

STATEMENT OF BASIS AND PURPOSE, FISCAL IMPACT, AND SPECIFIC STATUTORY AUTHORITY OF REVISIONS MADE TO VOLUME 8

Revisions to sections 8.350b, 8.310.10(1)(3)(4), 8.351.20(a)(b)(c)(d)(e)(g), 8.351.30, 8.352, 8.354.10(b)(c)(e)(f) were finally adopted at the 10/4/85 State Board meeting, with an effective date of 12/1/85 (Document 5). Statement of basis and purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.059.14 were finally adopted at the 10/4/85 State Board meeting, with an effective date of 12/1/85 (Document 6). Statement of basis and purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.059.15, 8.059.16, 8.400.12, 8.400.16, 8.402.33, 8.402.36, 8.402.61, 8.402.63, 8.484, 8.484.11, 8.484.18, 8.509 through 8.511, and 8.750 were adopted on an emergency basis at the 10/4/85 State Board meeting, with an effective date of 10/31/85 (Document 7). Statement of basis and purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100.52(c) and 8.120.27 were adopted on an emergency basis at the 10/4/85 State Board meeting, with an effective date of 10/4/85 (Document 8). Statement of basis and purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.495.20, 8.495.50, 8.495.79 and 8.496 were finally adopted at the 11/1/85 State Board meeting, with an effective date of 1/1/86 (Document 4). Statement of basis and purpose, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.110.53 was adopted on an emergency basis at the 12/6/85 meeting with an effective date of 1/1/86 (Document 3). Statement of basis and purpose, emergency statement, fiscal impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.201.10, et seq. were finally adopted at the 1/3/86 State Board, with an effective date of 3/1/86 (Document 1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.350, 8.351, 8.351.20 and 8.351.10, were finally adopted at the 1/3/86 State Board meeting, with an effective date of 3/1/86 (Document 2). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.058.73 - 8.059.12 thru 8.059.148 - 8.059.151 were finally adopted following

publication at the 2/7/86 State Board meeting, with an effective date of 4/1/86 (Document 4). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.120 - 8.120.21 to 8.120.22 - 8.120.27 and 8.100.36 - 8.100.42 to 8.100.43 - 8.110.52 were adopted as emergency revisions at the 2/7/86 State Board meeting, with an effective date of 4/1/86 (Document 2). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.200 - 8.200.20 thru 8.200.21 - 8.200.30 were finally adopted following publication at the 2/7/86 State Board meeting, with an effective date of 4/1/86 (Document 3). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100.36 - 8.100.42, 8.100.52, 8.120 - 8.120.21, 8.120.27 were emergency adopted at the 4/11/86 State Board meeting, with an effective date of 4/11/86 (Document 18). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.058.73 - 8.059.146, LTC-201(a) - LTC-210, 8.200 - 8.200.30, 8.356 - 8.356.20-Concl. were finally adopted following publication at the 5/2/86 State Board meeting with an effective date of 7/1/86 (Documents 22, 23 and 24). Statements of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rules. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.53, 8.110.4, 8.110.44, 8.110.45, 8.110.46, 8.110.47, 8.358.1, 8.358.2, 8.358.3, 8.358.4, 8.415.15, 8.415.23, 8.482.52, 8.482.84, 8.441.3, 8.120.3, 8.100.5 were finally adopted at the 1/3/86 State Board, with an effective date of 8/1/86 (Documents 5, 8, 15, 16). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.53, 8.110.4, 8.110.44, 8.110.45, 8.110.46, 8.110.47, 8.358.1, 8.358.2, 8.358.3, 8.358.4, 8.415.15, 8.415.23, 8.482.52, 8.482.84, 8.441.3, 8.120.3, 8.100.5 were finally adopted at the 6/6/86 State Board, with an effective date of 8/1/86 (Documents 5, 8, 15, 16). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100.15, 8.120.36, 8.448.7 were finally adopted as emergency revisions at the 7/11/86 State Board, with an effective date of 7/11/86 (Documents 9, 10). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Additions to sections 8.448.7 were emergency adopted at the 7/11/86 meeting and finally adopted at the 8/1/86 meeting with an effective date of 7/11/86 (Document 5). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.120.25 -.29, 8.441.2, were emergency adopted at the 8/1/86 meeting with an effective date of 8/1/86 (Documents 6, 15). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.71 through 8.534 were finally adopted at the 8/1/86 meeting with an effective date of 10/1/86 (Document 1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100.36, 8.100.52, 8.120.28 were emergency adopted at the 9/5/86 meeting with and effective date of 9/5/86 (Document 16). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.120.25 through 8.120.29, 8.120.36 and 8.441.2 were finally adopted emergency at the 9/5/86 State Board meeting, with an effective date of 8/1/86 (Documents 5, 7, 14). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100.5, 8.120.28 and 8.120.29 were finally adopted emergency at the 10/3/86 State Board meeting, with an effective date of 9/5/86 (Document 6). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.110.18, 8.110.19, 8.110.21, 8.110.22, 8.110.62, 8.110.64, and 8.120.36 were adopted emergency at the 10/3/86 State Board meeting, with an effective date of 10/3/86 (Documents 3, 10, 11). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Addition of sections 8.333 through 8.333.40 were finally adopted at the 10/3/86 State Board meeting, with an effective date of 12/1/86 (Document 4). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.059, 8.486.4, 8.486.8, 8.487.1 and 8.487.4 were finally adopted at the 11/7/86 State Board meeting, with an effective date of 1/1/87 (Documents 3 and 15). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.332 were emergency adopted at the 11/7/86 State Board meeting, with an effective date of 11/7/86 (Document 4). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.1, 8.110.2, 8.110.6, and 8.120.3 were finally adopted emergency at the 11/7/86 State Board meeting, with an effective date of 10/3/86 (Documents 7, 8, 17). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.332 were finally adopted emergency at the 12/5/86 State Board meeting, with an effective date of 11/7/86 (Document 1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.448.7 were finally adopted at the 12/5/86 State Board meeting, with an effective date of 2/1/87 (Document 2). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.110.53 and 8.441.2 were emergency adopted at the 12/5/86 State Board meeting, with an effective date of 12/5/86 (Documents 3, 5). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Additions to section 8.441.2 were emergency adopted at the 1/21/87 State Board meeting, with an effective date of 1/21/87 (Document 6). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.013.2 and 8.332 were finally adopted following publication at the 2/6/87 State Board meeting, with an effective date of 4/1/87 (Document 1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.110.53 and 8.441.2 were emergency adopted at the 2/6/87 State Board meeting, with an effective date of 2/6/87 (Documents 2, 13). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.013.2, 8.302, 8.253.1, 8.253.2 and 8.354.10 were finally adopted following publication at the 3/6/87 State Board meeting, with an effective date of 5/1/87 (Documents 10, 11 and 12). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.5 and 8.441.2 were finally adopted emergency at the 3/6/87 State Board meeting, with an effective date of 2/6/87 (Documents 3 and 13). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.2, 8.110.6 and 8.441.2 were adopted emergency at the 3/6/87 State Board

meeting, with an effective date of 3/6/87 (Documents 5 and 14). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.2, 8.110.6 and 8.441.2 were finally adopted emergency at the 4/3/87 State Board meeting, with an effective date of 3/6/87 (Documents 1 and 13). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100.5 and 8.120.2 were finally adopted following publication at the 4/3/87 State Board meeting, with an effective date of 6/1/87 (Document 11). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.44 - 8.110.55, 8.130.62 - 8.130.8, 8.201, 8.350 - 8.354.10, 8.570 - 8.580, 8.991, and 8.484 - 8.493 were finally adopted following publication at the 5/1/87 State Board meeting, with an effective date of 7/1/87 (Documents 3, 4, 5, 6, 8, 13, and 19). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.61 - 8.110.68 were emergency adopted at the 5/1/87 State Board meeting, with an effective date of 5/1/87 (Document 16). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110.61 - 8.110.68 were finally adopted emergency at the 6/5/87 State Board meeting, with an effective date of 5/1/87 (Document 2). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.500 - 8.500.43 were adopted emergency at the 6/5/87 State Board meeting, with an effective date of 6/5/87 (Document 14). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.850.01 - 8.850.02 were finally adopted following publication at the 6/5/87 State Board meeting, with an effective date of 8/1/87 (Document 12). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.500 - 8.500.43 were finally adopted emergency at the 7/10/87 State Board meeting, with an effective date of 7/1/87 (Document 3). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.463 through 8.645, 8.760 through 8.761, and 8.993 were finally

adopted following publication at the 7/10/87 State Board meeting, with an effective date of 9/1/87 (Documents 1 and 2). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.100, 8.110, and 8.762 were adopted emergency at the 7/10/87 State Board meeting, with an effective date of 7/10/87 (Documents 4 and 20). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.440 - 8.441.5, 8.443 - 8.446, 8.448 - 8.448.2, and 8.448.61 - 8.448.8 were adopted emergency at the 7/28/87 Special State Board meeting, with an effective date of 8/01/87 (Documents 1, 2, and 3). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions and additions to sections 8.100, 8.110, and 8.762 were finally adopted emergency at the 8/7/87 State Board meeting, with an effective date of 7/10/87 (Documents 1 and 7). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.120.3 and 8.993 were finally adopted following publication at the 8/7/87 State Board meeting, with an effective date of 10/1/87 (Documents 6 and 16). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.013, 8.014, 8.110, 8.120, and 8.200 were finally adopted following publication at the 9/11/87 State Board meeting, with an effective date of 11/1/87 (Documents 1, 2, 15, and 17). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100, 8.110, 8.120, 8.441, 8.532 - 8.534 and 8.762 were adopted emergency at the 9/11/87 State Board meeting, with an effective dates of 7/1/87 and 10/1/87 (Documents 4, 18, 19, 24, and 26). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.120, 8.441, and 8.532 - 8.534 were final adoption of emergency at the 10/2/87 State Board meeting, with effective dates of 7/1/87, 9/11/87, and 10/1/87 (Documents 11, 12 and 17). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.440, 8.441, 8.443, 8.445 and 8.448 were adopted emergency and final at the 10/2/87 State Board meeting, with an effective date of 10/2/87 (Documents 16 and 18). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100, 8.110, and 8.762 were adopted emergency and final at the 11/6/87 State Board meeting, with an effective date of 11/6/87 (Documents 3 and 8). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110, 8.120, and 8.992 were finally adopted following publication at the 11/6/87 State Board meeting, with an effective date of 1/1/88 (Documents 1, 6 and 12). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.013, 8.100, 8.210 - 8.212, 8.300 - 8.324, 8.333 - 8.354, and 8.356 were finally adopted following publication at the 12/4/87 State Board meeting, with an effective date of 2/1/88 (Documents 1, 2 and 7). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.110 were emergency adopted at the 12/4/87 State Board meeting, with an effective date of 12/4/87 (Documents 17). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.110 were finally adopted emergency at the 1/8/88 State Board meeting, with an effective date of 12/4/87 (Document 1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.250 - 8.253 and 8.831 - 8.836 were adopted emergency at the 1/8/88 State Board meeting, with an effective date of 1/8/88 (Document 16). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.250 - 8.253 and 8.831 - 8.836 were final adoption of emergency at the 2/5/88 State Board meeting, with an effective date of 1/8/88. Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.011, 8.040, 8.057, 8.062, 8.200, 8.202, 8.250 - 8.253, 8.284 - 8.287, 8.303 - 8.311, 8.321 - 8.332, 8.482, 8.485 - 8.486, 8.487, 8.490, 8.491 - 8.494, 8.495 - 8.496, 8.532 - 8.537, 8.590 - 8.665, 8.754, and 8.733 were adopted emergency at the 2/5/88 State Board meeting (CSPR#'s 87-12-2-1, 88-1-19-2, and 88-1-19-3), with an effective date of 2/5/88. Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.011, 8.040, 8.057, 8.062, 8.200, 8.202, 8.250 - 8.253, 8.284 - 8.287, 8.303 - 8.311, 8.321 - 8.332, 8.482, 8.485 - 8.486, 8.487, 8.490, 8.491 - 8.494, 8.495 - 8.496, 8.532 - 8.537, 8.590 - 8.665, 8.754, and 8.733 were final adoption of emergency at the 3/4/88 State Board meeting (CSPR#'s 87-12-2-1, 88-1-19-2, and 88-1-19-3), with an effective date of 2/5/88 or 3/1/88. Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated

by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.100, 8.110, and 8.120 were finally adopted following publication at the 3/4/88 State Board meeting (CSPR#s 87-11-12-1 and 87-11-13-3), with an effective date of 5/1/88. Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 8.754 were emergency and final adoption at the 4/1/88 State Board meeting, with an effective date of 2/5/88 (CSPR# 88-1-15-1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.200, 8.254 - 8.256, 8.312 - 8.317, 8.330 - 8.332, and 8.570 - 8.580 were finally adopted following publication at the 4/1/88 State Board meeting, with an effective date of 6/1/88 (CSPR# 88-1-11-1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.532 - 8.534 and 8.680 - 8.686 were finally adopted following publication at the 5/6/88 State Board meeting, with an effective date of 7/1/88 (CSPR# 88-3-11-1 and 88-3-16-1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110 and 8.482 were adopted emergency at the 5/6/88 State Board meeting, with an effective date of 5/6/88 (CSPR# 88-3-8-2). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.110 and 8.482 were final adoption of emergency at the 6/3/88 State Board meeting, with an effective date of 5/6/88 (CSPR# 88-3-8-2). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 8.050, 8.440-8.441, 8.442-8.443, and 8.448 were adopted emergency at the 7/8/88 State Board meeting, with an effective date of 7/1/88 (CSPR# 88-5-19-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.050, 8.440-8.441, 8.442-8.443, and 8.448 were final adoption of emergency at the 8/5/88 State Board meeting, with an effective date of 7/1/88 (CSPR# 88-5-19-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100, 8.110, 8.120, 8.287, 8.484 - 8.487, 8.489 - 8.490 and 8.493 were finally adopted following publication at the 8/5/88 State Board meeting, with an effective date of 10/1/88 (CSPR# 88-1-15-2, 88-2-29-1, 88-3-8-3 and 88-4-28-1). Statement of Basis and Purpose and specific statutory

authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.049, 8.200 and 8.287 were finally adopted following publication at the 9/9/88 State Board meeting, with an effective date of 11/1/88 (CSPR# 88-4-27-2 and 88-6-21-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions or additions to sections 8.000 - 8.011, 8.100 - 8.110, 8.202 - 8.211, 8.250 - 8.253, 8.300 - 8.303, 8.321 - 8.322, 8.330 - 8.332, 8.400, 8.520 - 8.523, 8.532 - 8.534, 8.540, 8.590, 8.680 - 8.681, 8.682, 8.750, 8.754, and 8.800 - 8.820 were emergency adopted at the 9/9/88 State Board meeting, with an effective date of 9/9/88 (CSPR#'s 88-7-22-3, 88-8-16-1) and with an effective date of 10/1/88 (CSPR#'s 88-7-12-1, 88-7-22-2, 88-8-11-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions or additions to sections 8.000 - 8.011, 8.100 - 8.110, 8.202 - 8.211, 8.250 - 8.253, 8.300 - 8.303, 8.321 - 8.322, 8.330 - 8.332, 8.400, 8.520 - 8.523, 8.532 - 8.534, 8.540, 8.590, 8.680 - 8.681, 8.682, 8.750, 8.754, and 8.800 - 8.820 were final adoption of emergency at the 10/7/88 State Board meeting, with an effective date of 9/9/88 (CSPR#'s 88-7-22-3, 88-8-16-1) and with an effective date of 10/1/88 (CSPR#'s 88-7-12-1, 88-7-22-2, 88-8-11-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Addition of section 8.401.4 was finally adopted following publication at the 10/7/88 State Board meeting, with an effective date of 12/1/88 (CSPR# 87-12-8-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions or additions to sections 8.350 - 8.354, 8.492 - 8.493, and 8.494 were emergency adopted at the 10/7/88 State Board meeting, with an effective date of 10/1/88 (CSPR# 88-8-12-4) and with an effective date of 10/7/88 (CSPR# 88-9-2-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.490, 8.493, and 8.494 were final adoption of emergency at the 11/4/88 State Board meeting, with an effective date of 10/1/88 (CSPR# 88-8-12-4). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.350 - 8.353 and 8.374 were final adoption of emergency at the 11/4/88 State Board meeting, with an effective date of 11/4/88 (CSPR# 88-9-2-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.404 - 8.353, 8.374 and 8.732 - 8.733 were emergency adopted at the 11/4/88 State Board meeting, with an effective date of 11/4/88 (CSPR# 88-9-27-1 and 88-10-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into

the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.404 and 8.732 - 8.733 were final adoption of emergency at the 12/2/88 State Board meeting, with an effective date of 11/4/88 (CSPR# 88-9-27-1 and 88-10-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.321-8.324 and 8.560-8.567 were finally adopted following publication at the 12/2/88 State Board meeting, with an effective date of 2/1/89 (CSPR#'s 88-5-19-1, 88-9-14-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110 were emergency adopted at the 12/2/88 State Board meeting, with an effective date of 12/2/88 (CSPR# 88-10-28-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110 were final adoption of emergency at the 1/6/89 State Board meeting, with an effective date of 12/2/88 (CSPR# 88-10-28-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110, 8.120, 8.482, 8.485, 8.486, 8.489, and 8.491 were adopted emergency at the 1/6/89 State Board meeting, with an effective date of 1/6/89 (CSPR# 88-9-15-1, 88-10-20-2, and 88-12-8-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.400 - 8.401, and 8.402 - 8.404 were adopted emergency and final at the 1/6/89 State Board meeting, with an effective date of 1/1/89 (CSPR# 88-11-1-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110 and 8.120 were final adoption of emergency at the 2/3/89 State Board meeting, with an effective date of 1/6/89 (CSPR# 88-9-15-1 and 88-12-8-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.485, 8.486, 8.489, and 8.491 were adopted emergency and final at the 2/3/89 State Board meeting, with an effective date of 1/6/89 and an amendment in section 8.485 effective 2/3/89 (CSPR# 88-10-20-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.110 were adopted emergency at the 2/3/89 State Board meeting, with an effective date of 2/3/89 (CSPR# 88-12-5-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social

Services.

Revisions to section 8.110 were final adoption of emergency at the 3/3/89 State Board meeting, with an effective date of 2/3/89 (CSPR# 88-12-5-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100 and 8.110 were final adoption following publication at the 3/3/89 State Board meeting, with an effective date of 5/1/89 (CSPR# 88-11-18-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.484, 8.486 and 8.491 were adopted emergency at the 3/3/89 State Board meeting, with an effective date of 3/3/89 (CSPR# 89-1-17-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.484, 8.486 and 8.491 were final adoption of emergency at the 4/7/89 State Board meeting, with an effective date of 3/3/89 (CSPR# 89-1-17-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.760 - 8.761 were finally adopted following publication at the 4/7/89 State Board meeting, with an effective date of 7/1/89 (CSPR# 88-12-30-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.110 were adopted emergency at the 4/7/89 State Board meeting, with an effective date of 4/7/89 (CSPR# 88-11-8-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.110 were final adoption of emergency at the 5/5/89 State Board meeting, with an effective date of 4/7/89 (CSPR# 88-11-8-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.356 and 8.500 were finally adopted following publication at the 5/5/89 State Board meeting, with an effective date of 7/1/89 (CSPR#'s 89-1-25-1 and 89-3-15-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.486 and 8.532 - 8.533 were finally adopted following publication at the 6/2/89 State Board meeting, with an effective date of 8/1/89 (CSPR#'s 89-3-20-1 and 89-3-20-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100, 8.111, 8.120, 8.484, 8.485 and 8.486 were adopted emergency at the 6/2/89 State Board meeting, with an effective date of 6/2/89 (CSPR# 89-4-20-1), and with an effective date of 7/1/89 (CSPR#'s 89-2-23-1, 89-4-4-1, 89-4-26-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.111 and 8.486 were final adoption of emergency at the 7/7/89 State Board meeting, with an effective date of 7/1/89 (CSPR#'s 89-4-4-1 and 89-4-26-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100, 8.120, 8.484 and 8.485 were adopted emergency and final at the 7/7/89 State Board meeting, with an effective date of 7/7/89 (CSPR# 89-4-20-1), and with an effective date of 7/1/89 (CSPR# 89-2-23-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.057 and 8.540 were adopted emergency at the 7/7/89 State Board meeting, with an effective date of 7/1/89 (CSPR# 89-4-19-1), and with an effective date of 7/7/89 (CSPR# 89-5-24-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.540 were final adoption of emergency at the 8/4/89 State Board meeting, with an effective date of 7/7/89 (CSPR# 89-5-24-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.057 - 8.059 were adopted emergency and final at the 8/4/89 State Board meeting, with an effective date of 7/1/89 (CSPR# 89-4-19-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.250 - 8.256 and 8.401 were final adoption following publication at the 8/4/89 State Board meeting, with an effective date of 10/1/89 (CSPR#'s 89-5-17-2 and 89-5-31-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.075, 8.400 and 8.401 were adopted emergency at the 8/4/89 State Board meeting, with an effective date of 8/4/89 (CSPR#'s 89-6-5-1 and 89-7-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.075 were final adoption of emergency at the 9/8/89 State Board meeting, with an effective date of 8/4/89 (CSPR# 89-6-5-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.400 and 8.401 were adopted emergency and final at the 9/8/89 State Board meeting, with effective dates of 8/4/89 and 9/8/89 (CSPR# 89-7-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.211 were adopted emergency at the 9/8/89 State Board meeting, with an effective date of 10/1/89 (CSPR# 89-5-9-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.211 were final adoption of emergency at the 10/6/89 State Board meeting, with an effective date of 10/1/89 (CSPR# 89-6-9-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.110 and 8.112 were adopted emergency at the 10/6/89 State Board meeting, with an effective date of 10/6/89 (CSPR#'s 89-8-11-2 and 89-9-14-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.110 and 8.112 were final adoption of emergency at the 11/3/89 State Board meeting, with an effective date of 10/6/89 (CSPR#'s 89-8-11-2 and 89-9-14-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.120, 8.200, 8.520 - 8.536, and 8.660 - 8.665 were final adoption following publication at the 11/3/89 State Board meeting, with an effective date of 1/1/90 (CSPR#'s 89-6-13-1, 89-6-20-1 and 89-7-25-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.420 - 8.425, 8.448, and 8.680 - 8.689 were final adoption following publication at the 12/1/89 State Board meeting, with an effective date of 2/1/90 (CSPR#'s 89-7-19-1 and 89-9-20-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110, 8.358, 8.442, and 8.481 - 8.482 were final adoption following publication at the 1/5/90 State Board meeting, with an effective date of 3/1/90 (CSPR# 89-11-8-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.485 were adopted emergency at the 1/5/90 State Board meeting, with an effective date of 1/5/90 (CSPR# 89-12-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.485 were final adoption of emergency at the 2/2/90 State Board meeting, with an

effective date of 1/5/90 (CSPR# 89-12-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revision to section 8.484 and addition of sections 8.501-8.505 were final adoption following publication at the 2/2/90 State Board meeting, with an effective date of 4/1/90 (CSPR# 89-9-11-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.441.2 and 8.448.2 were final adoption following publication at the 3/2/90 State Board meeting, with an effective date of 5/1/90 (CSPR# 89-10-17-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100 and 8.120 were adopted emergency at the 3/2/90 State Board meeting, with an effective date of 4/1/90 (CSPR# 89-11-22-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100 and 8.120 were adopted emergency and final at the 4/6/90 State Board meeting, with effective dates of 4/1/90 and 4/6/90 (CSPR# 89-11-22-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110 and 8.112 were adopted emergency at the 4/6/90 State Board meeting, with an effective date of 4/6/90 (CSPR#'s 90-3-9-1 and 90-3-20-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110 and 8.112 were final adoption of emergency at the 5/4/90 State Board meeting, with an effective date of 4/6/90 (CSPR#'s 90-3-9-1 and 90-3-20-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.441 were final adoption following publication at the 5/4/90 State Board meeting, with an effective date of 7/1/90 (CSPR# 89-9-6-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and/or additions to sections 8.110, 8.112, 8.484, 8.501 - 8.502, and 8.504 were adopted emergency at the 5/4/90 State Board meeting, with an effective date of 5/4/90 (CSPR#'s 90-3-26-1 and 90-4-9-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and/or additions to sections 8.484, 8.501 - 8.502, and 8.504 were final adoption of emergency at the 6/1/90 State Board meeting, with an effective date of 5/4/90 (CSPR# 90-3-26-1). Statement of

Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110 and 8.112 were emergency and final adoption at the 6/1/90 State Board meeting, with an effective dates of 5/4/90 and 6/1/90 (CSPR# 90-4-9-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.050, 8.402 - 8.405, 8.446 and 8.448 were final adoption following publication at the 6/1/90 State Board meeting, with an effective date of 8/1/90 (CSPR#'s 90-2-23-1 and 90-4-9-4). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.100, 8.121, and 8.850 - 8.870 were adopted emergency at the 6/1/90 State Board meeting, with an effective date of 6/1/90 (CSPR# 90-4-4-1) and with an effective date of 7/1/90 (CSPR#'s 90-4-9-3 and 90-4-24-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.100 and 8.121 were final adoption of emergency at the 7/6/90 State Board meeting, with an effective date of 6/1/90 (CSPR# 90-4-4-1) and with an effective date of 7/1/90 (CSPR# 90-4-24-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.250 - 8.254 and 8.486 - 8.494 were final adoption following publication at the 7/6/90 State Board meeting, with an effective date of 9/1/90 (CSPR#'s 90-4-24-2 and 90-4-25-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.850 through 8.870 were adopted emergency and final at the 7/6/90 State Board meeting, with an effective dates of 7/1/90 and 7/6/90 (CSPR# 90-4-9-3). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.100, 8.120, 8.441, and 8.533 - 8.535 were adopted emergency at the 7/6/90 State Board meeting, with an effective date of 7/6/90 (CSPR#'s 90-5-25-2 and 90-6-11-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.100, 8.120, 8.441, and 8.533 - 8.535 were adopted emergency and final at the 8/3/90 State Board meeting, with effective dates of 7/6/90 and 8/3/90 (CSPR#'s 90-5-25-2 and 90-6-11-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.120, 8.201 and 8.570 - 8.571 were final adoption following publication at the 8/3/90 State Board meeting, with an effective date of 10/1/90 (CSPR#'s 90-4-20-1, 90-5-16-1, and 90-5-

30-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Addition of sections 8.700 - 8.711 were adopted emergency at the 9/7/90 State Board meeting with an effective date of 9/7/90 (CSPR# 90-6-29-1); and, revisions to sections 8.750 - 8.753 were adopted emergency at the 9/7/90 State Board meeting with an effective date of 10/1/90 (CSPR# 90-6-22-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.750 - 8.753 were final adoption of emergency at the 10/5/90 State Board meeting with an effective date of 10/1/90 (CSPR# 90-6-22-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.430, 8.441, and 8.448 were final adoption following publication at the 10/5/90 State Board meeting, with an effective date of 12/1/90 (CSPR#'s 90-7-18-1 and 90-8-10-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Addition and/or revisions to sections 8.700 through 8.711 were adopted emergency and final at the 10/5/90 State Board meeting, with an effective dates of 9/7/90 and 10/5/90 (CSPR# 90-6-29-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule: These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and/or additions to sections 8.300 through 8.311, 8.355 through 8.356, and 8.374 were adopted emergency at the 10/5/90 State Board meeting, with an effective date of 10/5/90 (CSPR# 90-5-8-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and/or additions to sections 8.300 through 8.311, 8.355 through 8.356, and 8.374 were final adoption of emergency at the 11/2/90 State Board meeting, with an effective date of 10/5/90 (CSPR# 90-5-8-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100 and 8.110 were final adoption following publication at the 12/7/90 State Board meeting, with an effective date of 2/1/91 (CSPR# 90-9-17-3). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.441 and 8.485 were adopted emergency at the 12/7/90 State Board meeting, with an effective date of 12/7/90 (CSPR#'s 90-10-25-2 and 90-11-20-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.441 and 8.485 were final adoption of emergency at the 1/4/91 State Board meeting, with an effective date of 12/7/90 (CSPR#'s 90-10-25-2 and 90-11-20-2). Statement of Basis and

Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100, 8.111, 8.120 and 8.374 were adopted emergency at the 1/4/91 State Board meeting, with an effective dates of 1/1/91 (CSPR#'s 90-11-28-2 and 90-12-4-1) and 1/4/91 (CSPR# 90-11-7-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.111 and 8.374 were final adoption of emergency at the 2/1/91 State Board meeting, with effective dates of 1/1/91 (CSPR# 90-12-4-1) and 1/4/91 (CSPR# 90-11-7-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100, and 8.120 were adopted emergency and final at the 2/1/91 State Board meeting, with effective dates of 1/1/91 and 2/1/91 (CSPR# 90-11-28-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.210 through 8.211 were final adoption following publication at the 2/1/91 State Board meeting, with an effective date of 4/1/91 (CSPR# 90-11-19-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.465 and addition of section 8.585 were adopted emergency and final at the 2/1/91 State Board meeting, with an effective date of 3/1/91 (CSPR# 90-11-20-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100 and 8.211 were adopted emergency at the 3/8/91 State Board meeting, with an effective date of 3/8/91 (CSPR#'s 91-1-30-2 and 91-2-20-1), and addition of section 8.550 was adopted emergency (CSPR# 91-1-18-1), with an effective date of 3/31/91. Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100 and 8.211 were final adoption of emergency at the 4/5/91 State Board meeting, with an effective date of 3/8/91 (CSPR#'s 91-1-30-2 and 91-2-20-1), and addition of section 8.550 was final adoption of emergency (CSPR# 91-1-18-1), with an effective date of 3/31/91. Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.317 - 8.325 were final adoption following publication at the 4/5/91 State Board meeting, with an effective date of 6/1/91 (CSPR# 90-11-7-2) and revisions to sections 8.330 - 8.332 were final adoption following publication (CSPR# 91-1-23-1), with an effective date of 7/1/91. Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.211, 8.401, 8.402, 8.405, 8.408, 8.409, 8.415, 8.486 - 8.487, 8.510, 8.520 - 8.527, 8.532 - 8.533, 8.540, and 8.550 were final adoption following publication at the 5/3/91 State Board meeting, with an effective date of 7/1/91 (CSPR#'s 90-11-14-1, 90-11-23-1, 91-1-7-1, 91-2-15-1, 91-2-25-1, and 91-3-11-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.059, 8.112, 8.330 - 8.332, 8.356, 8.373, 8.374, 8.400 - 8.401, 8.402 - 8.403, 8.484, 8.485, 8.486 8.501, 8.504, and 8.550 were adopted emergency at the 5/3/91 State Board meeting, with an effective date of 5/3/91 (CSPR#'s 91-1-14-1, 91-2-26-2, 91-4-1-1, 91-4-3-1, 91-4-5-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.330 - 8.332, 8.373 and 8.374 were adopted emergency and final at the 6/7/91 State Board meeting, with an effective dates of 5/3/91 and 6/7/91 (CSPR# 91-1-14-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.059, 8.112, 8.356, 8.400 - 8.401, 8.402 - 8.403, 8.484, 8.485, 8.486, 8.501, 8.504, and 8.550 were final adoption of emergency at the 6/7/91 State Board meeting, with an effective date of 5/3/91 (CSPR#'s 91-2-26-2, 91-4-1-1, 91-4-3-1, 91-4-5-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.061, 8.100, 8.110, and 8.120 were adopted emergency at the 6/7/91 State Board Meeting, with an effective date of 7/1/91 (CSPR# 91-3-1-1), and sections 8.800 - 8.850 were adopted emergency at the 6/7/91 State Board meeting, with an effective date of 6/7/91 (CSPR# 91-4-19-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.061, 8.100, 8.110, and 8.120 were final adoption of emergency at the 7/12/91 State Board Meeting, with an effective date of 7/1/91 (CSPR# 91-3-1-1), and sections 8.800 - 8.850 were final adoption of emergency at the 7/12/91 State Board meeting, with an effective date of 6/7/91 (CSPR# 91-4-19-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.330 - 8.332 and 8.400 - 8.401 were final adoption following publication at the 7/12/91 State Board meeting, with an effective date of 9/1/91 (CSPR#'s 91-4-17-2 and 91-5-1-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.441 and 8.533 - 8.536 were adopted emergency at the 8/2/91 State Board meeting, with an effective date of 8/2/91 (CSPR#'s 91-5-23-1 and 91-7-17-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.533 - 8.536 were final adoption of emergency at the 9/6/91 State Board meeting, with an effective date of 8/2/91 (CSPR# 91-5-23-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are

available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.441 were adopted emergency and final at the 9/6/91 State Board meeting, with effective dates of 8/2/91 and 9/6/91 (CSPR# 91-7-17-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.312 - 8.315 and 8.356 were final adoption following publication at the 9/6/91 State Board meeting, with an effective date of 11/1/91 (CSPR#'s 91-5-8-1 and 91-7-10-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.130, 8.486 and 8.550 were final adoption following publication at the 10/4/91 State Board meeting, with an effective date of 12/1/91 (CSPR#'s 91-6-4-1, 91-8-7-1 and 91-8-16-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to or addition of sections 8.050, 8.356, 8.435, 8.430 and 8.754 were final adoption following publication at the 11/1/91 State Board meeting, with an effective date of 1/1/92 (CSPR#'s 91-1-10-2, 91-5-29-2, 91-9-13-1, 91-9-17-1 and 91-9-18-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.332 were adopted emergency and final at the 11/1/91 State Board meeting, with an effective date of 12/1/91 (CSPR# 91-8-5-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to and/or additions of Table of Contents and sections 8.014 and 8.020 through 8.040 were adopted emergency and final at the 12/6/91 State Board meeting, with an effective date of 1/1/92 (CSPR# 91-7-19-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.043, 8.461 - 8.464, and 8.800 - 8.834 were final adoption following publication at the 12/6/91 State Board meeting, with an effective date of 2/1/92 (CSPR#'s 91-9-23-1, 91-9-26-1, and 91-10-3-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.110 and were adopted emergency at the 12/6/91 State Board meeting, with an effective date of 1/1/92 (CSPR# 91-11-8-2); and, to section 8.540 with an effective date of 12/6/91 (CSPR# 91-10-29-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.540 were final adoption of emergency, with an effective date of 12/6/91 (CSPR# 91-10-29-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during

normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.110 were adopted emergency and final at the 1/10/92 State Board meeting, with an effective dates of 1/1/92 and 1/10/92 (CSPR# 91-11-8-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.300 - 8.302 and 8.330 - 8.332 were final adoption following publication at the 1/10/92 State Board meeting, with an effective date of 3/1/92 (CSPR# 91-9-27-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.441.2 were adopted emergency and final at the 1/10/92 State Board meeting, with an effective date of 2/1/92 (CSPR# 91-11-8-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.400 and 8.401 and addition of section 8.745 were final adoption following publication at the 2/7/92 State Board meeting, with an effective date of 4/1/92 (CSPR#'s 91-10-7-2 and 91-11-25-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.312 through 8.319 were adopted emergency and final at the 2/7/92 State Board meeting, with an effective date of 3/1/92 (CSPR# 91-9-30-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.355.90 were adopted emergency at the 2/7/92 State Board meeting, with an effective date of 2/7/92 (CSPR# 91-9-27-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.355.90 were final adoption of emergency at the 3/6/92 State Board meeting, with an effective date of 2/7/92 (CSPR# 91-9-27-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions, additions and/or deletions to sections 8.110, 8.356, 8.374, and 8.506 were final adoption following publication at the 3/6/92 State Board meeting, with an effective date of 5/1/92 (CSPR#'s 91-6-18-1, and 91-9-27-3, 91-9-27-4). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.318 were final adoption following publication at the 4/3/92 State Board meeting, with an effective date of 6/1/92 (CSPR# 91-10-29-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison,

Department of Social Services.

Revisions to section 8.120 were adopted emergency and final at the 4/3/92 State Board meeting, with an effective date of 5/1/92 (CSPR# 92-1-7-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Addition of section 8.063 and revisions to sections 8.100, 8.110, and 8.120 were final adoption following publication at the 5/1/92 State Board meeting, with an effective date of 7/1/92 (CSPR# 92-1-28-1 and 92-2-6-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.356 and addition of section 8.712 were final adoption following publication at the 6/5/92 State Board meeting, with an effective date of 8/1/92 (CSPR# 92-2-14-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Addition of section 8.500 was adopted emergency and final at the 6/5/92 State Board meeting, with an effective date of 6/5/92 (CSPR# 91-11-21-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.062 and 8.324 were adopted emergency and final at the 6/5/92 State Board meeting, with an effective date of 7/1/92 (CSPR# 91-10-21-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.201 and 8.506 were adopted emergency at the 6/5/92 State Board meeting, with an effective date of 7/1/92 (CSPR#'s 92-4-1-1 and 92-4-22-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.201 and 8.506 were final adoption of emergency at the 7/10/92 State Board meeting, with an effective date of 7/1/92 (CSPR#'s 92-4-1-1 and 92-4-22-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.040, 8.312 - 8.313, and 8.489 were final adoption following publication at the 7/10/92 State Board meeting, with an effective date of 9/1/92 (CSPR#'s 92-4-10-1, 92-4-22-1 and 92-4-23-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110.29 and 8.110.52 were adopted emergency at the 7/10/92 State Board meeting, with effective dates of 7/10/92 and 8/1/92 respectively (CSPR#'s 92-3-30-1 and 92-6-15-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110.29 and 8.110.52 were final adoption of emergency rules at the 8/7/92 State Board meeting, with effective dates of 7/10/92 and 8/1/92 respectively (CSPR#'s 92-3-30-1 and 92-6-15-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.356.20 and 8.441.2, 8.441.3 - 8.441.5, 8.441.8, 8.448.22, and 8.448.7 were adopted emergency at the 8/7/92 State Board meeting, with an effective date of 8/7/92 (CSPR#'s 92-7-2-1 and 92-7-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 8.441.2 through 8.441.5, 8.441.8, 8.448.22, and 8.448.7 were adopted emergency and final at the 9/4/92 State Board meeting, with effective dates of 8/7/92 and 9/4/92 (CSPR# 92-7-2-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.356.20 were final adoption of emergency at the 9/4/92 State Board meeting, with an effective date of 8/7/92 (CSPR# 92-7-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.501, 8.502, and 8.505 were final adoption following publication at the 9/4/92 State Board meeting, with an effective date of 11/1/92 (CSPR# 92-6-9-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.200, 8.325, 8.330 - 8.332, 8.442, 8.500, 8.522 - 8.525, 8.560 - 8.571, 8.660 - 8.666, 8.700, and 8.740 - 8.744 were adopted emergency at the 9/4/92 State Board meeting, with an effective date of 9/4/92 (CSPR#'s 92-7-24-2 and 92-7-28-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.200, 8.325, 8.330 - 8.332, 8.442, 8.500, 8.522 - 8.525, 8.560 - 8.571, 8.660 - 8.666, 8.700, and 8.740 - 8.744 were final adoption of emergency at the 10/2/92 State Board meeting, with an effective date of 9/4/92 (CSPR#'s 92-7-24-2 and 92-7-28-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.020, 8.021, 8.023, 8.024, 8.486, and 8.495 were final adoption following publication at the 10/2/92 State Board meeting, with an effective date of 12/1/92 (CSPR#'s 92-3-18-1 and 92-3-20-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.120, 8.121 - 8.122, 8.200 - 8.201, 8.286 - 8.287, and 8.563 - 8.567 were final adoption following publication at the 11/6/92 State Board meeting, with an effective date of 1/1/93 (CSPR#'s 92-7-24-1, 92-8-11-1, and 92-9-15-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department

of Social Services.

Revisions to sections 8.110, 8.487, and 8.502 were adopted emergency at the 1/8/93 State Board meeting, with an effective date of 1/8/93 (CSPR#'s 92-11-9-3 and 92-12-11-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110, 8.487, and 8.502 were final adoption of emergency at the 2/5/93 State Board meeting, with an effective date of 1/8/93 (CSPR#'s 92-11-9-3 and 92-12-11-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.210, 8.211, and 8.253 were adopted emergency and final at the 2/5/93 State Board meeting, with an effective date of 3/1/93 (CSPR# 92-11-27-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.506.2 were adopted emergency at the 2/5/93 State Board meeting, with an effective date of 2/5/93 (CSPR# 93-1-7-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.506.2 were final adoption of emergency at the 3/5/93 State Board meeting, with an effective date of 2/5/93 (CSPR# 93-1-7-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.400 through 8.403, 8.448, 8.484, and 8.485 were final adoption following publication at the 3/5/93 State Board meeting, with an effective date of 5/1/93 (CSPR#'s 92-10-26-2 and 92-11-9-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.011 and 8.356 were adopted emergency at the 3/5/93 State Board meeting, with an effective date of 3/5/93 (CSPR#'s 93-1-19-1 and 93-2-9-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.011 and 8.356 were final adoption of emergency at the 4/2/93 State Board meeting, with an effective date of 3/5/93 (CSPR#'s 93-1-19-1 and 93-2-9-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.110, 8.112, 8.358, 8.408, 8.415, and 8.481 - 8.482 were final adoption following publication at the 4/2/93 State Board meeting, with an effective date of 6/1/93 (CSPR# 92-9-21-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.043, 8.049, and 8.356.40 were final adoption following publication at the 5/7/93 State Board meeting, with an effective date of 7/1/93 (CSPR#'s 93-1-21-1, 93-2-10-1, and 93-2-19-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.330 - 8.332, 8.442, 8.550, 8.560 - 8.563, 8.660 - 8.663, 8.700, and 8.742 - 8.744 were adopted emergency at the 5/7/93 State Board meeting, with an effective date of 5/7/93 (CSPR# 93-3-8-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.330 - 8.332, 8.442, 8.550, 8.560 - 8.563, 8.660 - 8.663, 8.700, and 8.742 - 8.744 were final adoption of emergency at the 6/4/93 State Board meeting, with an effective date of 5/7/93 (CSPR# 93-3-8-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.373, 8.448 and 8.500 were final adoption following publication at the 6/4/93 State Board meeting, with an effective date of 8/1/93 (CSPR#'s 92-11-9-1, 93-3-8-1, and 93-3-29-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.401, 8.402, 8.484, and 8.501 - 8.505 were adopted emergency at the 6/4/93 State Board meeting, with an effective date of 7/1/93 (CSPR# 93-2-22-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.401, 8.402, 8.484, and 8.501 - 8.505 were final adoption of emergency at the 7/9/93 State Board meeting, with an effective date of 7/1/93 (CSPR# 93-2-22-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.200 were adopted emergency and final at the 7/9/93 State Board meeting, with an effective date of 7/1/93 (CSPR# 93-4-27-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.100, 8.110, 8.170 - 8.183, 8.202, 8.210 - 8.211, and 8.482 were final adoption following publication at the 7/9/93 State Board meeting, with an effective date of 9/1/93 (CSPR#'s 93-3-25-2 and 93-4-15-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.711 were final adoption following publication at the 8/6/93 State Board meeting, with an effective date of 10/1/93 (CSPR# 93-5-12-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to section 8.023 were adopted emergency at the 8/6/93 State Board meeting,

with an effective date of 8/6/93 (CSPR# 93-6-22-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.023 were adopted emergency and final at the 8/6/93 State Board meeting, with effective dates of 8/6/93 and 9/10/93 (CSPR# 93-6-22-2) and revisions to section 8.835 - 8.850 were adopted emergency and final at the 8/6/93 State Board meeting, with an effective date of 9/10/93 (CSPR# 93-5-26-3). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.059, 8.401, 8.408, 8.415, and 8.481 - 8.482 were adopted emergency at the 9/10/93 State Board meeting, with an effective date of 10/1/93 (CSPR# 93-7-6-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 8.059, 8.401, 8.408, 8.415, and 8.481 - 8.482 were final adoption of emergency at the 10/1/93 State Board meeting, with an effective date of 10/1/93 (CSPR# 93-7-6-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 8.253 through 8.254 and 8.303 through 8.311 were final adoption following publication at the 10/1/93 State Board meeting, with an effective date of 12/1/93 (CSPR# 93-3-25-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to Sections 8.356.40, 8.441, and 8.448 were approved by the Medical Services Board as emergency adoptions on June 9, 2000, final adoptions on July 14, 2000 and became effective July 1, 2000 (MSB 00-05-08-B and MSB 00-03-28-A, respectively). Revisions to Section 8.509 were approved initial adoption on May 12, 2000, final adoption on July 14, 2000, and becomes effective September 1, 2000 (MSB 00-02-08-A).

Revisions to Sections 8.110.5 and 8.110.3; 8.110.49 and 8.482; and 8.407 were approved by the Medical Services Board as initial adoptions on July 14, 2000, final adoptions on August 11, 2000 and become effective October 1, 2000 (MSB 00-01-28-A and MSB 00-05-08-A, MSB 00-05-04-A respectively). Revisions to Section 8.528 were approved emergency adoption on August 11, 2000, become effective September 1, 2000 (MSB 00-05-16-A, Option #2).

Revisions to Section 8.207 were approved emergency adoption on September 8, 2000, and become effective October 1, 2000 (MSB 00-08-23-A). Revisions to Sections 8.100 through 8.106 were approved by the Medical Services Board as initial adoptions on August 11, 2000, final adoptions on September 8, 2000 and become effective November 1, 2000 (MSB 00-03-13-A). Sections 8.214 and 8.900 were added and approved by the Medical Services Board as initial adoptions on August 11, 2000, final adoptions on September 8, 2000 and become effective November 1, 2000 (MSB 00-05-23-A and MSB 00-06-28-A respectively). Revisions to Section 8.528 were approved emergency adoption on August 11, 2000, final adoption on September 8, 2000, and became effective September 1, 2000 (MSB 00-05-16-A, Option #2).

Revisions to Section 8.207 were approved emergency adoption on September 8, 2000, final adoption on October 13, 2000, and became effective October 1, 2000 (MSB 00-08-23-A). Revisions to Sections 8.011, 8.100, and 8.205 were approved by the Medical Services Board as an emergency adoption on November 9, 2000, and becomes effective December 1, 2000 (MSB 00-09-19-A). Revisions to Section 8.205.2 were approved as an initial adoption on October 13, 2000, final adoption on November 9, 2000, and becomes

effective January 1, 2001 (MSB 00-07-26-A). Section 8.930 was added and approved by the Medical Services Board as an initial adoption on October 13, 2000, a final adoption on November 9, 2000 and becomes effective January 1, 2001 (MSB 00-08-03-A)

Revisions to Section 8.110.5 were approved emergency adoption on December 8, 2000, and become effective January 1, 2001 (MSB 00-10-24-A). Revisions to Sections 8.011, 8.100, and 8.205 were approved by the Medical Services Board as an emergency adoption on November 9, 2000, final adoption on December 8, 2000 and become permanent February 1, 2001 (MSB 00-09-19-A). Revisions to Sections 8.050, 8.075, 8.076 were approved as an initial adoption on November 9, 2000, final adoption on December 8, 2000, and become effective February 1, 2001 (MSB 00-03-20-A).

The Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rules. These materials are available for review by the public during normal working hours at the Medical Services Board Office of the Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, CO 80203.

8.011.1 GENERAL EXCLUSIONS FROM COVERAGE

The paragraphs which follow set forth the general exclusions from coverage of the Medical Assistance Program.

8.011.11 Excluded from coverage are items and services which generally enhance the personal comfort of the eligible person, but are not necessary in the diagnosis of, nor contribute meaningfully to the treatment of an illness or injury, or the functioning of a malformed body member; this exclusion does not apply to inoculations and immunizations provided.

.12 Also excluded are items and services for which neither the eligible person, nor any other person or organization, incurs a legal obligation to pay; an example of such an exclusion is the free chest X-rays provided by health organizations. In applying this particular exclusion, the determining factor is that there is a not legal obligation to pay for the items or services, and not merely the fact that the patient is not charged because of other considerations. A legal obligation to pay exists even when reimbursement is expected only to the extent of the patient's insurance coverage.

This exclusion, therefore does not prohibit program payment for such services rendered to the following persons:

- a. Indigents who because of their inability to pay are not charged by an institution which customarily charged for such services;
- b. Patients whose need for services resulted from the act or negligence of another who is or may be legally liable for the patient's medical expenses. The existence of a third party's liability does not affect the patient's obligation to pay for the services he received nor the ability of the Medical Assistance Program to provide such coverage in his behalf. (The additional consideration, however, is that such third-party liability and possible benefits must be sought, explored, and secured wherever possible);
- c. Individuals resident in homes for the aged when the agreement under which such residency is provided is inclusive of medical services and no payment is accepted from any person residing in the home regardless of their ability to pay. Payment could be made for services rendered by a source independent of such home or institution if that source customarily charges for such services. Thus, payment could be made for services furnished by a hospital or long-term care facility to which a resident of the home is sent (or for home health services by an agency), or for the services of a physician who is not an employee of such home. In addition, this sort of situation is true in certain types of nonprofit homes, certain homes operated by labor unions, and homes for members of

religious orders, etc.

- .13 Also excluded as benefits are items and services paid for by a governmental entity, including federal programs such as the National Institutes of Health, the Veterans' Administration medical care program and other similar types of government sponsored medical care.
- .14 Neither can payment be made for services in hospitals which serve only a special category of the population, such as prisoners, nor for services furnished to prisoners in hospitals serving the general community.
- .15 Also excluded as a benefit are items and services which are not provided within the United States. This is inclusive of the 50 states of the Union, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.
- .16 Also, specifically excluded from coverage are items and services which are required as a result of war or of an act of war occurring after the effective date of the patient's current eligibility.
- .17 Also, specifically excluded from coverage under the Medical Assistance Program are injuries received by individuals who are engaged in riots, civil disobedience, or other acts specifically excluded by the congressional statute relating thereto.
- .18 Specific non-benefit items and services in each of the benefit categories are identified in that section of this manual relating to each category.
- .19 Payment for prenatal services delivered through "The Prenatal Care for Undocumented Women Pilot Program" shall not be made under any circumstances other than through a contracted Managed Care Organization as specified in 8.011.02, Section B.

8.012 PROHIBITION OF CHARGES TO RECIPIENTS

- .01 The law (Section 26-4-112(1)) provides that "no recipient or his estate shall be liable for the cost of medical benefits properly rendered to him", except those contributions required pursuant to Section 26-4-110(4), which states "Any recipient receiving benefits under this article who receives any supplemental income, available for medical purposes under rules and regulations of the State Department or who receives proceeds from sickness accident, health, or casualty insurance shall apply such supplemental income to the cost of benefits required."
- .02 In billing and accepting payment for medical and remedial care and services, a provider agrees to do so under provisions of the law and rules related to such billing and payment. If such provider, due to failure to comply with said plan provisions, law, and/or appropriate rules, fails to qualify for or receive payment for such services, he is precluded from billing or collecting from such eligible recipient.
- .03 All providers of medical services in their submission of claim to the Medical Assistance Program certify that, "I will accept as payment in full, payment made under the Medical Assistance Program, and certify that no supplemental charges have been, or will be, billed to the patient, except for those non-covered items, or services, if any, which are not reimbursable under the Medical Assistance Act."
- .04 Providers who violate the provisions of this rule are subject to the penalties set forth in rules of the State Board of Social Services concerning termination of participation.

8.013 OUT-OF-STATE MEDICAL CARE

An eligible Colorado recipient, temporarily out of the state but still a resident of Colorado, is entitled to

receive benefits to the same extent that Medicaid is furnished to residents in the state under any one of the following conditions:

1) Medical services are needed because of a medical emergency.

For these services no prior authorization is needed. Whether an emergent condition exists is determined by the provider rendering service. Documentation of the emergency must be submitted with the claim.

2) Medical services are needed because the recipient's health would be endangered if he/she were required to return to Colorado for medical care and treatment.

For these services no prior authorization is required. The determination as to whether the recipient's health would be endangered is made by the provider rendering service. Documentation of why the recipient's health would be endangered must be submitted with the claim. However, the medical consultant of the Colorado Medicaid Program must be notified prior to the provision of services under this paragraph.

3) The State Medicaid Director determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the recipient is temporarily located.

Prior authorization from the Medicaid Program's medical consultant must be obtained for services provided under this paragraph.

4) It is the general practice for recipients in a particular locality to use medical resources in another state.

No prior authorization is necessary for services provided in accordance with this paragraph when the recipient of an area is obtaining services from a provider in a neighboring out of state locale. Prior authorization from the Medicaid Program's medical consultant is necessary if the recipient is receiving services from any other out of state provider not in a neighboring locale.

In addition, prior authorization from the Medicaid Program's medical consultant is required for all services which are only available out of state for Colorado Medicaid recipient's located in Colorado at the time services are necessary.

The above restrictions on out of state medical care shall not apply to children who reside out of the state for whom Colorado makes adoption assistance payments or foster care maintenance payments.

The county departments of social services shall advise all applicants and recipients of this policy.

8.013.1 ENROLLMENT PROCEDURES

To receive reimbursement, all out of state providers shall be required to enroll in the Colorado Medicaid Program. To enroll in the Colorado Medicaid Program, an out of state provider must provide the following to the fiscal agent:

- 1) Name 2) Address 3) Social Security Number or Tax Identification Number 4) Verification of Licensure

This information must be on file with the fiscal agent before providers can receive payment. Once approved, out of state providers will receive a Colorado Medicaid provider number. This number is necessary in order for claims to be processed.

8.013.2 REIMBURSEMENT PRINCIPLES

All claims except out of state nursing home claims must be submitted to the fiscal agent for the state with documentation showing that the above requirements have been met. (Out of state nursing home claims shall be paid in accordance with the Payment For Out Of State Nursing Home Care section of the Volume 8 staff manual.) All claims submitted to the fiscal agent must include:

- 1) A copy of the provider's current Medicaid provider agreement with its state (if applicable);
- 2) Its Colorado provider number; and
- 3) Complete address, including zip code.

In addition, providers must sign a provider agreement in order to receive reimbursement. The claim form and the information contained in it shall constitute provider agreement. Except as provided elsewhere in the Volume 8 staff manual, reimbursement for out of state care shall be as follows:

Reimbursement for inpatient hospital services shall be 90% of the Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services (DHHS).

Reimbursement for physician services shall be the lower of the following:

- A. HCFA Common Procedure Coding System (HCPCs) fee;
- B. Provider's Actual Charge.

Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These tests will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare.

Reimbursement for outpatient hospital services shall be 70% of billed charges.

The foregoing procedures shall be in effect for all out-of-state providers, except as provided for elsewhere in the staff manual Volume 8 regulations. Individual cases which are adversely affected by these procedures shall be presented to the Bureau of Medical Services, Director, Program Operations Division, Colorado Department of Social Services. Individual consideration shall be given to such cases.

The Department may negotiate a higher reimbursement rate for out-of-state hospital services that are prior authorized.

- A. These are cases which require procedures not available in Colorado and which must be prior authorized.
- B. The patient's physician may suggest where the patient should be sent, but the medical consultant for the Department is responsible for making the final determination based on the most cost effective institution consistent with quality of care.

8.014 NON EMERGENT MEDICAL TRANSPORTATION

8.014.1 The Department shall assure transportation to and from medically necessary services covered by the Colorado Medical Assistance Program for clients who have no other means of transportation. Payment will be made for the least expensive means suitable to the client's condition. The distance to be traveled, transportation and treatment facilities available and the physical condition and welfare of the client shall all determine the type of transportation service authorized.

8.040 RECOVERIES FROM PROVIDERS

In the event that an audit or other competent evidence (e.g. information provided by another government agency) reveals that a provider is indebted to the State for any reason, the Department shall recover this amount either through a repayment agreement with the provider; or by offsetting the amount owed against current and future claims of the provider; or through litigation; or by any other appropriate action within its legal authority.

Providers shall have the right to appeal pursuant to the guidelines for administrative review-provider appeal mechanism in the Medical Assistance Manual.

8.040.1 ENROLLMENT OF PROVIDERS

Before claims can be accepted for payment for services provided to eligible Medicaid recipients, the provider of service shall be enrolled in the Colorado Medical Assistance program and assigned a provider number.

8.040.2 SUBMISSION OF CLAIMS

Effective July 1, 1994, all Medicaid services providers shall be required to transmit in an approved electronic format to the Medicaid fiscal agent for the Department of Social Services all claims for services which are benefits of the Colorado Medical Assistance Program provided to eligible Medicaid recipients. Electronic claims format shall be required unless hard copy claims submittals are specifically authorized by the State Department.

A transaction fee shall be required for each electronic claim transmission. This transaction fee shall be collected from the Medicaid services provider against current and future claims of the provider through a reduction in claim reimbursement and shall be so described on the Medicaid Remittance Statement.

