persons, which is licensed by the state and in which services and supports are provided to persons with intellectual and developmental disabilities.

(5.5) "Competitive integrated employment" has the same meaning as set forth in section 8-84-301, C.R.S.

(5.7) "Conflict-free case management" has the same meaning as set forth in section 25.5-6-1702 (6).

(6) "Consent" means an informed assent that is expressed in writing and freely given. Consent shall always be preceded by the following:

(a) A fair explanation of the procedures to be followed, including an identification of procedures that are experimental;

(b) A description of the attendant discomforts and risks;

(c) A description of the expected benefits;

(d) A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts, and risks;

(e) An offer to answer any inquiries concerning procedures;

(f) An instruction that the person giving consent is free to withdraw consent and to discontinue participation in the project or activity at any time; and

(g) A statement that withholding or withdrawal of consent shall not prejudice future provision of appropriate services and supports to persons.

(7) "Contribution" means the benefits gained by the household or community in which a person lives as the result of the person engaging in meaningful activities, including but not limited to income-producing work, volunteer work, continuing education, and participation in community activities.

(8) "Court" means a district court of the state of Colorado or the probate court in the appropriate jurisdiction.

(9) "Defined service area" has the same meaning as set forth in section 25.5-6-1702 (7).

(10) "Developmental disabilities professional" has the same meaning as "intellectual and developmental disabilities professional" as set forth in subsection (25) of this section.

(11) (a) "Developmental disability" has the same meaning as "intellectual and developmental disability" as set forth in paragraph (a) of subsection (26) of this section.

(b) "Person with a developmental disability" or "individual with a developmental disability" has the same meaning as "person with an intellectual and developmental disability" as set forth in paragraph (b) of subsection (26) of this section.

(c) "Child with a developmental delay" has the same meaning as set forth in paragraph (c) of subsection (26) of this section.

(12) "Division" means the division of intellectual and developmental disabilities, created in this part 2.

(13) "Early intervention services and supports" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(13.5) "Eligible for home- and community-based services" means a "person with an intellectual and developmental disability", as defined in section 25.5-6-403, who meets the definition of an "eligible person", as defined in section 25.5-6-403.

(14) "Eligible for supports and services" refers to any person with an intellectual and developmental disability as determined by a case management agency pursuant to section 25.5-6-1704.

(15) "Enrolled" means that a person with an intellectual and developmental disability who is eligible for supports and services has been authorized, as defined by rules promulgated by the state board, to participate in the program funded pursuant to this section.

(15.3) "Entity" has the same meaning as set forth in section 25.5-6-1702 (8).

(15.5) "Exploitation" means an act or omission that:

(a) Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person with an intellectual and developmental disability of the use, benefit, or possession of any thing of value;

(b) Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person with an intellectual and developmental disability;

(c) Forces, compels, coerces, or entices a person with an intellectual and developmental disability to perform services for the profit or advantage of the person or another person against the will of the person with an intellectual and developmental disability; or

(d) Misuses the property of a person with an intellectual and developmental disability in a manner that adversely affects the person with an intellectual and developmental disability's ability to receive health care or health-care benefits or to pay bills for basic needs or obligations.

(16) (a) "Family" means the interdependent group of persons that consists of:

(I) A parent, child, sibling, grandparent, aunt, uncle, spouse, or any combination thereof and a family member with an intellectual and developmental disability;

(II) An adoptive parent of and a family member with an intellectual and developmental disability;

(III) One or more persons to whom legal custody of a person with an intellectual and developmental disability has been given by a court and in whose home such person resides; or

(IV) Any other family unit as may be defined in rules developed pursuant to section 25.5-10-306.

(b) State board rules must define the families that are eligible to receive services and supports pursuant to this article, and rules of the state board of human services must define the families that are eligible to receive services and supports pursuant to article 10.5 of title 27, C.R.S.

(17) "Family caregiver" means a family member of the person with an intellectual and developmental disability who provides care to the person with an intellectual and developmental disability in the family home, who meets the requirements for a qualified family caregiver, as established by rule of the state board, and who is working through a program-approved service agency, as established by rule of the state board.

(18) "Gastrostomy tube" means a tube that has been surgically inserted into the stomach through the abdominal wall, or a tube that has been inserted through the nasal passage into the stomach, or both.

(18.5) "Harmful act" means an act committed against a person with an intellectual and developmental disability by a person with a relationship to the person with an intellectual and developmental disability when such act is not defined as abuse, caretaker neglect, or exploitation but causes harm to the health, safety, or welfare of a person with an intellectual and developmental disability.

(19) "Human rights committee" means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and reviewing investigations of allegations of mistreatment of

persons with intellectual and developmental disabilities who are receiving services or supports under this article.

(20) "IDEA" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(21) "Inclusion" means:

(a) The use by persons with intellectual and developmental disabilities of the same community resources that are used by and available to other persons;

(b) The participation by persons with intellectual and developmental disabilities in the same community activities in which persons without intellectual and developmental disabilities participate. Participation includes regular contact with persons without intellectual and developmental disabilities.

(c) Vocational experiences for persons with intellectual and developmental disabilities in community settings that offer opportunities to associate with other persons who do not have intellectual and developmental disabilities; and

(d) Living in homes that are in residential neighborhoods and in proximity to community resources.

(21.5) "Individual residential services and supports" has the meaning set forth in section 25.5-6-415.

(22) "Individual residential services and supports setting" has the meaning set forth in section 25.5-6-415.

(23) "Individualized family service plan" or "IFSP" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(24) (a) "Individualized plan" means a written plan designed by an interdisciplinary team for the purpose of identifying:

(I) The needs and preferences of the person or family receiving services;

(II) The specific services and supports appropriate to meet those needs and preferences;

(III) The projected date for initiation of services and supports; and

(IV) The anticipated results to be achieved by receiving the services and supports.

(b) Every individualized plan must include a statement of agreement with the plan, signed by the person receiving services or other such person legally authorized to sign on behalf of the person and by a representative of the case management agency.

(c) Any other service or support plan designated by the state department that meets all of the requirements of an individualized plan is considered to be an individualized plan pursuant to this article.

(d) (I) Every individualized plan that includes the provision of respite care for medical purposes, pursuant to section 25.5-10-205, shall include a process by which the person receiving services and supports may receive necessary care if the person's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or caregiver must be duly informed by the interdisciplinary team of these alternative care provisions at the time the individualized plan is initiated.

(II) Nothing in this paragraph (d) requires the provision of respite care. However, any individual plan that includes the provision of respite care for medical purposes must contain a contingency plan.

(25) "Intellectual and developmental disabilities professional" means a person who has professional training and experience in the intellectual and developmental disabilities field, as defined by rule of the state board.

(26) (a) "Intellectual and developmental disability" means a disability that manifests before the person reaches twenty-two years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15002 (8) does not apply.

(b) "Person with an intellectual and developmental disability" means a person determined by a case management agency to have an intellectual and developmental disability and includes a child with a developmental delay.

(c) "Child with a developmental delay" means:

(I) A person less than five years of age with delayed development as defined by rule of the state board; or

(II) A person less than five years of age who is at risk of having an intellectual and developmental disability as defined by rule of the state board.

(27) "Interdependence" means those multiple interactive relationships that are necessary to create a sense of belonging and support between and among people that are mutually sought, sustained over time, and beneficial to those involved.

(28) "Interdisciplinary team" means a group of people convened by a designated case management agency that includes the person receiving services; the parents or guardian of a minor; a guardian or an authorized representative, as appropriate; the person who coordinates the provisions of long-term services and supports; and others chosen by the person receiving services, who are assembled to work in a cooperative manner to develop or review the individualized plan.

(29) "Least restrictive environment" means an environment that represents the least departure from the typical patterns of living and that effectively meets the needs and preferences of the person receiving services. "Least restrictive environment" may include, but need not be limited to, receiving services from a service agency, a case management agency, or a family caregiver in the family home.

(29.5) "Mistreated" or "mistreatment" means:

(a) Abuse;

(b) Caretaker neglect;

(c) Exploitation; or

(d) A harmful act.

(e) Repealed.

(30) "Office" means the office of community living created in part 1 of this article.

(31) "Person receiving services" means a person with an intellectual and developmental disability who is enrolled in a program funded pursuant to this article.

(32) "Program" means a specific group of services or supports as defined by rules promulgated by the state board and for which funding is available pursuant to this article to a person with an intellectual and developmental disability who is eligible for supports and services.

(33) "Regional center" has the same meaning as set forth in section 27-10.5-102, C.R.S.

(34) "Service agency" means a person or any publicly or privately operated program, organization, or business providing services or supports for persons with intellectual and developmental disabilities.

(35) "Service and support coordination" means planning, locating, facilitating access to, coordinating, and reviewing all aspects of needed services, supports, and resources that are provided in cooperation with the person receiving services, the person's family, as appropriate, the family of a child with a developmental delay, and the involved public or private agencies. Planning includes the development or review of an existing individualized plan. "Service and support coordination" also includes the reassessment of the needs and preferences of the person receiving services or the needs of the family of the person, with maximum participation of the

person receiving services and the person's parents, guardian, or authorized representative, as appropriate.

(36) "Services and supports" or "supports and services" means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided:

(a) To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience personal security and self-respect;

(b) To enhance child development and healthy parent-child and family interaction for eligible persons and their families; and

(c) To enable families, who choose or desire to maintain a family member with an intellectual and developmental disability at home, to obtain support and to enjoy a typical lifestyle.

(37) "Sterilization" means any surgical or other medical procedure that has as its primary purpose to render a person permanently incapable of reproduction.

(37.5) "Undue influence" means the use of influence to take advantage of a person with an intellectual and developmental disability's vulnerable state of mind, neediness, pain, or emotional distress.

(38) "Waiting list" means the list of persons with intellectual and developmental disabilities who are waiting for enrollment into a program provided pursuant to this article.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1745, § 1, effective March 1, 2014. **L. 2016:** (1) and (19) amended and (1.3), (1.6), (1.8), (15.5), (29.5), and (37.5) added, (HB 16-1394), ch. 172, p. 562, § 14, effective July 1; (5.5) added, (SB 16-077), ch. 360, p. 1505, § 4, effective July 1. **L. 2017:** IP, (4), (14), (24)(b), (28), (29), and IP(36) amended, (1.9), (5.7), and (13.5) added, and (2)(a) repealed, (HB 17-1343), ch. 320, p. 1721, § 1, effective June 5. **L. 2018:** (26) amended, (SB 18-074), ch. 98, p. 770, § 3, effective August 8; (26)(a) amended, (SB 18-096), ch. 44, p. 474, § 16, effective August 8. **L. 2019:** (26)(a) amended, (SB 19-241), ch. 390, p. 3474, § 41, effective August 2. **L. 2020:** (1)(c), IP(15.5), (29.5)(c), and (29.5)(d) amended, (18.5) added, and (29.5)(e) repealed, (HB 20-1302), ch. 265, p. 1275, § 10, effective September 14. **L. 2021:** (1.9), (2), (3), (5.7), (9), (14), (24)(b), (26)(b), (28), and (29) amended and (15.3) added, (HB 21-1187), ch. 83, p. 337, § 38, effective July 1, 2024; (4)(b) added by revision, (HB 21-1187), ch. 83, pp. 335, 354, §§ 38, 70. **L. 2026:** (21.5) added and (22) amended, (HB 26-1147), ch. 352, p. 2131, § 3, effective June 3.

Editor's note: (1) This section is similar to former § 27-10.5-102 as it existed prior to 2013.

(2) Amendments to subsection (26)(a) by SB 18-074 and SB 18-096 were harmonized.

(3) Subsection (4)(b) provided for the repeal of subsection (4), effective July 1, 2024. (See L. 2021, pp. 335, 354.)

Cross references: For the legislative declaration in SB 16-077, see section 1 of chapter 360, Session Laws of Colorado 2016. For the legislative declaration in SB 18-096, see section 1 of chapter 44, Session Laws of Colorado 2018. For the legislative declaration in HB 26-1147, see section 1 of chapter 352, Session Laws of Colorado 2026.

25.5-10-203. Division of intellectual and developmental disabilities - creation - functions - reporting - legislative declaration.

(1) (a) The general assembly finds and declares that:

(I) An effective system of community-based services and supports is essential to enable children and adults with intellectual and developmental disabilities to live in their communities;

(II) The demand for high-quality intellectual and developmental disabilities services is expected to grow; and

(III) Persons with intellectual and developmental disabilities need a system that promotes self-direction of services and self-determination and that is designed to improve personal outcomes.

(b) (I) The general assembly further finds and declares that state agencies should be organized in a manner that allows for improved delivery of long-term services and supports for persons and providers; and

(II) The transfer pursuant to part 1 of this article of the powers, duties, and functions relating to the programs, services, and supports for persons with intellectual and developmental disabilities to the office for administration by the division of intellectual and developmental disabilities, created in this section, is an initial step in the process of redesigning Colorado's long-term care system.

(2) There is created in the office the division of intellectual and developmental disabilities. The division is a **type 2** entity, as defined in section 24-1-105.

(3) The division shall administer the programs, services, and supports for persons with intellectual and developmental disabilities contained in this article.

(4) Because of the unique goal of the division in administering lifelong programs, services, and supports for persons with intellectual and developmental disabilities, as part of its annual briefing to the joint budget committee, the state department shall allow sufficient briefing time devoted solely to issues relating to the division and its administration of the programs, services, and supports contained in this article.

(5) Repealed.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1751, § 1, effective March 1, 2014. **L. 2022:** (2) amended, (SB 22-162), ch. 469, p. 3372, § 62, effective August 10.

Editor's note: Subsection (5)(b) provided for the repeal of subsection (5), effective July 1, 2015. (See L. 2013, p. 1751.)

Cross references: For the short title ("Debbie Haskins 'Administrative Organization Act of 1968' Modernization Act") in SB 22-162, see section 1 of chapter 469, Session Laws of Colorado 2022.

25.5-10-204. Duties of the executive director - state board rules - definitions.

(1) In order to implement the provisions of this article 10, the executive director shall, subject to available appropriations, carry out the following duties:

(a) Conduct monitoring and review activities that include case management agencies and service agencies;

(b) Provide or obtain training and technical assistance through case management agencies and service agencies in order to improve the quality of long-term services and supports provided to persons with intellectual and developmental disabilities;

(c) Prepare and transmit annually to the governor and the joint budget committee of the general assembly, in the form and manner prescribed pursuant to section 24-1-136, a report detailing the following information, as available and appropriate, that is broken down into defined service areas as well as provided in an overall statewide format:

(I) The total number of persons receiving services pursuant to this article;

(II) The types of services and supports provided;

(III) The costs of services and supports regardless of funding source;

(IV) An evaluation of the quality of the services and supports rendered;

(V) An evaluation of the effectiveness of the services and supports rendered in implementing the individualized plans of persons receiving services;

(VI) The numbers, types, and resolution of appeals that were heard by the state department arising from disputes specified in section 25.5-10-212; and

(VII) The number of persons determined to be eligible to receive services and supports who are not receiving services or supports pursuant to this article along with an analysis of the reasons they are not receiving services and supports;

(d) Designate a case management agency in each defined service area in the state;

(e) Implement the provision of home- and community-based services to eligible persons with intellectual and developmental disabilities and pursue other medicaid-funded services determined by the state department to be appropriate for persons with intellectual and developmental disabilities, pursuant to part 4 of article 6 of this title and subject to available appropriations;

(f) Promote effective coordination with agencies serving persons with intellectual and developmental disabilities in order to improve continuity of services and supports for persons facing life transitions from toddler to preschool, school to adult life, and work to retirement; and

(g) Facilitate employment first policies and practices by:

(I) Developing practices that reflect a presumption that all persons with disabilities are capable of working in competitive integrated employment if they choose to do so, and ensuring that options for competitive integrated employment with appropriate supports are explored before consideration of segregated activities;

(II) Providing state department input and assistance to the employment first advisory partnership described in section 8-84-303, C.R.S., in carrying out its duties;

(III) Establishing annual reporting of the following data, reported by county, for individuals eligible for supported employment services, including but not limited to home- and community-based waiver services:

(A) The number of individuals employed in group employment, the sector of employment, the mean wage per hour earned, and the mean hours worked per week;

(B) The number of individuals employed in competitive integrated employment, the sector of employment, the mean wage per hour earned, and the mean hours worked per week;

(C) The number of individuals employed and served in prevocational services, the sector of employment, the mean wage per hour earned, the mean hours worked per week, and the mean service hours per week;

(D) The number of individuals served in community-based nonwork and the mean service hours per week;

(E) The number of individuals served in specialized habilitation services and the mean service hours per week;

(F) The number of individuals employed or served, as applicable, in any other employment services or day services model, the sector of employment, and the mean wage per hour worked, mean hours worked per week, or the service hours per week, as applicable;

(G) The number of individuals eligible for employment services, regardless of whether the individual is utilizing employment services; and

(H) The number of individuals served earning less than minimum wage.