Required information concerning the recipient, the service, charges, and provider shall be submitted in the prescribed format. Records verifying the type of service provided, the signed state approved certification statements and agreements which serve as a contractual basis for payment, and required recipient information or additional documentation which can be matched to the claim for services shall be retained in the provider's file for six years. This documentation shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the State Department, and the Medicaid Fraud Control Unit and their authorized agents.

A. Hard Copy Claims

Hard copy (i.e., paper) claim forms shall be submitted only by authorization of the State Department. The state approved certification statements contained on the claim form become effective and serve as a contractual basis for payment when the provider signs the form.

B. Automated Medical Payments System/Electronic Transfer of Claims

All Medicaid services providers shall be required to transmit claims for services in the approved electronic format to the Medicaid fiscal agent for the State Department. Only those electronic formats which have been approved by the fiscal agent will be accepted for Automated Medical Payments System.

Before a provider can submit claims electronically, either directly to the fiscal agent or through a vendor or billing service, state approved provider certification agreements which contain all state approved certification statements and conditions shall be signed and accepted by both the provider and the State Department. The state approved certification statements become effective and serve as a contractual basis for payment once the provider signs the form. A billing service

shall also have a state approved billing service agreement signed and accepted by the Department before any claims will be accepted. The content of the agreements shall be determined by the Department.

If a provider chooses to submit claims for payment directly to the fiscal agent, source documents and source records used to create the claims shall be maintained in such a way that all electronic media claims can be readily associated and identified. These source documents, in addition to any work papers and records used to create electronic media claims, shall be retained by the provider for six years and shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the State Department, and the Medicaid Fraud Control Unit and their authorized agents.

A corporation composed of satellite facilities with a common ownership may be considered as a primary provider and bill as such even though each individual facility has a provider number. However, the submitted claims shall identify the facility providing the services. Original source documents used to create the claims transmission shall be maintained at the facility for six years.

If a provider utilizes a billing service to transmit claims, the provider shall provide source documents or other data transfer methods necessary to create the electronic claim shall become the source document. The billing service shall retain the source documents for a six year period except when these documents are maintained by the provider. Original source documents shall be made readily available and produced upon request of the Secretary of the Department of Health and Human Services, the State Department, and the Medicaid Fraud Control Unit and their authorized agents. If the provider furnishes the information to the billing service on a computer disc or some other method of electronic transmission, then the source documents used to create the disc or transmission shall be retained by the provider for six years and made readily available and produced upon request.

Upon cessation of business, the billing service shall immediately return all documents to each individual provider.

Upon receipt of the electronic transmission, the fiscal agent will process the claims to the M.M.I.S. If the transmission is rejected, the fiscal agent shall send an electronic acknowledgement of rejection to the sender. Claims denied through the M.M.I.S. shall be described on the Medicaid remittance statement.

Electronic transmission of claims shall be required of any provider or billing service. The Department may cancel any agreement for any violation of its contents. The Department also reserves the right to reject any electronic claims transmission methods.

Failure of the provider or billing service to maintain and certify appropriate records as required by the state approved provider agreements constitutes breach of the state approved provider agreement, and entitles the Department to recover any payments for services made to the provider and to terminate any state approved provider agreement. Thirty day written notice by registered mail shall be used by either party to terminate a state approved provider agreement unless the Department determines that good cause as defined in 8.051.01 exists in which immediate termination is necessary. Recovery may be accomplished by withholding the amount from future payments or requiring the provider to make payments directly to the state as described in 8.040.

Electronically submitted claims must have a certification field indicating that the sender has verified that the claim information transmitted is true and correct. A hard copy of this transmittal will be kept on file at the provider's or billing service's place of business. All claim transmissions which require a state authorized attachment for the purposes of reimbursement or certification of service, will be submitted on hard copy (i.e., paper) and maintained with the providers' original source documents for a period of six years.

8.041 CLAIMS REIMBURSEMENT AND STATUS

A system of electronic remittance statements shall be used by the Medicaid fiscal agent for the State Department to advise all Medicaid providers of claims reimbursement or claims status unless hard copy remittance statements are specifically authorized by the State Department.

8.043 TIMELY FILING REQUIREMENTS

.01 Effective 10/1/93, all claims for services provided to eligible Medicaid recipients must be received by the fiscal agent within 120 days from the date of service or 120 days from the Medicare processing date for all Medicare Crossover claims.

.02 Timely Filing Extensions for Circumstances Beyond the Control of the Provider

A. Delayed Processing by Third Party Resources

Medicaid is always the payer of last resort; however, if the initial timely filing period expires because of delays by the third party insurer in providing third party payment or denial documentation, the claim will be considered timely if it is received within 60 days from the date of the third party payment or denial or within 365 days from the date of service, whichever occurs first. A copy of the third party payment voucher or letter of denial must be attached to the claim form or the claim will be denied.

B. Delayed/Retroactive Recipient Eligibility

If the initial timely filing period expires because of delays by the county in establishing recipient eligibility or because recipient eligibility is back-dated, the claim will be considered timely; if it is received within the applicable initial timely filing period from the date that the recipient appears on the state eligibility files. Each claim must be accompanied by an authorized notification from the county department of social services which verifies the delayed or retroactive eligibility, and states the date when such action was entered on the eligibility system or the claim will be denied.

C. In all other instances, including possible exceptions to 8.043.02, A. and B. above, and 8.043.03 following, where extenuating circumstances beyond the provider's control allegedly existed, such circumstances as might have existed must be thoroughly documented and submitted as a reconsideration to the fiscal agent's Medicaid Exceptions Unit. However, employee negligence in carrying out their duties or employer negligence in making sufficient and well-trained employees available or in properly monitoring contractual employees/agents will not be considered extenuating circumstances beyond the control of the provider.

.03 Rebills/Adjustments/Reconsiderations

Denied and incorrectly paid claims may be resubmitted to the fiscal agent at any time during the initial timely filing period. However, if the initial timely filing period has expired, the fiscal agent must receive the rebill or adjustment/reconsideration request within 60 days from the latest Remittance Statement (RS) run date or the latest other written notification of adverse action. Copies of all Medicaid Remittance Statements and/or other written notifications of adverse action documenting initial and subsequent timely filing within the 60-day limit must be attached to the claim form or the rebill or request for adjustment/reconsideration will be denied.

.04 All original claims, rebills of denied claims, requests for adjustment of incorrectly paid claims, or requests for reconsideration of denied or incorrectly paid claims to the fiscal agent's Medicaid Exceptions Unit must be received by the fiscal agent within the applicable timely filing period;

and, it is the provider's responsibility to ensure that this receipt occurs.

A claim, whether filed for the first time, rebilled, or submitted for adjustment/reconsideration, is considered to be filed when the fiscal agent documents receipt of that claim. Dated claim signatures, certified mail receipts and postmarks, or internal office logs (computerized or manual), for example, shall not constitute filing for the purpose of meeting the timely filing requirements of this manual and the controlling federal regulations. The date of receipt is the date the fiscal agent receives the claim, as indicated by a date stamp, or an imprinted Transaction Control Number assigned by the automated claims processing system - on the claim .

If an original claim, a rebill of a denied claim, a request for adjustment of an incorrectly paid claim, or a request for reconsideration of a denied or incorrectly paid claim to the fiscal agent's Medicaid Exceptions Unit is not acknowledged in written/printed form within thirty (30) days, it is the responsibility of the provider to inquire concerning its status, or resubmit. The weekly Medicaid Remittance Statement shall be proper and sufficient notification of fiscal agent action resulting from any provider request or submittal.

.05 All valid claims must be paid within 12 months from the date of receipt, except in the following circumstances:

- A. This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system; that is, claims that are paid on the basis of a provisional payment rate set prospectively for an accounting period, and in which payments may be retrospectively adjusted on the basis of the cost experience during the accounting period.
- B. If a claim for payment under Medicare has been filed in a timely manner, payment may be made for a Medicaid claim relating to the same services within 6 months of notice of the disposition of the Medicare claim.
- C. The time limitation does not apply to claims from providers under investigation for fraud or abuse.
- D. Payment may be made at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it, including the resolution of an administrative reconsideration or appeal.

8.045.1 PROHIBITION AGAINST PROVIDER REASSIGNMENT OF CLAIMS TO BENEFITS

For purposes of this section, the following definitions shall apply:

- a. "Organized Health Care Delivery System" is a public or private organization for delivering health services. The system may include, but is not limited to, a clinic or a group practice prepaid capitation plan.
- b. "Factor" is an organization; i.e., collection agency or service bureau, which, or an individual who, advances money to a provider for his accounts receivable which the provider has assigned or sold, or otherwise transferred, including transfer through the use of a power of attorney, to this organization or individual. The organization or individual receives an added fee or a deduction of a portion of the face value of the accounts receivable in return for the advanced money. For purposes of this regulation, the term "factor" does not include business representatives, such as billing agents or accounting firms as described within this section.

- .11 No payment under the State Medical Assistance program for any care or services furnished to an eligible individual by a health care provider shall be made to anyone other than that provider, except as specified in this section.
- .12 Payments may be made to other than the provider of service when:
- a. That payment is made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order;
 - b. That payment is made to a business agent (such as a billing service or accounting firm) who renders statements and receives payments in the name of the provider, if the agent's compensation for this service is:
 - (1) Reasonably related to the cost of processing the billings,
 - (2) Not related on a percentage or other basis to the dollar amounts to be billed or collected, and
 - (3) Not dependent upon the actual collection of payment.

With respect to physicians, dentists or other individual practitioners, payment may be made:

- a. To the employer of the physician, dentist, or other practitioner if the practitioner is required as a condition of his employment to turn over his fees to his employer; or
 - b. To a foundation, plan, or similar organization, including a health maintenance organization, which furnishes health care through an organized health care delivery system if there is a contractual arrangement between the organization and the person furnishing the service under which the organization bills or receives payments for such person's services.
- .14 Payment under the Medical Assistance program for any care or service furnished to an eligible individual by a provider shall not be made to or through a factor, either directly, or by virtue of a power of attorney given by the provider to the factor.

8.049 RECONSIDERATION/APPEAL OF ADVERSE ADMINISTRATIVE ACTION

8.049.01 ROLE OF THE FISCAL AGENT

- A. The fiscal agent is authorized by the Colorado Department of Social Services to recognize and apply all applicable State and Federal rules and regulations to process claims to satisfactory claim payment. Adverse administrative action by the fiscal agent through routine fiscal agent operations which results in the reduction or claim denial to a Medicaid provider may be submitted for reconsideration. Providers shall submit rebills and adjustment requests through routine fiscal agent operations until all routine processing procedures have been exhausted.
- B. If satisfactory resolution is not obtained through routine fiscal agent operations, the provider may file a written reconsideration with the fiscal agent's Medicaid Exceptions Unit. The provider must provide documentation essential to review the request for reconsideration. Copies of all Medicaid Remittance Statements (RS) and other written notification of adverse action documenting initial and subsequent timely filing, along with a signed copy of the original claim (including original attachments), and a brief explanation of the nature of the reconsideration must be submitted. The Request for Reconsideration must clearly be identified by attaching a designated Request for Reconsideration form to the claim or by identifying the word "Reconsideration" on the face of the claim form. Requests for reconsideration that do not include a completed claim form will be returned to the provider.

- C. Requests for reconsideration will be reviewed and the result of the review will, upon completion, be reported on the Medicaid Remittance Statement.

8.049.02 FINAL ADMINISTRATIVE APPEAL

Adverse decisions of the fiscal agent's Medicaid Exceptions Unit or decisions made by state Medicaid in exceptional circumstances may be appealed to the Office of Administrative Courts, as set forth in the PROVIDER APPEALS AND HEARING section of this manual.

8.050 PROVIDER APPEALS

8.050.1 DEFINITIONS

Adverse Action means:

1. A finding of fact or interpretation of rules that does not involve a determination of medical necessity but that results in a determination of overpayments, or a reduction in, or denial of, other specific payments under the Medical Assistance program; or
2. The denial, non-renewal or termination of a Provider agreement; or
3. Denial of the application or request for additional information regarding an application pursuant to 10 C.C.R. 2505-10, Section 8.430. Provider means any person, public or private institution, agency, or business concern providing medical or remedial care, services or goods authorized under Medicaid 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. For purposes of these regulations, Provider does not include any person, public or private institution, agency, or business concern with which the Department does business pursuant to a capitated reimbursement contract.

8.050.2 NOTICE OF ADVERSE ACTION

8.050.2.A. A notice of Adverse Action shall be in writing and shall be mailed to the Provider.

8.050.2.B. A notice of Adverse Action regarding a nursing facility's rate determination shall include a description of the method of rate calculation, the recommended or proposed audit adjustments with an explanation of adjustments and the final rate established.

8.050.2.C. A notice of Adverse Action regarding a determination of overpayment(s) following a review or an audit of a provider shall include the offer of an informal reconsideration of the review or audit findings and notice that no recovery of the overpayment will be implemented until such informal reconsideration, if requested, has been completed.

8.050.3 PROVIDER APPEALS

8.050.3.A. A Provider, other than a nursing facility whose notice of Adverse Action is regarding a rate determination, may appeal a notice of Adverse Action by filing a written appeal within thirty (30) days from the date on the Notice of Adverse Action. The appeal shall be filed with the Office of Administrative Courts, Department of Personnel and Administration, 633 Seventeenth Street, Suite 1300, Denver, Colorado 80202.

8.050.3.B. The appeal shall specify the basis upon which the Provider appeals the Adverse Action.

8.050.3.C. The date of filing the appeal shall be the date the Office of Administrative Courts receives the appeal. Failure to file a timely appeal shall result in dismissal of the appeal.

8.050.4 NURSING FACILITY RATE DETERMINATION APPEALS

8.050.4.A. Mandatory Informal Reconsiderations

1. A nursing facility, whose notice of Adverse Action results from its rate determination, may file a written request for informal reconsideration with the Department within 30 days of the date the rate determination letter is mailed. The request shall state, with specificity, the adjustments to the cost report the nursing facility wants reconsidered and the nursing facility's position as to each adjustment.
2. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.
3. When the first rate letter that incorporates a nursing facility's new appraised value is issued, the nursing facility may file a written request with the Department for informal reconsideration of the appraisal within thirty (30) days of the date on the rate letter. Failure to file an informal reconsideration as set forth in this section shall cause any subsequent reconsideration or appeal of the appraisal at issue to be untimely and the reconsideration or appeal shall be dismissed.
4. Failure to file a written request for reconsideration as set forth in this section shall result in a waiver of the right to appeal the Adverse Action. Any issue not presented for informal reconsideration shall not be considered timely filed and shall not be appealable to the Office of Administrative Courts.
5. At informal reconsideration, the Provider shall not be allowed to present any information that was not submitted during the audit process prior to the issuance of the rate determination.

8.050.4.B. The nursing facility may file an appeal with the Office of Administrative Courts of the Department's written decision on the informal reconsideration within thirty (30) days of the date of the written decision. The appeal shall conform to the requirements of Section 8.050.3.

8.050.4.C. Should the Department not issue a written decision on the informal reconsideration within forty-five (45) days of the Department's receipt of the request for informal reconsideration, the nursing facility may file an appeal with the Office of Administrative Courts within thirty (30) days of the 45th day following receipt of the request for informal reconsideration.

8.050.4.D. Notwithstanding the position of the parties, their conduct or statements made during the Informal Reconsideration process, any subsequent appeal initiated by the nursing facility shall be a *de novo* proceeding, and neither the Department nor the nursing facility shall be bound by their positions, conduct or statements. The evidence submitted by the nursing facility and considered at the *de novo* proceeding, shall be limited to that which was submitted during the audit process prior to the issuance of the rate determination being appealed. No new nursing facility information or documentary evidence shall be admissible at the *de novo* proceeding.

8.050.4.E. The administrative law judge (ALJ) shall not under any circumstances alter the appraisal methodology which is described in the most recent Request for Proposal (RFP). This limitation means the RFP defines how the appraisal is to be conducted and the ALJ may not change the RFP's described method. In particular, where the RFP describes which variables or components from the Boeckh program are to be specifically calculated through Boeckh's built-in data, those requirements from the RFP cannot be altered by the ALJ. This limitation on the ALJ's scope of review also means that where the RFP requires physical depreciation to be calculated through the use of the tables published in the Boeckh manual, the ALJ has no authority to consider appeals from providers requesting the use of alternative tables or any other method of calculating

depreciation.

8.050.4.F. The ALJ may alter the findings of fact, judgments and opinions contained in the appraisal report (e.g. measurements, decisions regarding the depreciation components of effective age and building condition).

8.050.5 EXEMPTIONS FROM MANDATORY INFORMAL RECONSIDERATION IN NURSING FACILITY RATE DETERMINATION APPEALS

8.050.5.A. The following nursing facility rate issues are exempt from mandatory informal reconsideration.

1. In the case of Class I and Class II nursing facilities or private for-profit or non-profit nursing facility Class IV Providers, the nursing facility's right to appeal shall commence on the mailing date of the rate letter setting a rate based on the maximum reasonable cost calculation or on the date the facility array and other data used by the Department in its determination of the maximum reasonable rate is made available to Providers. This appeal period shall then expire thirty (30) days after the commencement date.
2. In the case of state-administered Class IV intermediate nursing care facilities for the mentally retarded which are not subject to maximum reasonable cost calculations, the nursing facility's right to appeal shall commence on the mailing date of the nursing facility's rate letter setting the final rate based on the facility's actual allowable audited costs as reported on the form MED-13. Such appeal period shall then expire thirty (30) days after the commencement date. The Office of Administrative Courts shall not conduct the appeal hearing. The appeal process shall be resolved by both agencies presenting their position to the Governor's office. The Governor's decision shall be binding on both agencies.
3. An appeal from the imposition of a civil money penalty or the denial of a Medicaid payment for a Medicaid-only certified nursing facility's failure to meet federal requirements for participation in Medicaid, shall follow the formal appeal process set forth in 10 C.C.R. 2505-10, Section 8.050.3. The penalty shall not be enforced or collected until the Department sends a certified letter to the Provider explaining the penalty or the denial of payment. In cases where the Provider appeals the penalty, collection of the penalty shall be suspended until the administrative law judge adjudicates the appeal.

8.050.6 INFORMAL RECONSIDERATIONS IN APPEALS OF OVERPAYMENTS RESULTING FROM REVIEW OR AUDIT FINDINGS

8.050.6.A. A Provider whose notice of Adverse Action results from a determination of overpayment(s), may file a written request for informal reconsideration with the Department within thirty (30) days of the date of the notice of Adverse Action. The request shall state the specific overpayments the Provider wants reconsidered and the Provider's position as to each overpayment.

8.050.6.B. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.

8.050.6.C. The Provider may file an appeal with the Office of Administrative Courts of the Department's written decision on the informal reconsideration within thirty (30) days of the date of the written decision. The appeal shall conform to the requirements of Section 8.050.3.

8.050.6.D. Should the Department not issue a written decision on the informal reconsideration within forty-five (45) days of the Department's receipt of the request for informal reconsideration, the Provider may file an appeal with the Office of Administrative Courts within thirty (30) days of the 45th day following receipt of the request for informal reconsideration.

8.050.6.E. Notwithstanding the position of the parties, their conduct or statements made during the Informal Reconsideration process, any subsequent appeal initiated by the Provider shall be a de novo proceeding, and neither the Department nor the Provider shall be bound by their positions, conduct or statements.

8.050.7 STAY

If an appeal is timely filed, upon motion of the Provider, the administrative law judge may stay the effective date of the adverse action until final agency action.

8.050.8 CONDUCT OF HEARINGS

8.050.8.A. Except as otherwise specifically provided in these rules, the provisions of Section 24-4-105, C.R.S., as amended, shall apply to the conduct of fair hearings.

8.050.8.B. For nursing home appeals regarding appraisals, the administrative law judge shall not, under any circumstance, alter the appraisal methodology from the most recent RFP but may alter the finding of fact, judgments and opinions contained in the appraisal report.

8.057 RECIPIENT APPEALS

8.057.1 DEFINITIONS

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

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

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

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

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

1. A statement of what action the Department or its designee intends to take;
2. The reasons for the intended action;
3. The specific regulations that support, or the change in federal or state law that requires the action;
4. An explanation of
 - a. The individual's right to request an evidentiary hearing if one is available; or
 - b. In cases of an action based on a change in law, the circumstances under which a hearing will

be granted.

5. The method by which the individual may obtain a hearing;
6. That the individual may represent himself/herself or use legal counsel, a relative, a friend, or other spokesman at the hearing; and
7. An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

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

1. The reason for transfer or discharge;
2. The effective date of the transfer or discharge;
3. The location to which the resident is transferred or discharged;
4. The name, address and telephone number of the State long term care ombudsman;
5. For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and
6. For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

Request for a hearing means a clear expression by the applicant or recipient, or his/her authorized representative that he/she wants an opportunity to present his/her case to a reviewing authority.

8.057.2 ADVANCE NOTICE

8.057.2.A. Notice shall be mailed at least 10 calendar days before the date of the intended action except as permitted in 8.057.2.B and 8.057.2.C. Requirements for the timing of notice before the facility can transfer or discharge a resident shall be governed by 8.057.2.D and 8.057.2.E.

8.057.2.B. Notice for any action other than when a nursing facility seeks to transfer or discharge a resident, may be mailed less than 10 calendar days before the date of the intended action if:

1. The Department or its designee has factual information confirming the death of a recipient;
2. The Department or its designee receives a clear written statement signed by a recipient that
 - a. The recipient no longer wishes services; or
 - b. The recipient gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information;
 - c. The recipient has been admitted to an institution where he/she is ineligible for further services;
 - d. The recipient's whereabouts are unknown and the post office return agency mail

directed to him/her indicating no forwarding address;

- e. The recipient has been accepted for Medicaid services by another State, territory or commonwealth;
- f. A change in the level of medical care is prescribed by the recipient's physician; or
- g. The notice involves an adverse determination made with regard to the preadmission screening and annual resident review requirements.

8.057.2.C. Notice for any action other than when a nursing facility seeks to transfer or discharge a resident, shall be sent 5 calendar days before the date of the action if:

- 1. The Department or its designee has facts indicating that action should be taken because of probably fraud by the recipient; and
- 2. The facts have been verified, if possible, through secondary sources.

8.057.2.D. Except as specified in 8.057.2.E, the required notice when a nursing facility seeks to transfer or discharge a resident shall be at least 30 calendar days before the resident is transferred or discharged.

8.057.2.E. The required notice by a nursing facility before transfer or discharge shall be as soon as practicable when:

- 1. The safety of individuals in the facility would be endangered;
- 2. The health of individuals in the facility would be endangered;
- 3. The resident's health improves sufficiently to allow a more immediate transfer or discharge because the resident no longer needs the services provided by the facility;
- 4. An immediate transfer or discharge is required by the resident's urgent medical needs; or
- 5. A resident has not resided in the facility for 30 calendar days.

8.057.3 OPPORTUNITY FOR HEARING

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

- 1. An application for services is denied or is not acted upon with reasonable promptness;
- 2. The recipient requesting the hearing believes the action is erroneous;
- 3. The resident of a nursing facility believes the facility has erroneously determined that he/she must be discharged; and
- 4. An individual who believes the determination with regard to the preadmission and annual resident review requirements is erroneous.

8.057.3.B. An individual does not have the right to an opportunity for hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients.

8.057.3.C. An individual does not have the right to an opportunity for hearing for a preadmission screening and annual resident review Level I Screen finding.

8.057.3.D. A provider of medical assistance or any other provider of goods and services to an applicant or recipient, shall not have the right to a hearing concerning an action or an adverse determination to an applicant or recipient.

8.057.4 REQUEST FOR HEARING

8.057.4.A. The request for a hearing shall be in writing and contain:

1. The recipient or applicant's name, address and State Identification Number, if applicable;
2. The action, denial or failure to act promptly on which the requested appeal is based; and
3. The reason for appealing the action, denial or failure to act promptly.

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

1. Within 30 calendar days of the date of the notice of action if the action concerns Medicaid eligibility; or
2. Within 20 calendar days of the date of the notice of action if the action is not related to Medicaid eligibility.

8.057.4.C. The recipient or applicant or his/her authorized representative shall be entitled to examine the complete case file and any other documents to be used at hearing at a reasonable time before the hearing or during the hearing. Documents and information that are confidential as a matter of law shall be exempt from this requirement unless they are to be offered as evidence during the hearing.

8.057.4.D. If the recipient or applicant makes an oral request for a hearing to the Department or its designee, the Department or its designee shall prepare a written request for the individual's signature or have the individual prepare such a request.

8.057.5 MAINTAINING SERVICES

8.057.5.A. Where the recipient requests a hearing before the date of action, the recipient's services may not be terminated or reduced until a final agency decision is rendered after the hearing unless:

1. It is determined at the hearing that the sole issue is one of federal or state law or policy; and
2. The recipient is promptly informed that services are to be terminated or reduced pending the hearing decision.

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

8.057.5.C. Continued Benefits During an SSA Appeal. If an individual receiving Medicaid based upon disability is determined by SSA not to be disabled, and he or she is not eligible for Medicaid on some other basis, Medicaid is continued during the 60-day period within which an SSA appeal may be filed. If the individual does not appeal the SSA decision within the 60-day period, Medicaid shall be terminated.

If an SSA hearing is requested within the 60-day period, Medicaid may not be terminated until a final decision is made after the SSA hearing. A final administrative decision occurs when the

Medicaid recipient has no right to further administrative appeal with the SSA. The Department shall provide 10-days notice to the individual that Medicaid shall be terminated after the 60-day period if the individual fails to appeal the SSA decision.

8.057.6 DENIAL OR DISMISSAL OF REQUEST FOR HEARING

8.057.6.A. The request for hearing shall be denied or dismissed if:

1. The applicant or recipient withdraws the request in writing; or
2. The applicant or recipient fails to appear at a scheduled hearing without good cause. Good cause shall mean a sudden severe illness, an accident, or other particular occurrence which, by its emergent nature and drastic effect, prevented appearance at the hearing.

8.057.6.B. The applicant or recipient shall have 10 calendar days from the date of the notice of dismissal scheduled hearing to explain, in a letter to the Administrative Law Judge, the reason for his/her failure to appear. If the Administrative Law Judge finds that there was good cause for the nonappearance, the Administrative Law Judge shall schedule another hearing date.

8.057.7 FAIR HEARINGS

8.057.7.A. A hearing shall cover:

1. Action, denial or failure to act with reasonable promptness regarding eligibility or services;
2. Decisions regarding changes in the type or amount of services;
3. Decision by a nursing facility to transfer or discharge a resident; and
4. Determination with regard to the preadmission screening and annual resident review requirements.

8.057.7.B. Conference telephone hearings may be conducted as an alternative to face-to-face hearings. All applicable provisions of the face-to-face hearing shall apply to telephone hearings.

8.057.7.C. Upon receipt of notice of a Department hearing of an appeal, the county department shall arrange for a suitable hearing room appropriate to accommodate the number of persons, including witnesses, who are expected to be in attendance.

8.057.7.D. Except as otherwise specifically provided in these rules, the provisions of Section 24-4-105, C.R.S., as amended, shall apply to the conduct of fair hearings.

8.057.7.E. Hearings related to an applicant or recipient's disability determination, level of care determination or target group eligibility shall be held within 20 calendar days after the Office of Administrative Courts receives the request for a fair hearing unless the client demonstrates good cause for postponement of the hearing. Under no circumstances shall the hearing be conducted more than 45 calendar days after receipt of the request for a fair hearing.

8.057.7.F. In hearings related to an applicant or recipient's disability determination, where the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report or a medical review team's decision, the Administrative Law Judge may order a medical assessment other than that in the record of the Department or its designee making the disability determination if the Administrative Law Judge considers such medical assessment necessary. The assessment shall be at the expense of the Department or its designee and shall be made part of the record.

8.057.7.G. The hearing shall be private unless the applicant or recipient requests, on the record, that the hearing be open to the public.

8.057.7.H. If the appellant is not fluent in English or has a language difficulty, the Department will arrange with county assistance to have present at the hearing a qualified interpreter who will be sworn to translate correctly.

8.057.8 INITIAL DECISIONS

8.057.8.A. The Administrative Law Judge shall promptly prepare and issue a written Initial Decision and file it with the Office of Appeals of the Department. Initial decisions shall be based exclusively on evidence introduced at the hearing.

8.057.8.B. The Administrative Law Judge shall issue the Initial Decision following a disability determination hearing, a level of care denial hearing or a target group eligibility hearing within 20 calendar days of the hearing date.

8.057.8.C. The Initial Decision shall be in writing and shall:

1. Summarize the facts;
2. Identify the regulations and evidence supporting the decision;
3. Advise the applicant or recipient that failure to file exceptions to the provisions of the Initial Decision shall waive the right to seek judicial review of a final agency decision affirming those provisions.