(IV) Maintaining Colorado's membership in the state employment leadership network that was founded as a joint partnership between the national association of state directors of developmental disabilities services and the institute for community inclusion at the university of Massachusetts Boston or another similar organization that facilitates collaboration with other states to share effective solutions to increase employment outcomes for persons with disabilities; and

(V) Presenting the reports and recommendations of the employment first advisory partnership to the state department's legislative committee of reference pursuant to section 8-84-303 (7), C.R.S.

(2) The state board shall adopt such rules, in accordance with section 24-4-103, as are necessary to carry out the provisions and purposes of this article 10, including but not limited to the following subjects:

(a) Standards for services and supports, including preparation of individualized plans;

(b) Repealed.

(c) Purchase of services and supports and financial administration;

(d) Procedures for resolving disputes over eligibility determination and the modification, denial, or termination of services;

(e) Eligibility determination, the criteria for determination, and admission to the program;

(f) Systems of quality assurance and data collection;

(g) The rights of a person receiving services;

(h) Confidentiality of records of a person receiving services;

(i) Designation of authorized representatives and delineation of their rights and duties pursuant to this article;

(j) (I) The establishment of guidelines and procedures for authorization of persons for administration of nutrition and fluids through gastrostomy tubes.

(II) The state department shall require that a service agency providing residential or day program services or supports have a staff member qualified pursuant to subparagraph (III) of this paragraph (j) on duty at any time the facility administers said nutrition and fluids through gastrostomy tubes, and that the facility maintain a written record of each nutrient or fluid administered to each person receiving services, including the time and the amount of the nutrient or fluid.

(III) A person who is not otherwise authorized by law to administer nutrition and fluids through gastrostomy tubes is allowed to perform the duties only under the supervision of a licensed nurse, a licensed certified midwife, or a licensed physician. A person who administers nutrition and fluids in compliance with this subsection (2)(j) is exempt from the licensing requirements of the "Colorado Medical Practice Act", article 240 of title 12, and the "Nurse and Nurse Aide Practice Act", article 255 of title 12. Nothing in this subsection (2)(j) shall be deemed to authorize the administration of medications through gastrostomy tubes. A person administering medications through gastrostomy tubes is subject to the requirements of part 3 of article 1.5 of title 25.

(IV) As used in this subsection (2)(j):

(A) "Administration" means assisting a person in the ingestion of nutrition or fluids according to the direction and supervision of a licensed nurse, a licensed certified midwife, or a licensed physician.

(B) "Certified midwife" has the same meaning as set forth in section 12-255-104 (3.2).

(k) (I) No later than July 1, 2019, the state board, in conjunction with the department of labor and employment, shall require a nationally recognized supported employment training certificate or nationally recognized supported employment certification for all vendors of supported employment services, including supported employment professionals who provide individual competitive integrated employment outcomes, and excluding those professionals exclusively providing group or other congregate services. The state board's rules must include time frames for compliance with the training or certification requirement for existing staff and for newly hired staff and requirements for supervision of newly hired staff until the staff member has completed the training or certification. The time frames established in the state board's rules must provide for training to be completed over a five-year period, subject to the availability of appropriations for reimbursement of vendors pursuant to subsection (2)(k)(II) of this section.

(II) The training or certification requirement in subsection (2)(k)(I) of this section is contingent upon appropriations to the department of health care policy and financing for reimbursement to vendors of supported employment services for the cost of training and certification. The state board shall adopt rules for administering the reimbursement to vendors, which reimbursement must be three hundred dollars for each certification exam and twelve hundred dollars for each training program certificate, which includes reimbursement for both the cost of the training and wages paid to employees during training. The state board may increase the fixed reimbursement amount over time based on increases in the cost of the exam and employee wages.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1752, § 1, effective March 1, 2014. **L. 2016:** (1)(e) and (1)(f) amended and (1)(g) added, (SB 16-077), ch. 360, p. 1505, § 5, effective July 1. **L. 2017:** IP(1), (1)(a), and (1)(b) amended, (HB 17-1343), ch. 320, p. 1722, § 2, effective June 5. **L. 2018:** (1)(g)(III) and IP(2) amended and (2)(k) added, (SB 18-145), ch. 215, p. 1370, § 3, effective August 8. **L. 2019:** (2)(j)(III) amended, (HB 19-1172), ch. 136, p. 1711, § 192, effective October 1. **L. 2020:** (2)(j)(III) amended, (HB 20-1183), ch. 157, p. 704, § 63, effective July 1. **L. 2021:** (1)(a), (1)(b), IP(1)(c), and (1)(d) amended, (HB 21-1187), ch. 83, p. 339, § 39, effective July 1, 2024; (2)(b)(II) added by revision, (HB 21-1187), ch. 83, pp. 339, 354, §§ 39, 70. **L. 2023:** (2)(j)(III) and (2)(j)(IV) amended, (SB 23-167), ch. 261, p. 1550, § 63, effective May 25.

Editor's note: (1) This section is similar to former § 27-10.5-103 as it existed prior to 2013.

(2) Subsection (2)(b)(II) provided for the repeal of subsection (2)(b), effective July 1, 2024. (See L. 2021, pp. 339, 354.)

Cross references: For the legislative declaration in SB 16-077, see section 1 of chapter 360, Session Laws of Colorado 2016. For the legislative declaration in SB 18-145, see section 1 of chapter 215, Session Laws of Colorado 2018.

25.5-10-205. Case management agencies - local public procurement units.

For purposes of entering into a cooperative purchasing agreement pursuant to section 24-110-201, a nonprofit case management agency or a nonprofit service agency may be certified as a local public procurement unit as provided in section 24-110-207.5.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1754, § 1, effective March 1, 2014. **L. 2021:** Entire section amended, (HB 21-1187), ch. 83, p. 339, § 40, effective July 1, 2024.

Editor's note: This section is similar to former § 27-10.5-103.5 as it existed prior to 2013.

25.5-10-206. Authorized long-term services and supports - conditions of funding - purchase of services and supports - adult protective services data system check - boards of county commissioners - appropriation.

(1) Subject to annual appropriations by the general assembly, the state department shall provide or purchase, pursuant to subsection (4) of this section, authorized long-term services and supports from case management agencies or service agencies for persons who have been determined to be eligible for such long-term services and supports pursuant to section 25.5-6-1704 and as specified in the eligible person's individualized plan. Those long-term services and supports may include, but need not be limited to, the following:

(a) Family support services, including an array of supportive services provided to the person receiving services and the person's family, that enable the family to maintain the person in the family home, thereby preventing or delaying the need for out-of-home placement that is unwanted by the person or the family, pursuant to section 25.5-10-301;

(b) Case management services;

(c) Respite care services, including temporary care of a person with an intellectual and developmental disability to offer relief to the person's family or caregiver or to allow the family or caregiver to deal with emergency situations or to engage in personal, social, or routine activities and tasks that otherwise may be neglected, postponed, or curtailed due to the demands of supporting a person who has an intellectual and developmental disability;

(d) Day services and supports that offer opportunities for persons with intellectual and developmental disabilities to experience and actively participate in valued adult roles in the community. These services and supports will enable persons receiving services to access and participate in community activities, such as work, recreation, higher education, and senior citizen activities. Day services may also include the administration of nutrition or fluids through gastrostomy tubes, if administered by a person authorized pursuant to section 25.5-10-204 (2)(j) and supervised by a licensed nurse or physician.

(e) Residential services and supports, including an array of training, learning, experiential, and support activities provided in living alternatives designed to meet the individual needs and preferences of persons receiving services and may include the administration of nutrition or

fluids through gastrostomy tubes, if administered by a person authorized pursuant to section 25.5-10-204 (2)(j) and supervised by a licensed nurse or physician; and

(f) Ancillary services, including activities that are secondary but integral to the provision of the services and supports specified in this subsection (1).

(2) Service agencies and case management agencies receiving funds pursuant to subsection (1) of this section shall comply with all of the provisions of this article 10 and the rules promulgated thereunder.

(3) Case management services must be purchased from the case management agency, except as otherwise provided in subsection (4) of this section.

(4) (a) The state department may purchase long-term services and supports directly from service agencies and case management services from case management agencies if:

(I) Required by the federal requirements for the state to qualify for federal funds under Title XIX of the federal "Social Security Act", as amended, including programs authorized pursuant to part 4 of article 6 of this title; or

(II) The executive director has determined that a long-term service or support provided or purchased by a case management agency does not meet established standards and the continuation of purchase of the long-term service or support through the case management agency is not in the best interests of the persons receiving services.

(b) (I) The state department shall only purchase long-term services and supports directly from those case management agencies or service agencies that meet established standards.

(II) The standards referenced in subsection (4)(b)(I) of this section must include a requirement that, on and after January 1, 2019, prior to employment, the name of a person who will be providing direct care, as defined in section 26-3.1-101 (3.5), to an at-risk adult, as defined in section 26-3.1-101 (1.5), as well as any other required identifying information, is submitted to the department of human services for a check of the Colorado adult protective services data system pursuant to section 26-3.1-111, to determine if the person is substantiated in a case of mistreatment of an at-risk adult.

(c) The state department may purchase services and supports, including service and support coordination, from a family caregiver if the executive director has determined that the provision of a service or support by a family caregiver in the family home would provide the person receiving the service or support with the least restrictive environment.

(d) Nothing in this section shall be construed to prohibit the provision of services and supports, including case management services, directly by the department of human services through regional centers, for persons receiving services in regional centers.

(e) Nothing in this section shall be construed to require the provision of services and supports, including case management services, directly by the state department.

(5) Governmental units, including but not limited to counties, municipalities, school districts, health service districts, and state institutions of higher education, are authorized at their own expense to furnish money, materials, or long-term services and supports to persons with intellectual and developmental disabilities, or to purchase long-term services and supports for such persons through designated case management agencies or service agencies, so long as no conditions or requirements imposed as a result of the provision or purchase conflict with the provisions of this article 10 or the rules promulgated thereunder.

(6) Boards of county commissioners may levy up to one mill for the purpose of purchasing services and supports for persons with intellectual and developmental disabilities. To the extent authorized by federal law, and subject to annual appropriation by the general assembly, and pursuant to rules established by the state board, a county may transfer the revenue raised pursuant to the mill levy to the state department to receive matching federal funds to provide medicaid-approved waiver services to persons with intellectual and developmental disabilities.

(7) (a) Each year the general assembly shall appropriate moneys to the state department to provide or purchase services and supports for persons with intellectual and developmental disabilities pursuant to this section. Unless specifically provided otherwise, services and supports shall be purchased on the basis of state funding less any federal or cash funds received for general operating expenses from any other state or federal source, less funds available to a person receiving residential services or supports after such person receives an allowance for personal needs or for meeting other obligations imposed by federal or state law, and less the required local school district funds specified in paragraph (b) of this subsection (7). The yearly appropriation, when combined with all other sources of funds, shall in no case exceed one hundred percent of the approved program costs as determined by the general assembly.

(b) Each school district shall pay to the case management agency purchasing programs attended by a student with an intellectual and developmental disability, who is domiciled in the school district and may be counted in the district's pupil enrollment, an amount at least equal to the district's per pupil revenues as determined pursuant to the "Public School Finance Act of 2025", article 54 of title 22. This subsection (7) applies to students who are less than twenty-two years of age.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1754, § 1, effective March 1, 2014. **L. 2017:** (4)(b) amended, (HB 17-1284), ch. 272, p. 1505, § 12, effective May 31; IP(1), (2), (3), IP(4)(a), (4)(b), and (5) amended, (HB 17-1343), ch. 320, p. 1723, § 3, effective June 5. **L. 2021:** IP(1), (2), (3), IP(4)(a), (4)(a)(II), (4)(b)(I), (5), and (7)(b)

amended, (HB 21-1187), ch. 83, p. 339, § 41, effective July 1, 2024. **L. 2024:** (7)(b) amended, (HB 24-1448), ch. 236, p. 1537, § 60, effective May 23.

Editor's note: (1) This section is similar to former § 27-10.5-104 as it existed prior to 2013.

(2) Amendments to subsection (4)(b) by HB 17-1284 and HB 17-1343 were harmonized.

ANNOTATION

Annotator's note. The following annotations include cases decided under a former provision similar to this section.

School board lacks standing to challenge the constitutionality of this section because, as a political subdivision of the state whose duty it is to carry out the educational policies of the state, the school district and officers thereof cannot question the constitutionality of a statute fixing their duties. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Kindergarten included in school district's "regular school program". Where the defendant school board conceded that they maintain a free kindergarten for children who are five years of age and, but for the mental retardation or serious handicap of the children being educated through the board, they would attend the district's free kindergarten, such kindergarten is included in the school district's "regular school program" as that phrase is used in this section. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Mandamus proper remedy. Subsection (7)(b) clearly requires that the "school district shall provide to the community incorporated board" a sum of money determined by a stated formula; therefore, the clear right of a school board to demand performance, and the clear legal duty on a school district to act, makes this a proper case for disposition by mandamus. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Superintendent not proper party defendant in mandamus action. Since under § 22-32-107 the official duty of paying over the amounts in question as required by this section was that of the treasurer, as authorized by the board of education, and not that of the superintendent, the superintendent was not a proper party defendant in a mandamus action to require such payment. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Amounts payable under section not subject to prejudgment interest. Since the amounts to be paid under this section arise neither out of contract nor out of a fiduciary relationship, the plaintiffs were not entitled to prejudgment interest. Denver Ass'n for Retarded Children v. Sch. Dist. No. 1, 188 Colo. 310, 535 P.2d 200 (1975).

Applied in Adams County Cmty. Center for Retarded & Seriously Handicapped, Inc. v. State Dept. of Insts., 197 Colo. 448, 594 P.2d 1046 (1979).

25.5-10-207. Long-term services and supports - waiting list reduction - cash fund - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1757, § 1, effective March 1, 2014. **L. 2014:** (1.5), (2), and (3) amended and (3.5) added, (HB 14-1252), ch. 18, p. 135, § 1, effective March 1; (2) repealed, (HB 14-1051), ch. 33, p. 184, § 1, effective August 6. **L. 2015:** (6) added, (SB 15-168), ch. 16, p. 40, § 1, effective March 13. **L. 2016:** (7) added, (SB 16-196), ch. 226, p. 866, § 4, effective June 6; (3)(b) and (3)(c) amended and (3)(d) added, (SB 16-192), ch. 256, p. 1052, § 2, effective June 8. **L. 2017:** IP(3), (3)(c), and (3)(d) amended and (3)(e), (8), and (9) added, (HB 17-1343), ch. 320, p. 1724, § 4, effective June 5. **L. 2021:** (3)(c) and (3)(e) amended, (HB 21-1187), ch. 83, p. 340, § 42, effective July 1, 2024; (3)(d)(II) added by revision, (HB21-1187), ch. 83, pp. 340, 354, §§ 42, 70.

Editor's note: Subsection (9)(a) provided for the repeal of this section, effective July 1, 2022. (See L. 2017, p. 1724.)

25.5-10-207.5. Strategic plan for long-term services and supports - joint hearing - appropriation - reporting - legislative declaration - rules.

(1) (a) The general assembly finds that:

(I) Colorado has a long commitment to supporting persons with intellectual and developmental disabilities in communities of their choosing;

(II) Coloradans with intellectual and developmental disabilities who are eligible for state services and supports should be able to access services and supports in a timely manner to allow them to benefit from those services and supports and lead lives that build on their independence;

(III) Providing early and timely access to services and supports for persons with intellectual and developmental disabilities is an excellent and cost-effective investment that results in substantial future savings;

(IV) The presence of a waiting list as long as fifteen years for essential services and supports contradicts Colorado's commitment to supporting persons in the least restrictive environment of their choosing;

(V) Colorado must have accurate data concerning the need for services and supports for persons with intellectual and developmental disabilities and their families and must regularly forecast this data to ensure that effective policy and programs are directed to meet these needs;

(VI) The waiting list includes persons with intellectual and developmental disabilities who are at risk of experiencing a crisis due to the advanced age, reduced capacity, and illness of their caregivers;

(VII) After a lifetime of providing continuous support, these caregivers deserve the comfort of knowing that their loved one will have needed services and supports; and

(VIII) Persons with intellectual and developmental disabilities and their caregivers should not have to experience a crisis before getting needed assistance, as each crisis puts undue hardship and strain on the person and caregiver, and the services system.

(b) Therefore, the general assembly declares that Colorado is committed to developing a strategic plan to ensure that Coloradans with intellectual and developmental disabilities and their families will be able to access the services and supports they need and want at the time that they need and want those services and supports.

(2) During each regular session of the general assembly, the joint budget committee and the health and human services committees of the senate and the house of representatives, or any successor committees, shall hold a joint hearing and take public testimony on the status of the waiting lists for persons with intellectual and developmental disabilities who are waiting for enrollment into a home- and community-based services program or a program provided pursuant to this article 10 and the availability of general fund money to reduce the number of persons on the waiting lists and the amount of time eligible persons wait for such services. Notwithstanding the provisions of section 24-1-136 (11)(a)(I), the state department shall present testimony, including the information provided in the report pursuant to subsection (3) of this section, as well as information concerning the ongoing implementation of the strategic plan required pursuant to subsection (4) of this section, including any revisions to the strategic plan. Additionally, the state department, case management agencies, and providers shall report on the use and effectiveness of any money appropriated in the preceding state fiscal year for increasing system capacity. The goal of the hearing is to propose an appropriation from the general fund to the intellectual and developmental disabilities services cash fund.

(3) (a) Notwithstanding the provisions of section 24-1-136 (11)(a)(I), on or before November 1, 2014, and November 1 of each year thereafter, in accordance with section 24-1-136 (9), the state department shall report to the general assembly the total number of persons with intellectual and developmental disabilities who are waiting at the time of the report for enrollment into a home- and community-based services program or a program provided pursuant to this article 10. The report must also include information concerning the ongoing implementation of the strategic

plan required pursuant to subsection (4) of this section, including any revisions to the strategic plan.

(b) The information reported pursuant to paragraph (a) of this subsection (3) relating to persons with intellectual and developmental disabilities who are waiting for enrollment into a home- and community-based services program or a program provided pursuant to this article shall be disaggregated by:

(I) The specific medicaid waiver program or other intellectual and developmental disabilities program, service, or support;

(II) The persons who need services immediately but who are not currently receiving services;

(III) The persons who need services immediately who are currently receiving some services; and

(IV) The persons who are eligible for services but who do not need services at this time.

(4) (a) On or before November 1, 2014, the state department shall develop, in consultation with intellectual and developmental disability system stakeholders, a comprehensive strategic plan including administrative procedures and adequate funding to enroll eligible persons with intellectual and developmental disabilities into home- and community-based services programs and programs provided pursuant to this article 10 at the time those persons choose to enroll in the programs or need the services or supports. As part of developing the strategic plan, the state department shall review the statutory definition of "waiting list" set forth in section 25.5-10-202 and make recommendations concerning amendments to the definition. In engaging stakeholders, the state department shall include both persons and families receiving services, as well as persons and families waiting for enrollment into programs, services, or supports. These persons and families must include, at a minimum, persons and families who reside in each defined service area within the state. In developing the strategic plan, the state department shall review relevant recommendations from the community living advisory group created in the office pursuant to the governor's executive order D 2012-027, as well as other relevant information. The strategic plan must include specific recommendations and annual benchmarks for achieving this enrollment goal by July 1, 2020, including recommendations relating to increasing system capacity. The state department shall review the strategic plan annually and revise the plan as needed to meet the enrollment goal. Nothing in this section precludes the state department from considering changes in the structure of the state's intellectual and developmental disabilities programs, including medicaid waiver modification.

(b) The state department shall submit the strategic plan to the general assembly in accordance with section 24-1-136 (9), C.R.S., and shall present the strategic plan to the joint budget committee on or before December 1, 2014.

(5) In its annual submission of the state department's budget request to the joint budget committee, the governor's office of state planning and budgeting shall reference the number of persons who are waiting at the time of the November 1 report for enrollment into a home- and community-based services program or a program provided pursuant to this article and shall indicate to the joint budget committee those budget requests related specifically to achieving the enrollment goal set forth in the strategic plan required pursuant to this section.

(6) (a) Subject to the availability of reserve capacity enrollment, a person with an intellectual and developmental disability who is on the waiting list for services and who is at risk of experiencing an emergency due to any of the criteria included in subsection (6)(b) of this section and who meets other applicable criteria for enrollment established by the state board shall be offered enrollment into the home- and community-based services developmental disabilities waiver using a person-centered transition process.

(b) No later than June 1, 2019, the state board shall promulgate rules regarding the criteria for reserve capacity enrollments for those persons described in subsection (6)(a) of this section, which criteria must include but is not limited to:

(I) The age of the custodial parent or caregiver;

(II) The loss of the custodial parent or caregiver;

(III) Incapacitation of the custodial parent or caregiver;

(IV) Any life-threatening or serious persistent illness of the custodial parent or caregiver; and

(V) A threat to health or safety that the custodial parent or caregiver places on the person with intellectual and developmental disabilities.

(c) As part of the rule-making process for reserve capacity enrollment pursuant to subsection (6)(b) of this section, the state board shall solicit feedback from persons with intellectual and developmental disabilities and family members of persons with intellectual and developmental disabilities.

(7) During the state fiscal year beginning July 1, 2018, the state department shall initiate three hundred nonemergency enrollments from the waiting list for the home- and community-based services developmental disabilities waiver.

(8) Beginning July 2018, and continuing monthly thereafter, the state department shall include in its monthly premiums, expenditures, and caseload report the number of persons who were moved off the developmental disabilities waiting list, specifying the enrollments initiated under the order of selection and the enrollments initiated under the reserve capacity criteria.

Source: L. 2014: Entire section added, (HB 14-1051), ch. 33, p. 184, § 2, effective August 6. **L. 2017:** (2) and (3)(a) amended, (HB 17-1060), ch. 6, p. 17, § 10, effective November 2. **L. 2018:** (1)(a)(IV) amended and (1)(a)(VI), (1)(a)(VII), (1)(a)(VIII), (6), (7), and (8) added, (HB 18-1407), ch. 248, p. 1531, § 3, effective May 24. **L. 2021:** (2) and (4)(a) amended, (HB 21-1187), ch. 83, p. 341, § 43, effective July 1, 2024.

Editor's note: Subsection (2) is similar to former § 25.5-10-207 (2) as it existed prior to 2014.

Cross references: For the legislative declaration in HB 18-1407, see section 1 of chapter 248, Session Laws of Colorado 2018.

25.5-10-208. Service agencies and case management agencies - money - rules.

(1) A service agency and a case management agency shall comply with the requirements set forth in this article 10 and the rules promulgated thereunder.

(2) The state board shall promulgate rules to implement the purchase of long-term services and supports from a service agency, case management agency, or family caregiver. The rules must include, but need not be limited to:

(a) Terms and conditions necessary to promote the effective delivery of services and supports, including those services and supports delivered by a family caregiver;

(b) Procedures for obtaining an annual audit of case management agencies and service agencies to provide financial information deemed necessary by the state department to establish costs of long-term services and supports and to ensure proper management of money received pursuant to section 25.5-10-206;

(c) Repealed.

(d) Specification of which long-term services and supports are to be reimbursed by the state department and secondarily by the case management agency, the source of reimbursement, actual long-term service or support costs, incentives, and program service objectives that affect reimbursement;

(e) The methods of coordinating the purchase of services and supports, including but not limited to service and support coordination, with other federal, state, and local programs that provide funding for authorized services and supports; and

(f) Criteria for and limitations on any rates that case management agencies charge to service agencies based upon a percentage of the rates that service agencies charge for long-term services and supports.

(3) Any incorporated service agency that is registered in Colorado as a foreign corporation shall organize a local advisory board consisting of persons who reside within the defined service area. The advisory board shall be representative of the community at large and persons receiving services and their families.

(4) Upon a determination by the executive director that services or supports have not been provided in accordance with the program or financial administration standards specified in this article 10 and the rules promulgated thereunder, the executive director may reduce, suspend, or withhold payment to a case management agency or service agency under contract with a case management agency, or service agency from which the state department purchased long-term services or supports directly. When the executive director decides to reduce, suspend, or withhold payment, the executive director shall specify the reasons therefor and the actions that are necessary to bring the case management agency or service agency into compliance.

(5) Nothing in this article or in any rules promulgated pursuant thereto and no actions taken by the executive director pursuant to this article shall be construed to affect the obtaining of funds from local authorities, including those funds obtained from a mill levy assessed by a county or municipality for the purpose of purchasing services or supports for persons with intellectual and developmental disabilities, or to require that such funds from local authorities be used to supplant state or federal funds available for purchasing services and supports for persons with developmental disabilities.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1758, § 1, effective March 1, 2014. **L. 2017:** (1), IP(2), (2)(b), (2)(c), and (4) amended, (HB 17-1343), ch. 320, p. 1724, § 5, effective June 5. **L. 2021:** IP(2), (2)(b), (2)(d), (2)(f), (3), and (4) amended, (HB 21-1187), ch. 83, p. 342, § 44, effective July 1, 2024; (2)(c)(II) added by revision, (HB 21-1187), ch. 83, pp. 342, 354, §§ 44, 70.

Editor's note: (1) This section is similar to former § 27-10.5-104.5 as it existed prior to 2013.

(2) Subsection (2)(c)(II) provided for the repeal of subsection (2)(c), effective July 1, 2024. (See L. 2021, pp. 342, 354.)

25.5-10-209. Community-centered boards - designation - purchase of services and supports - performance audits - Colorado local government audit law - public disclosure of board administration and operations - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1760, § 1, effective March 1, 2014. **L. 2016:** (4), (5), (6), (7), and (8) added, (SB 16-038), ch. 199, p. 702, § 2, effective August 10. **L. 2017:** (2)(e) amended, (HB 17-1343), ch. 320, p. 1725, § 6, effective June 5. **L. 2021:** (9) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2022:** (2)(d) and (2)(f) amended, (HB 22-1295), ch. 123, p. 848, § 77, effective July 1.

Editor's note: (1) Prior to its repeal, this section was similar to former § 27-10.5-105 as it existed prior to 2013.

(2) Subsection (9) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

ANNOTATION

Nonprofit corporation offering services to the developmentally disabled pursuant to this section is not a political subdivision for purposes of the federal National Labor Relations Act. The corporation functions not as a state-created department or administrative arm of government, but essentially as a private contractor. Jefferson County Cmty. Center v. N.L.R.B., 732 F.2d 122 (10th Cir. 1984) (decided under former § 27-11-103).

25.5-10-209.3. Cross-system behavioral health crisis response - comprehensive care coordination and treatment model - training - legislative declaration.

(1) (a) The general assembly declares that persons with intellectual and developmental disabilities and co-occurring behavioral health diagnoses and needs:

(I) Experience limited access to appropriate treatment, including crisis intervention, stabilization, and prevention, and such individuals who live in rural areas of Colorado are particularly impacted by this limited access to appropriate treatment;

(II) Deserve to live, work, play, and thrive in their communities;

(III) Require a heightened level of care;

(IV) Require evidence-based treatment to help lead full lives within their communities; and

(V) Experience significant gaps in care, including a lack of access to appropriate treatment.

(b) Therefore, as a preliminary measure to close these gaps in care, the general assembly finds that the state must invest in extensive, expanded training using a comprehensive model of care that is available via teleconference. The training must be available for up to thirty individuals across the state in order to adequately address the limited access to treatment in rural areas.

(2) (a) As soon as possible, the state department shall obtain a vendor to provide extensive statewide training to professional persons who work with persons with intellectual and developmental disabilities and co-occurring behavioral health needs.

(b) A qualified vendor must:

(I) Utilize a comprehensive care coordination and treatment model that is evidence-based;

(II) Be able to show demonstrated success in multiple states;

(III) Have experience with rural issues;

(IV) Have at least ten years of experience working with professionals who work with individuals with intellectual and developmental disabilities;

(V) Maintain a national database that involves the standardized collection, analysis, and reporting of outcomes associated with the impact of the training on the individuals being served; and

(VI) Be able to provide the training statewide using teleconference technology.

(3) (a) No later than sixty calendar days after a vendor is obtained pursuant to subsection (2)(a) of this section, case management agencies, mental health centers, and other program-approved service agencies in the state shall nominate one provider in their geographic service area to be trained in the comprehensive care coordination and treatment model designed and provided by the vendor selected pursuant to subsection (2) of this section. Up to twenty providers may be selected for training pursuant to this subsection (3)(a). Selected providers must have a clinical background and prior experience working with the intellectual and developmental disabilities population. If more than twenty providers are nominated through this process, the state department shall make final selections, giving preference to providers in underserved areas.

(b) The state department shall coordinate with case management agencies in underserved areas of the state to select an additional ten providers to be trained in the comprehensive care coordination and treatment model.

(4) Participating providers shall complete the training provided no later than one calendar year after a provider is nominated pursuant to subsection (3)(a) of this section.

(5) The state department shall reimburse participating providers at the provider's current pay rate for time spent in training.

Source: L. 2021: Entire section added, (HB 21-1166), ch. 234, p. 1233, § 1, effective June 15. **L. 2022:** (2)(a), (3)(a), and (4) amended, (HB 22-1189), ch. 15, p. 126, § 1, effective August 10.

25.5-10-209.5. Case management agencies - certification - purchase of services and supports - rules - repeal. (Repealed)

Source: L. 2017: Entire section added, (HB 17-1343), ch. 320, p. 1725, § 7, effective June 5. **L. 2021:** (6) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70.

Editor's note: Subsection (6) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-10-210. Revocation of designation - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1762, § 1, effective March 1, 2014. **L. 2021:** (3) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70.

Editor's note: (1) Prior to its repeal, this section was similar to former § 27-10.5-105.5 as it existed prior to 2013.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-10-211. Eligibility determination - individualized plan - periodic review - rules - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1762, § 1, effective March 1, 2014. **L. 2017:** (1), (2), and (3) amended and (2.5) added, (HB 17-1343), ch. 320, p. 1726, § 8, effective June 5. **L. 2021:** (6) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2022:** (2)(a), (2)(b)(II), (4)(a), and (4)(c) amended, (HB 22-1295), ch. 123, p. 849, § 78, effective July 1.

Editor's note: (1) Prior to its repeal, this section was similar to former § 27-10.5-106 as it existed prior to 2013.

(2) Subsection (6) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-10-211.5. Conflict-free case management - implementation - legislative declaration - definition - repeal. (Repealed)

Source: L. 2017: Entire section added, (HB 17-1343), ch. 320, p. 1727, § 9, effective June 5. **L. 2021:** (6) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2024:** (3)(f), (3)(g), and (4)(f) amended, (SB 24-176), ch. 152, p. 674, § 101, effective August 7.

Editor's note: (1) SB 24-176 amended subsections (3)(f), (3)(g), and (4)(f), effective August 7, 2024, but those amendments did not take effect due to the repeal of this section, effective July 1, 2024.

(2) Subsection (6) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-10-212. Procedure for resolving disputes over eligibility, modification of services or supports, and termination of services or supports.

(1) Every state or local service agency receiving state money pursuant to section 25.5-10-206 shall adopt a procedure for the resolution of disputes arising between the service agency and any member of, or applicant for, services or supports authorized pursuant to section 25.5-10-206. Procedures for the resolution of disputes regarding early intervention services must comply with IDEA and with part 4 of article 3 of title 26.5. The procedures must be consistent with rules promulgated by the state board pursuant to article 4 of title 24 and must apply to the following disputes:

(a) A contested decision that the applicant is not eligible for services or supports;

(b) A contested decision to provide, modify, reduce, or deny services or supports set forth in the individualized plan or individualized family service plan of the person receiving services;

(c) A contested decision to terminate services or supports;

(d) A contested decision that the person receiving services is no longer eligible for services or supports.

(2) The state board shall promulgate rules pursuant to article 4 of title 24, C.R.S., setting forth procedures for the resolution of disputes specified in subsection (1) of this section that must:

(a) Require that all applicants for services and supports and the parents or guardian of a minor, the guardian, or an authorized representative be informed orally and in writing, in their native language, of the dispute resolution procedures at the time of application, at the time the individualized plan is developed, and any time changes in the plan are contemplated;

(b) Require that a service agency keep a written record of all proceedings specified pursuant to this section;

(c) Require that no person receiving services be terminated from such services or supports during the resolution process;

(d) Require that utilizing the dispute resolution procedure must not prejudice the future provision of appropriate services or supports to persons; and

(e) Require that the intended action not occur until after reasonable notice has been provided to the person, the parents or guardian of a minor, the guardian, or an authorized representative, along with an opportunity to utilize the resolution process, except in emergency situations, as determined by the state department.

(3) The resolution process need not conform to the requirements of section 24-4-105, C.R.S., as long as the rules adopted by the state board include provisions specifically setting forth procedures, time frames, notice, an opportunity to be heard and to present evidence, and the opportunity for impartial review of the decision in dispute by the executive director or designee, if the resolution process has failed.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1764, § 1, effective March 1, 2014. **L. 2022:** IP(1) amended, (HB 22-1295), ch. 123, p. 849, § 79, effective July 1. **L. 2024:** IP(1) amended, (SB 24-176), ch. 152, p. 675, § 102, effective August 7.

Editor's note: This section is similar to former § 27-10.5-107 as it existed prior to 2013.

25.5-10-213. Discharge - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1765, § 1, effective March 1, 2014. **L. 2021:** (3) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70.

Editor's note: (1) Prior to its repeal, this section was similar to former § 27-10.5-108 as it existed prior to 2013.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-10-214. Community residential home - licenses - rules.