8.057.8.D. The Administrative Law Judge shall be bound by the Department's interpretation of statutes where the Department has regulations implementing such statutes.

8.057.8.E. The Administrative Law Judge shall have no jurisdiction or authority to determine issues of constitutionality or legality of the Department's regulations.

8.057.8.F. In hearings concerning disability determinations, the only factual issue to be determined by the Administrative Law Judge is whether the applicant or recipient meets the Medicaid definition of disability or blindness set forth in sections 8.110.32 and 8.110.33. The Administrative Law Judge's determination shall be limited to whether or not the applicant or recipient met the definition of disability or blindness on the date that the disability determination was completed.

8.057.8.G. In hearings concerning level of care determinations, the only factual issue to be determined by the Administrative Law Judge is whether the applicant or recipient meets the level of care screen applicable to the program at issue. The Administrative Law Judge's determination shall be limited to whether or not the applicant or recipient met the level of care on the date that the level of care determination was completed.

8.057.9 REVIEW BY THE OFFICE OF APPEALS

8.057.9.A. The Department's Office of Appeals shall promptly serve the Initial Decision upon each party to the fair hearing by first class mail. Party shall include the Department even if the Department has not previously appeared as a party to the appeal.

8.057.9.B. Any party seeking to reverse, modify or remand the Initial Decision shall file exceptions with the Office of Appeals within 15 calendar days, plus 3 calendar days for mailing, of the date the Initial Decision is mailed to the parties.

8.057.9.C. Exceptions to Initial Decisions shall be in writing and shall state the specific grounds for reversal, modification or remand of the Initial Decision.

8.057.9.D. A transcript or a copy of the hearing tape is required where the party filing the exceptions asserts that the findings of fact in the Initial Decision are not supported by the weight of the evidence.

1. The party requiring a transcript or a copy of the hearing tape shall request the transcript or tape from the Office of Administrative Courts prior to the filing of exceptions or with the exceptions. The exceptions shall state that a transcript or tape has been requested.
2. The party requesting a transcript or copy of the hearing tape shall advance the cost therefor to the Office of Administrative Courts within 5 calendar days of the request.
3. While review of the initial decision is pending, the transcript or a copy of the hearing tape shall be available for examination by any party to the appeal, during regular business hours of the Office of Appeal.

8.057.9.E. The Office of Appeals shall promptly serve a copy of the exceptions on each party by first class mail. Each party may file a written response to an exception filed by another party within 10 calendar days from the date the exceptions were mailed to the parties.

8.057.9.F. The parties shall not have the right to oral argument to the Office of Appeals.

8.057.10 FINAL AGENCY DECISIONS

8.057.10.A. The Final Agency Decision shall be based on the record except that the Office of Appeals may remand for rehearing if a party establishes in its exceptions that material evidence has been discovered which the party could not, with reasonable diligence, have produced at the hearing.

8.057.10.B. The record shall consist only of:

1. The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
2. All papers and requests filed in the proceeding;
3. The initial decision of the administrative law judge; and
4. Any exceptions and requests filed in response to the initial decision of the administrative law judge.

8.057.10.C. The applicant or recipient shall have access to the record at a convenient place and time.

8.057.10.D. The Office of Appeals shall issue a Final Agency Decision within 90 calendar days from the date the request for a hearing is received unless an extension has been granted to the applicant or recipient in which case the 90 calendar day period shall be increased accordingly.

8.057.11 NOTIFICATION OF DECISION

8.057.11.A. The applicant or recipient shall be provided, in writing, with:

1. A copy of the Final Agency Decision; and
2. Notification of his/her right to seek judicial review and the effective date of the Final Agency

Decision for purposes of requesting judicial review.

8.057.11.B. For purposes of requesting judicial review, the effective date of the Final Agency Decision shall be the third day after the date the decision is mailed to the parties, even if the third day falls on Saturday, Sunday or a legal holiday.

8.057.12 CORRECTIVE ACTION

8.057.12.A. If the Final Agency Decision is favorable to the applicant or recipient, corrective action shall be taken, within three working days after the effective date of the Final Agency Decision, retroactive to the date the incorrect action was taken.

8.057.13 RECONSIDERATION OF FINAL AGENCY DECISION

8.057.13.A. A party may file a motion for reconsideration of a Final Agency Decision with the Office of Appeals:

1. Upon a showing of good cause for failure to file exceptions to the Initial Decision within the allowed 15 calendar day period; or
2. Upon a showing that the Final Agency Decision is based upon a clear or plain error of fact or law.

8.057.13.B. The motion for reconsideration shall be filed, in writing, with the Office of Appeals within 15 calendar days of the date that the Final Agency Decision is mailed to the parties. The motion shall state the specific grounds for reconsideration.

8.057.13.C. The Office of Appeals shall promptly serve a copy of the motion for reconsideration on each party by first class mail. Each party may file a written response to a motion for reconsideration filed by another party within 10 calendar days from the date the motion was mailed to the parties.

8.057.13.D. The Office of Appeals shall promptly serve a copy of its decision on the motion for reconsideration on all parties by first class mail.

8.057.14 INFORMAL CLIENT CONFERENCE IN DISABILITY DETERMINATIONS

8.057.14.A. Prior to the issuance of an action regarding an applicant or recipient's disability determination, the Department or the entity designated to conduct the disability determination shall provide the applicant or recipient with the opportunity for an informal conference, in person or by telephone, at which time the applicant or recipient may provide new or additional information relevant to the applicant or recipient's claim of disability or blindness.

8.057.14.B. If an action issues from the Department or the designated entity, the appeal procedures set forth in 8.057, Recipient Appeals, shall apply to disability determinations.

8.057.15 ALTERNATIVES TO INSTITUTIONAL CARE

8.057.15.A Recipients who are determined to be likely to require a level of care available in an institution shall have the right to request a hearing where:

1. The recipient is not given the choice of home and community-based services as an alternative to the institutional care or
2. The recipient is denied the service of their choice or available provider of their choice.

8.058 REQUEST FOR PRIOR AUTHORIZATION

- 8.058.1 Certain services, supplies, equipment, and drug items are available as a benefit of the Medical Assistance program only with prior authorization from the Department or its designee. With respect to benefits not specifically dealt with elsewhere in the Volume VIII staff manual, prior authorization shall be requested by submission of a Request for Prior Authorization form, or in the case of dental services, submission of a Dental Claim form.
- 8.058.2 Upon receipt of a request for prior authorization which is inadequate or incomplete, the Department or its designee shall contact the requesting provider by phone or mail, as appropriate, within 10 working days to request the missing information.
- 8.058.3 Based upon medical information included on the appropriate request form, the Department or its designee shall approve or deny all requests for prior authorization within 10 working days following receipt of a complete and adequate request.
- 8.058.4 The provision of care, drugs, services, or equipment during an emergency situation is exempt from the regular prior authorization system. In such cases, benefits which would have been authorized in the absence of the emergency may be authorized retroactively. An emergency is defined as any condition in which care, drugs, services, or equipment must be immediately dispensed due to a life threatening condition or a condition requiring immediate medical intervention. The treating physician shall determine the existence of an emergency, and shall reduce the request to writing, including a description of the emergency. Such description shall serve as justification of the emergency benefits, and shall be submitted with a Form 10013 within 60 days following the emergency situation. The Department shall review the emergency request in order to determine the need for continuing or ongoing benefits arising from the emergency.

ADVANCE NOTICE OF ADVERSE ACTION CONCERNING MEDICAID BENEFITS

SI NO ENTIENDE ESTA NOTICIA, LLAME POR
TELÉFONO EL DEPARTAMENTO DEL CONDADO

IF YOU DO NOT UNDERSTAND THIS NOTICE, CALL
YOUR COUNTY DEPARTMENT OF SOCIAL SERVICES

CASE NUMBER			CATG	
CNTY	BASIC	SUF		

- I. The State Department of Social Services has determined from its records that it must reduce your Medicaid Benefits, or that it must suspend certain benefits, or that you are restricted to receiving certain benefits, or that you are to be locked in to particular providers. The proposed action, the reasons therefore and the applicable rules are as follows:

- a. The proposed action is to:

SUSPEND CERTAIN BENEFITS	REDUCE BENEFITS	RESTRICTED TO PROVIDERS	LOCKED IN TO PROVIDERS	OTHER

- b. The reasons and rules which apply are:

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- II. If the State took an action which you think wrongs you and which involved interpretation of the law or the rules as applied in your particular situation, you have the right to a hearing before the State department of Administration to contest this decision. The hearing place, date, and time will be set by the Hearing Officer. You will be notified directly by the Hearing Officer in writing where and when the hearing shall be. You may be able to get an extension of this scheduled hearing date by calling the Hearing Officer. Your call or written request for extension, questions, request for further information, or other communication with State Staff or the Hearing Officer about this proposed action must be received two days before the proposed effective action date listed in Section I-B.

If you disagree with the above-described proposed action and want to appeal, i.e., have a State hearing, you must request a hearing in writing. If you want to do this, you must get your request in the mail not later than 15 days from the date shown in Part V of this form. If you do not come to the State hearing on the date and time set by the Hearing Officer, you will be considered as having abandoned the State level appeal, and the proposed action will be taken by the State department.

- III. If you wish to have a hearing, you have the right to appear personally to examine papers and documents to give additional facts or information, to confront, challenge, and cross-examine the people who made the decision, and to bring a lawyer or any other person you choose to represent you.

STATE DEPARTMENT STAFF SIGNATURE	TELEPHONE NO.	SIGNATURE OF IMMEDIATE SUPERVISOR

- V. I certify that I have mailed this form as above completed to the above named individual by deposit of the same in the United States mail, postage prepaid, on the date shown.

SIGNATURE OF PERSON RECEIVING NOTICE	DATE RECEIVED

EXPLANATION OF PRIOR NOTICE PROCEDURE, APPEAL PROCESS, AND RIGHTS

The following is an explanation of the notice appearing on the other side of this form, the procedure which it initiates, and your rights of appeal. Generally, you are given one chance to appeal to the State. The State can not make the change it tells you about until the end of the prior notice period. The material below talks about these and other rights you have.

- 1. Prior Notice** When the State department determines that it must take an action which adversely affects your Medicaid benefits, the State is required to provide an advance notice of such intended action to you at least 15 days before the date that it would become effective (which is "the prior notice period"). The notice must tell you what the State intends to do, why the action appears necessary, and the Department of Social Services' rule, or rules, which appear to be applicable and on which the intended action is based. This gives you time to receive the mailed notice, get further explanation from the State (or for you to provide additional information), to decide whether to go to the State hearing, and if so, to prepare for that hearing.

- 2. State Appeals** After you get the prior notice, and if you disagree with the intended action and want to appeal, you must write to say that you want to appeal. This contact must be made within 16 days of the date this form was mailed to you as shown in Part V on the other side of this form.

All State evidentiary hearings are reserved and scheduled by the Hearing Officer. When there is good reason for a person not to be able to get to the hearing on the reserved day, an extension can be given, but you will have to call the Hearing Officer within the 15-day prior notice period to get this extension. If you do not come to the State hearing on the reserved day or get an extension, the conclusion is made that this hearing right is given up and the State will carry out its intended action. The State hearing is run by an individual who is not involved in your case and is required to be impartial. That person will make the decision as to whether the State-intended action is right or wrong. If it is determined to be wrong, the action intended will not be carried out. If the intended action is determined by the State Hearing Officer to be correct, the action will be carried out.

When you want to appeal something which is not covered in the notice process, you must start that appeal (get your request in the mail) not later than 15 days from the date the improper action took place.

The State department is required to give you full and complete explanations of actions it takes, so it is suggested that you get a full understanding from them as to what the action is before you file an appeal. However, the right to appeal is yours in any case.

If you want to start a State appeal, you should write a letter to:

Colorado Department of Social Services
Division of Hearing Officers
1525 Sherman Street, Room 207
Denver, Colorado 80203

Say in that letter that you want to appeal and why. If you need help to do this, you can ask anyone you desire to help you, or talk to a Legal Aid Office, or ask your County or State Social Services people to help you.

When such an appeal is received, you will get a letter from them explaining what will be done and the date, etc., for the appeal hearing. They also will tell you about who can come with you, present testimony, and other details about an appeal hearing.

You should be aware that the State and County are required to attempt collection or get repayment of all benefits provided you for which you are not entitled.

- 3. Interim Relief** At any time during the appeal process concerning a suspension, reduction, or lock-in of benefits, you may request interim relief, i.e., that the action described upon the other side of this form be postponed until the appeal process is completed. If it can be shown that irreparable damage will occur if the action is completed, interim relief will be granted. Requests for interim relief should be directed to the Division of Hearing Officers at the address given above and should be accompanied by an appropriate statement regarding potential harm.

- 4. Judicial Review** If you disagree with the decision from the State appeal, you have the right to apply for Judicial Review in the appropriate State District Court. Such requests for Judicial Review must be filed in accordance with the rules of civil procedure for Courts of Record in Colorado and must be filed within thirty days after the appeal decision becomes effective.

- 5. Discrimination** If you believe that you have been discriminated against because of race, color, religion, sex, handicap, national origin, age, or political beliefs, you have a right to file a complaint with:

Colorado Department of Social Services or:
Complaints Section
1575 Sherman Street
Denver, Colorado 80203

The Secretary of Health and Human Services
330 Independence Avenue, S.W.
Washington, D.C. 20201

8.061 USE OF OTHER RESOURCES IN THE PROVISION OF MEDICAL ASSISTANCE BENEFITS

- .1 Individuals are expected to utilize, to the extent possible, all those resources which are available to them through Social Security, Medicare or other private or public medical care programs which provide benefits to such individuals.
- .2 Benefits provided under the Medical Assistance Program (Medicaid) will not duplicate those available

to the client from private insurance policies. (See Section 26-4- 106(4), C.R.S.)

- .3 Clients who are eligible for medical care or benefits through the Veterans Administration. Military Dependency (CHAMPUS), United States Public Health Service, or other health programs are expected to make maximum use of these services before Medical Assistance benefits are utilized.
- .4 If a client has primary health coverage through a third party (i.e., a commercial or individual policy, an HMO, PPO, automobile or worker's compensation policy), the client must utilize that primary third party coverage prior to utilizing Medicaid services.
- .5 If a client fails to comply with the primary health coverage requirements (including not using the primary coverage's provider network, not obtaining a referral or other cost containment provisions), the client will be liable to the provider for the health services and Medicaid will not be liable.
- .6 If a provider knowingly provides health services to a Medicaid client who is not enrolled into a client's primary health coverage, neither the client nor Medicaid will be liable for the costs of services.
- .7 If written or oral communication regarding the health coverage requirements is not provided to the client by the liable third party or the provider of service, then the client will not be liable for the service. The client will only be liable if written documentation exists that the client was provided with instructions regarding the plan requirements. The client will not be liable to the provider for the cost of health services if the client is unable to comply with the requirements of the primary health coverage due to an emergency medical condition. (See Section 26-4-403(1)(III)(A).
- .8 Emergency medical condition means the sudden, and at the time, unexpected onset of a health condition that required immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Benefits cannot be denied for conditions which a prudent lay person would perceive as emergency medical conditions as specified by the Division of Insurance Regulation 4-2-17, Section 6.G. (Vol. 8. Sec. 8.205 C.).
- .9 A client may enter into an agreement with a third party or provider whereby the client agrees to be personally liable for payment of services not covered by the third party or Medicaid. This agreement must set forth the specific services provided by the third party or provider, the approximate cost of services provided and the method of payment by the client. The agreement must be signed and dated by both the client and the third party or provider in advance of the services being rendered. (See Section 26-4-403 (1)(III)(B).
- .10 A client who becomes liable for medical services under this rule has the right to the formal adjudication process described at Section 8.058 of this staff manual, also known as the Fair Hearing process at which an Administrative Law Judge (ALJ) presides. An appeal to the ALJ shall be in writing.

8.061.2 RESPONSIBILITY FOR SECURING MEDICAL RESOURCE INFORMATION

- .21 The county department is required to secure information concerning the health insurance or other medical coverage of an individual at the time that individual applies or is predetermined eligible for public assistance. Such information relates to the name(s) and State ID. number(s) of the individual(s) covered by the medical coverage, the name of the insurance company, policy number, policy holder, the effective dates of the policy coverage, the address where the medical claim forms must be submitted, and any other information determined necessary for third party liability purposes. This information is to be entered on the State prescribed Client Health Resource Information Form (MS-10). The completed form will be given to the State Department

(or its fiscal agent). The information so supplied will be entered into a computerized file and will serve as the basis for claims payment or denial.

- .22 The county must enter the required medical resource code for a client on either the AP-800 Financial and Medical Eligibility Reporting Form, PCS 100 or FCS 700, Family and Children Services/Child Welfare Medical Forms. This medical resource indicator will be available on the eligibility verification. Medical providers will be required to bill the resource listed (if applicable) before submitting the claim to the Medical Assistance Program for payment.
- .23 The individual providers, e.g., hospitals, physicians, home health agencies, etc., are required to make inquiry regarding other medical resources a client has at the time medical services are furnished. If the eligibility verification indicates that a resource appropriate to the medical service provided exists, that resource must pay or deny the claim before the Medical Assistance Program can be billed. It is the responsibility of providers to obtain any necessary assignment of benefits from the client.

8.061.3 RIGHT OF RECOVERY IN THIRD PARTY LIABILITY CASES

Section 26-4-403(3), as amended, establishes the State Department's right to recover the cost of medical care provided to an eligible Medicaid client when a third party is liable.

- .31 Examples of situations in which third party may be liable are: work-related injury covered by worker's compensation, automobile accidents, accident or personal injury claims.
- .32. County department staff shall report any and all possible cases of this type involving a Medicaid client to the State Department. Specific information regarding the case should be provided whenever known. This includes date and nature of the accident, injuries sustained, name and address of potentially liable third party, name and address of client's attorney.

8.061.40 AGREEMENTS AND PROCEDURES UTILIZING OTHER AGENCY - RESOURCES

The State Department of Health Care Policy & Financing has working agreements with various agencies which provide medical care under other programs to individuals. To the extent possible, Medical Assistance Program benefits are to be coordinated with the activities and efforts made by other agencies. This includes details on how referrals are made and utilization of other agency benefits, etc.

8.062 SOCIAL SECURITY MEDICARE BENEFITS

8.062.10 SOCIAL SECURITY "MEDICARE" HOSPITAL INSURANCE BENEFITS (HIB) (PART "A")

- .11 Individuals who receive financial benefits under OASDI or Railroad Retirement and are 65 years of age and over are automatically enrolled for HIB. All other persons must complete an application form for HIB.
- .12 Certain of the benefits provided under HIB have deductible provisions, co-insurance, or both. The State Department shall reimburse deductible and cost sharing amounts for skilled nursing homes at the Medicare or Medicaid maximum allowable reimbursement limits, whichever is the lesser. The State Department's reimbursement for hospital inpatient and hospital outpatient deductible and cost sharing shall not exceed Medicare reimbursement to the hospital.

8.062.20 SOCIAL SECURITY "MEDICARE" SUPPLEMENTARY MEDICAL INSURANCE BENEFITS (SMIB) (PART "B")

- .21 The State Department shall pay the monthly SMIB premium for all recipients of the Medical Assistance Program who are found eligible for participation by Social Security. These eligibles

include:

- A. People 65 and over who have Medicare Part "A".
- B. All other people 65 and over who are U.S. citizens, or aliens lawfully admitted to the U.S. and residing here for at least five years.
- C. People under 65 who have been receiving monthly Social Security disability benefits under Title II for 24 months.
- D. People under 65 who are eligible for Medicare Part "A" because they have chronic renal disease.

In addition to the charge for premium payment, individuals who have SMIB coverage are charged a yearly deductible, plus 20% of the Medicare maximum allowable reimbursement for services. The state department shall reimburse the deductible and cost sharing amounts for non-institutional services up to the Medicare or Medicaid maximum allowable limit, whichever is lower.

- .22 The county department is responsible for notification to the State Department, using the appropriate "Notice of Action" form, of individuals who are newly eligible or no longer eligible, and who are covered under SMIB.

8.062.30 METHOD OF ADMINISTRATION

Administrative arrangements have been made between the State Department and the Medicare fiscal intermediaries for payment of the deductibles and co-insurance payments to vendors.

8.062.40 REFUSAL TO APPLY FOR TITLE XVIII BENEFITS

In some instances, an individual who refuses to sign a Medicare Application can be determined to be incompetent and an application can be signed in his behalf by another person. The following is in accordance with a guidance statement from the Social Security Administration for such cases:

If a recipient is incompetent, the application for Medicare benefits (Form SSA-18) can be signed by someone else in his behalf. Such person can be the recipient's legal guardian, a relative, an interested friend, an authorized official of an institution where the individual may reside, or an authorized official of the county department (such as the director, a supervisor, or a caseworker, etc.). Where such an application is made for Medicare benefits only (as opposed to monthly money payments for Social Security Retirement or Survivor's benefits, etc.), there does not necessarily have to be a physician's statement concerning incompetency. The person making such an application must, however, enter a statement on the form, describing the recipient's condition to the extent necessary to leave no reasonable doubt regarding such condition. Only where doubt exists as to incompetency, need a doctor's statement be attached as to the person's incompetency for Medicare application.

8.062.50 USE OF CERTIFIED FACILITIES

When a recipient is hospitalized in a licensed hospital or utilized a licensed facility which is not certified, or accredited, as a participant in the Title XVIII Medicare Program, benefits under Title XVIII are unavailable for the care of the recipient. In such situation, the Medical Assistance Program will provide the recipient with emergency services only.

Whenever feasible, the county department shall encourage recipients to utilize certified facilities.

8.063 MEDICAL ASSISTANCE ESTATE RECOVERY

- .11 The state department may seek to recover medical assistance expenditures correctly paid from the estate of a deceased person who:
- A. was 55 years of age or older at the time he/she received medical assistance: or
 - B. was institutionalized at the time he/she received medical assistance; and
 - C. where recovery is cost-effective.
- .12 The term "cost effective" means that the amount of medical assistance expenditures likely to be recovered is greater than the likely cost to the state of the recovery.
- .13 The state department may file a lien on the real property of an institutionalized person for the amount of medical assistance correctly paid on behalf of the person, only if:
- A. the department determines that the medical assistance recipient cannot reasonably be expected to be discharged from the institution and to return home; and
 - B. there is no spouse of the recipient lawfully residing in the home; and
 - C. there is no child of the recipient under age 21 or blind or disabled dependent of the recipient lawfully residing in the home; and
 - D. there is no sibling of the recipient who has an equity interest in the home and who was lawfully residing in the home for at least one year immediately prior to the date the recipient was admitted to the institution; and
 - E. later recovery from the estate is likely to be cost-effective.

Medical assistance payments made on behalf of an institutionalized recipient during the time that all lien criteria are not met will be subject to a lien at such time that all lien criteria are met.

- .14 The state department shall determine whether a medical assistance recipient reasonably can be expected to be discharged from the institution and to return home. This determination shall be made by the Utilization Review Contractor after notice and opportunity for a hearing. The determination that the recipient is not likely to return home will be used to decide if a lien will be filed. This determination will not change an exempt home into a countable resource for eligibility purposes.

The notice to the recipient shall include the following:

- A. A statement of the action that the Utilization Review Contractor intends to take, the reasons for the intended action, and the specific regulations that support the action.
- B. An explanation of the term "lien", and that imposing a lien does not mean that the individual will lose ownership of the home.
- C. A statement that the determination will not result in a loss of eligibility for medical assistance benefits.
- D. The process by which a recipient may request a hearing to appeal the decision of the Utilization Review Contractor.

The decision may be appealed through the procedures in the RECIPIENT APPEALS PROTOCOLS/PROCESS Section of this staff manual.

The state department shall dissolve any lien on a recipient's home if the recipient is discharged from the institution and returns to the home subject to the lien.

- .15 The state department shall not recover medical assistance expenditures correctly paid from the estate of a medical assistance recipient if:
 - A. There is a surviving spouse of the recipient; or
 - B. There is a child of the recipient under age 21 or a blind or disabled dependent of the recipient.
- 8.063.16 In addition to the prohibitions of 8.063.15, the state department shall not recover medical assistance expenditures correctly paid from the sale of the recipient's home, whether or not the home was subject to a lien, if:
 - A. there is a sibling of the recipient who was lawfully residing in the home for at least one year immediately prior to the date the recipient was admitted to the institution and who has continuously lived in the home since that date; or
 - B. there is a son or daughter of the recipient who was lawfully residing in the home for at least two years immediately prior to the date the recipient was admitted to the institution and who has continuously lived in the home since that date, and who provided care to the recipient which permitted the recipient to reside at home rather than in an institution.

If either of the two conditions above exist, the state department may recover medical assistance expenditures correctly paid from assets in the estate other than the sale of the recipient's home.
- .17 The state department shall file liens and recover expenditures for medical assistance provided on or after July 1, 1992.
- .18 The state department may compromise, settle, or waive recovery of medical assistance expenditures if it determines good cause to do so. The department shall determine that good cause exists if:
 - A. it concludes that without receipt of the proceeds of the estate, the heirs would become eligible for assistance payments and/or medical assistance programs; or
 - B. it concludes that allowing the heirs to receive the inheritance from the estate will enable these individuals to discontinue eligibility for assistance payments and/or medical assistance programs; or
 - C. it concludes that the home is part of a business, including a working farm or ranch, and recovery of medical assistance expenditures will result in the heirs to the estate losing their means of livelihood.
- .19 The state department may agree to a payment plan for repayment of any debt owed the state under the Medical Assistance Estate Recovery Program.
- .20 The state department shall make no recovery under the Medical Assistance Estate Recovery Program unless federal funds are available for persons who would qualify for medical assistance as a result of the creation of a trust that meets the criteria set forth in section 26-4-506.5(3), C.R.S., and in the SSI FINANCIAL ELIGIBILITY REQUIREMENTS FOR INDIVIDUALS ELIGIBLE FOR THE COLORADO MEDICAID PROGRAM section of the Staff Manual, Volume VIII.

8.065 RECOVERY OF MEDICAL ASSISTANCE OVERPAYMENTS

- 8.065.1 For purposes of Section 8.065, an "overpayment" includes any medical assistance payments,

including capitation payments, paid on behalf of a recipient who was not lawfully entitled to receive the benefits for which the payments were made. The County Department of Social Services shall recover all overpayments except that no recovery shall be made where the overpayment occurred through no fault of the recipient.

8.065.2 RECOVERY PROCESS

- .21 When it is determined that an overpayment has occurred, the county department shall within 90 days:
- A. Document the facts and circumstances which produced the overpayment and retain this documentation until the overpayment is paid in full or otherwise resolved.
 - B. Initiate timely and adequate notice as set forth in Section 8.057, ADVANCE NOTICE, of this Staff Manual. Such notice shall include applicable rules concerning the overpayment and recovery sought, and shall request the client to voluntarily repay the amount overpaid.
 - C. Pursue all legal remedies in order to recover the overpayment following the 10-day advance notice period and appeal, if any, pursuant to 8.058, RECIPIENT APPEALS PROTOCOLS/PROCESS of this Staff Manual. Legal remedies include, but are not limited to, judgments, garnishments, claims on estates, interception of other grants in aid, and the State Income Tax Refund Intercept process.
- .22 In accordance with Sections 26-2-133 et seq., C.R.S., the state and county departments may recover overpayments of medical service benefits through the offset (intercept) of a taxpayer's state income tax refund. This method may be used to recover overpayments which have been:
- A. determined by final agency action, or
 - B. ordered by a court as restitution, or
 - C. reduced to judgment.
- .23 Prior to certifying the taxpayer's name and other information to the Department of Revenue, the county department shall notify the taxpayer, in writing at his/her last-known address, that the State intends to use the tax refund offset to recover the overpayment. The pre-offset notice shall include the name of the county department claiming the overpayment, a reference to Medicaid as the source of the overpayment, and the current balance owed.
- .24 The taxpayer is entitled to object to the offset by filing a request for a county evidentiary conference or state hearing within 30 days from the date that the county department mails its pre-offset notice to the taxpayer. In all other respects, the procedures applicable to such hearings shall be those which are stated in this Staff Manual (Section 8.057). At the hearing on the offset, the county department or Administrative Law Judge shall not consider whether an overpayment has occurred, but may consider the following issues if raised by the taxpayer in his/her request for a hearing:
- A. Whether the taxpayer was properly notified of the overpayment.
 - B. Whether the taxpayer is the person who owes the overpayment.
 - C. If the amount of the overpayment has been paid or,
 - D. If the offset amount is incorrect, or
 - E. If the debt created by the overpayment has been discharged through bankruptcy.