(1) The department of public health and environment and the state department shall implement a system of joint licensure and certification of community residential homes. Individual residential services and supports provided by the state department do not require licensure by the department of public health and environment. An individual residential services and supports setting must be treated as residential property in the application of local regulations, including zoning, land use development, fire and life safety, sanitation, and building codes. Local governing authorities shall not impose additional regulations on an individual residential services and supports setting that do not apply to other residential properties.

(2) (a) The department of public health and environment and the state department shall develop standards for the licensure and certification of community residential homes. The standards shall include health, life, and fire safety, as well as standards to ensure the effective delivery of services and supports to residents; except that any community residential home must comply with local codes.

(b) (I) The state department or the state board of health, as appropriate, shall adopt the standards by rule and shall specify the responsibilities of each department in the program. Surveys undertaken to ensure compliance with these standards shall, as appropriate, be undertaken as joint surveys by the departments.

(II) If a service agency operates a community residential home and provides personal care services, as defined in section 25-27.5-102, C.R.S., the department of public health and environment or the state department, as appropriate, is responsible for surveying those services

provided by the service agency, which survey shall be conducted simultaneously with the survey of the community residential home.

(3) Any community residential home applying for a license or certification on or after January 1, 1986, shall accommodate at least four but no more than eight persons with intellectual and developmental disabilities. All licenses and certificates issued by the department of public health and environment or the state department shall bear the date of issuance and shall be valid for not more than a twenty-four-month period.

(4) The issuance, suspension, revocation, modification, renewal, or denial of a license or certification shall be governed by the provisions of section 24-4-104, C.R.S. The failure of a community residential home to comply with the provisions of this article and the rules promulgated thereunder, or any local fire, safety, and health codes shall be sufficient grounds for the department of public health and environment or the state department to deny, suspend, revoke, or modify the community residential home's license or certification.

(5) The state department and the state board of health shall promulgate such rules as are necessary to implement this section, pursuant to the provisions specified in article 4 of title 24, C.R.S. The rules shall include, but shall not be limited to, the following:

(a) Requirements concerning the distance between the location of community residential homes and factors to be considered in waiving such requirements for existing community residential homes;

(b) Procedures to secure the health and safety of persons receiving services or supports residing in a community residential home in the event the community residential home closes or its license is denied, suspended, or revoked pursuant to this section; and

(c) Prohibiting the cultivation, use, or consumption of retail marijuana on the premises of a community residential home.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1765, § 1, effective March 1, 2014. **L. 2026:** (1) amended, (HB 26-1147), ch. 352, p. 2131, § 4, effective June 3.

Editor's note: (1) This section is similar to former § 27-10.5-109 as it existed prior to 2013.

(2) Subsection (5)(c) was numbered as § 27-10.5-109 (6)(d) in Senate Bill 13-283 (see L. 2013, p. 1896). That provision was harmonized with subsection (5)(c) as it appears in House Bill 13-1314, effective March 1, 2014.

Cross references: For the legislative declaration in HB 26-1147, see section 1 of chapter 352, Session Laws of Colorado 2026.

ANNOTATION

Applied in Adams County Ass'n for Retarded Citizens, Inc. v. City of Westminster, 196 Colo. 79, 580 P.2d 1246 (1978) (decided under former law).

25.5-10-215. Compliance with local government zoning regulations - notice to local governments - provisional licensure.

(1) The state department shall require any community residential home seeking licensure pursuant to section 25.5-10-214 to comply with any applicable zoning regulations of the municipality, city and county, or county where the home is situated. Failure to comply with applicable zoning regulations shall constitute grounds for the denial of a license to a home; except that nothing in this section shall be construed to supersede the provisions of sections 30-28-115 (2), 31-23-301 (4), and 31-23-303 (2), C.R.S.

(2) The state department shall ensure that timely written notice is provided to the municipality, city and county, or county where a community residential home is situated, including the address of the home and the population and number of persons to be served by the home, when any of the following occurs:

(a) An application for a license to operate a community residential home pursuant to section 25.5-10-214 is made;

(b) A license is granted to a community residential home pursuant to section 25.5-10-214;

(c) A change in the license of a community residential home occurs; or

(d) The license of a community residential home is revoked or otherwise terminated for any reason.

(3) In the event of a zoning or other delay or dispute between a community residential home and the municipality, city and county, or county where the home is situated, the state department may grant a provisional license to the home for up to one hundred twenty days pending resolution of the delay or dispute.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1767, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-109.5 as it existed prior to 2013.

25.5-10-216. Imposition of legal disability - removal of legal right.

(1) Any interested person may petition the court to impose a legal disability on or to remove a legal right from a person with an intellectual and developmental disability as defined in section 25.5-10-202. The petition must set forth the disability to be imposed or the legal right to be removed and the reasons therefor. The petition may affect the right to contract, the right to determine place of abode or provisions of services and supports, the right to operate a motor vehicle, and other similar rights.

(2) (a) Prior to granting the petition, the court must find:

(I) That the person subject to the petition has been determined to be a person with an intellectual and developmental disability pursuant to the provisions of this article; and

(II) That the requested disability or removal is both necessary and desirable to implement the individualized plan developed for the person receiving services or supports under the supervision of an intellectual and developmental disabilities professional and the interdisciplinary team. Such professional must have an understanding of the rights of persons receiving services as set forth in sections 25.5-10-218 to 25.5-10-229. Such plan must be submitted to the court and must be signed by the intellectual and developmental disabilities professional.

(b) When a petition filed pursuant to subsection (1) of this section seeks to impose a disability or to remove a legal right, related to the selection of place of abode by the person with an intellectual and developmental disability, the court must also find:

(I) That, based on the recent overt actions or omissions of the person subject to the petition, and because of the presence of an intellectual and developmental disability, without the relief requested in the petition such person poses a probable threat of serious physical harm to such person or others or is unable to care for such person's own needs to the extent that such person's own life or safety is seriously threatened; and

(II) That the place of abode requested in the petition is the least restrictive residential setting that is appropriate for the individual needs of the person with an intellectual and developmental disability.

(3) Within six months after a legal disability has been imposed or a legal right has been removed, the court shall hold a hearing to review its order and either reaffirm the findings made pursuant to subsection (2) of this section and continue the legal disability or removal or remove the legal disability or restore the legal rights to the person subject to the petition. The court may remove a legal disability from or restore a legal right to a person without a hearing upon the

filing of a motion requesting such relief containing affidavits in support of the motion signed by all of the parties.

(4) Any interested person may move that the court remove a legal disability or restore a legal right. If such motion is contested, it must be served on the person whose rights are affected and upon the party who filed the original petition if the person is not the moving party.

(5) The following procedures must apply to any proceedings instituted pursuant to this section:

(a) When a petition is filed pursuant to subsection (1) of this section, the person subject to the petition shall be advised by the court of such person's right to retain and consult with an attorney at any time, and that if such person cannot afford to pay an attorney, one will be appointed by the court without cost. Attorney fees for court-appointed counsel shall be paid by the court.

(b) Upon the request of an indigent respondent or such respondent's attorney, the court shall appoint one or more intellectual and developmental disabilities professionals of the respondent's choice to assist the respondent in the preparation of the respondent's case. The court shall pay the fees for such intellectual and developmental disabilities professionals.

(c) The court may issue a temporary order imposing a legal disability or removing a legal right, pending a hearing, for a period not to exceed ten days, based upon the standards required for issuance of a temporary restraining order. No individualized plan shall be required by the court to support the issuance of such order.

(d) The burden of proof is at all times upon the party seeking imposition of a disability or removal of a legal right or opposing removal of a disability or restoration of a legal right, and the standard of proof is by clear and convincing evidence.

(e) Except as otherwise provided in this subsection (5), all proceedings must be held in conformance with the Colorado rules of civil procedure, but no costs must be assessed against the respondent.

(6) In order to provide representation to eligible persons as provided in this section, the judicial department may pay moneys, out of appropriations made therefor by the general assembly, directly to appointed counsel or intellectual and developmental disabilities professionals on a case-by-case basis or, on behalf of the state, to contract with individual attorneys, legal partnerships, legal professional corporations, public interest law firms, or nonprofit legal services corporations to provide legal representation for an agreed-upon lump sum.

(7) A person shall not be admitted to a regional center, as defined in section 27-10.5-102, without a court order issued pursuant to this section except in an emergency, if the person meets

the criteria for an enhanced protective placement pursuant to section 16-8.5-118, or for the purpose of temporary respite care.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1767, § 1, effective March 1, 2014. **L. 2026:** (7) amended, (SB 26-149), ch. 142, p. 787, § 24, effective May 21.

Editor's note: This section is similar to former § 27-10.5-110 as it existed prior to 2013.

25.5-10-217. Conduct of court proceedings.

All court proceedings arising under section 25.5-10-216 shall be conducted by the district attorney of the county where the proceeding is held or by a qualified attorney acting for the district attorney appointed by the district court for that purpose; except that, in any county or in any city and county having a population exceeding one hundred thousand persons, the proceedings shall be conducted by the county attorney or by a qualified attorney acting for the county attorney appointed by the district court. In any case in which there has been a change of venue to a county other than the county of residence of the respondent or the county in which the proceeding was commenced, the county from which the proceeding was transferred shall either reimburse the county in which the proceeding was held for the reasonable costs incurred in conducting the proceeding or conduct the proceeding itself using its own personnel and resources, including its own district or county attorney, as the case may be.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1769, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-111 as it existed prior to 2013.

25.5-10-218. Persons' rights.

(1) Unless a person's rights are modified by court order, a person with an intellectual and developmental disability has the same legal rights and responsibilities guaranteed to all other persons under the federal and state constitutions and federal and state laws. No otherwise qualified person, by reason of having an intellectual and developmental disability, may be

excluded from participation in, denied the benefits of, or subjected to discrimination under any program or activity which receives public funds.

(2) The receipt of services and supports pursuant to this article does not deprive any person of any other rights, benefits, or privileges or cause the person to be declared legally incompetent.

(3) The rights of any person receiving services which are specified in this article 10 may be modified to protect the person receiving services from endangering the person, others, or property. The rights may be modified only with the informed consent of the person receiving services or the person's legally authorized representative and with subsequent review by the person receiving services, the person's legally authorized representative, the person's interdisciplinary team, and by the human rights committee in order to provide specific services or supports to the person receiving services, which will promote the least restriction on the person's rights. The person's legal rights may be removed by a court pursuant to section 25.5-10-216.

(4) None of the rights established pursuant to this article shall be construed to interfere with the rights and privileges of parents regarding their minor child.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1770, § 1, effective March 1, 2014. **L. 2021:** (3) amended, (HB 21-1187), ch. 83, p. 343, § 45, effective July 1, 2024.

Editor's note: This section is similar to former § 27-10.5-112 as it existed prior to 2013.

ANNOTATION

Applied in Adams County Ass'n for Retarded Citizens, Inc. v. City of Westminster, 196 Colo. 79, 580 P.2d 1246 (1978) (decided under former law).

25.5-10-219. Right to individualized plan or individualized family service plan - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1770, § 1, effective March 1, 2014. **L. 2021:** (3) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70. **L. 2022:** (1) and (2) amended, (HB 22-1295), ch. 123, p. 850, § 80, effective July 1.

Editor's note: (1) Prior to its repeal, this section was similar to former § 27-10.5-113 as it existed prior to 2013.

(2) Subsection (3) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-10-220. Right to medical care and treatment.

(1) Each person receiving services must have access to appropriate dental and medical care and treatment for any physical ailments and for the prevention of any illness or disability.

(2) No medication for which a prescription is required shall be administered without the written order of a physician. A physician shall conduct a review of all prescriptions and other orders for medications in order to determine the appropriateness of the person's medication regimen annually, or more often, if required by law.

(3) All service agencies which administer medication shall require that notation of the medication of a person receiving services be kept in the person's medical records. All medications must be administered pursuant to part 3 of article 1.5 of title 25, C.R.S.

(4) Persons receiving services must have a right to be free from unnecessary or excessive medication. The service agency's records must state the effects of psychoactive medication if administered to the person receiving services. When dosages of such are changed or other psychoactive medications are prescribed, a notation must be made in such person's record concerning the effect of the new medication or new dosages and the behavior changes, if any, which occur.

(5) Medication must not be used for the convenience of the staff, for punishment, as a substitute for a treatment program, or in quantities that interfere with the treatment program of the person receiving services.

(6) Only appropriately trained staff shall be allowed to administer medications.

(7) The executive director has the power to direct the administration or monitoring of medications to persons receiving services and supports in centers for persons with intellectual and developmental disabilities pursuant to section 25-1.5-301 (2)(h), C.R.S.

(8) No person receiving services may be subjected to any experimental research or hazardous treatment procedures without the consent of such person, if the person is over eighteen years of age and is able to give such consent, or of the person's parent, if the person is under eighteen years of age, or of the person's legal guardian. Such consent may be given only after consultation with the interdisciplinary team and an intellectual and developmental disabilities professional not affiliated with the facility or community residential home in which the person receiving services

resides. However, no such person of any age may be subjected to experimental research or hazardous treatment procedures if said person implicitly or expressly objects to such procedure.

(9) A person receiving services must not have any organs removed for the purpose of transplantation without the person's consent if the person is over eighteen years old and is able to give consent. Consent for the removal of organs for transplantation may be given by the parents of a person receiving services, if the person is under eighteen years old, or by the person's legal guardian. A parent's or legal guardian's consent may be given only after consultation with the interdisciplinary team and an intellectual and developmental disabilities professional not affiliated with the facility or community residential home in which the person receiving services resides. However, a person receiving services of any age shall not be a donor of an organ if the person implicitly or expressly objects to the procedure.

(10) (a) As used in subsections (8) and (9) of this section, consent also requires that the person whose consent is sought has been adequately and effectively informed as to the:

(I) Method of experimental research, hazardous treatment, or transplantation;

(II) Nature and consequence of such procedures; and

(III) Risks, benefits, and purposes of such procedures.

(b) The consent of any person may be revoked at any time.

(11) Subsections (8), (9), and (10) of this section do not apply when a physician renders emergency medical care or treatment to any resident.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1771, § 1, effective March 1, 2014. **L. 2026:** (9) amended, (HB 26-1040), ch. 27, p. 125, § 2, effective August 12.

Editor's note: This section is similar to former § 27-10.5-114 as it existed prior to 2013.

25.5-10-221. Right to humane treatment.

(1) Corporal punishment of persons with an intellectual and developmental disability is not permitted.

(2) All service agencies shall prohibit mistreatment, exploitation, neglect, or abuse in any form of any person receiving services.

(3) Service agencies shall provide every person receiving services with a humane physical environment.

(4) Each person receiving services must be attended to by qualified staff in numbers sufficient to provide appropriate services and supports.

(5) Seclusion, defined as the placement of a person receiving services alone in a closed room for the purpose of punishment, is prohibited.

(6) "Time out" procedures, defined as separation from other persons receiving services and group activities, may be employed under close and direct professional supervision, as defined by rule by the state board, and only as a technique in behavior-shaping programs. Behavior-shaping programs utilizing a "time out" procedure may be implemented only when it incorporates a positive approach designed to result in the acquisition of adaptive behaviors. Such behavior programs may only be implemented following the completion of a comprehensive functional analysis, when alternative nonrestrictive procedures have been proven to be ineffective, and only with the informed consent of the person, parents, or legal guardian. Such behavior programs may be implemented only following the review and approval process defined in rules. Behavior development programs must be developed in conjunction with the interdisciplinary team and implemented only following review by the human rights committee. Behavior development programs involving the use of the procedure in a "time out room" are prohibited.

(7) Behavior development programs involving the use of aversive or noxious stimuli are prohibited.

(8) Physical restraint, defined as the use of manual methods intended to restrict the movement or normal functioning of a portion of a person's body through direct contact by staff, may be employed only when necessary to protect the person receiving services from injury to self or others. Physical restraint may not be employed as punishment, for the convenience of staff, or as a substitute for a program of services and supports. Physical guidance or prompting techniques of short duration such as those employed in training techniques are not considered physical restraint. Physical restraint may be applied only if alternative techniques have failed and only if such restraint imposed the least possible restriction consistent with its purpose. If physical restraint is used in an emergency or on a continuing basis its use shall be reviewed by the interdisciplinary team and the human rights committee in accordance with the rules of the state board.

(9) The use of a mechanical restraint, defined as the use of mechanical devices intended to restrict the movement or normal functioning of a portion of a person's body, is subject to special review and oversight, as defined in rules. Use of mechanical restraints may be applied only in an emergency if alternative techniques have failed and in conjunction with a behavior development program. Mechanical restraints must be designed and used so as not to cause physical injury to the person receiving services and so as to cause the least possible discomfort. The use of

mechanical restraints shall be reviewed by the human rights committee. The use of posey vests, straight jackets, ankle and wrist restraints, and other devices defined in rules is prohibited.