8.066 HEALTH INSURANCE BUY-IN

The purpose of the Department of Health Care Policy & Financing (Department)'s Health Insurance Buy-In (HIBI) program is to reduce, or shift, Medicaid liability by paying the cost of private health insurance premiums and out-of-pocket expenses for Medicaid clients, when it is cost-effective for Medicaid to do so. The health insurance premiums, deductibles, coinsurance, or other cost-sharing obligation for services, of Medicaid clients who are enrolled in a group or individual health insurance plan, will be paid by the Department, when it is cost-effective to do so. Payment of said services shall be treated as payment for medical assistance. This program is in addition to a client's regular Medicaid benefits.

.1 ELIGIBILITY/CONDITIONS FOR ENROLLMENT

- .11 In order to be eligible to participate in the HIBI program, the following criteria must be met:
 - A. Client must be eligible for Medicaid during the time period for which premium or cost-sharing payment is requested.
 - B. Client must be covered by, or have access to, a cost-effective group or individual health insurance plan.
 - C. Client must comply with the requirements of their health insurance plan.
 - D. Client must provide documentation required by the Department, sufficient to verify eligibility, continuing coverage, and to permit accurate reimbursement.
- .12 Once shown to be cost-effective, enrollment in a group or individual health insurance plan shall be required of clients as a condition of obtaining or retaining Medicaid. A client who is a policyholder shall be required to enroll his or her dependents in the insurance plan, if the dependents are Medicaid-eligible and also eligible to enroll in the cost-effective health insurance plan. However, Medicaid for such dependents shall not be discontinued if a policyholder fails to enroll the Medicaid-eligible dependent.

8.066.2 COST-EFFECTIVENESS

- .21 The determination of cost-effectiveness shall be in accordance with applicable state and federal guidelines.
- .22 A Medicaid client's enrollment in a group or individual health plan is cost-effective when the amount paid for premiums and other cost-sharing obligations plus the State's administrative costs are less than Medicaid's expenditure for an equivalent set of services for the average person in the same category of service.
- .23 If a plan is determined not to be cost-effective using average Medicaid costs in the above process, the specific client's known historical medical costs may be substituted for the average Medicaid costs in the above formula.
- .24 If a Medicaid client has access to more than one health insurance plan, a cost-effectiveness evaluation shall be performed on each. The client shall be informed as to which plan(s), if any, are likely to be cost-effective to Medicaid. The Medicaid client shall be required to enroll in the health plan that indicates the greatest cost savings to Medicaid. If multiple health plans are equally cost-effective, the client may choose which plan to enroll in.
- .25 Written notification shall be mailed to the Medicaid client upon approval for participation in HIBI. The notification will include the effective date, participation requirements, and applicable instructions.

- .26 The enrollment in, or continuation of, a health insurance plan determined not to be cost-effective shall be the client's decision. The client shall be required to notify the county of any plan change or termination. The disposition of such non-cost-effective health insurance plan shall not affect a client's Medicaid eligibility.

8.066.3 PAYMENT OF PREMIUMS

- .31 Premiums and cost-sharing will be paid by the Department, from the date the Department receives a premium claim or an approved referral.
- A. Up to three (3) months of premium back-payments will only be considered in the following circumstances:
- (1) Consolidated Omnibus Budget Reconciliation Act (COBRA) invoice, which may cover one to three months.
 - (2) The first invoice of any new plan, which may cover more than one month.
 - (3) Reinstatement of an insurance plan in arrears, if shown to be cost-effective to Medicaid.
 - (4) In certain cases, if it is cost-effective to Medicaid, and good cause is shown. The term "good cause" is defined as conditions outside the control of the individual such as, but not limited to, sudden illness, fire, theft, or acts of God.
- B. For pregnant women, premiums will be paid by the Department through the end of the month following the birth of the baby.
- .32 Premium payment will be made to an insurance carrier, employer, COBRA administrator, or directly to the client or policyholder, if circumstances warrant.
- .33 Only the portion of the premium that covers the Medicaid client will be paid (i.e., the amount the policyholder would save if he/she were to drop the Medicaid client from coverage). This amount shall be obtained from the premium cost breakdown supplied by the employer or insurance company.
- .34 The portion of the premium covering plan members who are not Medicaid-eligible will be paid if paying the full premium amount is necessary to obtain coverage for the Medicaid-eligible client(s).
- .35 If payment is made in error, the Department has the right to recover the funds paid in error. If a Medicaid client fails to return monies received, participation in the HIBI program may terminate, and the client's county technician may be notified of undeclared income, which may jeopardize Medicaid eligibility.

8.066.4 CRITERIA FOR EXCLUSION

- .41 Criteria for exclusion from the HIBI program are as follows:
- A. Medicaid payment of the client's health insurance premium is not found to be cost-effective.
 - B. Client is no longer eligible for Medicaid.
 - C. Eligibility for, or access to, the health insurance plan has ended.
 - D. Payment of the Medicaid client's health insurance premium cannot be made because the

insurance coverage is a court-ordered obligation.

E. Health Insurance is provided at no cost to either the client or policyholder.

F. Policyholder intends to continue premium payment and does not want to participate in HIBI.

G. Client has not provided documentation required by the Department.

H. Client does not comply with the requirements of their health insurance plan.

.42 Written notification of denial or discontinuation shall be mailed to the Medicaid client upon determination that the Medicaid client is not eligible for participation in the HIBI program. The notification will include the effective date and reason for denial or discontinuation.

.5 USE OF/NON-MEDICAID PROVIDERS

The Medicaid client can continue to use his/her own medical provider that participates in the cost-effective health insurance plan. If the provider is not an approved Medicaid provider, the cost of deductibles, coinsurance, and other cost-sharing amounts will be paid by the Department, if it would still be cost-effective to do so.

.6 CLIENT APPEAL RIGHTS

If a Medicaid client is denied or discontinued from participation in the HIBI program, he/she may appeal the decision to the Department of Health Care Policy and Financing. The aggrieved Medicaid client shall file his or her written appeal within sixty (60) days of the mailing date of the adverse action to the HIBI program, the Department of Health Care Policy & Financing. The written appeal will be reviewed by the HIBI officer and manager. A written response to the appeal will be sent to the appellant within 60 calendar days of receipt of the written appeal. A cost-effectiveness evaluation may be resubmitted to the Department with additional information for consideration. Denial or discontinuation at one point in time does not preclude future participation.

8.070 MISUTILIZATION, FRAUD, OR ABUSE

8.070.01 ACTIONS CONCERNING INDIVIDUALS SUSPECTED OF FRAUDULENT ACTS

It is the duty of the county department to take action against any person suspected of obtaining Medicaid benefits to which he is not entitled or in a greater amount than that to which he is entitled.

* Much of Section 8.070 was eliminated and Section 8.076 was created and adopted by the Medical Services Board on December 8, 2000.

8.075 CLIENT OVERUTILIZATION PROGRAM

8.075.1 Authority is given in 42 CFR 456.3 and 431.54(e) to establish a process that safeguards against unnecessary or inappropriate utilization of care and services. This program allows for the development and review of client utilization profiles, provider service profiles and exception criteria. It identifies excessive patterns in order to rectify overutilization practices of clients, providers and institutions.

8.075.2 The Client Overutilization Program restricts Medicaid clients to one designated pharmacy, primary care physician (PCP) or managed care organization (MCO) when there is documented evidence of abuse or overutilization of benefits.

8.075.3 DEFINITIONS

Client Overutilization Program means a process used to restrict a Medicaid client to a single physician or managed care organization and a single pharmacy to control excessive Medicaid benefits usage.

Overutilization means the improper or excessive utilization of medical care and services that are not medically necessary.

8.075.4 Clients whose utilization of Medicaid benefits without medical necessity has exceeded any one of the following parameters during a quarter shall be subject to placement in the program:

1. Use of three or more drugs in the same therapeutic category;.
2. Use of three or more pharmacies;
3. Use of sixteen or more prescriptions; or
4. By referral, review or other analysis that indicates possible overutilization.

8.075.4.A. Once the Department identifies a client that falls under 8.075.4, a post-payment review of documented information may be initiated, which includes but is not limited to:

1. Medicaid Management Information System reports;
2. Billing invoices;
3. Investigative reports;
4. Medical record reviews.

8.075.4.B. The Department shall inform the client in writing of program placement. The client will be notified of client's appeal rights granted in accordance with 8.057. The client will not be placed in the Overutilization Program until the appeal has been heard and a decision rendered or if no appeal, the appeal timeline has passed. The client has 10 days from the date the notification is mailed to appeal the decision.

8.075.4.C. The client will work in conjunction with the Department to select one physician or managed care organization and one pharmacy in which to receive their care. Clients shall be in the Client Overutilization Program for at least 12 consecutive months.

8.075.4.D. If a client becomes ineligible for Medicaid benefits during the restricted period, restrictions shall automatically commence for 12 consecutive months from the month eligibility is reestablished unless determined otherwise by the Department.

8.075.4.E. The following shall apply when the client has been assigned to the selected physician/MCO and pharmacy:

1. The client shall receive notification that identifies the program restrictions and providers. It is the responsibility of the client to request services only from the providers identified on the card. Emergency services are available to the client without the need to prior authorize the services.
2. The client shall have the right to a second surgical opinion should surgery be deemed necessary by the designated physician.

8.075.-4.F. The designated provider shall serve as the case manager for the client. The physician shall

authorize and monitor services rendered to the client by any other provider.

8.075.4.G. A change in designated providers may be granted if any of the following occur:

1. The provider moves, retires, dies, discontinues Medicaid participation or refuses to continue providing care to the client; or
2. The client moves from the physician's service area.

8.075.4.H. Restrictions will be rescinded upon the written recommendations of the client's designated provider and the Department. The Department will notify the client in writing of the decision to rescind restrictions. If, after the case review the decision is not to rescind the restrictions the client shall be afforded the opportunity to appeal in accordance with 8057.

8.075.5 CLIENT REFUSAL TO COOPERATE

8.075.5.A. If the client refuses to cooperate with the Department and does not appeal the decision to be placed in the program, the Department shall proceed with program placement. The Department shall notify the client of the providers and the effective date of implementation.

8.076 PROGRAM INTEGRITY

8.076.1 DEFINITIONS

Abuse means Provider practices that are inconsistent fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. These practices include, but are not limited to:

1. Billing for services and/or supplies without valid documentation to support the claims submitted.
2. Unbundling charges on claims for medical services and supplies by separating components of a group of procedures that are required to be billed together (or bundled), and billing each component separately.
3. Submitting a fee-for-service claim or claims for goods or services before they have been provided.
4. Signing prior authorizations or physician's orders for services or supplies that are inappropriate or not medically necessary for the client.

Conviction or Convicted means that a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

Exclusion means that items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

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 or 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 deliberate ignorance of or with reckless disregard for the 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.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to her/himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a Provider, or other supplier of services.

Good cause, for the purpose of denying, terminating, or not renewing a Provider agreement means:

1. The Provider has failed to comply substantially with Provider agreements, Provider billing manuals and/or Provider bulletins.
2. The Provider has not complied with applicable federal and state statutes and regulations.
3. The Provider, either by omission or commission, is endangering or has endangered the health, safety, or well-being of a program services beneficiary or beneficiaries.
4. The Provider's license has expired, been revoked or suspended, or surrendered while a formal disciplinary proceeding was pending before a state licensing authority, or for any other reason is invalid at the time services for which claims are submitted are rendered.
5. The Provider has been excluded or suspended from the Medicaid program or has been excluded or suspended from reimbursement under the Medicare program unless a waiver is granted by the Department of Health and Human Services Office of Inspector General.
6. The Provider has failed to fully and accurately make any disclosures required by federal and state statutes or regulations.
7. Any person with an ownership or controlling interest in the Provider, or who is a Provider's agent or managing employee, who has been convicted of a criminal offense related to that person's involvement in any program established under Medicare or Medicaid.
8. The Provider has demonstrated a pattern of abuse.
9. The Provider has engaged in false representation and/or fraud in submitting claims to Medicaid.

Medical necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and
2. Meets at least one of the following criteria:
 - a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.
 - b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability.

- c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.
- d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living.

Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

Overpayment means the amount paid by a Medicaid agency to a Provider which is in excess of the amount that is allowable for services furnished under Section 1902 of the Social Security Act and which is required to be refunded under Section 1903 of the Act.

Provider means any person, public or private institution, agency, or business concern providing medical or remedial care, services or goods authorized under Medicaid 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. For purposes of these regulations, Provider does not include any person, public or private institution, agency, or business concern with which the Department does business pursuant to a capitated reimbursement contract.

Suspension means that items or services furnished by a specific Provider who has been convicted of a program-related offense in a federal, state or local court will not be reimbursed under Medicaid.

8.076.2 COMPLIANCE MONITORING

8.076.2.A. Providers shall comply with the Department's efforts to monitor Provider compliance with federal and state Medicaid program statutes and regulations in order to detect and correct noncompliance and prevent fraud and abuse.

8.076.2.B. Compliance monitoring includes, but is not limited to:

- 1. Conducting post-payment and/or concurrent reviews.
- 2. Verifying Provider adherence to professional licensing and certification requirements.
- 3. Reviewing services rendered for fraud and abuse.

8.076.2.C. Compliance monitoring activities may include, but are not limited to:

- 1. Site reviews.
- 2. Desk audits.
- 3. Medical records review.
- 4. Claims review.

8.076.3 RECOVERY OF OVERPAYMENTS

8.076.3.A. Any identified overpayment to a Provider shall be recoverable.

- 1. Overpayments and/or other indebtedness to the state are recoverable through a repayment agreement with the Provider; by offsetting the amount owed against current and future

claims of the Provider, through litigation; or by any other appropriate action within the Department's legal authority.

2. The offset rate shall be 100% of the total amount owed to be withheld from subsequent payments until the entire amount owed is recovered. The overpayment offset rate may be reduced if the Provider shows good cause that withholding payment at the established rate will result in undue hardship.
3. In cases where multiple overpayments to the same Provider have been found, the recovery may be determined through scientific statistical analysis and extrapolation of data from a statistically valid selected sample of the claims.

8.076.4 WITHHOLDING OF PAYMENTD DURING INVESTIGATION FOR FRAUD AND/OR WILLFUL MISREPRESENTATION

8.076.4.A. Medicaid payments to a provider may be withheld, in whole or in part, upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program. Payments may be withheld without first notifying the Provider of the intention to withhold such payments. A Provider shall be granted appeal rights upon request.

8.076.4.B. Notice of withholding shall be sent to the Provider within five (5) days of taking such action. The notice shall:

1. State that payments are being withheld in accordance with this provision;
2. State that the withholding is for a temporary period, as stated in 8.076.4.C and cite the circumstances under which withholding will be terminated;
3. Specify, when appropriate, to which type or types of Medicaid claims withholding is effective; and
4. Inform the Provider of the right to submit written evidence for consideration by the Department.

8.076.4.C. All withholding of payment actions under 8.076.4 shall be temporary and shall not continue after:

1. The Department or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the Provider; or
2. Legal proceedings related to the Provider's alleged fraud or willful misrepresentation are completed.

8.076.5 DENIAL, TERMINATION AND/OR NONRENEWAL OF PROVIDER AGREEMENTS

8.076.5.A. The Department may deny an application for a Provider agreement, terminate or not renew a Provider agreement for Good Cause.

8.076.5.B. A potential Provider shall be notified of the Department's decision to deny an application for a Provider agreement by a notice of Adverse Action.

8.076.5.C. A Provider shall be notified of the Department's decision to terminate or not renew a Provider agreement by a notice of Adverse Action. Termination and/or nonrenewal shall not be effective sooner than fifteen days (15) from the date of the notice except as provided for an emergency termination.

8.076.5.D. Provider agreements may be terminated without prior notice if the Provider has been found guilty of fraud or has been found to have made a false representation or the termination is imperatively necessary for the preservation of the public health, safety, or welfare and observance of the requirements of notice would be contrary to the public interest. Within five (5) days of the emergency termination, the provider shall receive a notice of Adverse Action.

8.079 QUALITY IMPROVEMENT

8.079.1 DEFINITIONS

Managed Care Entity means, for purposes of Section 8.079, any person, public or private institution, agency or business concern with which the Department does business pursuant to a capitated reimbursement contract.

Provider means any person, public or private institution, agency, or business concern providing medical or remedial care, services or goods authorized under Medicaid 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. Provider does not include a Managed Care Entity.

8.079.2 EXTERNAL QUALITY REVIEW (EQR)

Providers and Managed Care Entities shall comply with annual EQR activities. EQR may include, but is not limited to the following activities:

1. Performance improvement projects.
2. Performance improvement project validation.
3. Performance improvement measurement.
4. Performance improvement measurement validation.
5. Consumer satisfaction survey.
6. Medical record review.
7. Review of individual cases.
8. PCPP credentialing and recredentialing.

8.079.3 MONITORING AND REVIEW

8.079.3.A. All Providers and Managed Care Entities shall comply with Department efforts to monitor performance through site visits, reviews, desk audits, emergency site visits, profiling, compliance reporting requirements and other quality and program integrity review activities. Monitoring activities shall be conducted for the purpose of determining compliance with state and federal requirements, contracts or Provider agreements, Medicaid service provision and billing procedures, and/or Medicaid Bulletins and Provider Manuals.

1. Managed Care Entities - The Managed Care Entity shall be subject to annual site visits to determine compliance with established standards. The annual site visit process shall consist of a desk audit component and an onsite visit. The Managed Care Entities and/or its subcontractors shall, upon request, provide and make available staff to assist in the audit or inspection efforts and provide adequate space on the premises to reasonably accommodate review personnel.

2. Providers – the Department may conduct site reviews, desk audits, medical records review and/or claims review for Providers as it deems appropriate. The Department shall provide a written request to the Provider to review records. This request shall include the option of providing either a reproduction of records or an inspection of the records by the Department at the Provider's site. The Provider shall submit or produce requested materials within twenty-one (21) calendar days, unless the review is based on quality of care concerns, in which case the materials shall be submitted within fourteen (14) calendar days of the request. Medical records requested for review shall be provided to the Department at the expense of the Provider.
 - a. Records received by the Department after the twenty-one (21) calendar day deadline shall not be considered in the review, unless the Department has granted a written extension. The request for an extension must be received by the Department within ten (10) calendar days from the date of the Department's request, must specify the additional time requested, and reasons for requesting the extension.
 - b. Any claims submitted for which documentation is not received within the time limits specified in this section shall be an overpayment subject to recovery regardless of whether or not services have been provided.
 - c. The Department's post-review formal correspondence shall indicate areas of strength, suggestions for improvement and required actions, unless the review is conducted for the purpose of post-payment review. For all post payment reviews, the Provider shall receive a letter identifying the overpayment demand, or notice of no repayments.
 - d. Duplication of Records - The Department staff, its designated representatives, or the Medicaid Fraud Control Unit may photocopy or otherwise duplicate any document, chart, policy, or other record relating to medical care or services provided, or goods dispensed for which a claim is submitted. The Department or its designee and the Medicaid Fraud Control Unit shall be allowed to use duplicating equipment on the Provider's premises to the extent that such use results in minimal disruption of the Provider's business. If such use of duplicating equipment will cause more than minimal disruption of business, the Provider will notify the Department, which will attempt to resolve the issue with the Provider or make other arrangements.
3. The Department reserves the right to deem other State agencies or private accreditation organizations approved reviews to constitute compliance with specific contractual obligations or regulatory requirements.
4. The Department may delegate monitoring activities.
5. The Department shall conduct unannounced or emergency site visits in instances where patient safety, quality of medical care, potential fraud or financial failure is imminent.

8.080 MEDICAID ELIGIBILITY QUALITY CONTROL

- 8.080.1 County departments of social/human services and other Department-designated eligibility sites shall maintain, store and preserve electronic and physical individual Medicaid case record(s) and other client-related confidential material to permit the Department to periodically evaluate the accuracy of Medicaid eligibility determinations. Medicaid case records are the property of the Department and shall be restricted to use by the state and county departments of social/human services and other Department-designated eligibility sites.

8.080.2 County departments of social/human services and other Department-designated eligibility sites shall provide records to the Department within ten (10) working days of request.

8.080.3 County departments of social/human services and other Department-designated eligibility sites shall respond to the eligibility review findings by completing the Department-prescribed MEQC response form documenting the corrective action taken. The response shall be forwarded to the Department within ten (10) working days from the date of the review finding notification.

8.080.4 To be considered by the Department, requests from county departments of social/human services and Department-designated eligibility sites for specific program policy interpretation relevant to MEQC pilot projects shall be received by the Department within ten (10) days of the MEQC review findings. All program policy decisions are final.

8.080.5 County departments of social/human services and Department-designated eligibility sites shall make electronic or physical records available for on-site reviews as requested.

8.090 MEDICAID CLAIMS PROCESSING AND THIRD PARTY LIABILITY QUALITY CONTROL

8.091 PURPOSE

.10 Medicaid Quality Control is a unit within the Medical Assistance Division of the Colorado Department of Social Services. This unit is independent of and functionally different (as described below) from the Quality Control Unit described in Colorado State Department of Social Services Staff Manual 3 Section 3.870.11 et seq.

.11 Medicaid Quality Control is a federally required ongoing review conducted by the Division of Medical Assistance to determine the extent to which third party liability or claims processed by the fiscal agent contain errors.

.12 The Medicaid Quality Control system is a method of State administration that is intended to reduce the incidence of claims processing and third party liability errors. This is accomplished by means of three processes.

A. A continuous review of the Medicaid claims processed for a statistically reliable statewide sample of cases;

B. The periodic assembly and analysis of findings to determine the incidence of errors; and

C. The taking of corrective action to reduce the level of error, and, if necessary, bring such error rate within established tolerance.

8.090.2 METHOD

.20 The Medicaid Quality Control Review covers:

A. The manner in which county departments identified and then documented recipient's third party medical insurance benefits and coverage;

B. Accuracy of information provided by client;

C. Accuracy of fiscal agent action with respect to claims processing and third party liability for paid claims.

D. Medically necessary transportation authorized by the State or county departments.

E. Medical certification for recipients in long term care facilities.

.21 Errors are of two types:

A. Third party liability errors - when there is a third party(ies) which is available to pay for medical services for eligible recipients, but the party(ies) was not known or fully utilized prior to claims payments.

B. Claims processing errors - when claims were paid which did not contain all necessary information, which did not meet the service or payment amount restrictions, or which did not reflect liability for payment correctly.

.22 Third party liability errors are reported to the county departments by the Quality Control Unit via the Third Party Recovery Unit, Division of Medical Assistance, Colorado State Department of Social Services with requests for the county's report of corrective action.

.23 Claims processing errors are reported to the appropriate section within the Medical Assistance Division and/or fiscal agent with requests for corrective action.

.24 At periodic intervals, the findings of Medicaid Quality Control are assembled, tabulated, and summarized for use by the State Department of Social Services to meet federal reporting requirements.

8.100 MEDICAL ASSISTANCE PROGRAM REQUIREMENTS

8.100.1 LEGAL BASIS

.11 Constitution of Colorado, Article XXIV, Old Age Pensions, Section 7, established a health and medical care fund for persons who qualify to receive old age pensions.

.12 Colorado Revised Statutes, Title 26, Article 4, Colorado Medical Assistance Act, Section 102, provides for a program of medical assistance for individuals and families, whose income and resources are insufficient to meet the costs of necessary medical care and services, to be administered in cooperation with the federal government.

.13 The Social Security Act, Title XIX, Grants to States for Medical Assistance Programs, and the consequent federal regulations, Title 42, CFR (Code of Federal Regulations), Chapter IV, Subchapter C, set forth the conditions for states to obtain federal financial participation in medical assistance expenditures.

.14 Under the Colorado Medical Assistance Program, the Medicaid program provides coverage of certain groups specified in Title XIX of the Social Security Act. The Colorado Modified program provides coverage to certain old age pension clients entitled to health and medical care under the Colorado Constitution.

8.100.2 GENERAL PROVISIONS

.21 The Department of Health Care Policy and Financing is the single State agency designated to administer the Colorado Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes. The Office of Medical Assistance of the Department is delegated the duties and responsibilities for administration of the Colorado Medical Assistance Program.

.22a. The county department shall advise individuals concerning the benefits of the medical assistance program and determine and redetermine eligibility for medical assistance in accordance with rules and regulations of the State Department. A person who is applying for Medicaid or a client who is

discontinued from Medicaid in one category shall be evaluated under other categories of eligibility. There is no time limit for Medicaid coverage as long as the client remains categorically eligible.

- b. Designated staff of the Department of Health Care Policy and Financing shall be authorized to determine eligibility for medical assistance as part of the eligibility review conducted for the Childrens Basic Health Plan. This eligibility determination is restricted to the Family and Children's categories including those identified in Section 8.101.1. Eligibility will be determined in accordance with rules and regulations applicable to the Families and Children's categories outlined in Sections 8.100.2 through 8.100.5 and 8.100.8 through 8.106. Once eligibility is determined and the timeframe for an appeal has lapsed, the case file will be transferred to the county department in which the applicant(s) resides. The county department shall be responsible for the on-going maintenance and redetermination of the case.
- .23 The county department shall provide written information from the state department to the following people explaining the provisions of the Medical Assistance Estate Recovery Program and how those provisions may pertain to the applicant/client:
- A. Applicants age 55 and older.
 - B. Applicants who are institutionalized.
 - C. Applicants/clients who will turn age 55 before their next eligibility redetermination.
 - D. Clients approved for admittance to an institution.
- .235 An applicant and community spouse of an applicant for HCBS, PACE or institutional services shall disclose a description of any interest the applicant or spouse has in an annuity or similar financial instrument at the time of application, regardless of whether the annuity is irrevocable or treated as an asset.
- .236 The county department or medical assistance site shall provide written notice to any applicant for HCBS, PACE or institutional services that the Department shall be a preferred remainder beneficiary in any interest in any annuity or similar financial instrument of a Medicaid recipient or community spouse of a Medicaid recipient. This remainder beneficiary interest is for the total amount of medical assistance provided to the individual and applies to any annuity purchased on or after February 8, 2006.
- .237 The county department or medical assistance site shall notify in writing the issuer of any annuity or similar financial instrument described in 8.100.236 that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of medical assistance provided to the individual. This notice shall require the issuer to notify the county department when there is a change in the amount of income or principal that is being withdrawn from the annuity.
- .24 A person who is eligible for medical assistance shall be free to choose any qualified and approved participating institution, agency, or person offering care and services which are benefits of the program unless that person is enrolled in a managed care program operating under Federal waiver authority.
- .25 Details concerning the nature and scope of benefits of the Colorado Medical Assistance Program are contained in other chapters of this manual.
- .26 A person who is applying for or receiving Medicaid shall assign to the State all rights against any

other person (including but not limited to the sponsor of an alien) for medical support or payments for medical expenses paid on the applicant's or client's behalf or on the behalf of any other person for whom application is made or assistance is received. All appropriate clients of Medicaid shall be referred, using the form as specified by the State Department, for child support enforcement services.

.27 The county department shall process an application for Medicaid benefits within the following deadlines:

- A. 90 days for persons who apply for Medicaid on the basis of disability.
- B. 45 days for all other Medicaid applicants.
- C. The above deadlines cover the period from the date of application to the date the county department mails a notice of its decision to the applicant.
- D. In unusual circumstances documented in the case record, the county department may delay its decision on the application beyond the applicable deadline. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action, or an administrative or other emergency beyond the agency's control.
- E. The county department shall not use the above timeframes as a waiting period before determining eligibility, or as a reason for denying eligibility.
- F. For clients who apply for Medicaid on the basis of disability, the county department shall send a notice informing the applicant of the reason for a delay beyond the applicable deadline, and of the applicant's right to appeal if dissatisfied with the delay. The county department shall send this notice 91 days following the application for Medicaid on the basis of disability.
- G. For information regarding continuation of benefits during the pendency of an appeal to the SSA based upon termination of disability benefits see Section 8.057.5.C

.28 Effective July 1, 1997, as a condition of eligibility for Medicaid, any legal immigrant who is applying for or receiving Medicaid shall agree in writing that, during the time period the client is receiving Medicaid, he or she will not sign an affidavit of support for the purpose of sponsoring an alien who is seeking permission from the Immigration and Naturalization Service to enter or remain in the United States. A legal immigrant's eligibility for Medicaid shall not be affected by the fact that he or she has signed an affidavit of support for an alien before July 1, 1997.