(10) A record must be maintained of all physical injuries to any person receiving services, all incidents of mistreatment, exploitation, neglect, or abuse, and all uses of physical or mechanical restraint. All records are subject to review by the human rights committee.

(11) Behavior development programs must be supervised by an intellectual and developmental disabilities professional having specific knowledge and skills to develop and implement positive behavioral intervention strategies.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1772, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-115 as it existed prior to 2013.

ANNOTATION

A school district is not a "service agency" within the meaning of this article. A.B. v. Adams-Arapahoe 28J Sch. Dist., 831 F. Supp. 2d 1226 (D. Colo. 2011) (decided under former law).

25.5-10-222. Right to religious belief, practice, and worship.

No person receiving services is required to perform any act or be subject to any procedure whatsoever which is contrary to the person's religious belief, and each such person has the right to practice such religious belief and be accorded the opportunity for religious worship. Provisions for religious worship must be made available to all persons receiving services on a nondiscriminatory basis. No such person shall be coerced into engaging in or refraining from any religious activity, practice, or belief.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1773, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-116 as it existed prior to 2013.

25.5-10-223. Rights to communications and visits.

(1) Each person receiving services has the right to communicate freely and privately with others of the person's own choosing.

(2) Each person receiving services has the right to receive and send sealed, unopened correspondence. No such person's incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person.

(3) Each person receiving services shall have the right to receive and send packages. No such person's outgoing packages shall be opened, delayed, held, or censored by any person.

(4) Each person receiving services must have reasonable access to telephones, both to make and to receive calls in privacy, and must be afforded reasonable and frequent opportunities to meet with visitors.

(5) All service agencies shall ensure that persons receiving services have suitable opportunities for interaction with persons of their choice. Nothing in this section will limit the protections provided under article 3.1 of title 26, C.R.S.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1774, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-117 as it existed prior to 2013.

25.5-10-224. Right to fair employment practices.

(1) No person receiving services shall be required to perform labor; except that persons receiving services may voluntarily engage in such labor if the labor is compensated in accordance with applicable minimum wage laws.

(2) No person receiving services shall be involved in the physical care, care and treatment, training, or supervision of other persons receiving services unless such person has volunteered, has been specifically trained in the necessary skills, and has the judgment required for such activities, is adequately supervised, and is reimbursed in accordance with the applicable minimum wage laws.

(3) Each person receiving services may perform vocational training tasks, subject to a presumption that an assignment longer than three months to any task is not a training task, if the specific task or any change in task assignment is an integral part of such person's individualized plan. If such person performs vocational training tasks for which the service agency is receiving

compensation from any outside source, the person shall be compensated in accordance with the applicable minimum wage laws.

(4) Each person receiving services may voluntarily engage in labor for which the service agency would otherwise have to pay an employee if the specific labor or any change in labor is an integral part of such person's individualized plan and the person is compensated in accordance with the applicable minimum wage laws.

(5) Each person receiving services may be required to perform tasks of a personal housekeeping nature or tasks oriented to improving community living skills in accordance with the person's individualized plan.

(6) Payment to persons receiving services pursuant to this section shall not be collected by the service agency to offset the costs of providing services and supports to such person.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1774, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-118 as it existed prior to 2013.

25.5-10-225. Right to vote.

Each person receiving services who is eligible to vote according to law has the right to vote in all primary and general elections. As necessary, all service agencies shall assist such persons to register to vote, to obtain mail ballots, to comply with other requirements that are prerequisite to voting, and to vote.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1775, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-119 as it existed prior to 2013.

25.5-10-226. Records and confidentiality of information pertaining to eligible persons or their families - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1775, § 1, effective March 1, 2014. **L. 2017:** (4) amended, (SB 17-294), ch. 264, p. 1409, § 93, effective May 25. **L. 2021:** (5) added by revision, (HB 21-1187), ch. 83, pp. 353, 354, §§ 69, 70.

Editor's note: (1) Prior to its repeal, this section was similar to former § 27-10.5-120 as it existed prior to 2013.

(2) Subsection (5) provided for the repeal of this section, effective July 1, 2024. (See L. 2021, pp. 353, 354.)

25.5-10-227. Right to personal property.

(1) Each person receiving services has the right to the possession and use of such person's own clothing and personal effects. If the service agency holds any of such person's personal effects for any reason, such retention shall be promptly recorded in such person's record and the reason for retention shall also be recorded.

(2) Upon the request of a person receiving services, a service agency may hold money or funds belonging to the person receiving services, received by such person, or received by the service agency for such person. All such money or funds shall be held by the service agency as trustee for the person receiving services. Upon request, an accounting shall be rendered by the service agency.

(3) Upon request, a person receiving services is entitled to receive reasonable amounts of such person's money or funds held in trust.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1776, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-121 as it existed prior to 2013.

25.5-10-228. Right to influence policy.

The persons receiving services of a service agency are entitled to establish a committee to hear the views and represent the interests of all such persons served by the agency and to attempt to influence the policies of the agency to the extent that they influence provision of services and supports.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1776, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-122 as it existed prior to 2013.

25.5-10-229. Right to notification.

Each person receiving services has the right to read or have explained, in each person's or family's native language, any rules adopted by the service agency and pertaining to such person's activities.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1777, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-123 as it existed prior to 2013.

25.5-10-230. Discrimination.

No person who has received services or supports under any provision of this article shall be discriminated against because of such status. For purposes of this section, "discrimination" means the giving of any unfavorable weight to the fact that a person has received such services or supports.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1777, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-124 as it existed prior to 2013.

25.5-10-231. Sterilization rights - legislative intent.

(1) It is the intent of the general assembly that the consent required in subsection (2) of this section applies to any person with an intellectual and developmental disability when sterilization is being considered for the primary purpose of rendering the person incapable of reproduction.

(2) A person with an intellectual and developmental disability who has decision-making capacity shall not be sterilized in the absence of the person's informed consent. A person with an intellectual and developmental disability who lacks decision-making capacity shall not be sterilized in the absence of the person's informed consent except in circumstances where the decision is made in accordance with a process, requirements, or limitations set forth in article 14 of title 15 or any other applicable law or court order.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1777, § 1, effective March 1, 2014. **L. 2026:** Entire section amended, (HB 26-1040), ch. 27, p. 124, § 1, effective August 12.

Editor's note: This section is similar to former § 27-10.5-128 as it existed prior to 2013.

ANNOTATION

Law reviews. For article, "Involuntary Sterilization of Retarded Minors in Colorado", see 11 Colo. Law. 421 (1982). For article, "Cruzan: The Right to Die, Parts I and II", see 19 Colo. Law. 2055 and 2237 (1990). For article, "In re Romero: Sterilization and Competency", see 68 Den. U. L. Rev. 105 (1991).

Annotator's note. Since § 25.5-10-231 is similar to § 27-10.5-128 as it existed prior to the 2013 amendment to parts 1, 4, and 5 of article 10.5 of title 27, which resulted in the relocation of provisions, a relevant case construing that provision has been included in the annotations to this section.

Constitutional rights extend to incompetents. The constitutionally-protected procreative alternatives available to competent adults must also extend where possible to individuals who are not mentally competent to make the choice for themselves. In re A.W., 637 P.2d 366 (Colo. 1981).

Sterilization sections not limited to competent adults. The general assembly did not intend §§ 27-10.5-128 through 27-10.5-132 to limit sterilizations to competently consenting adults. In re A.W., 637 P.2d 366 (Colo. 1981).

Court's power to act in absence of statutory authorization. A district court acting in its probate capacity has the power in the absence of statutory authorization to act on a petition for sterilization of a

mentally retarded minor. In re A.W., 637 P.2d 366 (Colo. 1981).

A court's inherent parens patriae jurisdiction over incompetents may extend to decisions involving irrevocable consequences for the incompetent individual. In re A.W., 637 P.2d 366 (Colo. 1981).

Since statutory provisions concerning sterilization of mentally retarded persons do not address the issue of sterilization of a minor, it is within the district court's inherent authority to consider a petition for sterilization of a minor, and, in the absence of legislative pronouncement, it is proper and necessary for the supreme court to promulgate standards for determining the circumstances under which such a procedure may be performed. In re A.W., 637 P.2d 366 (Colo. 1981).

Preliminary determinations court must make. In considering a petition to sterilize a mentally retarded minor, the district court must make the following preliminary determinations. First, while the mentally retarded person need not testify or be present at the proceedings if the person's presence would serve no useful purpose, the trial judge should talk with the person and observe the person's physical and mental condition. The wishes of the person, although not conclusive, are relevant, and a strong indication that the person does not wish to be sterilized must weigh heavily against authorizing the procedure. Second, the district court must determine that the person's capacity to make a decision about sterilization is unlikely to improve in the future. Third, the person for whom sterilization is requested must be proven capable of reproduction. In re A.W., 637 P.2d 366 (Colo. 1981).

Sterilization of mentally retarded minor must be medically necessary. Once a district court determines preliminary matters relating to a petition to sterilize a mentally retarded minor, it must find by clear and convincing evidence that the sterilization is medically essential. A sterilization is medically essential if clearly necessary, in the opinion of experts, to preserve the life or physical or mental health of the mentally retarded person. In re A.W., 637 P.2d 366 (Colo. 1981).

For legislative history of provisions relating to sterilization, see In re A.W., 637 P.2d 366 (Colo. 1981).

25.5-10-232. Competency to give consent to sterilization. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1778, § 1, effective March 1, 2014. **L. 2026:** Entire section repealed, (HB 26-1040), ch. 27, p. 126, § 3, effective August 12.

Editor's note: Prior to its repeal, this section was similar to former § 27-10.5-129 as it existed prior to 2013.

25.5-10-233. Court-ordered sterilization. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1778, § 1, effective March 1, 2014. **L. 2026:** Entire section repealed, (HB 26-1040), ch. 27, p. 126, § 3, effective August 12.

Editor's note: Prior to its repeal, this section was similar to former § 27-10.5-130 as it existed prior to 2013.

25.5-10-234. Confidentiality of sterilization proceedings. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1779, § 1, effective March 1, 2014. **L. 2026:** Entire section repealed, (HB 26-1040), ch. 27, p. 126, § 3, effective August 12.

Editor's note: Prior to its repeal, this section was similar to former § 27-10.5-131 as it existed prior to 2013.

25.5-10-235. Limitations on sterilization.

(1) Consent to sterilization shall be made neither a condition for release from any institution nor a condition for the exercise of any right, privilege, or freedom.

(2) Nothing in this article requires any hospital or any person to participate in any sterilization, nor shall any hospital or any person be civilly or criminally liable for refusing to participate in any sterilization.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1779, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-132 as it existed prior to 2013.

25.5-10-236. Civil action and attorney fees.

A violation of any provision of this article gives rise to a civil cause of action by the person adversely affected by such violation, and any judgment may include plaintiff's reasonable attorney fees.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-134 as it existed prior to 2013.

25.5-10-237. Terminology.

(1) Whenever the terms "insane", "insanity", "mentally or mental incompetent", "mental incompetency", or "of unsound mind" are used in the laws of the state of Colorado, they refer to the insane, as defined in sections 16-8-101 and 16-8-101.5, or to a person with an intellectual and developmental disability, as defined in section 25.5-10-202, as the context of the particular law requires.

(2) Whenever the term "mentally deficient person" is used in the laws of the state of Colorado, it shall be deemed to mean and be included with the term "person with an intellectual and developmental disability", as defined in section 25.5-10-202.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014. **L. 2025:** (1) amended, (HB 25-1058), ch. 15, p. 59, § 26, effective August 6.

Editor's note: This section is similar to former § 27-10.5-135 as it existed prior to 2013.

25.5-10-238. Federal funds.

The state department is authorized to accept, on behalf of the state, any grants of federal funds made available for any purposes consistent with the provisions of this article. The executive director of the state department, with the approval of the governor, shall have power to direct the disposition of any such grants so accepted in conformity with the terms and conditions under which they are given.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-137 as it existed prior to 2013.

25.5-10-239. Evaluations to determine whether a defendant is mentally retarded or has an intellectual and developmental disability for purposes of class 1 felony trials.

Upon request of the court, the executive director, or his or her designee, shall recommend specific professionals who are qualified to perform an evaluation to determine whether a defendant is mentally retarded or is a defendant with an intellectual and developmental disability, as defined in section 18-1.3-1101. A recommended professional must be licensed as a psychologist in the state of Colorado and must have experience in and demonstrated competence in determination and evaluation of persons with intellectual and developmental disabilities. The executive director shall convene a panel of not fewer than three persons with expertise in intellectual and developmental disabilities to assess the qualifications of licensed psychologists and make recommendations to the executive director or his or her designee.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014. **L. 2018:** Entire section amended, (SB 18-096), ch. 44, p. 474, § 17, effective August 8.

Editor's note: This section is similar to former § 27-10.5-139 as it existed prior to 2013.

Cross references: For the legislative declaration in SB 18-096, see section 1 of chapter 44, Session Laws of Colorado 2018.

25.5-10-240. Retaliation prohibited.

No person shall be discriminated against because the person has made a complaint, testified, assisted, or participated in any manner in an investigation, proceeding, or hearing pursuant to this article 10, including the dispute resolution procedures in section 25.5-10-212 and section 27-10.5-107. A service agency, including the state department and any case management agency, shall not coerce, intimidate, threaten, or interfere with any person in the exercise or enjoyment of any right pursuant to this article 10, or on account of the person having exercised or enjoyed any right pursuant to this article 10, or on account of the person having aided or encouraged any other person in the exercise or enjoyment of any right pursuant to this article 10.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1780, § 1, effective March 1, 2014. **L. 2021:** Entire section amended, (HB 21-1187), ch. 83, p. 343, § 46, effective July 1, 2024.

Editor's note: This section is similar to former § 27-10.5-141 as it existed prior to 2013.

25.5-10-241. Host home provider stakeholder collaboration - report.

(1) No later than September 1, 2023, the state department shall engage in a stakeholder process, which must include but is not limited to equitable representation among program-approved service agencies, case management agencies, host home providers under contract with a provider agency, individuals with lived experiences, and advocacy groups that represent the disability community, to address concerns and identify viable solutions related to individuals who receive long-term services and supports pursuant to this article 10. At a minimum, the stakeholder process must address:

(a) The timeline, process, and procedure for reporting and resolving a grievance or complaint by an individual receiving long-term services and supports, including regular notifications to the individual about the grievance and complaint procedure and process, the right to an appeal, how an individual can easily access information related to the process and procedure, and how to report retaliation;

(b) The process by which a host home provider under contract with a provider agency that is convicted of abuse or neglect may be determined ineligible to continue providing services and supports; and

(c) Consistency of contract language between program-approved service agencies and host home providers under contract with a provider agency.

(2) No later than January 2025, the state department shall report as part of its "SMART Act" hearing required by section 2-7-203 on the stakeholder process described in subsection (1) of this section, including identifying any administrative resources needed to address the concerns and solutions identified during the stakeholder process.

Source: L. 2023: Entire section added, (HB 23-1197), ch. 281, p. 1659, § 2, effective May 30.

Cross references: For the legislative declaration in HB 23-1197, see section 1 of chapter 281, Session Laws of Colorado 2023.

PART 3

FAMILY SUPPORT SERVICES

25.5-10-301. Legislative declaration.

(1) It is the intent of the general assembly that the service delivery system for persons with intellectual and developmental disabilities emphasize community living for persons with intellectual and developmental disabilities and provide supports to persons that enable them to enjoy typical lifestyles. One way to accomplish this is to recognize that families are the greatest resource available to persons who have an intellectual and developmental disability and that families must be supported in their role as primary care givers. The general assembly finds that supporting families in their effort to provide supports for their family members at home is more efficient, cost-effective, and humane than maintaining persons with intellectual and developmental disabilities in out-of-home residential settings. In recognition of the importance of families, the general assembly states that the following principles should be used as guidelines in developing programs to support a family that has a child with disabilities:

(a) Families of persons with intellectual and developmental disabilities are best able to determine their own needs and preferences and should be empowered to make decisions concerning necessary, desirable, and appropriate services and supports;

(b) Families must receive the services and supports necessary to care for their children at home;

(c) Family support must be responsive to the needs of the entire family unit;

(d) Family support must be sensitive to the unique strengths and needs of individual families;

(e) Family support must build on existing social networks and natural sources of support;

(f) Family support is needed throughout the life span of the person who has a disability;

(g) Family support must encourage the inclusion of people with intellectual and developmental disabilities within the community;

(h) Family support services must be flexible enough to accommodate unique needs of families as they evolve over time;

(i) Family support services must be consistent with the cultural preferences and orientations of individual families;

(j) Family support services should be comprehensive and coordinated across the numerous agencies likely to provide resources, supports, or services to families;

(k) Family support services should be based on the principles of sharing ordinary places, developing meaningful relationships, learning things that are useful, making choices, as well as increasing the status and enhancing the reputation of people served;

(l) Supports should be developed by the state that are necessary, desirable, and appropriate to support families;

(m) Intellectual and developmental disabilities programs and policies must enhance the development of the person with an intellectual and developmental disability and the family;

(n) State programs should provide sufficient services and supports to enable families to keep their family members with intellectual and developmental disabilities at home;

(o) A comprehensive, coordinated system of supports to families effectively uses existing resources and minimizes gaps in supports to families and persons in all areas of the state;

(p) Services and supports provided through the family support program must be closely coordinated with early intervention services and must foster collaboration and cooperation with all agencies providing services and supports to infants and preschool children; and

(q) Any rights, entitlements, services, or supports created by this part 3 are not to be considered a limitation, modification, or infringement on any existing rights, entitlements, services, or supports, otherwise expressly provided by this article.