.29 All regulations for the administration of the Medicaid programs for Families and Children are included in this Staff Manual Volume 8, from 8.100 through 8.106. Staff Manual Volume 3 rules do not apply to these programs.

8.100.3 PROCESSING STANDARDS

.31 Persons applying to the county for assistance need complete only one application form to apply for both medical assistance and financial assistance under the federal or State financial assistance programs administered in the county. The application will be the application designated by the Colorado Department of Health Care Policy and Financing.

Persons requesting Medicaid Only for Family and Children's categories, including 1931 Medicaid, need only to complete the "Application for Colorado Health Care."

Pregnant women and children may apply for medical assistance at sites other than the County Department of Social Services. These sites shall be approved by the State Department to receive and initially process these applications. The application shall not be the same as those used to apply for financial assistance programs. The County Department of Social Services shall determine eligibility.

Application interviews or requested trips to the county office for medical assistance shall not be required. All correspondence may be done by mail or telephone.

- .33 For the purpose of medical assistance, when an applicant is incompetent or incapacitated and unable to sign an application, or in case of death of the applicant, the application shall be signed by someone acting responsibly in behalf of the applicant: either

A. a parent, or other relative, or legally appointed guardian or conservator, or

B. for a person in a medical institution for whom none of the above are available, an authorized official of the institution may sign the application.

- .34 The application processing requirements and verification requirements which apply for purposes of medical assistance are determined by the Colorado Department of Health Care Policy and Financing and set forth in rules approved by the Medical Services Board. A consent form (IM-12) shall not be required to request information from Social Security regarding medical assistance applicants or clients.

- .35 When an individual applies for Medicaid on the basis of disability or blindness, the county department shall take the application and determine whether the individual is eligible for Medicaid long term care or any of the categories of assistance described at 8.110.2 under SSI RELATED CASES and at 8.121 under QUALIFIED DISABLED AND WORKING INDIVIDUALS. If the applicant does not qualify for Medicaid on one of those bases, he/she shall be referred to the local Social Security office to apply for SSI by use of the DEN-DO-A/P-88.

Applicants who apply for long term care Medicaid on the basis of disability or blindness shall complete a disability determination form in addition to the required medical assistance application. The disability determination form shall be collected by a designated county representative and shall be forwarded the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated county representative.

- .36 County departments and outreach sites in which an individual is able to apply for Medicaid benefits shall also provide the applicant the opportunity to register to vote.

A. The county department/outreach site shall provide to the applicant the prescribed voter registration application.

B. The county department/outreach site shall not:

1. Seek to influence the applicant's political preference or party registration;
2. Display any political preference or party allegiance;
3. Make any statement to the applicant or take any action, the purpose or effect of which is to discourage the applicant from registering to vote; and
4. Make any statement to an applicant which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of

services or benefits.

- C. The county department/outreach site shall ensure the confidentiality of individuals registering and declining to register to vote.
 - D. Records concerning registration and declination to register to vote shall be maintained for two years by the county department. These records shall not be part of the public assistance case record and are not subject to subpoena.
 - E. A completed voter registration application shall be transmitted to the county clerk and recorder for the county in which the county department/outreach site is located not later than ten (10) days after the date of acceptance, except that, if a registration application is accepted within five (5) days before the last day for registration to vote in an election, the application shall be transmitted to the county clerk and recorder for the county not later than five (5) days after the date of acceptance.
- .37 Individuals who transfer from one Colorado county to another shall be provided the same opportunity to register to vote. The resident county shall follow the above procedure. The paying county shall notify its county clerk and recorder of the client's change in address within five (5) days of receiving the information from the client.
- .38 The county departments shall refer Medicaid applicants who are pregnant and/or under 21 years old to EPSDT by copying the page of the Medicaid only application that includes the EPSDT benefit questions. The county department will then forward this page to the EPSDT office within five working days from the date of receipt of the application.

8.100.4 FURNISHING ASSISTANCE

- .41 Medical assistance shall be approved effective as of the date of application for medical assistance or as of the date the person becomes eligible for medical assistance, whichever is later. Individuals held in correctional facilities or who are held in community corrections programs that are determined eligible for medical assistance shall be approved effective as of the individual's date of release. Additionally, an applicant for medical assistance shall be provided such assistance any time during the three (3) months preceding the date of application, or as of the date the person became eligible for medical assistance, whichever is later. That person shall have received medical services at any time during that period and met all applicable eligibility requirements.
- .42 An explanation of the conditions for retroactive medical assistance shall be given to all applicants. Those applicants who within the three (3) months period prior to the date of application or as of the date the person became eligible for medical assistance, whichever is later, have received medical services which would be a benefit of the Colorado Medicaid Program or the Colorado Modified Medical Program as applicable, can request retroactive coverage on the application form. The determination of eligibility for retroactive medical assistance shall be made as part of the application process. An applicant does not have to be eligible in the month of application to be eligible for retroactive medical assistance. The applicant or client may verbally request retroactive coverage at any time following the completion of an application. Minimum verification required for the Medicaid program, as defined at 8.105.5,A, shall be secured to determine backdating eligibility. Proof of the declared medical service shall not be required.
- .43 To be eligible for retroactive medical assistance, the categorically needy disabled or blind person shall either
- A. have received SSI money payment or Social Security disability insurance (DIB) for that time, or

- B. be determined to have met the SSI definition of disability or blindness at that time through the procedure for processing applicant/client determinations as described in the chapter on AID TO NEEDY DISABLED OR BLIND PERSONS in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1).

.44 Any person at any time during a calendar month who is determined to be eligible for medical assistance shall be eligible for benefits during all the subsequent portion of that month.

8.100.5 GROUPS ASSISTED UNDER THE PROGRAM

.51 The Colorado Medicaid Program provides benefits to persons who meet the federal definition of categorically needy.

.52 The following are considered as categorically needy:

- A. Families and children listed at 8.101.11.
- B. Persons who are eligible for cash assistance under the Colorado Works Program (Temporary Assistance to Needy Families) pursuant to C.R.S. 26-2-706.
- C. Persons who are legal immigrants and fall into one of the categories in 8.100.53,A,2 or 3, who were or would have been eligible for SSI but for their alien status, if such persons meet the resource, income and disability requirements for SSI eligibility.
- D. Persons who are receiving financial assistance; and who are eligible for a SISC Code of A or B.
- E. Persons who are eligible for financial assistance under OAP and SSI, but are not receiving the money payment;
- F. Persons who would be eligible for financial assistance from OAP or SSI, except for the receipt of Social Security Cost of Living Adjustment (COLA) increases, or other retirement, survivors, or disability benefit increases to their own or a spouse's income. This group also includes persons who lost OAP or SSI due to the receipt of Social Security Benefits and who would still be eligible for Medicaid except for the cost of living adjustments (COLA's) received.
- G. Persons who are blind, disabled, or aged individuals residing in the medical institution or intermediate care facility whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment.
- H. Persons who are blind, disabled or aged receiving Home and Community Based Services whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment.
- I. Disabled adult children who are at least 18 years of age and who lost their SSI on or after May 1, 1987, due to the receipt of social security benefits drawn from his/her parents' Social Security Number as disabled adult child (DAC).
- J. Children age 18 and under who would otherwise require institutionalization in an Intermediate Care Facility (ICF), Skilled Nursing Facility (SNF), or an acute care hospital in lieu of a SNF as described in 1902(e)(3) of the Act Public Law No. 97-248 (Section 134).
- K. Persons receiving OAP-A, OAP-B, and OAP Refugees who do not meet SSI eligibility criteria but do meet the state eligibility criteria for the Colorado Modified Medical Program. These

persons qualify for a SISC Code C.

- L. Persons who apply for and meet the criteria for one of the categorical Medicaid assistance programs, but do not meet the criteria of citizenship shall receive Medicaid that can only be used for emergencies.

8.100.53 To be eligible to receive medical assistance, an eligible person shall:

A. Prior to the implementation of SB 03-176, fall into one of the following categories:

1. Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or
2. Be an alien who entered the United States prior to August 22, 1996, who falls into one of the following categories:
 - a. lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA"); or
 - b. paroled into the United States for at least one year under Section 212(d)(5) of the INA; or
 - c. granted conditional entry under Section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or
 - d. determined by the county department, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. sec. 1641, has been battered or subjected to extreme cruelty which necessitates the provision of medical assistance (Medicaid); or
3. Be an alien who arrived in the United States on any date, who falls into one of the following categories:
 - a. lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children); or
 - b. lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried, dependent children); or
 - c. granted asylum under Section 208 of the INA; or
 - d. refugee under Section 207 of the INA; or
 - e. deportation withheld under Section 243(h) (as in effect prior to September 30, 1996) or Section 241(b)(3) (as amended by P.L. 104-208) of the INA; or
 - f. Cuban or Haitian entrant, as defined in Section 501(e)(2) of the Refugee Education Assistance Act of 1980; or
 - g. an individual who (1) was born in Canada and possesses at least 50

percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 450b(e); or

h. admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461); or

i. lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict.

4. Be an alien who entered the United States on or after August 22, 1996, who falls into one of the four categories described in paragraphs a-d under Section 8.100.53,A,2, and who is applying for Medicaid benefits to begin no earlier than five years after the alien's date of entry into the U.S.;

A1. Upon implementation of SB 03-176, fall into one of the following categories:

1. A citizen or national of the United States, the District of Columbia, Puerto Rico Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island.
2. An alien who is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse, and unmarried dependent children).
3. An alien who is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried dependent children).
4. An individual who was born in Canada and possesses at least 50 percent American Indian blood or is a member of an Indian tribe as defined in 25 U.S.C. Section 450b(e).
5. An alien who, after five years from the date of entry into the U.S., is a legal permanent resident and has 40 qualifying quarters as defined in the Social Security Act.
6. An asylee granted asylum under Section 208 of the INA, for seven years after the granting of asylum status.
7. A refugee under Section 207 of the INA, for seven years following the date of entry into the United States.
8. An alien granted withholding of deportation under Section 243(h) or Section 241(b)(3) of the INA for seven years after receiving such status.
9. A Cuban or Haitian entrant, as defined in Section 501(e)(2) of the Refugee Education Assistance Act of 1980, for seven years after the date of entry into the United States.
10. An Amerasian admitted to the U.S. pursuant to Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988(as amended by P.L. 100-461) for five years after date of entry into the United States.
11. A victim of a severe form of trafficking in persons, as defined in Section 103 of the Trafficking Victims Act of 2000, 22 U.S.C. 7102, for seven years after the date of

entry into the United States.

A2. For determinations of initial eligibility and redeterminations of eligibility for medical assistance made on or after July 1, 2006, if an individual declares that he or she is a citizen or national of the United States, the individual must provide satisfactory documentary evidence of citizenship or nationality. Satisfactory documentary evidence of citizenship or nationality is:

1. Any one of the following:

- a. A United States passport,
- b. Form N-550 or N-570 (Certificate of Naturalization),
- c. Form N-560 or N-561 (Certificate of United States Citizenship); or

2. Any one of the following:

- a. A certificate of birth in the United States,
- b. Form FS-545 or Form DS-1350 (Certification of Birth Abroad),
- c. Form I-97 (United States Citizen Identification Card),
- d. Form FS-240 (Report of Birth Abroad of a Citizen of the United States); and

3. Any one of the following:

- a. A state-issued driver's license, or
- b. A state-issued identification card.

4. Any reference to a form in Section 8.100.53.A2. includes a reference to any replacement form.

B. Be a resident of Colorado;

C. Not be an inmate of a public institution, except as a patient in a public medical institution or as a resident of an intermediate care facility or as a resident of a publicly operated community residence which serves no more than 16 residents;

D. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Colorado Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medicaid reimbursement. See the section on NEEDY PERSONS UNDER 21 for special provisions extending Medicaid coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

E. Furnish a Social Security Account Number (SSN) or evidence that an application for a SSN has been submitted;

F. Meet all financial eligibility requirements of the Medical Assistance program for which application is being made, including but not limited to the provisions for deeming the income and resources, if applicable, of alien sponsors;

G. Meet the definition of disability or blindness, when applicable. Those definitions appear in this staff manual at 8.110.32 under PERSONS IN MEDICAL FACILITIES OR OTHER RESIDENTIAL PLACEMENT.

H. Meet all other requirements of the Medical Assistance program for which application is being made.

EXCEPTION: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medicaid assistance programs, but do not meet the criteria of citizenship shall receive Medicaid that can only be used for emergency medical care.

Non-qualified aliens need not furnish evidence that an application for a SSN has been made. The rules on confidentiality prevent the agency from reporting to the Immigration and Naturalization Service persons who have applied for or are receiving assistance. These persons need not select a primary care physician, since they are eligible only for emergency medical services.

For non-qualified aliens receiving Medicaid emergency only benefits, the following medical conditions will be covered:

An emergency medical condition is a medical condition (including labor and delivery) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- (a) placing the patient's health in serious jeopardy,
- (b) serious impairment of bodily function, or
- (c) serious dysfunction of any bodily organ or part.

A physician shall make a written statement certifying the presence of a medical emergency condition when services are provided and shall indicate that services were for a medical emergency on the claim form.

Coverage is limited to care and services that are necessary to treat immediate emergency medical conditions. Coverage does not include prenatal care or follow-up care, such as postpartum care. Coverage will include prenatal care, if and only if, the client receives prenatal care through "The Prenatal Care for Undocumented Women Pilot Program" delivered in a geographic area covered by the Managed Care Organization contracting with the State for the delivery of such services and according to specifications contained within C.R.S. 26-4-203.

.54 Individuals shall live in the county in which they make application. Individuals held in correctional facilities or who are held in community corrections programs shall apply for medical assistance in the county specified as his/her county of residence upon release. Individuals who reside in a county but who do not reside in a permanent dwelling nor have a fixed mailing address shall be considered eligible for medical assistance, provided all other eligibility requirements are met. In no instance shall there be a durational residency requirement imposed upon the applicant, nor shall there be a requirement for the applicant to reside in a permanent dwelling or have a fixed mailing address. If an individual without a permanent dwelling or fixed mailing address is hospitalized, the county where the hospital is located shall be responsible for processing the application to completion. If the individual moves prior to completion of the eligibility determination, the origination county completes the determination and transfers the case as applicable.

.55 A resident of Colorado is defined as a person that is living in, other than temporarily, within the state of Colorado at the time of application. For institutionalized individuals who are incapable of

indicating intent as to their state of residence, the state where the institution is located shall be the person's state of residence unless that state determines that the individual is a resident of another state, by applying the following criteria:

- a. for any institutionalized individual who is under age 21 or who is age 21 or older and become incapable of indicating intent before age 21, the state of residence is that of the individual's parents or legally appointed guardian at the time of placement;
- b. for any institutionalized individual who became incapable of indicating intent at or after age 21, (1) the state of residence is the state in which the person was living when he or she became incapable of indicating intent, or (2) if this cannot be determined, the state of residence is the state in which the person was living when he or she was first determined to be incapable of indicating intent;
- c. upon placement in another state, the new state is the state of residence unless the current state of residence is involved in the placement;
- d. in the case of conflicting opinions between states, the state of residence is the state where the individual is physically located.

.56 For purposes of this section on establishing an individual's state of residence, an individual is considered incapable of indicated intent if:

- a. the person has an I.Q. of 49 or less or has a mental age of 7 or less, based on standardized tests as specified in the persons in medical facilities section of this manual;
- b. the person is judged legally incompetent; or
- c. medical documentation, or other documentation acceptable to the county, supports a finding that the person is incapable of indicating an intent.

.57 If a state arranged for an individual to be placed in an institution located in another state, the state making the placement shall be the individual's state of residence, irrespective of the individual's indicated intent or ability to indicate intent.

8.100.6 FEDERAL FINANCIAL PARTICIPATION

.61 The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of groups covered under the Colorado Medicaid Program and also for the Medicare supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain groups of categorically needy persons. The FFP/SMIB status shall be specified for all aged, disabled or blind recipients by submitting the applicable Supplemental Income Status Code (SISC) on the eligibility reporting form.

.62 The SISC codes are as follows:

- A. Code A - for institutionalized persons whose income is under 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; and non-institutionalized persons receiving Home and Community Based Services, whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; code A signifies that FFP is available in expenditures for medical care and services which are benefits of the medical assistance program but not for SMIB premium payments;
- B. Code B - for persons eligible to receive financial assistance under SSI; persons eligible to

receive financial assistance under OAP "A" who, except for the level of their income, would be eligible for an SSI payment; persons who are receiving mandatory State supplementary payments; and persons who continue to be eligible for medical assistance after disregarding certain Social Security increases; code B signifies that FFP is available in expenditures for medical care and services which are benefits of the medical assistance program and also for SMIB premium payments;

C. Code C - for persons eligible to receive assistance under OAP "A", OAP "B", or OAP Refugee Assistance for financial assistance only; who do not receive SSI payment and do not otherwise qualify under SISC code B as described in item B. above; code C signifies that no FFP is available in medical assistance program expenditures.

- .63 The specifications for each coverage group are contained in subsequent sections of this chapter on medical assistance eligibility. The SISC codes which apply to the coverage groups are shown in the left-hand margin.
- .64 Recipients of financial assistance under State AND, State AB, or OAP "C" are not eligible for medical assistance and the SISC code which shall be entered on the eligibility reporting form is C.

8.100.7 REDETERMINATION OF ELIGIBILITY

- .71 A redetermination of eligibility shall mean a case review and necessary verification to determine whether the Medicaid client continues to be eligible to receive medical assistance. Beginning as of the case approval date, a redetermination shall be accomplished each 12 months for Title XIX Category 04 (Medicaid only) cases.
- .72 The county department shall provide to the Medicaid client the opportunity to register to vote, in accordance with the provisions of Section 8.100.36 of this staff manual.
- .73 The county department shall promptly redetermine eligibility when:
 - A. it receives and verifies information which indicates a change in a client's circumstances which may affect continued eligibility for medical assistance; or
 - B. it receives direction to do so from the State Department.
- .74 A redetermination form, approved by the Colorado Department of Health Care Policy and Financing, shall be mailed to the person at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed, but the form itself can not be required to be returned. The only verification that can be required at redetermination is the same minimal verification listed in Section 8.105.5 of this Staff Manual. The following procedures relate to mail-out redetermination:
 - A. A Redetermination Form shall be mailed to the client together with any other forms to be completed;
 - B. A self-addressed, stamped, return envelope shall be mailed to the client with the required forms;
 - C. Required verification shall be returned by the client to the county department no later than ten working days after their receipt of the redetermination verification information requires form;
 - D. When the individual is unable to complete the forms due to physical, mental or emotional

disabilities, or other good cause, and has no one to help him/her, the county shall either assist the client or refer him/her to a legal or other resource. When initial arrangements or a change in arrangements are being made, an extension of up to thirty days may be allowed. The action of the county department in assistance or referral shall be recorded in the case record.

E. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE or institutional services disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of medical assistance provided to the individual.

F. The county department shall notify in writing the issuer of any annuity or financial instrument described in 8.100.74.E. that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of medical assistance provided to the individual. This notice shall require the issuer to notify the county department when there is a change in the amount of income or principal that is being withdrawn from the annuity.

.75 When the redetermination verification information is not returned within the ten working day time period:

A. A second request form shall be mailed to the client;

B. A State approved notice of proposed action taken shall be mailed with the forms notifying the client of termination of Medicaid eligibility, but such action will not be taken if the completed and signed forms are returned within the prior notice period, or the client can show good cause as to why the forms cannot be returned timely.

C. If no response is received by the end of the prior notice period, action to terminate shall be taken.

.76 When the redetermination verification information is received by the county department, it shall be date stamped. Within ten working days, the verification information shall be thoroughly reviewed for completeness, accuracy, and consistency. All factors shall be evaluated as to their effect on eligibility. Verifications shall be documented in the case file. The case file shall be used as a checklist in the redetermination process, and shall be used to keep track of matters requiring further action. When additional information is needed:

A. due to incomplete information, the request form shall be mailed back to the client with a letter specifying the items that require completion. A self-addressed, stamped, return envelope shall be enclosed;

B. due to inaccurate or inconsistent data, the Medicaid client shall immediately be contacted by telephone or in writing so that the worker may secure the proper information.

8.100.8 CONFIDENTIALITY

.81 All information obtained by the county department concerning an applicant for or a recipient of Medicaid is confidential information.

.82 A signature on the Application for Colorado Health Care allows a county worker to consult banks, employers, or any other agency or person to obtain information or verification to determine

eligibility. The identification of the worker as a county employee will, in itself, disclose that an application for Medicaid has been made by an individual. In this type of contact, as well as other community contacts, the county should strive to maintain confidentiality.

The signature on the Application for Colorado Health Care also provides permission for the release of the client's medical information to be provided by health care providers to the State and its agents for purpose of administration of the Medicaid program.

- .83 County department staff may release a client's Medicaid state identification number and approval eligibility spans to a Medicaid provider for billing purposes. County department staff may inform a Medicaid provider that an application has been denied but may not inform them of the reason why.
- .84 Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State and county agency.
- .85 The county must obtain permission from a family or individual, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of medical assistance payment. Unless the request is from State authorities, federal authorities, or State contractors acting within the scope of their contract.

If, because of an emergency situation, time does not permit obtaining consent before release, the county must notify the family or individual immediately after supplying the information.

- .86 The counties policies must apply to all requests for information from outside sources, including government bodies, the courts, or law enforcement officials.

If a court issues a subpoena for a case record or for any county representative to testify concerning an applicant or recipient, the county must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

- .87 The following types of information are confidential and shall be safeguarded:

- a. Names and addresses of applicants for and recipients of Medicaid;
- b. Medical services provided;
- c. Social and economic conditions or circumstances;
- d. Agency evaluation of personal information;
- e. Medical data, including diagnosis and past history of disease or disability;
- f. All information obtained through the Income and Eligibility Verification System (IEVS), SSA or Internal Revenue Service;
- g. Any information received in connection with third party resources;
- h. Any information received for verifying income and resources if applicable, or other eligibility and the amount of medical assistance payments.

- .88 The confidential information listed above may be released to persons outside the county department only as follows:

- a. In response to a valid subpoena or court order;
 - b. To State or Federal auditors, investigators or others designated by the Federal or State departments on a need-to-know basis;
 - c. To individuals executing Income and Eligibility Verification System;
 - d. Child Support enforcement officials;
 - e. To a recipient or applicant themselves or their designated representative.
- .89 The applicant/recipient may give a formal written release for disclosure of information to other agencies, such as hospitals, or the permission may be implied by the action of the other agency in rendering service to the client. Before information is released, the county department should be reasonably certain the confidential nature of information will be preserved, the information will be used only for purposes related to the function of the inquiring agency, and the standards of protection established by the inquiring agency are equal to those established by the State Department. If the standards for protection of information are unknown, a written consent from the recipient shall be obtained.
- 8.100.9 PROTECTION AGAINST DISCRIMINATION**
- .91 County departments are to administer Medical assistance programs in such a manner that no person will, on the basis of race, color, sex, age, religion, political belief, national origin, or handicap, be excluded from participation, be denied any aid, care, services, or other benefits of, or be otherwise subjected to discrimination in such program.
- .92 The county department shall not, directly or through contractual or other arrangements, on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap:
- A. Provide aid, care, services, or other benefits to an individual which is different, or provided in a different manner, from that to others;
 - B. Subject an individual to segregation barriers or separate treatment in any manner related to access to or receipt of assistance, care services, or other benefits;
 - C. Restrict an individual in any way in the enjoyment or any advantage or privilege enjoyed by others receiving aid, care, services, or other benefits provided under Medical assistance programs;
 - D. Treat an individual differently from others in determining whether he/she satisfies any eligibility or other requirements or conditions which individuals shall meet in order to receive aid, care, services, or other benefits provided under Medical assistance programs;
 - E. Deny an individual an opportunity to participate in programs of assistance through the provision of services or otherwise, or afford him/her an opportunity to do so which is different from that afforded others under Medical programs of assistance.
- .93 No distinction on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap is permitted in relation to the use of physical facilities, intake and application procedures, caseload assignments, determination of eligibility, and the amount and type of benefits extended by the county department to Medical assistance recipients.
- .94 An individual who believes he/she is being discriminated against may file a complaint with the county department, the State Department, or directly with the Federal government. When a complaint is

filed with the county department, the county director is responsible for an immediate investigation of the matter and taking necessary corrective action to eliminate any discriminatory activities found. If such activities are not found, the individual is given an explanation. If the person is not satisfied, he/she is requested to direct his/her complaint, in writing, to the State Department, Complaint Section, which will be responsible for further investigation and other necessary action consistent with the provisions of Title VI of the 1963 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

8.101.1 MEDICAID ELIGIBILITY FOR FAMILIES AND CHILDREN

- .11 Medical assistance shall be provided to families and children who meet the federal definition of categorically needy. All references to 1931 Medicaid apply to AFDC rules effective on July 16, 1996. The following are considered under this group.
 - A. Persons who would have been eligible for AFDC (1931 Medicaid).
 - B. Children who would be eligible for 1931 Medicaid except for the consideration of income from a stepparent outside the assistance unit, or a grandparent outside the assistance unit.
 - C. Persons who would be eligible for 1931 Medicaid except for the inclusion in the assistance unit of a child/children whose income makes the unit ineligible. This also applies to parents with only one child.
 - D. Persons who would be eligible for 1931 Medicaid except for the income of a child(ren) outside the assistance unit whose income makes the unit ineligible.
 - E. A child born to a woman eligible for and receiving Medicaid at the time of the child's birth, is continuously eligible for one year as long as the child remains a member of the household. This applies to children born to undocumented aliens and certain legal aliens as outlined in Section 8.100.53. To receive Medicaid under this category, the family need not file an application nor provide a social security number or proof of application for a social security number for the newborn. Anyone can report the birth of the baby by telephone. Information provided shall include the baby's name, date of birth, and mother's name or Medicaid number. A newborn can be reported to the county department at any time. Once reported a newborn meeting the above criteria shall be put on Medicaid from date of birth.
 - F. Children up to age six whose income does not exceed their proportionate share of 133% of the federal poverty level; or whose total family income does not exceed 133% of the federal poverty level.
 - G. Children born after September 30, 1983, not 19 years of age whose income does not exceed their proportionate share of 100% of the federal poverty level; or whose total family income does not exceed 100% of the federal poverty level.
 - H. If an individual is found ineligible because his/her income exceeds their proportionate share of the federal poverty level, a recalculation shall be performed to look at the Medicaid required household as a whole. The household's total income, after the allowable Medicaid deductions, shall be compared to the maximum federal poverty level. If the individual is then eligible under this process, he/she shall be coded under the same category for which they originally were determined ineligible.
 - I. Medical assistance shall be provided to persons in a facility eligible for Medical reimbursement who, if they left the facility, would be eligible for 1931 Medicaid.

J. Medical assistance shall be provided to a woman:

- a. whose pregnancy is medically verified in writing by a medical professional (a certified medical assistant or higher level position supervised by a registered nurse or doctor), if pregnancy is not observable; and
- b. whose income does not exceed her proportionate share of 133% of the federal poverty level or whose total family income does not exceed 133% of federal poverty level; and
- c. for a period beginning with the date of application for medical assistance or as of the date the person becomes eligible for medical assistance, whichever is the later calendar date, through 60 additional days from the date the pregnancy ends.

K. Until the implementation of SB 03-176, a pregnant legal alien is eligible for state-funded prenatal medical care if she meets the eligibility requirements for expectant mothers listed in J.

L. A pregnant woman may apply for presumptive eligibility for ambulatory services through Medicaid presumptive eligibility sites.

To be eligible for presumptive eligibility, a woman shall have a verified pregnancy, declare that her household's income shall not exceed 133% of federal poverty level and declare that she is a United States citizen or a documented immigrant.

Presumptive eligibility sites shall be certified by the Department of Health Care Policy and Financing to make presumptive eligibility determinations. Sites shall be re-certified by the Department of Health Care Policy and Financing every 2 years to remain approved presumptive eligibility sites.

The presumptive eligibility sites shall require the applicant to provide all necessary verification within fourteen calendar days of application. If the applicant fails to provide the necessary documentation on the fourteenth calendar day following application, the presumptive eligibility period shall terminate.

The presumptive eligibility site shall forward the application to the county within five business days of being completed. If the application is not completed within fourteen calendar days, on the fifteenth calendar day following application, the presumptive eligibility sites shall forward the application to the appropriate county.

The presumptive eligibility period shall be no longer than 60 days. The county department shall make a Medicaid eligibility determination within 45 days from receipt of a completed application. The effective date of Medicaid eligibility will be the date of application.