(2) In addition, the general assembly recognizes that the state department has for several years developed and maintained a family resource service program that provides support services to families of children with intellectual and developmental disabilities who are at risk of out-of-home placement. Because of the success of this program the general assembly recommends that this valuable program be continued and expanded so that more families in this state are able to receive appropriate services, supports, and assistance needed to stabilize the family unit. In recognition of the basic goal to support families, on an individual family basis, in maintaining a person with an intellectual and developmental disability at home and in recognition of the

principles stated in subsection (1) of this section, the general assembly declares that its purpose in enacting this part 3 is to create, subject to annual appropriation, a comprehensive statewide family support service program.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1781, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-401 as it existed prior to 2013.

25.5-10-302. Purpose.

The purpose of the family support services program created in this part 3 is to provide support to families in their role as primary care givers for a family member with an intellectual and developmental disability.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1782, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-402 as it existed prior to 2013.

25.5-10-303. Administration - duties of department.

(1) Subject to annual appropriation by the general assembly, the state department shall administer the family support services program and shall coordinate family support services with other existing services provided to families and individuals. Family support services must be provided in a manner that develops comprehensive, responsive, and flexible support to families in their role as the primary care givers for a family member with an intellectual and developmental disability.

(2) The state department may contract with case management agencies or entities approved by the state department to provide family support services in accordance with this part 3. Programs developed shall be flexible in order to address individual family needs.

(3) In administering the family support services program, the state department shall have the following duties:

(a) To design the program;

(b) To pursue a family support model 200 waiver for approval by the federal centers for medicare and medicaid services in order to utilize medicaid funds for the provision of family support services, implemented subject to appropriation;

(c) To develop rules to be promulgated by the state board pursuant to section 25.5-10-306, with consultation from service agencies, including representatives of families of persons with intellectual and developmental disabilities;

(d) To allocate funds;

(e) To coordinate training and provide technical assistance to case management agencies or entities approved to provide family support services;

(f) To monitor and evaluate the program;

(g) To coordinate contracts, expenditures, and billing of the program; and

(h) To recommend changes in the program.

(4) Subject to annual appropriation by the general assembly, out of the appropriation to the state department for community programs in the general appropriation act, the state department is authorized to use up to seven percent of such appropriation allocated for family support services to pay for administrative costs within the state department and the service agency.

(5) The state department shall take any necessary action relating to the termination and wind up of the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal. The state department shall receive payments relating to outstanding loans made from the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal, which payments shall be transferred to the state treasurer and credited to the family support services fund created in section 25.5-10-303.5.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1783, § 1, effective March 1, 2014. **L. 2017:** (5) added, (HB 17-1078), ch. 27, p. 82, § 4, effective July 1. **L. 2021:** (2), (3)(b), (3)(c), (3)(e), and (4) amended, (HB 21-1187), ch. 83, p. 343, § 47, effective July 1, 2024.

Editor's note: This section is similar to former § 27-10.5-404 as it existed prior to 2013.

25.5-10-304. Family support councils.

(1) The state department shall ensure that each case management agency or service agency approved to provide family support services establishes a family support council in each defined

service area. The family support councils must consist of professionals, interested citizens, family members of persons with an intellectual and developmental disability, and persons with an intellectual and developmental disability with a majority of the council being made up of family members.

(2) The family support council shall:

(a) Provide direction and assistance to the case management agency in the development of a family support plan for the defined service area;

(b) Make recommendations regarding other family supports or services not specifically listed in this part 3;

(c) Monitor the implementation of the supports or services provided pursuant to the plan; and

(d) Provide a written report to the state department of its involvement in the duties specified in this subsection (2).

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1783, § 1, effective March 1, 2014. **L. 2021:** (1) and (2)(a) amended, (HB 21-1187), ch. 83, p. 344, § 48, effective July 1, 2024.

Editor's note: This section is similar to former § 27-10.5-405 as it existed prior to 2013.

25.5-10-305. Authorized family support services.

(1) The family support services included in this program include, but are not limited to, family support grants, family support services coordination, information and referral, educational materials, emergency and outreach services, and other person- and family-centered assistance services such as:

(a) Medical and dental expenses not covered by medical or health insurance or other programs;

(b) Insurance expenses;

(c) Respite;

(d) Mobility aids; adaptive equipment; assistive technology, including the cost of therapies essential for a child's development, as prescribed by a physician or specialized therapist; and home adaptations;

(e) Home health services and therapies;

(f) Family counseling, training, and support groups;

(g) Recreation and leisure needs;

(h) Transportation;

(i) Special diets, clothing, materials, and equipment; and

(j) Homemaker services.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1784, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-406 as it existed prior to 2013.

25.5-10-305.5. Family support services fund - creation - transfer.

(1) The family support services fund, referred to in this section as the "fund", is hereby created in the state treasury. The fund consists of money transferred to the fund from the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal, payments relating to outstanding loans made from the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal, and any other money that the general assembly may appropriate or transfer to the fund.

(2) The state treasurer shall credit all interest and income derived from the deposit and investment of money in the fund to the fund.

(3) Subject to annual appropriation by the general assembly, the state department may expend money from the fund for necessary expenditures relating to the administration of outstanding loans made from the Colorado family support loan fund as created in section 25.5-10-402 prior to its repeal, and to provide family support services pursuant to this part 3.

(4) Repealed.

Source: L. 2017: Entire section added, (HB 17-1078), ch. 27, p. 81, § 3, effective July 1. **L. 2025:** (4) added, (HB 25-1215), ch. 312, p. 1631, § 8, effective May 30.

Editor's note: Subsection (4)(b) provided for the repeal of subsection (4), effective July 1, 2026. (See L. 2025, p. 1631.)

Cross references: For the legislative declaration in HB 25-1215, see section 1 of chapter 312, Session Laws of Colorado 2025.

25.5-10-306. Rules.

(1) The state board shall develop rules concerning:

(a) Further definition of services and supports to be provided by the family support services program described in this part 3;

(b) The requirements for eligibility for services and supports;

(c) The manner of providing services and supports; and

(d) The size, makeup, and duties of family support councils.

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1784, § 1, effective March 1, 2014.

Editor's note: This section is similar to former § 27-10.5-407 as it existed prior to 2013.

PART 4

COLORADO FAMILY SUPPORT LOAN FUND

25.5-10-401. Legislative declaration. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1785, § 1, effective March 1, 2014. **L. 2017:** Entire section repealed, (HB 17-1078), ch. 27, p. 81, § 1, effective July 1.

Editor's note: This section was similar to former § 27-10.5-501 as it existed prior to 2013.

25.5-10-402. Colorado family support loan fund - creation - loans to families - repeal. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1785, § 1, effective March 1, 2014. **L. 2017:** (6) added, (HB 17-1078), ch. 27, p. 81, § 2, effective July 1.

Editor's note: (1) This section was similar to former § 27-10.5-502 as it existed prior to 2013.

(2) Subsection (6)(a) provided for the repeal of this section, effective July 1, 2017. (See L. 2017, p. 81.)

25.5-10-403. Duties relating to the fund. (Repealed)

Source: L. 2013: Entire article added with relocations, (HB 13-1314), ch. 323, p. 1786, § 1, effective March 1, 2014. **L. 2017:** Entire section repealed, (HB 17-1078), ch. 27, p. 81, § 1, effective July 1.

Editor's note: This section was similar to former § 27-10.5-503 as it existed prior to 2013.

PART 5

PROTECTIVE PLACEMENT AND ENHANCED PROTECTIVE PLACEMENT

25.5-10-501. Definitions.

As used in this part 5, unless the context otherwise requires:

(1) "Behavioral health administration" or "BHA" means the behavioral health administration established in section 27-60-203.

(2) "Danger to others" has the meaning set forth in section 27-65-102.

(3) "Danger to the person's self", or similar terminology, has the meaning set forth in section 27-65-102.

(4) "Department of health care policy and financing" or "HCPF" means the department of health care policy and financing created in section 24-1-119.5.

(5) "Department of human services" or "CDHS" means the department of human services.

(6) "Intellectual and developmental disability" has the meaning set forth in section 25.5-10-202.

(7) "Intervening professional" has the meaning set forth in section 27-65-102.

(8) "Mental health disorder" has the meaning set forth in section 27-65-102.

(9) "Neurocognitive disorder" means a substantial and persistent acquired disorder of the cognitive or neurological processes that grossly impairs judgment, memory, or capacity to recognize reality or to control behavior, general intellectual functioning, or adaptive behavior that is attributable to a neurological or cognitive disorder or related condition, including, but not limited to, a traumatic brain injury, a degenerative disorder, or dementia. "Neurocognitive disorder" does not include an intellectual and developmental disability.

(10) "Professional person" has the meaning set forth in section 27-65-102.

(11) "Regional center" means a facility or program operated directly by the department of human services that provides services and supports to persons with intellectual and developmental disabilities.

(12) "Substantial risk of serious harm to others" has the meaning set forth in section 27-65-102.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 764, § 22, effective May 21.

25.5-10-502. Criteria and standards for protective placement.

(1) The court may order the protective placement of a respondent if:

(a) The respondent, by clear and convincing evidence, has a neurocognitive disorder;

(b) With the consideration of all reasonably available information, including the relevant history of the respondent, there are reasonable grounds to believe that the respondent will not remain in a voluntary treatment program; and

(c) The respondent, by clear and convincing evidence, is a danger to the respondent's self or a danger to others.

(2) When evaluating a person to determine whether the person meets the criteria pursuant to subsection (1) of this section, the court, evaluator, intervening professional, or professional person shall take into consideration:

(a) The person's statements and insights into the person's own neurocognitive disorder;

(b) Clinical diagnosis and clinical perspective on the person's current mental state and prognosis;

(c) The person's willingness to voluntarily seek and comply with a treatment plan in the reasonably foreseeable future;

(d) Recent overt acts by the person to threaten, cause, or attempt to cause harm to the person's self or others;

(e) Previous patterns of deterioration that resulted in the person's hospitalization, arrest, certification for short-term treatment, or protective placement;

(f) Whether the person was found in a condition where the person was not able to care for the person's own basic needs in order to avoid the risk of serious physical harm; and

(g) The frequency, recency, and severity of the considerations described in subsections (2)(b) to (2)(f) of this section and the likelihood that the conditions and events will reoccur without involuntary treatment.

(3) When evaluating whether a person is a danger to the person's self or a danger to others, is gravely disabled, or poses a substantial risk of serious harm to others, the court, evaluator, or intervening professional shall, whenever possible, use all reasonable efforts to learn about prior relevant behaviors and prior diagnoses through available and reliable sources, including the person's prior medical and mental health records, police reports, and information from reliable individuals who have a relationship or regular substantial interactions with the person.

(4) The court or professional person shall assess an incarcerated person as if the person were in the community when evaluating whether the person meets the criteria pursuant to subsection (1) of this section.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 765, § 22, effective May 21.

25.5-10-503. Short-term protective placement for incompetent defendants in a criminal matter.

(1) Upon petition of a professional person or intervening professional acting within the scope of their authority and licensure, an appointed legal guardian, or a representative of the BHA or HCPF, a court may certify a person for short-term protective placement for not more than three months under the following conditions:

(a) The person is or recently was a defendant in a criminal matter in which the person has been found incompetent to proceed;

(b) The court hearing the criminal matter referred the matter for filing of a petition pursuant to section 16-8.5-117;

(c) A professional person or intervening professional acting within the scope of their authority and licensure:

(I) Has an established treatment relationship with the person, including having provided care to the person in the past three months, which care forms the basis for requesting the short-term protective placement; and

(II) Has evaluated the person within the past three months and produced a written opinion that the person meets the criteria for protective placement pursuant to section 25.5-10-502;

(d) There is a skilled nursing facility, a regional center, or another placement willing to accept care and custody of the respondent and to hold the protective placement; and

(e) The person, the person's legal guardian, and the person's lay person, if applicable, have been advised of the person's right to an attorney and to contest the short-term protective placement.

(2) The petition filed pursuant to subsection (1) of this section must:

(a) State sufficient facts to establish reasonable grounds that the respondent meets the criteria for short-term protective placement pursuant to section 25.5-10-502, including attaching the professional person's or intervening professional's written opinion produced pursuant to subsection (1)(c)(II) of this section;

(b) Be filed within fourteen days after the initiating party received the court order from the criminal court initiating the short-term protective placement; and

(c) Be filed with the court in the county where the respondent resided or was physically present immediately prior to the filing of the petition; except that, if the person was arrested for the prior case and held in custody, the petition may be filed in the county where the respondent resided or was physically present immediately prior to the respondent's arrest.

(3) Within twenty-four hours after certification, copies of the short-term protective placement must be personally delivered to the respondent and HCPF who shall retain a copy of the certification as part of the respondent's record. If the criminal case is pending, or not yet dismissed, the petitioning party shall provide notice of the filing of the petition to the criminal court. The criminal court shall provide the notice to the prosecuting and defense attorneys in the criminal case and any attorney appointed the respondent pursuant to subsection (5) of this section.

(4) The petitioner shall ask the respondent to designate one other person whom the respondent wants to be informed regarding the petition. If the respondent is incapable of making a designation at the time the petition is delivered, the court may ask the respondent to designate a

person as soon as the respondent is capable. If the petitioner fails to ask the respondent to designate a person, the respondent's attorney appointed pursuant to subsection (5) of this section shall report to the court any person whom the respondent wants to be informed regarding the petition.

(5) Whenever a petition is filed pursuant to this section, the court shall immediately appoint an attorney to represent the respondent. The court shall provide the respondent with a written notice that the respondent has a right to a hearing on the petition and may make a written request for a jury trial. The respondent has the right to an attorney for all proceedings conducted pursuant to this section, including any appeals. The attorney representing the respondent must be provided with a copy of the petition and any supporting materials immediately upon the attorney's appointment. The respondent may only waive counsel when the respondent makes a knowing and voluntary waiver in front of the court.

(6) Upon filing a petition pursuant to this section and affording the respondent a chance to contest the petition, the court may grant or deny the protective placement based on the facts established in the petition, subject to the court's further review or a jury trial.

(7) Within fourteen days after receipt of the petition filed pursuant to this section, the respondent, or the respondent's attorney, may request a jury trial by filing a written motion with the court.

(8) The respondent may knowingly and voluntarily consent to the petition in writing.

(9) The respondent or the respondent's attorney may, at any time, file a written request for the court to review the short-term protective placement. If a review is requested, the court shall hear the matter within fourteen days after the request, and the court shall give notice to the respondent, the respondent's attorney, HCPF, and the community or facility provider who is or will provide treatment. The hearing must be held in accordance with section 25.5-10-510. At the conclusion of the hearing, the court may enter or confirm the short-term protective placement, discharge the respondent, or enter any other appropriate order.

(10) (a) The BHA, HCPF, the department of human services, and care providers may share information with each other and the parties as necessary. The BHA, HCPF, the department of human services, and care providers may receive and possess all information relevant to the proceedings held pursuant to this section, including any evaluations; any medical and mental health records for which a waiver or privilege has been found in proceedings held pursuant to this part 5, article 65 of title 27, or article 8 or 8.5 of title 16; and relevant criminal justice records, including any criminal history of the respondent.

(b) The court may order the district attorney responsible for prosecuting a criminal case that led to proceedings pursuant to this section or section 16-8.5-117 to send relevant records to HCPF within seven days after the court's order.

(c) Any current or former attorney who represented the respondent in any proceeding shall send materials to HCPF with the respondent's consent.

(11) (a) Unless an appropriate provider has already been identified and is willing to accept the protective placement, the court shall notify HCPF regarding the need for care coordination.

(b) Once HCPF is notified pursuant to subsection (11)(a) of this section, HCPF shall make diligent efforts to find a provider for the respondent, assist with intensive coordination, and mitigate barriers to appropriate placement. HCPF shall collaborate and coordinate with other state executive agencies, law enforcement, the court, the parties, community partners, regional accountable entities, and case management agencies to identify an appropriate placement for the respondent, which placement is subject to medicaid reimbursement.

(c) The case management agency must provide case management services, as defined in section 25.5-6-1702.

(d) HCPF shall keep the court informed, in writing, of efforts made to find an appropriate placement for the respondent.

(12) Upon ordering a short-term protective placement of the respondent, the provider ordered to receive the respondent has care and physical custody of the respondent.

(13) Whenever it appears to the court that a respondent in a short-term protective placement should be transferred to another provider for treatment and the safety of the respondent or the public requires that the respondent be transported by a secure transportation provider or a law enforcement agency, the court may issue an order directing the law enforcement agency where the respondent resides or secure transportation provider to deliver the respondent to the designated provider.

(14) In accordance with the procedures described in section 25.5-10-506, a short-term protective placement may be terminated upon the signature of the treating medical professional and the medical director of the facility. A facility or program shall make the respondent's discharge instructions available to the respondent, the respondent's attorney, and the respondent's legal guardian.

(15) If the professional person in charge of the respondent's evaluation and treatment believes that a period longer than three months is necessary to treat the respondent, the professional person shall file with the court a request for an extended protective placement at least thirty days prior to the expiration date of the original protective placement. An extended protective placement for treatment must not be for a period of more than three months. The respondent is entitled to a hearing on the extended protective placement under the same conditions as an original protective placement. The attorney initially representing the respondent shall continue to represent the respondent, unless the court appoints another attorney.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 766, § 22, effective May 21.

25.5-10-504. Long-term protective placement of persons with a neurocognitive disorder - procedure.

(1) If a respondent has received an extended protective placement pursuant to section 25.5-10-503, the professional person in charge of the extended protective placement, the appointed legal guardian, or the county attorney may file a petition with the court at least thirty days prior to the expiration date of the extended protective placement for a long-term protective placement of the respondent under the following conditions:

(a) The professional staff of the agency or facility providing short-term protective placement has analyzed the respondent's condition and found the respondent continues to meet the criteria for protective placement pursuant to section 25.5-10-502 (1); and

(b) HCPF, in collaboration with the BHA, has identified an appropriate provider or placement to provide care and treatment of the respondent.

(2) A petition for long-term protective placement must include a request for a hearing before the court prior to the expiration of six months after the date of the original order for a protective placement and provide a recommendation as to whether the long-term protective placement should take place on an inpatient or outpatient basis. A copy of the petition must be delivered personally to the respondent for whom long-term protective placement is sought and electronically delivered to the respondent's attorney of record simultaneously with the filing.

(3) Within ten days after receipt of the petition, the respondent may request a hearing before the court or a jury trial by filing a written request with the court.

(4) The court or jury shall determine whether the conditions of subsection (1) of this section are met and whether the respondent continues to meet the criteria and standards for protective placement pursuant to section 25.5-10-502 (1). The court shall issue an order of long-term protective placement for a term not to exceed six months, discharge the respondent for whom long-term protective placement was sought, or enter any other appropriate order. An order for long-term protective placement must grant custody of the respondent to the provider or placement identified pursuant to subsection (1)(b) of this section. When a petition contains a request that a specific legal disability be imposed or that a specific legal right be deprived, the court may order the disability imposed or the right deprived if the court or a jury has determined that the respondent meets the criteria and standards for protective placement pursuant to section 25.5-10-502 (1) and that, as a result, the respondent is unable to competently exercise the specific legal right or perform the function for which the disability is sought to be imposed. Any interested person may ask leave of the court to intervene as a copetitioner for the purpose of seeking the imposition of a legal disability or the deprivation of a legal right.

(5) An original order of long-term protective placement and an extension of the order expires on the date specified, unless further extended as provided in this subsection (5). If an extension is being sought, the professional person in charge of the evaluation and treatment shall certify to the court at least thirty days prior to the expiration date of the order in force that an extension of the order is necessary for the protective placement of the respondent subject to the order in force, and a copy of the order must be simultaneously delivered to the respondent and electronically delivered to the respondent's attorney of record. At least twenty days before the expiration of the order, the court shall give written notice to the respondent and the respondent's attorney of record that a hearing upon the extension may be had before the court or a jury upon written request to the court within ten days after receipt of the notice. If a hearing is not timely requested by the respondent, the court may proceed ex parte. If a hearing is timely requested, the hearing must be held before the expiration date of the order in force. If the court or jury finds that the conditions of subsection (1) of this section continue to be met and that the respondent continues to meet the criteria and standards for protective placement pursuant to section 25.5-10-502 (1), the court shall issue an extension of the order. Any extension must not exceed six months, but there may be as many extensions as the court orders pursuant to this section.

(6) A respondent placed in long-term protective placement may be discharged from the provider or facility upon the signature of the treating professional person and medical director of the facility, and the facility shall notify the court prior to the respondent's discharge. The facility shall make the respondent's discharge instructions available to the respondent, the respondent's attorney, the respondent's lay person, and the respondent's legal guardian, if applicable, within one week after discharge, if requested. A facility that is transferring a respondent to a different facility or to an outpatient program shall provide all treatment records to the facility or provider accepting the respondent at least twenty-four hours prior to the transfer.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 770, § 22, effective May 21.

25.5-10-505. Connect respondent to home- and community-based services.

When a respondent is discharged from a protective placement or a protective placement is terminated, HCPF shall refer the respondent to any home- and community-based services for which the respondent may be eligible and shall make diligent efforts to connect the respondent with home- and community-based services.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 771, § 22, effective May 21.

25.5-10-506. Termination of protective placement - short-term and long-term placement.

A protective placement terminates when the professional person in charge of treatment of the respondent, after a reasonable observation and treatment period, determines the respondent no longer meets the criteria for protective placement pursuant to section 25.5-10-502 (1). When a protective placement is terminated pursuant to this section, the professional person in charge of providing care or treatment to the respondent shall notify the court in writing within five days after the termination.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 771, § 22, effective May 21.

25.5-10-507. Court supervision of incompetent and unrestorable persons ordered into an enhanced protective placement.

(1) Once a criminal court has transferred jurisdiction of an enhanced protective placement pursuant to section 16-8.5-118 to a civil court with jurisdiction pursuant to section 25.5-10-509, the civil court has exclusive jurisdiction over the enhanced protective placement.

(2) Upon receiving jurisdiction of an enhanced protective placement, the court shall:

(a) Notify the county attorney;

(b) Appoint an attorney to represent the respondent and provide copies of any documents sent from the criminal court to the respondent's attorney; and

(c) Set a review hearing and order the respondent brought before the court.

(3) At the review hearing, the court shall:

(a) Ensure the respondent is represented by counsel; and

(b) Advise the respondent of the following rights:

(I) The right to appear in person at any proceeding, unless waived by the respondent;

(II) The right to be represented by privately retained counsel, or court-appointed counsel if the respondent does not have privately retained counsel, during any proceeding held pursuant to this part 5, including any appeals;

(III) The right to request modification of the terms of the enhanced protective placement; and

(IV) The right to periodic review of the enhanced protective placement and the right to contest, including by trial, whether the respondent qualifies for termination of the enhanced protective placement.

(4) At any time during the enhanced protective placement, the court may:

(a) Modify any court order or any term of the enhanced protective placement upon request of the parties after giving the parties an opportunity to object and be heard;

(b) Issue a warrant for the respondent's arrest and order the respondent be brought before the court if the court determines the respondent has failed to comply with any of the court's orders, including the respondent's unauthorized departure from the physical custody of a provider;

(c) Order CDHS to provide to the court:

(I) An updated opinion on whether the respondent meets the criteria for termination of the enhanced protective placement pursuant to section 25.5-10-508; and

(II) An opinion on whether the respondent has an intellectual and developmental disability or neurocognitive disorder that substantially contributes to whether the respondent is a danger to the respondent's self or a danger to others, or is gravely disabled;

(d) Upon the request of any party, the request of the individual or entity with physical care and custody of the respondent, or the court's own motion, conduct a review of the respondent's placement and enter any orders necessary for sharing or receiving information necessary to review and modify the placement, unless the respondent is placed into inpatient care at the discretion of CDHS;

(e) Order, as necessary, appropriate entities, including the sheriff, to bring the respondent before the court or take the respondent to the placement where physical custody of the respondent has been ordered;

(f) Appoint a legal guardian pursuant to article 14 of title 15; or

(g) Issue orders as necessary to effectuate and enforce the court's powers and responsibilities pursuant to this section, including authorization for the reasonable use of force, warrants for the arrest of the respondent, or contempt proceedings against a noncompliant individual or entity.

(5) (a) The court shall ensure the respondent is placed in the least-restrictive placement adequate to protect the victim and the community and provide, to the greatest extent possible, the appropriate level of care, treatment, and supervision of the respondent.

(b) If the respondent is not placed into inpatient care at the discretion of CDHS or if CDHS proposes to move the respondent into or out of inpatient care, the court shall, prior to modifying the enhanced protective placement to change the respondent's provider or placement, review the appropriateness of the proposed provider or placement, including whether the provider fits the respondent's diagnosis and treatment needs and whether the placement sufficiently protects the community from the substantial risk of serious harm to others posed by the respondent.

(c) Upon request, the court shall permit CDHS, the parties, or the appointed legal guardian the opportunity to object and be heard prior to the court's decision. The court may permit testimony if the court believes it would be helpful to the court's decision.

(d) When deciding whether to approve the new provider or placement, the court shall give deference to CDHS and the opinion of any medical professional on the appropriateness of the provider and placement for the respondent, but deference must not be given to CDHS or a medical professional as to whether the placement sufficiently protects any victims and the community from the substantial risk of serious harm to others posed by the respondent. When considering the appropriateness of the placement for the respondent, victims, and the community, the court shall consider the totality of the circumstances, including:

(I) The respondent's statements and insights into the respondent's own neurocognitive disorder or intellectual and developmental disability;

(II) The clinical diagnosis and clinical perspective on the respondent's current mental state and prognosis;

(III) The respondent's willingness and demonstrated ability to voluntarily seek and comply with treatment and services in the reasonably foreseeable future;

(IV) Recent overt acts by the respondent to threaten, cause, or attempt to cause harm to the respondent's self or others;

(V) Previous patterns of deterioration that resulted in the respondent's hospitalization, arrest, certification for short-term treatment, or protective placement;

(VI) Whether the respondent was found in a condition where the respondent was not able to care for the respondent's own basic needs in order to avoid the risk of serious physical harm;

(VII) The frequency, recency, and severity of the considerations described in subsections (5)(d)(II) to (5)(d)(VI) of this section and the likelihood that the conditions and events will reoccur without inpatient treatment;

(VIII) Whether the respondent opposes the placement;

(IX) Whether community-based placement can be reasonably accommodated;

(X) The limited resources of the state and the needs of others; and

(XI) The placement recommendations of any treating professionals.

(e) The court shall not permit or order a respondent to be placed into a community-based setting outside of inpatient care, as defined in section 16-8.5-101, for the first time since being in an enhanced protective placement unless:

(I) The victims have been notified of a critical stage, as defined in section 24-4.1-302 (2)(q.3), and given the opportunity to be heard; and

(II) The district attorney in the case that sought civil commitment or enhanced protective placement has been notified and given an opportunity to object and be heard.

(f) If the court modifies the respondent's provider or placement, the court shall issue any orders necessary to mitigate the respondent's risk to any victims or the community, including ordering the provider to take reasonable and practicable protective measures to prevent the respondent from contacting any victims; except that the court shall not order the respondent to comply with any conditions that are not necessary to mitigate the respondent's risk or with which the respondent cannot comply.

(6) (a) If the court orders the respondent to be placed into inpatient care at the discretion of CDHS, as defined in section 16-8.5-101, the executive director of CDHS shall designate the state facility at which the respondent is held for care and treatment and may transfer the respondent from one facility to another if, in the opinion of the executive director, it is appropriate to do so in the interest of the proper care, custody, and treatment of the respondent or for the protection of the public or personnel at the facilities in question.

(b) Notwithstanding subsection (6)(a) of this section, HCPF shall:

(I) Ensure the respondent is placed in the least-restrictive placement adequate to protect the victim and the community and provide, to the greatest extent possible, the appropriate level of care, treatment, and supervision of the respondent; and

(II) Not place the respondent in a community-based setting outside of inpatient care, as defined in section 16-8.5-101, for the first time since the respondent was subjected to an enhanced protective placement without prior approval of the court pursuant to subsection (5) of this section.

(7) Termination of the enhanced protective placement is governed by section 25.5-10-508.

(8) The provider charged with the physical care and custody of the respondent shall submit a report to the court and the parties annually by the date the respondent was ordered into enhanced protective placement unless a substantially similar examination was ordered within the previous twelve months. The report must include:

(a) The provider's opinion about whether the respondent is appropriately placed and meets the criteria for termination of the enhanced protective placement pursuant to section 25.5-10-508;

(b) A summary of the materials reviewed, assessments conducted, and other bases of opinions rendered;

(c) The respondent's diagnosis and whether the respondent's symptoms are in remission;

(d) A summary of the services or treatment provided to the respondent since the last report and the respondent's progress;

(e) A summary of the respondent's compliance with treatment or services, including information about medications currently prescribed to the respondent and whether the respondent is compliant with taking the prescribed medications;

(f) An assessment of the respondent's risk of harm to others;

(g) A summary of the respondent's treatment or service needs by utilizing evidence-based standards of individualized treatment and management of individuals with an enhanced protective placement;

(h) A summary of the specific treatment or service options available to the respondent in the community and the specific treatment or service options available to the respondent at a facility designated by the executive director;

(i) A summary of whether and how ongoing risks could be mitigated if the respondent were placed in the community; and

(j) Specific facts and evidence supporting each opinion made pursuant to subsection (8)(a) of this section.

(9) The court may order any treatment or service provider who has agreed or who has been ordered to provide services or treatment to the respondent to issue regular progress reports containing information required pursuant to subsection (8) of this section or other information deemed necessary for the court's supervision of the enhanced protective placement, but the court shall not require a provider to submit progress reports more frequently than every ninety days.

(10) (a) The court may, upon a showing of good cause, order CDHS to facilitate an examination by a professional person regarding the respondent's progress with treatment and whether the respondent meets the criteria for conversion of the enhanced protective placement to certification for short-term treatment or short-term protective placement, or meets the criteria for termination of the enhanced protective placement pursuant to section 25.5-10-508, unless CDHS has facilitated a similar examination of the respondent in the past one hundred twenty days. The respondent shall cooperate with any examinations ordered pursuant to this subsection (10)(a).

(b) Statements made by the respondent during an examination conducted pursuant to this subsection (10) must not be used in any criminal prosecution.

(c) Good cause includes a respondent's timely request for an evaluation that allows a competency evaluator to provide a second opinion in response to the report provided pursuant to subsection (8) of this section that opines that the respondent does not meet the criteria for termination.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 772, § 22, effective May 21.

25.5-10-508. Termination of enhanced protective placement.

(1) The court shall terminate a respondent's enhanced protective placement ordered pursuant to section 25.5-10-507 when the respondent:

(a) No longer poses a substantial risk of serious harm to others; or

(b) No longer has a neurocognitive disorder or intellectual and developmental disability that is likely to cause the respondent to be a danger to the respondent's self or a danger to others and the respondent has demonstrated sufficient capacity and willingness to conform the respondent's conduct to the requirements of the law.

(2) (a) If a treatment provider charged with the physical care and custody of the respondent determines that the respondent meets the standard for termination from enhanced protective placement pursuant to subsection (1) of this section, the provider or the provider's designee shall report the determination to the court that placed the respondent into the provider's care and custody, the county attorney, and the district attorney who originally requested a civil commitment or an enhanced protective placement pursuant to section 16-8.5-118. The court shall furnish a copy of the report to the respondent and the respondent's counsel.

(b) The determination reported pursuant to subsection (2)(a) of this section must include:

(I) The treatment provider's opinion that the respondent meets the criteria for termination of the enhanced protective placement pursuant to subsection (1) of this section;

(II) An assessment of the respondent's risk of harm to others; and

(III) Specific facts and evidence supporting each opinion in the report, including a summary of the materials reviewed, assessments conducted, and other bases of opinions rendered.

(3) (a) The respondent may request termination of the enhanced protective placement in writing at any time the respondent would not be prohibited from having a subsequent termination trial pursuant to subsection (7) of this section.

(b) The court shall deny the request unless the request for termination includes an opinion from a professional person that the respondent currently meets the criteria for termination of the enhanced protective placement pursuant to subsection (1) of this section.

(4) (a) If the court does not deny the request for termination without a hearing, the court shall permit the county attorney and the district attorney who originally sought enhanced protective placement pursuant to section 16-8.5-118 fourteen days to object to termination or request an opportunity to conduct an independent evaluation by an expert of the county attorney's or district attorney's own choosing and expense.

(b) If neither the county attorney nor the district attorney objects or requests an opportunity to request an independent evaluation, the court shall terminate the respondent's enhanced protective placement.