A Presumptive eligible woman may not appeal the end of a presumptive eligibility period.

M. Presumptively eligible women and Medicaid clients may appeal the county department's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in Section 8.058 of staff manual Volume 8 entitled "State Hearings".

N. Household size for all Medicaid categories shall include the unborn child(ren) as a child(ren) living in the home in determining eligibility.

8.101.2 NEEDY PERSONS UNDER 21

Medical assistance shall be provided to certain needy persons under 21 years of age, including the following:

- A. Those receiving care in an intermediate care facility eligible for Medicaid reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medicaid reimbursement.
- B. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. See Colorado Department of Human Services "Social Services Staff Manual" Section 7 for specific eligibility requirements (12 CCR 2599). A child shall be the responsibility of the county, even if the child may be in a medical institution at that time.
- C. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.
- D. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose family income is less than the AFDC needs standard for his/her family size excluding step-parent income.
- E. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.
- F. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption program, including a clause in the subsidized adoption agreement to provide Medicaid for the child.

8.101.3 NON-FINANCIAL REQUIREMENTS

- .31 Residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. An absence shall be considered to be temporary when the person, at the time he/she leaves, intends to return.
- .32 A non-resident shall mean a person who considers his/her place of residence to be other than Colorado. Persons who come to the state to receive medical assistance or for any other reason do not acquire residence so long as they consider their permanent place of residence to be elsewhere.
- .33 When a family or individual moves from one county to another within Colorado, the client shall report their change of address to the county that carries their current active Medicaid case(s). The originating county shall leave the Medicaid case(s) active for a minimum of 30 days from the date the change of address was reported. During this period the originating county shall ensure that the annual redetermination has been completed if it is due within the next 2 months and case coding is correct. Then the case will be closed for the discontinuation reason "out of the county" and a notice sent to the client. The originating county must contact the receiving county of the clients transfer of Medicaid.
- .34 The receiving county shall accept a phone call from the originating county or the client that he/she

has moved to the receiving county. If the family or individual wishes to apply for other types of assistance or wishes to apply for Medicaid for additional family members, they shall submit a new application.

.35 If the household is transferring the current Medicaid eligibility, the receiving county can not mandate a new application, verification, or an office visit to authorize the transfer. The receiving county shall activate the case effective the day after the originating county's case is closed.

.36 If a household applies in the county they live in and then moves out of that county during the application determination process, the originating county shall complete the processing of that application. The originating county will then follow the same transfer process.

.37

A. Cases closed for the discontinuation reason of "unable to locate" in the originating county shall be treated the same in the receiving county as those closed for the discontinuation reason of "out of county".

B. If a case is closed for any other discontinuation reason than "unable to locate" or "out of county" and the client provides appropriate information to overturn the discontinuation with the originating county, the originating county shall reopen the case and then close it for the appropriate discontinuation reason "out of county".

8.101.4 ELEMENTS CONSIDERED IN DETERMINING NEED

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A. In determining eligibility for medical assistance for household members, financial responsibility is limited to spouse being responsible for spouse, and parent being responsible for a dependent child. Financial responsibility of parents for a dependent child is not changed by the fact that the child may be pregnant or that she is a mother and caretaker of her own child.

B. A declared common law spouse retains the same financial responsibility as a legally married spouse. Once declared as common law, financial responsibility remains unless separation or divorce occurs.

.41 A parent means only a natural (including expectant) or adoptive parent.

.42 Dependent children are those who are;

A. under age 18 years of age; or

B. between the ages of 18 and 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19. Such children are eligible through the month of completion.

A dependent child is still considered to be a student in regular attendance during official school or training program vacation periods; absences due to illness, convalescence or family emergency; or the month which the child completes a school or training program.

Regular attendance means enrolled in a program of study or training leading to certificate, or diploma and physically attending:

1. full-time, or

2. at least half-time and regularly employed in or actively seeking part-time employment,
or
3. at least half time and precluded from full-time attendance or part-time employment
because of a verified physical handicap.

Full-time attendance in a program of study or training means secondary school attendance (including cooperative training programs), vocational or technical school of twenty-five (25) clock hours per week or as defined by the school. Participation in an approved program of training through employment and related education and technical instruction apprenticeship program may also meet the requirement as full-time attendance. Half-time attendance exists when the individuals attends school between twenty-four (24) to twelve (12) clock hours per week.

- .43 Any family member who is receiving financial assistance from SSI or OAP-A is not considered a member of the Medicaid required household and the individual's income and resources are disregarded in making the determination of need for medical assistance.

The following family members living in the same residence shall be included in the Medicaid required household:

- A. dependent children who are not receiving SSI benefits,
 - B. parents of the dependent children not receiving benefits from SSI or Old Age Pension because he/she is age 65 or older.
- .44 If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other.
- .45 Income of parents of minor parents under the age of 18 living in the same household shall be attributed to the minor parent unless the minor parent is married or separated from marriage. Financial responsibility is between spouses, with each spouse being responsible for the spouse.

8.102.1 GENERAL RESOURCES AND INCOME EXEMPTIONS

- .41 For the purpose of determining eligibility for medical assistance the following shall be exempt from consideration as either resources, if applicable, or income:
- A. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a repayment agreement. Declaration of such loans is sufficient verification.
 - B. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act.
 - C. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for women, infants and children (WIC).
 - D. Home produce utilized for personal consumption.
 - E. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act; relocation payments to a displaced homeowner toward the purchase of a replacement dwelling are considered exempt for up to 6 months.
 - F. Experimental Housing Allowance Program (EHAP) payments made by HUD under Section 23 of the U.S. Housing Act.

- G. Payments made from Indian judgement funds and tribal funds held in trust by the Secretary of the Interior and/or distributed per capita; and initial purchases made with such funds. (Public Law No 98-64 and Public Law No. 97-458).
- H. Distributions from a native corporation formed pursuant to the Alaska Native Claims Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to exceed \$2000 per individual per calendar year; stock; a partnership interest; or an interest in a settlement trust. Cash payments, up to \$2000, received by a client in one calendar year which is retained into subsequent years is excluded as income and resources; however, cash payments up to \$2000 received in the subsequent year would be excluded from income in the month(s) received but counted as a resource if retained beyond that month(s).
- I. Assistance from other agencies and organizations.
- J. Major disaster and emergency assistance provided to individuals and families, and comparable disaster assistance provided to states, local governments and disaster assistance organizations shall be exempt as income and resources in determining eligibility for medical assistance.
- K. Payments received for providing foster care.
- L. Payments to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than the minimum wage, and Title II and Title III of the Domestic Volunteer Services Act.
- M. The benefits provided to eligible persons or households through the Low Income Energy Assistance (LEAP) Program.
- N. Any grant or loan to an undergraduate student for educational purposes made or insured under any programs administered by the Commissioner of Education (Basic Education Opportunity Grants, Supplementary Education Opportunity Grants, National Direct Student Loans and Guaranteed Student Loans), Pell Grant Program, the PLUS Program, the BYRD Honor Scholarship programs and the College Work Study Program.
- O. Any portion of educational loans and grants obtained and used under conditions that preclude their use for current living cost (need-based).
- P. Financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act that is made available for attendance cost shall not be considered as income or resources. Attendance cost includes tuition, fees, rental or purchase of equipment, materials or supplies required of all students in the same course of study, books, supplies, transportation, dependent care and miscellaneous personal expenses of students attending the institution on at least a half-time basis, as determined by the institution.
- Q. Training allowances granted by the Workforce Investment Act (WIA) to enable any individual whether dependent child or caretaker relative, to participate in a training program.
- R. Payments received from the youth incentive entitlement pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs under the Youth Employment and Demonstration Project Act.

- S. Social Security benefit payments and the accrued amount thereof to a client when an individual plan for self-care and/or self-support has been developed. In order to disregard such income and resources, it shall be determined that (1) SSI permits such disregard under such developed plan for self-care-support goal, and (2) assurance exists that the funds involved will not be for purposes other than those intended.
- T. Monies received pursuant to the "Civil Liberties Act of 1988" P.L. No. 100-383, (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts).
- U. Effective January 1, 1989, payments made from the Agent Orange Settlement Fund or any fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No 381 (E.D.N.Y).
- V. A child receiving subsidized adoption funds shall be excluded from the Medicaid budget unit and his income shall be exempt from consideration in determining eligibility, unless such exclusion results in ineligibility for the other members of the household.
- W. Effective January 1, 1991, the Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month.
- X. Any money received from the Radiation Exposure Compensation Trust Fund, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510.
- Y. Reimbursement or restoration of out-of-pocket expenses.
- Z. Effective 8/1/1994, payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286.
- AA. General Assistance, SSI, OAP-A and cash assistance under the Temporary Assistance to Needy Families (TANF) funds.
- BB. Effective March 1, 2000, all wages paid by the United States Census Bureau for temporary employment related to U.S. Census 2000 activities.

8.103.1 CONSIDERATION OF INCOME FOR FAMILIES AND CHILDRE MEDICAID PROGRAM

Income for Categorical Medicaid eligibility is that income which is received by an individual or family in the month in which they are applying for or receiving medical assistance.

- .11 Income, in general, is the receipt by an individual of a gain or benefit in cash or in kind during a calendar month. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, interest, etc., that are received by an individual or family.
- .12 Earned in kind income shall be income produced as a result of the performance of services by the applicant/client, for which he/she is compensated in cash, shelter or other items in lieu of wages.
- .13 Received, as is used in the preceding paragraphs, means "actually" received or legally becomes available, whichever occurs first; that is, the point at which the income first is available to the individual to use. For example, interest income on a savings account is counted when it is credited to the account.
- .14 Compensation received from the Crime Victims Compensation Act shall be considered as income to the extent that it exceeds the expenses for which it was designated, i.e., medical and/or burial expenses.

- .15 The first \$50 per household per month of any current monthly support obligation shall be disregarded. Monthly support includes child support, and/or maintenance, and/or alimony.
- .16 All Home Care Allowance (HCA) income paid to a Medicaid applicant/client by the HCA recipient to provide home care services is countable earned income.
- .17 Participation in the Workforce Investment Act (WIA) affects eligibility for medical assistance as follows.
 - A. Wages derived from participation in a program carried out under WIA (work experience or on-the-job training) and paid to a caretaker relative is considered countable earned income.
 - B. Training allowances granted by WIA to a dependent child or a caretaker relative of a dependent child to participate in a training program is exempt.
 - C. Wages derived from participation in a program carried out under Workforce Investment Act (WIA) and paid to any dependent child who is applying for or receiving medical assistance are exempt in determining eligibility for a period not to exceed six months in each calendar year.
- .18 Income of a medical assistance applicant/client who is attending school (student in a secondary education or undergraduate degree program) shall be treated as follows:
 - A. Income received from a college work-study program grant shall be exempt when it is part of a "need-based package" administered by the U.S. Commission of Education.
 - B. Scholarships given to individuals for education and training are exempt.
 - C. Income received by the medical assistance client which exceeds the work study grant specified in the need-based package shall be considered earned income.
 - D. All earned income that is received by a dependent child who is a full-time student or a part-time student who is not a full-time employee shall be disregarded for the eligibility test as long as they remain a student.
 - E. All earned income of dependent children who are not students (except income from WIA for up to six months in each calendar year) shall be considered in determining eligibility for medical assistance. All disregards from the earned income shall apply as listed in Section 8.104.10 of this manual.

8.103.19 An individual involved in a profit making activity shall be classified as self-employed.

- A. To determine the net profit of a self-employed applicant/client deduct the cost of doing business from the gross income. These expenses include, but are not limited to:
 - 1. the rent of business premises,
 - 2. wholesale cost of merchandise,
 - 3. utilities,
 - 4. taxes,
 - 5. labor, and

6. upkeep of necessary equipment.

B. The following are not allowed as business expenses:

1. Depreciation of equipment;
2. The cost of and payment on the principal of loans for capital asset or durable goods;
3. Personal expenses such as personal income tax payments, lunches, and transportation to and from work.

C. Appropriate allowances for cost of doing business for medical assistance clients who are licensed, certified or approved day care providers are (1) \$55 for the first child for whom day care is provided, and (2) \$22 for each additional child. If the client can document a cost of doing business which is greater than the amounts above set forth, the procedure described in A, shall be used.

D. When determining self employment expenses and distinguishing personal expenses from business expenses it is required to only allow the percentage of the expense that is business related.

8.103.20 Self-employment income includes, but is not limited to, the following:

A. Farm income - shall be considered as income in the month it is received. When an individual ceases to farm the land, the income is no longer deducted.

B. Rental income - shall be considered as self- employment income only if the medical assistance client actively manages the property at least an average of 20 hours per week.

C. Board (to provide a person with regular meals only) payment shall be considered earned income in the month received to the extent that the board payment exceeds the maximum food stamp allotment for one-person household per boarder and other documentable expenses directly related to the provision of board.

D. Room (to provide a person with lodging only) payments shall be considered earned income in the month received to the extent that the room payment exceeds documentable expenses directly related to the provision of the room.

E. Room and board payments shall be considered earned income in the month received to the extent that the payment for room and board exceeds the food stamp allotment for a one-person household per room and boarder and documentable expenses directly related to the provision of room and board.

8.104 EARNED INCOME DISREGARDS

.10 The earned income disregards described in this section shall be applied to the gross wages of each individual who is employed in the following order:

- A. deduct the employment expense disregard of \$90; and
- B. deduct dependent care disregard.

For purposes of this section, a dependent is defined as a dependent child or adult included in the Medicaid required household. The employed person is allowed a dependent care deduction of the

actual verified amount of the dependent care expenses of up to \$175 per month per each dependent two (2) years and older; up to \$200 per month per dependent less than two (2) years old.

In order to receive a dependent care deduction, declaration from the client is acceptable. The declaration, verbal, or written on the application, shall include the total dependent care costs paid per child for the month(s) Medicaid eligibility is being determined. The client may also present receipts or other documentation of paid costs for dependent care for these months.

8.105.1 1931 MEDICAID--GROUPS ASSISTED UNDER CERTAIN AFDC PROGRAM RULES, AS OUTLINED IN THIS SECTION, THAT WERE EFFECTIVE ON JULY 16, 1996.

- .11 Medical assistance shall be provided to needy families who would have been eligible for Aid to Families with Dependent Children(AFDC) under regulations in effect on July 16, 1996. No other TANF/Colorado Works criterion applies to this group. Counties shall not require that a Medicaid applicant/ recipient comply with any TANF/Colorado Works requirements. All references to the 1931 Medicaid Program apply to AFDC rules effective on July 16, 1996.
- .12 Needy families are those whose income is less than the State standard of assistance.
- .13 Dependent Children are those who are:
 - A. deprived of parental support or care due to the family income falling at or below the federal poverty level, and
 - B. living in the home of a parent or specified relative, or in foster care under certain conditions.
- .14 Parent means only a natural (including expectant) or adoptive parent.
- .15 In this section on 1931 Medicaid, the term's "applicant" and "client" include all the family members for whom 1931 Medicaid assistance would have been considered.
- .16 Only certain family members are eligible persons and shall be in the same Medicaid required household:
 - A. dependent children under the age of 18;
 - B. dependent children between the ages of 18 and 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training and expected to complete the program before age 19. Such children are eligible through the month of completion;
 - C. The caretaker relative (a parent(s) or specified relative of a dependent child).
- .17 Application for 1931 Medicaid Only assistance shall be made by a specified relative with whom the dependent child is living. A specified caretaker relative is any relation by blood, marriage or adoption who is within the fifth degree of kinship to the dependent child, such as:
 - A. a parent;
 - B. a brother, sister, uncle, aunt, first cousin, first cousin once removed, nephew, niece, or persons of preceding generations denoted by prefixes of grand, great, great-great, or great-great-great;
 - C. a spouse of any person included in the above groups even after the marriage is terminated by

death or divorce; or

D. stepparent, stepbrother, stepsister, step-aunt, etc.

There is no age requirement for the caretaker nor is the status of emancipation a requirement in regard to the caretaker relative. The caretaker relative is a specified relative who exercises responsibility for the care and control of the dependent child.

8.105.2 SITUATIONAL REQUIREMENTS

.21 To receive medical assistance as an 1931 Medicaid Only, a person shall meet the requirements at 8.100.53, and not be receiving financial assistance from AFDC foster care, OAP-A or SSI.

.22 Persons who may be eligible for benefits under either 1931 or SSI

A. shall be advised of the benefits available under each program;

B. may apply for a determination of eligibility under either or both programs, and

C. have the option to receive benefits under the program of their choice, but may not receive benefits under both programs at the same time;

D. may change their selection if their circumstances change or if they decide later that it would be more to their advantage to receive benefits from the other program;

E. if they choose to receive benefits from SSI, their resources and income are disregarded for the purpose of determining the eligibility of any other family members for 1931. The SSI recipient's resources and income (including any resources jointly owned or received) are disregarded in determining the 1931 resource limit and/or standard of assistance.

F. An individual receiving Aid to the Needy Disabled (AND) may also receive 1931 Medicaid Only. An AND recipient shall be eligible for 1931 Medicaid Only, if the recipient meets all the requirements of 1931 Medicaid including the Medicaid required household. For these individuals counties shall include the applicants AND payment as unearned income to the Medicaid required household along with all other income.

If the AND individual's AND payment and other income makes the 1931 Medicaid required household ineligible, counties shall disregard the AND individual and give the remaining members 1931 Medicaid as long as their income is within the allowable limits.

.23 Before 1931 Medicaid assistance is provided,

A. each person for whom Medicaid assistance is being requested shall furnish a Social Security Number, or, if one has not been issued or is unknown, shall apply for the number. The application for an SSN shall be verified and documented in the case record by the county. Upon receipt of the assigned Social Security Number, the client shall provide the number to the county department;

This requirement does not apply to those individuals who are not requesting Medicaid assistance yet appear on the application, nor does it apply to undocumented individuals or eligible newborns born to a Medicaid mother.

B. An eligible person shall provide information regarding any third party resources available to any member of the assistance unit. Third party resources is any health coverage or insurance other than Medicaid.

- .24 A 1931 applicant's or client's refusal to furnish or apply for a Social Security Number or provide information regarding third party resources affects the family's eligibility for assistance as follows:
- A. that person's needs cannot be taken into account in determining eligibility for Medicaid, or
 - B. if the person with no SSN or proof of application for SSN is the only dependent child on whose behalf assistance is requested or received, assistance shall be denied or terminated.
- .25 The applicant's signature on the application form is required to receive medical assistance.
- .26 Medical assistance is not available to the unborn child, but only to the pregnant mother.

Medical assistance is not available to meet the needs of the father of an unborn child when there are no other children in the 1931 Medicaid assistance unit.

8.105.3 APPLICATION FOR 1931 MEDICAID ONLY

- .31 Applicants may file an application at any time a county department is open for business. They will not be restricted to a certain time of day. Applicants may also file an application at any state approved outreach site.
- .32 If the specified relative is not able to participate in the completion of the application forms due to physical or mental incapacity, the spouse, other relative, friend, or representative may complete the forms. When no such person is available to assist in these situations, the county department shall assist the relative in the completion of the necessary forms. This type of situation should be identified clearly in the case record.
- .33 The county has the responsibility to assure that the specified relative receives information regarding program benefits and requirements applicable to the family members, but the county can make no restrictions regarding which family members on whose behalf the specified relative may request assistance.
- If found to be ineligible for a particular program, the Single Purpose application is reviewed and processed for other programs the household has requested on the Single Purpose Application, Part One. This may include food stamps, adult services, refugee services and categories of medical only under the Social Services program. Referrals to other community agencies and organizations shall be made for the applicant.
- If the applicant applied for Medicaid on the Application for Colorado Health Care and was found ineligible, this application shall be reviewed for all other Family and Children's Medicaid eligibility programs. If any child(ren) are found ineligible for all other Medicaid categories, and denied with cause (over age, income, or as defined by the Colorado Office of Program Development) the application shall be forwarded to the Child Health Plan Plus Program with the reason of denial.
- .34 Persons required to be in the same assistance unit shall file for 1931 Medicaid as one assistance unit. Persons not required to be in one assistance unit, but residing in the same household shall have the option of applying for 1931 Medicaid assistance as separate units. Each assistance unit shall be budgeted using the appropriate need standard for the unit.
- .35 Any person(s) in the Medicaid required household that are found ineligible for any financial program shall be continued on Medicaid unless the reason of ineligibility is specific to the requirements specified in this Volume 8.

8.105.4 LIVING IN THE HOME OF THE CARETAKER RELATIVE

.41 A dependent child is considered to be living in the home of the caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child and even though

- A. the child is under the jurisdiction of the court (for example, receiving probation services);
- B. legal custody is held by an agency that does not have physical possession of the child;
- C. the child is in regular attendance at a school away from home;
- D. either the child or the relative is away from the home to receive medical treatment;
- E. either the child or the relative is temporarily absent from the home;
- F. the child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court-ordered, the child is no longer considered to be living in the AFDC home as of the time the foster care plan is changed.

8.105.5 ESTABLISHING THE FACTS OF ELIGIBILITY

The particular circumstances of a family will indicate the appropriate documentation needs and sources. Documentation to establish that a situational requirement is met is needed only when inadequate or inconsistent information supplied by the caretaker relative warrants securing verification to clarify a question of eligibility.

A. Minimal Verification - The following items shall be verified for all needy families applying for medical assistance:

1. A Social Security Number shall be provided for each individual on the application for whom Medicaid assistance is being requested, or proof shall be submitted that an application for a Social Security Number has been made.
2. Verification of earned income shall be provided if the applicant earned money in the month for which eligibility is being determined or during the previous month.
 - a. Prior to implementation of the Colorado Benefits Management System (CBMS), earned income shall be verified by a full calendar month of wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month has not ended or the earned income information is not yet available. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. If the applicant is self employed, detailed ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable.
 - b. Upon implementation of CBMS, estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility

if the client provides verification for the full calendar month.

3. Pregnancy verification, if applicable, and if the pregnancy is not observable.
 4. Immigrant registration cards or papers, if applicable, to determine if the client is eligible for full Medicaid benefits. If an applicant does not provide this, he/she shall only be eligible for emergency Medicaid if they meet all other eligibility requirements.
 5. Verification of all unearned income may be declared by the client verbally or on the application.
- B. Additional Verification - No other verification shall be required of the client unless information is found to be questionable on the basis of fact. Questionable is defined as tangible information that contradicts other statements, documents, or file records.
- C. The determination that information is questionable shall be documented in the applicant's case file.
- D. Each applicant shall be given the state-approved eligibility checklist which will provide 1931 Medicaid-specific eligibility factors which shall be verified and suggested methods for verifying each essential eligibility factor.
- E. Information that exists in another case record shall be used to verify those factors that are not subject to change, if the information is reasonably accessible.
- F. Upon request, applicants will be given an extension of time in which to submit requested verification within the 45-day period. Notification of the right to this extension is provided in the state-approved eligibility checklist.

Applicants may request an extension of time beyond 45 days to obtain necessary verification. The extension beyond the 45 days may be granted at the county's discretion.

.52 The criteria of age, school attendance, and relationship can be declared by the client unless questionable (as defined in 8.105.5B). If questionable, these criteria can be established with information provided from:

- A. official papers such as: a birth certificate, order of adoption, marriage license, immigration or naturalization papers; or,
- B. records or statements from sources such as: a court, school, government agency, hospital, or physician.

.53 Establishing that a dependent child meets the eligibility criterion of

- A. age, if questionable - requires (1) viewing the birth certificate or comparably reliable document, and (2) recording the source of verification in the case file;
- B. school attendance, if questionable - requires (1) obtaining confirmation from the school by phone or in writing, and (2) recording the means of verification on the review record;
- C. living in the home of the caretaker relative, if questionable - requires (1) viewing the appropriate documents which identify the relationship, (2) recording these sources of verification on the review record, and (3) recording on the review record the information used to determine that the child is living with the caretaker relative. As an example, the

review record may show that the child was seen during the home visit...or, if the child is of school age, the school attendance verification may be used to confirm the home address.

- .54 To receive medical assistance as an expectant mother, the fact of pregnancy, if not observable, shall be verified by a written medical statement confirming the pregnancy and the estimated date of delivery.
- .55 The caretaker relative shall be given an opportunity to provide additional information or documentation.
- .56 A contact with a collateral source to secure documentation may be made only if the caretaker relative has provided written authorization.

8.106 DEPRIVATION FOR MEDICAID ONLY ASSISTANCE

- .70 The only deprivation factor for Medicaid is that one or two parent households are at or below the income limits for the category for which they are applying.

8.106.7 TRANSITIONAL MEDICAID

- .71 Eligibility for transitional medical assistance shall be extended for up to twelve months (beginning with the first month of ineligibility) for families who would otherwise become ineligible for medical assistance under 1931 Medicaid. The extension shall be applied for an individual who is eligible and receiving assistance under 1931 Medicaid in at least 3 of the 6 months immediately preceding the month in which the family would have become ineligible for 1931 Medicaid assistance, and

- A. who becomes ineligible for 1931 Medicaid solely because of new or increased income from employment, or hours of employment, provided the employed member of the family continues to be employed, or

- B. who becomes ineligible for 1931 Medicaid after allowable deductions of \$90, Daycare (\$200 < 2, \$175 > 2years old) due solely to the loss of the \$30 plus 1/3 or \$30 disregards because of the expiration of the time limit.

Required members of the Medicaid required household who come into the household after the unit is receiving transitional Medicaid are eligible for the remaining months of transitional Medicaid. Transitional Medicaid applies to the members of the Medicaid required household.

- .72 To be eligible for the first six months of Transitional Medicaid, the assistance unit shall be eligible in all respects before the increased earnings or hours, or loss of the \$30 + 1/3 or \$30 disregards. The employed family member shall be included in the 1931 Medicaid assistance unit. The employed family member or a family member who was excluded because he/she did not meet an eligibility requirement need not be in the assistance unit.

- .73 Eligibility for Transitional Medicaid occurs:

- A. When the individual is a dependent child under 18 or under 19 if expected to graduate by 19th birthday; or

- B. When the household continues to include at least one child who was a member of the household in the month the assistance unit became ineligible for 1931 Medicaid benefits. The child need not be dependent under Title IV-A. For purposes of Transitional Medicaid, a dependent child is one who is under age 18 (or under 19 if expected to graduate from

high school by 19th birthday).

If it is determined that the household no longer has a child living in the home, Transitional Medicaid is discontinued at the end of the month in which the household does not include child under 18 or under 19 if expected to graduate by 19th birthday.

.74 To remain eligible for Transitional Medicaid:

- A. The employed member of the Assistance Unit cannot terminate employment without good cause.
- B. Assistance Units are required to report earnings and necessary child care costs by the 21st of the fourth month of the twelve-month Transitional Medicaid period via the appropriate reporting form. Failure to report without good cause shall result in ineligibility for Transitional Medicaid for months seven (7) through twelve (12) of the twelve-month Transitional Medicaid period.
- C. If health insurance is available from the employer to the employee, at no cost to the 1931 Medicaid recipient, the client shall enroll in the insurance program.

.75 To continue to receive Medicaid during the second six months of Transitional Medicaid:

- A. The family shall meet all initial eligibility requirements of the first six months of Transitional Medicaid;
- B. The family shall request the benefits;
- C. Family's average gross earnings minus the caretaker's necessary child care cost cannot exceed 185% of the federal poverty level for the household size; and
- D. If health insurance is available from the employer to the employee, at no cost to the former 1931 Medicaid recipient, the recipient shall enroll in the insurance program.
- E. The family shall report the gross earnings and the necessary child care costs by the 21st day of the seventh month for each of the three preceding months; and by the 21st day of the tenth month for each of the three preceding months via the appropriate reporting form. Failure to report without good cause by the appropriate deadline causes ineligibility for the remainder of the second six-month period.
- F. When Transitional Medicaid ends, the county shall review the file for all other categories of Medicaid for which the family members may be eligible. A new application shall not be required for this process.

.76 Eligibility for medical assistance shall be extended for four months (beginning with the first month of ineligibility) for certain families who become ineligible for 1931 Medicaid due solely or partially to the receipt of support income. Support income may be child support, maintenance, or alimony. The extension shall be applied for a family which receives assistance under 1931 Medicaid in at least three of the six months immediately preceding the month in which the family becomes ineligible for assistance. To be eligible for the four-month Medicaid extension, the family shall be eligible for 1931 Medicaid in all respects before the support income is applied. The support recipient shall be included in the 1931 Medicaid calculation for the extension to apply.