(c) If either the county attorney or the district attorney requests an opportunity to conduct an independent evaluation, the court shall grant that request, order the respondent to comply with the evaluation, and permit the county attorney or district attorney a reasonable period of time to identify an expert, conduct the evaluation, and issue a report. If both the county attorney and district attorney request an independent evaluation, the court shall treat the request as a joint request for a single independent evaluation. The cost of the independent evaluation must be paid for by the requesting party.

(d) If the respondent does not cooperate with the evaluation, the court may grant additional time or deny the respondent's request for termination.

(e) Upon receipt of the independent evaluation report, the county attorney or district attorney must provide a copy to the respondent's counsel and the court within fourteen days.

(f) If neither the county attorney nor district attorney objects within the time permitted by the court, the court shall terminate the respondent's enhanced protective placement.

(5) (a) If either the county attorney or district attorney timely objects, the court shall, as soon as practicable, bring the respondent before the court, ensure the respondent and the respondent's counsel received a copy of any reports received, and advise the respondent of the right to demand a trial by the court or the right to demand, in writing, a jury trial of not more than six individuals to determine whether the respondent meets the criteria for termination pursuant to subsection (1) of this section.

(b) If the respondent demands a trial before the court, the court shall schedule the trial within thirty-five days after the demand. If the respondent demands a jury trial, the court shall schedule the trial within seventy-two days after the demand. A delay attributable to the respondent is excluded from the time limitations in this subsection (5)(b). If the court does not begin the trial within the time permitted pursuant to this subsection (5)(b), the court shall terminate the enhanced protective placement and release the respondent from the provider's care and custody.

(c) If the county attorney does not object to termination but the district attorney does, the district attorney has standing to serve as the county attorney for the limited purpose of trial and any appeals related to the trial. The county attorney shall timely provide the district attorney all information and records relevant to the trial in the county attorney's possession or control without subpoena or court order. The district attorney's limited standing does not extend to any other matters related to the enhanced protective placement and terminates upon resolution of the trial and any related appeals.

(6) (a) At the trial, if any evidence is introduced that shows the respondent does not meet the criteria for termination of the enhanced protective placement pursuant to subsection (1) of this section, the respondent has the burden to show by a preponderance of the evidence that the respondent meets the criteria for termination pursuant to subsection (1) of this section.

(b) If the trier of fact finds the respondent meets the criteria for termination pursuant to subsection (1) of this section, the court shall order the respondent released from the provider's care and custody and terminate the respondent's enhanced protective placement. If the trier of fact finds the respondent does not meet the criteria for termination pursuant to subsection (1) of this section, the court shall continue the enhanced protective placement and may enter or modify any orders to assist in progressing the treatment of the respondent or that are necessary to protect the public.

(7) If the trier of fact finds the respondent does not meet the criteria for termination pursuant to subsection (1) of this section, the respondent is not entitled to another termination trial within one year after the conclusion of the previous trial for termination.

(8) If the respondent does not meet the criteria for termination pursuant to subsection (1) of this section and no longer has an intellectual and developmental disability or a neurocognitive disorder that substantially contributes to any danger posed to the respondent's self or to others, or any grave disability from which the respondent suffers, the court shall convert the enhanced protective placement to a civil commitment and may modify the terms of the civil commitment in accordance with section 27-65-201.

(9) If the defendant does not meet the criteria for termination pursuant to subsection (1) of this section and has a co-occurring mental health disorder that does not include an intellectual and developmental disability or a neurocognitive disorder that substantially contributes to whether the respondent is a danger to the respondent's self or a danger to others, or is gravely disabled, the court may, upon the recommendation of CDHS, convert the enhanced protective placement to a civil commitment and modify the terms of the civil commitment in accordance with section 27-65-201.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 777, § 22, effective May 21.

25.5-10-509. Jurisdiction - transfer.

(1) (a) The court in which a petition is filed pursuant to this part 5, or a court authorized to conduct proceedings pursuant to this part 5 that receives a court order transferring jurisdiction of an enhanced protective placement, is the court of original jurisdiction and of continuing jurisdiction for any further proceedings pursuant to this part 5.

(b) When the convenience of the parties and the ends of justice would be promoted by a change in the court having jurisdiction, the court may order a transfer of the proceeding to another county. Until further order of the transferee court, if any, it is the court of continuing jurisdiction. If multiple criminal courts refer a matter for proceedings pursuant to this part 5, any court with jurisdiction may transfer the proceeding to another county and allow for consolidation of proceedings into one proceeding, which may occur in any county that promotes the convenience of the parties and the ends of justice.

(2) (a) Except as otherwise provided in this subsection (2), any petition, order, transfer of jurisdiction of an enhanced protective placement, or request for a proceeding may be filed where the respondent resides or is physically present for treatment.

(b) A petition or request for a protective placement pursuant to section 25.5-10-502 may be filed in the jurisdiction where the respondent resides or where the respondent is currently in an inpatient setting receiving treatment.

(c) A petition or request for a protective placement for an incompetent defendant in a criminal matter pursuant to section 25.5-10-502 or transfer of jurisdiction of an enhanced protective placement may be filed in the jurisdiction where the respondent resides, was physically present immediately prior to the filing of the petition, or is receiving inpatient treatment or where the criminal court that referred the matter is located.

(3) In any case in which there has been a change of venue to a county other than the county of residence of the respondent or the county in which the proceeding was commenced, the county from which the proceeding was transferred shall either reimburse the county to which the proceeding was transferred and in which the proceeding was held for the reasonable costs incurred in conducting the proceeding or conduct the proceeding itself using its own personnel and resources, including its own district or county attorney, as the case may be.

(4) If a proceeding is initiated pursuant to this article 10 but a proceeding pursuant to article 65 of title 27 is more advisable because the court determines that the respondent does not have an intellectual and developmental disability or a neurocognitive disorder or has a mental health disorder in addition to an intellectual and developmental disability or neurocognitive disorder, the court may maintain jurisdiction and order the case to proceed pursuant to article 65 of title 27.

(5) (a) If an enhanced protective placement is ordered against a respondent pursuant to section 16-8.5-118 or if a respondent's enhanced protective placement is supervised pursuant to section 25.5-10-507, and the respondent refuses to accept medication, the court with jurisdiction over the enhanced protective placement or the court with jurisdiction where the facility or provider treating the respondent is located has jurisdiction and venue to accept a petition by the treating physician to enter an order requiring that the respondent accept the treatment or that the medication be forcibly administered to the respondent. The court with jurisdiction where the

facility or provider is located shall not exercise its jurisdiction without the permission of the court with jurisdiction over the enhanced protective placement. Upon filing the petition, the court shall appoint an attorney to represent the respondent if one has not been appointed and shall hear the matter within ten days after the filing.

(b) In any case brought pursuant to subsection (5)(a) of this section, the county where the court with jurisdiction over the enhanced protective placement is located shall either reimburse the county in which the proceeding pursuant to subsection (5)(a) of this section was filed and held for the reasonable costs incurred in conducting the proceeding or conduct the proceeding itself using its own personnel and resources, including its own county attorney.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 780, § 22, effective May 21.

25.5-10-510. Hearing procedures.

(1) A hearing held pursuant to this part 5 must be conducted in the same manner as other civil proceedings before the court.

(2) The court, after consultation with the respondent's counsel to obtain the counsel's recommendations, may appoint a professional person to examine the respondent for whom a protective placement is sought and testify at the hearing as to the results of the professional person's examination. The court-appointed professional person shall act solely in an advisory capacity, and no presumption is attached to the professional person's findings.

(3) Upon request of a legal guardian appointed pursuant to article 14 of title 15, the legal guardian may intervene in any proceeding brought pursuant to this part 5 concerning the legal guardian's ward and, through counsel, may present evidence and represent to the court the views of the legal guardian concerning the appropriate disposition of the case.

(4) A lay person may submit an affidavit to the court concerning the lay person's relationship to the respondent, how long the lay person has known the respondent, the lay person's physical address, and the lay person's views concerning the appropriate disposition of the respondent's case.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 781, § 22, effective May 21.

25.5-10-511. County attorney and district attorney responsibilities.

(1) The county attorney or the district attorney in a county or city and county that has a population equal to or less than fifty thousand people, or a qualified attorney acting as the county attorney's or district attorney's designee who is appointed by the district court, has the following powers and responsibilities:

(a) To file and appear on behalf of the county or state in all proceedings brought pursuant to this part 5 or transferred from the criminal court pursuant to section 16-8.5-118;

(b) To exercise due diligence in gathering information from available sources for use in proceedings brought pursuant to this part 5; and

(c) To share and provide information about proceedings brought pursuant to this part 5 to interested parties as allowable by law.

(2) This section only applies to proceedings conducted pursuant to this part 5.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 782, § 22, effective May 21.

25.5-10-512. Appeals.

(1) Appellate review of any order for protective placement or enhanced protective placement may be had as provided in the Colorado appellate rules. An appeal must be advanced upon the calendar of the appellate court and must be decided at the earliest practicable time. Pending disposition by the appellate court, the court may make such order as the court may consider proper in the premises relating to the care and custody of the respondent.

(2) A respondent subject to an order for protective placement or enhanced protective placement shall be advised of the respondent's right to appeal the order by the court at the conclusion of any hearing, and, as a result, the order may be entered.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 782, § 22, effective May 21.

25.5-10-513. Habeas corpus.

Any person detained pursuant to this part 5 is entitled to an order in the nature of habeas corpus upon proper petition to any court generally empowered to issue orders in the nature of habeas corpus.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 782, § 22, effective May 21.

25.5-10-514. Rights of respondents ordered into enhanced protective placement or protective placement.

(1) A respondent in a proceeding brought pursuant to this part 5 or who is under a protective placement or an enhanced protective placement has the same rights as a person with an intellectual and developmental disability under this article 10, including the rights provided in sections 25.5-10-218, 25.5-10-220, 25.5-10-221, 25.5-10-222, 25.5-10-223, 25.5-10-225, 25.5-10-227, 25.5-10-228, 25.5-10-229, 25.5-10-230, 25.5-10-236, and 25.5-10-240.

(2) A respondent placed in the custody of CDHS at a state hospital has the same rights as a person subject to proceedings pursuant to article 65 of title 27, including the rights provided in sections 27-65-105, 27-65-108, 27-65-117, 27-65-118, 27-65-119, 27-65-122, and 27-65-124.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 783, § 22, effective May 21.

25.5-10-515. Records - rules.

(1) Except as provided in subsection (2) of this section, all information obtained and records prepared in the course of providing any services to any person pursuant to any provision of this part 5 are confidential and privileged. The information and records may be disclosed only:

(a) In communications between qualified professionals, facility personnel, or state agencies in the provision of services or appropriate referrals;

(b) When the recipient of services designates persons to whom information or records may be released, but, if a recipient of services is a ward or conservatee and the ward's or conservatee's guardian or conservator designates, in writing, persons to whom records or information may be disclosed, the designation is valid in lieu of the designation by the recipient; except that nothing in this section compels a physician, psychologist, social worker, nurse, attorney, or other professional personnel to reveal information that has been given to the person in confidence by members of a patient's family or other informants;

(c) To the extent necessary to make claims on behalf of a recipient of aid, insurance, or medical assistance to which the recipient may be entitled;

(d) If HCPF has adopted rules for the conduct of research. The rules must include, but are not limited to, the requirement that all researchers must sign an oath of confidentiality. All identifying information concerning individual patients, including names, addresses, telephone numbers, and social security numbers, must not be disclosed for research purposes.

(e) To the courts, as necessary for the administration of this part 5;

(f) To persons authorized by an order of court after notice and opportunity for hearing to the person to whom the record or information pertains and the custodian of the record or information pursuant to the Colorado rules of civil procedure;

(g) To family members upon admission of a person with a neurocognitive disorder or intellectual and developmental disability for inpatient or residential protective placement;

(h) To family members or a lay person actively participating in the care and treatment of a person with a neurocognitive disorder or intellectual and developmental disability, regardless of the length of the participation. The information released pursuant to this subsection (1)(h) is limited to one or more of the following: The diagnosis, the prognosis, the need for hospitalization and anticipated length of stay, the discharge plan, the medication administered and side effects of the medication, and the short-term and long-term treatment goals.

(i) In accordance with state and federal law, to the agency designated pursuant to the federal "Protection and Advocacy for Individuals with Mental Illness Act", 42 U.S.C. sec. 10801 et seq., as the governor's protection and advocacy system for Colorado.

(2) Subsection (1)(g) or (1)(h) of this section does not preclude the release of information to a parent concerning the parent's minor child.

(3) (a) This part 5 does not render any information privileged or confidential, except written medical records and information that is privileged pursuant to section 13-90-107, concerning observed behavior that constitutes a criminal offense committed upon the premises of any facility providing services pursuant to this part 5 or any criminal offense committed against any person while performing or receiving services pursuant to this part 5.

(b) Subsection (1) of this section does not apply to physicians or psychologists eligible to testify concerning a criminal defendant's mental condition pursuant to section 16-8-103.6.

(c) This section does not prohibit the limited disclosure of necessary information to the prosecuting attorney and criminal defense counsel if a criminal case is still pending against the person.

(4) (a) Court records in proceedings brought pursuant to this part 5 must be maintained separately by the clerk of the several courts, and the case number and proceedings must not be made public or released, except as provided in this section.

(b) Upon the termination of a protective placement pursuant to section 25.5-10-506 or the termination of an enhanced protective placement pursuant to section 25.5-10-508, the clerk of the court shall immediately seal the record in the case and omit the respondent's name from the index of cases in the court until and unless the respondent becomes subject to an order or long-term protective placement pursuant to section 25.5-10-504 and unless the court orders the

records opened for good cause shown. In the event a petition is filed pursuant to section 25.5-10-504 or 25.5-10-507, the record may be opened and become part of the record in the long-term protective placement case and the name of the respondent indexed.

(c) Notwithstanding subsection (4)(b) of this section, while a matter is pending or after a case is sealed, the court may disclose the existence of the proceeding, the case number, and court records to the respondent or any attorney representing the respondent in any proceeding or matter with a release signed by the respondent or pursuant to a court order. When a court order specifically authorizing disclosure or a valid release for a record is presented to the clerk of the court, the clerk of the court shall acknowledge the existence of the case and provide the case number and records to the respondent or authorized requestor possessing a court order or a release.

(5) If a certified peace officer initiates or participates in the initiation of an emergency mental health hold, the court, county attorney, or district attorney conducting any subsequent proceedings pursuant to this part 5 and the provider who conducts an evaluation or provides care may, without court authorization, provide the certified peace officer's agency with the following limited information, if available:

(a) Whether or not a professional person found the respondent met the criteria for short-term protective placement pursuant to section 25.5-10-503;

(b) Whether the respondent was released or remains in inpatient care and whether further care is being provided to the respondent; and

(c) Whether or not further proceedings were initiated for short-term protective placement.

(6) Sealing records by the court does not prevent a party to related criminal cases, a party to a proceeding brought pursuant to this part 5, HCPF, the BHA, the department of human services, a professional person, or an intervening professional with lawful possession of records from maintaining and using the records, unless prohibited by law.

(7) A party to related criminal cases, a party to a proceeding brought pursuant to this part 5, HCPF, the BHA, the department of human services, a professional person, or an intervening professional may seek to unseal case records for good cause, which includes the need to use the records in other criminal proceedings involving competency pursuant to article 8.5 of title 16 or proceedings brought pursuant to this part 5.

(8) The district attorney may provide information to a victim when necessary to comply with the "Victim Rights Act", part 3 of article 4.1 of title 24.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 783, § 22, effective May 21.

25.5-10-516. Payment for counsel.

In order to provide legal representation to persons eligible for an attorney pursuant to this article 10, the judicial department shall pay, out of money appropriated by the general assembly, money directly to the appointed attorney on a case-by-case basis or, on behalf of the state, shall pay lump-sum grants to and contract with individual attorneys, legal partnerships, legal professional corporations, public interest law firms, or nonprofit legal services corporations.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 786, § 22, effective May 21.

25.5-10-517. Authority to increase payments to nursing facility and regional center providers - rules.

Subject to available appropriations and federal authorization, HCPF may increase payments to nursing facility providers and regional center providers for the purpose of achieving the least restrictive placement requirement for individuals subject to a protective placement pursuant to this part 5. HCPF shall adopt rules defining the qualifications and payment schedule for nursing facility providers and regional center providers that serve the individuals subject to a protective placement.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 786, § 22, effective May 21.

25.5-10-518. Repeal of part.

This part 5 is repealed, effective July 1, 2031.

Source: L. 2026: Entire part added, (SB 26-149), ch. 142, p. 786, § 22, effective May 21.

HEALTH CARE COST SAVINGS ACT

ARTICLE 11

Health Care Cost Savings Act

25.5-11-101 to 25.5-11-106. (Repealed)

Source: L. 2019: Entire article added, (HB 19-1176), ch. 381, p. 3424, § 2, effective May 31.

Editor's note: Section 25.5-11-106 provided for the repeal of this article, effective September 1, 2022. (See L. 2019, p. 3428.)