8.110 MEDICAL ASSISTANCE FOR THE AGED, DISABLED OR BLIND

8.110.1 SSI ELIGIBLES

.11 Benefits of the Colorado Medicaid Program must be provided to the following:

- a. persons receiving financial assistance under the federal Supplemental Security Income program (SSI);
- b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;
- c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and
- d. persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.

.12 The State Department of Social Services has entered into an agreement with the Social Security Administration (SSA) in which SSA shall determine Medicaid eligibility for all SSI applicants.

Medicaid benefits shall be provided to all individuals receiving SSI benefits as are determined by SSA to be eligible for Medicaid.

The county department shall receive a weekly unmatched listing of all individuals newly approved and also, a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the county to complete an eligibility form authorizing medical assistance.

.121 All individuals receiving Medicaid who are under 21 years of age and have an absent parent must be referred, using the form as specified by the State Department, to the Child Support Enforcement unit. Failure of the family to cooperate in establishing child support shall not affect the eligibility for Medicaid of the Medicaid recipient.

.13 The weekly unmatched listing shall include the answer to the following two (2) questions:

- a. Do you have any other medical resources?
- b. Do you have any prior medical bills?

If the SSI recipient answers "No" to both of the questions, the county shall approve the SSI recipient for Medicaid only effective the date of the SSI approval as indicated on the SDX.

The county shall notify the individual of the approval for Medicaid. This notice shall advise the SSI recipient that he/she may also be eligible for financial assistance and if the individual is interested, he/she should contact the county department. An application is required if these individuals request financial assistance (AND/AB/SSI-CS).

If the unmatched list indicates that the recipient answered "Yes" to either or both of the questions, the county department shall contact the individual prior to processing the eligibility reporting form to obtain the medical resources and determine eligibility for retroactive Medicaid for up to three (3) months prior to SSI approval as described in this volume in the section on FURNISHING ASSISTANCE.

.14 Medicaid eligibility shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.

The completed eligibility reporting form authorizing medical assistance shall be submitted to the State Department within ten (10) days of the receipt of the unmatched SSI listing by the county department. Notification, also, shall be sent to the SSI recipient within this time frame, advising

him/her of the approval of Medicaid and that financial assistance may be available.

The SISC Code for this type of assistance is B .

If the county is unable to contact the individual or obtain the information needed within the ten (10) day time limit, the eligibility reporting form shall be completed as though the questions were answered "No." The county, upon obtaining the necessary information, shall correct and re-submit the eligibility reporting form entering the appropriate information.

- .15 When Medicaid eligibility has been denied or terminated, based on a denial or termination of SSI which is later overturned, Medicaid eligibility must then be approved for the months the initial SSI payment was intended to cover.
- .16 Medicaid benefits must be provided to persons who remain eligible under SSI but are not receiving the SSI payment, since for purposes of Medicaid eligibility such individuals continue to be considered as SSI recipients. This group includes persons whose SSI payments are being withheld as a means of recovering an overpayment, whose checks are undeliverable due to change of address or representative payee, and persons who lost SSI financial assistance due to earned income. These will show up on the SDX (SSI/State Data Exchange System) as payment status codes C01 with "zero" payment and S06, S07, and S08. SDX status code M01 with "zero" payment or status code S09 must be checked with the local SSA/SSI office to determine whether the individual is SSI eligible.
- .17 If the county obtains information affecting the eligibility of these SSI recipients, they shall forward such information to the local Social Security office.

8.110.2 SSI RELATED CASES

- .21 Medical assistance must be provided to a person who was receiving financial assistance under SSI or a mandatory state supplementary payment and who lost such assistance because of the Social Security (excludes RRB) cost of living adjustment (COLA) paid in July 1977 or after. Medical assistance must also be provided to a person who loses eligibility for SSI or a mandatory state supplement any time after July 1977 due to the receipt of Social Security benefits. The situations that require continued medical assistance are outlined as follows:
 - A. The person lost OAP and/or SSI because of a cost of living adjustment to his/her own Social Security benefits.
 - B. The person lost OAP and/or SSI because of increased income deemed from a parent or spouse due to a cost of living adjustment received by the parent or spouse.
 - C. The person lost OAP and/or SSI due to the receipt of Social Security benefits (OASDI) during the current or previous years, and would be eligible for OAP and/or SSI except for the cost of living adjustments (COLA's) received since the last month for which the individual was both eligible for and received SSI and/or OAP and was eligible for OASDI concurrently.
- .22 The cost-of-living increase disregard specified in the preceding action must continue to be applied in each subsequent eligibility determination and the disregard amount then must include the increase that resulted in loss of eligibility for financial assistance plus subsequent OASDI cost-of-living increases paid to that time. This disregard must also be applied to any OASDI cost-of-living increases paid to any financially responsible individual such as a parent or spouse whose income is considered in determining the person's continued eligibility for medical assistance (see B above). This provision is retroactive to November 1, 1985, in accordance with U.S. District Court injunction of Lynch vs. Rank.

.23 Some of the disabled or blind persons who lose eligibility for SSI due to an OASDI cost-of-living increase may still be eligible for financial assistance under State AND or AB, or OAP "B". The county must determine eligibility for assistance under these programs. For such cases, the SISC code which must be entered on the reporting form is B .

.24 To redetermine eligibility of medical assistance recipients to whom the 1977 and later cost-of-living increase disregards apply, the county must:

A. establish whether the person received payments under SSI or OAP and, for the same month, was entitled to Social Security (OASDI) payment;

B. determine the Social Security income before the loss of financial assistance;

C. determine the current income;

D. subtract the previous Social Security income from the current income to find the cumulative OASDI COLAs since financial assistance was lost;

E. subtract the cumulative COLAs from the current income.

If the figure in step E is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria, such as age, resources, disability, citizenship and residency, medical eligibility must continue.

.25 An SSI medical only individual who loses SSI due to an OASDI cost-of-living increase shall be contacted by the county department to determine if the individual would continue to remain eligible for medical assistance under the provisions for SSI-related cases. The individual must complete an application for assistance to continue receiving benefits.

.26 Medical assistance must be provided to a person who was receiving financial assistance under AND or AB for August 1972 and who - except for the October 1972 Social Security (includes RRB) 20% increase amount - would currently be eligible for financial assistance. This disregard must also be applied to a person receiving medical assistance in August 1972 who was eligible for financial assistance but was not receiving the money payment and to a person receiving medical assistance as a resident in a medical institution in August 1972.

.27 To redetermine the eligibility of medical assistance recipients to whom the 1972 disregard applies, the county must:

A. review the case against the current applicable program definitions and requirements;

B. apply the resource and income criteria specified in the section on SSI FINANCIAL ELIGIBILITY REQUIREMENTS;

C. subtract the 1972 disregard amount from the income;

D. consider the remainder against the current appropriate SSI benefit level.

.28 Medical assistance must be provided to an SSI recipient who is receiving benefits as a child disabled prior to the age of 22 and who loses SSI due to the receipt of OASDI drawn from his/her parents' Social Security Number, and who would continue to be eligible for SSI if the above OASDI and all subsequent cost of living adjustments were disregarded.

.29 Medical assistance shall be provided retroactive to July 1, 1986, to qualified disabled widow(er)s who lost SSI and/or state supplementation due to the 1983 change in the actuarial reduction formula

prescribed in Section 134 of P.L. 98-21.

In order for these widow(er)s to qualify, these individuals must:

- A. have been continuously entitled to Title II benefits since December 1983;
- B. have been disabled widow(er)s in January 1984;
- C. have established entitlement to Title II benefits prior to age 60;
- D. have been eligible for SSI/SSP benefits prior to application of the revised actuarial reduction formula;
- E. have subsequently lost eligibility for SSI/SSP as a result of the change in the actuarial table; and
- F. reapply for assistance prior to July 1, 1987.

.291 Effective January 1, 1991, medical assistance shall be provided to disabled widow(er)s age 50 through 64 who lost SSI and/or state supplementation due to the receipt of Social Security benefits as a disabled widow(er). The individual shall remain eligible for Medicaid until he/she becomes eligible for Part A of Medicare (hospital insurance).

To qualify these individuals must:

- A. be a widow(er);
- B. have received SSI in the past;
- C. be at least 50 years old but not 65 years old by January 1, 1991;
- D. no longer receive SSI payments because of Social Security payments;
- E. not have hospital insurance under Medicare; and,
- F. meet all other Medicaid requirements.

8.110.3 PERSONS IN MEDICAL FACILITIES OR OTHER RESIDENTIAL PLACEMENT

.30 Medical assistance shall be provided to an institutionalized adult who meets the following criteria:

- A. Has attained the age of 65 years or is disabled according to the definition of disability and blindness applicable to Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), as stated in Title 20 of the Code of Federal Regulations. This includes individuals who meet the disability requirement by virtue of age; and
- B. Has been institutionalized for at least 30 consecutive days. The 30 day consecutive stay may be a combination of days in a hospital, nursing facility, or receiving services from a Home and Community Based Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE). Following 30 consecutive days of institutionalization, Medicaid benefits start as of the first day when institutionalization began if all other eligibility requirements were met as of that date; and
- C. Is in a facility eligible for Medicaid reimbursement if the individual is in a hospital or nursing facility; and

- D. Whose gross income does not exceed 300% of the current individual SSI benefit level. This special income standard must be applied for:
 - 1. A person 65 years of age or older, or disabled or blind receiving care in a hospital, nursing home, or an HCBS or PACE program or
 - 2. A person 65 years of age or older receiving active treatment as an inpatient in a psychiatric facility eligible for Medicaid reimbursement; or
 - E. Is in a nursing facility or in an HCBS or PACE program and whose gross income exceeds the 300% level and who establishes an income trust in accordance with the rules on income trusts in this volume; and
 - F. Whose resources conform with the regulations regarding resource limits and exemptions set forth in the section on Financial Eligibility for Individuals Eligible for the Colorado Medicaid Programs in this volume; and
 - G. Who has not transferred assets for less than fair market value on or after the look-back date defined in Section 8.110.53.B.4. which would incur a penalty period of ineligibility in accordance with the regulations on transfers without fair consideration in the section on Financial Eligibility for Individuals Eligible for the Colorado Medicaid Program in this volume.
 - H. In addition, if the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of trust, the trust document shall be submitted to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on Medicaid eligibility.
- .32 Medicaid programs for the aged, blind and disabled require clients under age 65 to meet the definition of disability or blindness used by the U.S. Social Security Administration for the Supplemental Security Income (SSI) Program. Those definitions are as follows:
- 1. disability means the inability to do any substantial gainful activity (or, in the case of a child, having marked and severe functional limitations) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of 12 months or more;
 - 2. blindness means (1) vision in the better eye of 20/200 or less with the use of a correcting lens, or (2) tunnel vision to the extent that the field of vision is no greater than 20 degrees.
33. Beginning on July 1, 2001, the Department or its contractor shall determine whether the client is disabled or blind in accordance with the requirements and procedures set forth elsewhere in this staff manual, and in accordance with the following federal regulations:
- A. 42 C.F.R. §435.530 through §435.540; §435.541(a), (b)(1), (e), and (f); and §435.916 (revised as of 10/1/00);
 - B. the requirements for evidence and periodic reexaminations applicable to disability determinations under the SSI program, as specified in 20 C.F.R. §416.901 through §416.995, and §416.998 (revised as of 4/1/00); and
 - C. the requirements concerning the composition and qualifications of disability review teams, as specified in 20 C.F.R. §416.1015 through §416.1016 (revised as of 4/1/00).

D. No amendments or later editions of those federal regulations are incorporated. Upon request, copies of the federal regulations are available for public inspection or will be provided at cost by the Department of Health Care Policy and Financing, Office of Medical Assistance, 1575 Sherman Street, Denver, CO, 80203; may be examined at any State Publications Depository Library; or may be accessed on the Internet at www.access.gpo.gov/nara/cfr .

A client who disagrees with the decision on disability or blindness shall have the right to appeal that decision to a state-level fair hearing in accordance with the procedures at 8.059.115.

NOTE: Sections 8.110.31 and 8.110.34 were deleted effective October 1, 2000.

.35 For the purpose of applying the special income standard for aged, disabled or blind persons in medical facilities, gross income means income before application of any deductions, exemptions or disregards appropriate to the SSI program.

.36 When assistance is provided to an individual who is admitted to a nursing home on or after January 1, 1981, the county of domicile immediately prior to admission to the nursing home must be determined. This information is entered into the automated system.

.37 County of domicile refers to the county or State where the person made his permanent home immediately prior to institutionalized long term care. The permanent home or domicile may sometimes be different than the county of current residence.

County of domicile is determined the first time a person is admitted to a nursing home and does not change unless the person is absent from the nursing home for more than one month. When new placement or readmittance to a nursing home occurs, the county department that is processing the nursing home admittance (application) will make the determination of the county of domicile using the criteria of determining the county or state of permanent home just prior to institutionalized long term care.

In cases where a person leaves a nursing home to go to the home of a relative or friend, where he may or may not wish to establish a permanent home, the county of domicile does not change until the client shows the intent to make that home a permanent residence.

For those persons whose permanent home or domicile is in another state, no Colorado county will be regarded as county of domicile, and the State Department of Social Services in that case shall be responsible for full payment.

If the county of domicile is not indicated on the system when an individual is admitted to the nursing home, the county that is currently providing assistance will be assumed to be on the county of domicile.

The county processing the nursing home admission shall enter an explanation of the determination of county of domicile in the case record. If the county of domicile is not the county processing the admission, the county department in the county of domicile must be notified using a DSS-1 or equivalent form.

.371 If the county of domicile cannot be agreed to by the county departments involved in making a determination, the situation will be referred to the Director. Office of Field Administration or such other unit in the State Department designated by the Executive Director. The Director. Office of Field Administration or such other unit will determine the county of domicile, and such decision shall be binding on the county departments involved.

.38 When a recipient moves from his/her home to a nursing home in another county or when a recipient

moves from one nursing home to another in a different county:

- A. the paying county will send a Form NH-TR-1 to the county of new residence informing that county of:
 - 1. all identifying information about the client;
 - 2. name of the new nursing home;
 - 3. date of the move;
 - 4. the date of proposed closure of the case;
 - 5. contact person for eligibility information.
- B. the paying county will send a copy of this form to the nursing home administrator of the new nursing home. AP-5615 form should be attached showing the date of closure.
- C. the county of new residence will obtain the AP-R1 (Redetermination) form.
- D. the county of new residence will send a Form NH-TR-2 requesting eligibility information and/or informing the paying county of proposed date of approval. The county of new residence will use information from the AP-R1 and information from the paying county to determine continuing eligibility.
- E. the county of new residence notifies the client of approval.
- F. the county of new residence will initiate an AP-5615 to show the date of approval.
- G. the paying county shall send a PA-75 to the nursing home client.

Should Medicaid reimbursement be interrupted, the county of residence will have the responsibility to process the application and back date the Medicaid eligibility date to cover the period of eligibility.

Communications between each county department and the nursing facility administrator in the counties regarding the transfer process is essential.

.381 Medical assistance must be provided to an institutionalized child less than 18 years of age:

- A. whose family income and assets exceed the SSI limits, but whose gross family income does not exceed 300% of the current SSI benefit level; and
 - 1. who meets all other SSI program definitions and requirements; and
 - 2. who has been determined to be institutionalized for at least 30 consecutive days The 30 day consecutive stay must be in a medical facility and may be a combination of days in a hospital, nursing facility, or receiving services from a HCBS program as an HCBS recipient. For example, an individual hospitalized on March 10 cannot meet this requirement until April 8. Following 30 consecutive days of institutionalization. Medicaid benefits start as of the first day when institutionalization began (March 10 in the example), assuming that all other eligibility requirements were met as of that date; or

- B. In the alternative to A. who is determined by the federal Social Security Administration to be SSI eligible because he/she meets all SSI eligibility criteria, including financial, due to the disregard to family income or assets because the child is institutionalized and not living in the parents' home. Medical assistance will be provided beginning the first day of the month following the month during which the child ceases to live with his or her parent(s).

.382 An appeal process is available to children identified by C.R.S. 27-103-101 to 107, The Child Mental Health Treatment Act, who are denied residential treatment. The appeal process is outlined in the Income Maintenance Staff Manual of the Department of Human Services (9 CCR 2503-1). A determination made in connection with this appeal shall not be the final agency action with regard to medical assistance eligibility.

.39 Medical assistance must be provided to an institutionalized child less than 18 years of age when either of the following conditions are met:

- A. The child's family's income and assets exceed the SSI limits, but their gross family income does not exceed 300% of the current SSI benefit level; and

- 1. the child meets all other SSI program definitions and requirements; and

- 2. the child has been determined to be institutionalized for at least 30 consecutive days. The 30 day consecutive stay must be in a medical facility and may be a combination of days in a hospital, nursing facility, or receiving services from a HCBS program as an HCBS recipient. For example, an individual hospitalized on March 10 cannot meet this requirement until April 9. Following 30 consecutive days of institutionalization, Medicaid benefits start as of the first day when institutionalization began (March 10 in the example), assuming that all other eligibility requirements were met as of that date; or

- B. the child is determined by the federal Social Security Administration to be SSI eligible because he/she meets all SSI eligibility criteria, including financial, due to the disregard of family income or assets because the child is institutionalized and not living in the parents' home. Medical assistance will be provided beginning the first day of the month following the month during which the child ceases to live with his or her parent(s).

.391 An appeal process is available to children identified by C.R.S. 27-10.3-104, The Child Mental Health Treatment Act, who are denied residential treatment. The appeal process is outlined in the Income Maintenance Staff Manual of the Colorado Department of Human Services (9CCR 2503-1). A determination made in connection with this appeal shall not be the final agency action with regard to medical assistance eligibility.

8.110.4 NURSING FACILITY RECIPIENT INCOME

.41 Except as specified below, once a nursing facility/hospitalized applicant has been determined eligible for medical assistance, all income of the recipient which is in excess of the amount reserved for personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, and less home maintenance allowance, and less allowable expenses for medical and remedial care (see PETI deductions as defined in Medical Assistance Staff Manual sections 8.110.49 and 8.482.33), must be applied to the cost of care. For persons with income below \$50, no PETI deduction will be allowed. Specific instructions for computing the patient payment amount are contained in the Medical Assistance Staff Manual section on nursing facility care.

.42 The amount to be reserved for personal needs is \$50/month with the following exceptions:

- A. Effective 7/1/91, the personal needs allowance shall be \$90/month for a veteran in a nursing facility who has no spouse or dependent child and who receives a non-service connected disability pension from the U.S. Veterans Administration. The personal needs allowance shall also be \$90/month for the widow(er) of a veteran with no dependent children.
 - B. For aged, disabled, or blind nursing facility recipients engaged in income-producing activities, an additional amount of \$65 per month plus one-half of the remaining gross income may be retained by the individual
 - C. Effective September 15, 1994, aged, disabled, or blind nursing facility residents or HCBS recipients with mandatory withholdings from earned or unearned income to cover federal state, and local taxes may have an additional amount included in their personal needs allowance. The personal needs allowance must be for a specific accounting period when the taxes are owed and expected to be withheld from income or paid by the individual in the accounting period. The county must verify that the taxes were withheld. If the taxes are not paid, the county must establish a recovery.
- .43 The reserve specified in Section 8.110.42, B, of this Staff Manual shall apply to nursing facility residents who are engaged in income-producing activities on a regular basis. Types of income-producing activities include:
 - A. work in a sheltered workshop or work activity center;
 - B. "protected employment" which means the employer gives special privileges to the individual;
 - C. an activity that produced income in connection with a course of vocational rehabilitation;
 - D. employment training sessions;
 - E. activities within the facility such as crafts products and facility employment.
- .44 In determining the personal needs reserve amount for nursing facility residents engaged in income-producing activities:
 - A. The \$50 allowance for personal needs is reserved from earned income only when the person has insufficient unearned income to meet this need;
 - B. In determining countable earned income of a nursing facility resident, the following rules shall apply:
 - 1. \$65 shall be subtracted from the gross earned income.
 - 2. The result shall be divided in half.
 - 3. The remaining income is the countable earned income and shall be considered in determining the patient payment.
 - C. When the \$50 allowance is reserved from unearned income, the additional reserve is computed based on the total gross earned income.
- .45 Other Deductions Reserved from Recipient's Income:
 - A. In the case of a married, long-term care recipient who is institutionalized in a nursing facility or hospital and who has a spouse (and, in some cases, other dependent family members) living in the community, there are "spousal protection" rules which permit the contribution

of the institutionalized spouse's income toward their living expenses. See those sections in Staff Manual Volume 8 under "TREATMENT OF INCOME AND RESOURCES FOR INSTITUTIONALIZED SPOUSES".

B. For a nursing facility/hospitalized recipient with no family at home, an amount in addition to the personal needs allowance may be reserved for maintenance of the recipient's home for a temporary period, not to exceed 6 months, if a physician has certified that the person is likely to return to his/her home within that period. In regard to this additional reserve from recipient income for home maintenance, the amount of the deduction:

1. must be based on actual expenses such as mortgage payments, taxes, utilities to prevent freeze, etc.;
2. may not exceed the total of the current shelter and utilities components of the applicable standard of assistance (OAP for aged recipients; AND/SSI-CS or AB/SSI-CS for disabled or blind recipients).

C. Effective April 8, 1988, an additional amount may be deducted from the patient payment for expenses incurred by a nursing facility recipient for medical or remedial care that is not paid for by Colorado Medicaid or any third party insurance. See those sections in Staff Manual Volume 8 under "POST ELIGIBILITY TREATMENT OF INCOME".

.46 The necessity for the deduction from a recipient's income specified in Section 8.110.45 shall be fully explained in the case record. Such additional reserve amount must be entered on the eligibility reporting form.

.47 As of July 1, 1988, an SSI cash recipient may continue to receive SSI benefits when he/she is expected to be institutionalized for three months or less. This provision is intended to allow temporarily institutionalized recipients to pay the necessary expenses to maintain the principal place of residence.

Payments made under this continued benefit provision are not considered over-payments of SSI benefits if the recipient's stay is more than 90 days.

The amount of Supplemental Security Income (SSI) benefit paid to an institutionalized individual is deducted from gross income when computing the patient payment.

8.110.49 POST ELIGIBILITY TREATMENT OF INCOME

Effective April 8, 1988, with respect to the post-eligibility treatment of income of individuals who are institutionalized there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by Colorado Medicaid or third party insurance, including health insurance premiums, deductibles or co-insurance, dental care, hearing aids, supplies and care, and corrective lenses, eye care, and supplies, and other incurred expenses for medical or remedial care that are not subject to payment by a third party.

All PETI expenses in excess of \$400 per calendar year must be prior authorized by the Colorado Department of Health Care Policy and Financing (HCPF) or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supply, to validate that the requested expense is not a benefit of the Colorado Medicaid program, and to determine if the expenses requested are duplication of expenses previously prior authorized.

The allowable expenses are subject to the following criteria:

A. Health insurance premiums, deductibles, or co-insurance (as defined by State law).

1. Monthly premium payment paid by the resident for health insurance. If payments exceed the patient payment amount for one month, calculate a monthly average by dividing the total premium by the number of months of coverage. The resulting amount is to be applied as a monthly PETI expense for the months of coverage.
2. Medicare premiums are not an allowable deduction except in "medical only" eligibility cases and only for the first two (2) months not covered by Medicaid.
3. Health insurance premiums will be allowed for the resident only.
4. Health insurance premiums will only be allowed if the health insurance information is entered into the COIN system and MMIS for purposes of third party recovery.
5. Health insurance premiums, deductibles, and co-insurance must be reviewed by the Colorado Department of Health Care Policy and Financing or its designee for final approval. If duplicate coverage has been purchased, only the cost of the least expensive policy will be allowed. Premiums, deductibles and co-insurances which the Department or its designee determine to be too expensive in relation to coverage purchased shall not be allowed.

B. Special Medical Services (dental care, hearing aids, and corrective lenses).

1. General Instructions (applies to all special medical services).
 - a. All PETI expenses exceeding \$400 per calendar year for equipment, supplies, or services must be authorized by the Colorado Department of Health Care Policy and Financing or its designee to be considered an allowable cost.
 - b. Costs will be allowed only if they are not a benefit of the Medicaid program, or not a benefit of other insurance coverage the recipient may have.
 - c. All allowable costs must be documented in the resident's record with date of purchase and receipt of payment, whether or not it meets the requirements for prior authorization. Lack of documentation shall cause the patient payment deduction to be disallowed, causing the provider to be overpaid by the Medicaid program.
 - d. All allowable costs must be for items that are medically necessary as described in 8.011, and medical necessity must be documented by the attending physician. The physician statement must be current, within one year of the authorization.
 - e. The resident or legally appointed guardian must agree to the purchase of service/equipment and charge, with signed documentation in the resident's record.
 - f. Nursing homes are not permitted to assess any surcharge or handling fee to the patient's income.
 - g. For special medical services/supplies provided but not yet paid for, the encumbrance agreement and monthly payment schedule must be documented in the resident's record, as well as receipts of payment.
 - h. The allowable costs for services and supplies may not exceed the basic

Medicaid rate.

- i. In the case of damage or loss of supplies, replacement items may be requested with relevant documentation. If the damage or loss is due to negligence on the part of the nursing home, the nursing home is responsible for the cost of replacement.
- j. Costs will not be allowed if the equipment, supplies or services are for cosmetic reasons only.
- k. If the client does not make a patient payment, then no PETI will be allowed.
- l. PETI payments may not exceed the patient payment. Payments made over a period of time shall only be allowed if the provider agrees to accept installment payments.

2. Dental Care Instructions

- a. Prescription of dentures (partial or full plate, fixed or removable), or dental care, must be made by a licensed dentist (Doctor of Dental Surgery, Doctor of Medical Dentistry).
- b. The prescription (as defined in 2.a.) must be part of a comprehensive evaluation to determine the medical necessity and suitability for wearing dentures or for other dental care.
- c. Oral and maxillofacial surgery that is required to render soft-tissue and bony structures suitable for wearing dentures must be prior authorized by the Department as defined in 8.200.10 and 8.200.30.

3. Hearing Aid Instructions

- a. All referrals for hearing aids must be certified by the attending physician, and must include an evaluation for suitability and specifications of the appropriate appliance, as per Section 8.287.02.
- b. Purchase of new hearing aids to replace pre-existing hearing aids must include documentation of reason the pre-existing hearing aid must be replaced. The documentation shall also describe the trade-in value given for the pre-existing aid if appropriate.

4. Corrective Lenses Instructions

- a. The evaluation of the need for corrective eye- glasses (lenses) must be a part of a comprehensive general visual examination conducted by a licensed ophthalmologist or
- b. The medical necessity for prescribed corrective lenses should not be based on the determination of the refractive state of the visual system alone, but should be identified by the current procedural terminology in the Physician Current Procedures Terminology (CPT) code as established by the American Medical Association. This document is available through the American Medical Association, 515 North State Street, Chicago, Illinois 60610 or <http://www.ama-assn.org/catalog>.

C. Prior Authorization Request Process:

For allowable expenses that exceed \$400 per client in a calendar year, costs must be prior authorized by the Colorado Department of Health Care Policy and Financing or its designee. The process is as follows:

1. Prior authorization requests must be submitted to the Colorado Department of Health Care Policy and Financing or its designee by the nursing facility on the form prescribed by the State. In addition to the information requested on the form, the following attachments must be included:
 - a. A description of the service or supply, and the estimated cost.
 - b. A physician's statement indicating the medical necessity of the service or supply.
2. Prior authorizations will be certified based on the following criteria:
 - a. The request is not a benefit of the Medicaid program.
 - b. The cost of the request does not exceed the basic Medicaid rate for such services or supply.
 - c. The special medical service or supply is medically necessary, as defined in 8.011.
3. The Colorado Department of Health Care Policy and Financing or its designee shall review and approve/deny the PETI Prior Authorization Request within ten (10) working days of receipt.
4. Upon receipt of the approved Prior Authorization Request from the DHCPF or its designee, the nursing facility may adjust the patient payment by the amount authorized on the following month's Medicaid billing or on the nursing facility's next billing cycle.
5. All documentation of the incurred expenses must be available in the client's financial and medical record for audit purposes. Lack of documentation shall cause the patient payment deduction to be disallowed causing the provider to be overpaid by the Medicaid program.

8.110.50 FINANCIAL ELIGIBILITY REQUIREMENTS FOR ELDERLY, BLIND AND DISABLED INDIVIDUALS

The following regulations for financial eligibility apply to individuals who are age 65 or over or who have been determined to be disabled or blind in accordance with Social Security regulations. Staff Manual Volume 3 (9 CCR 2503-1) is not applicable to these individuals.

Treatment of income: Income is defined as anything received in cash or in kind that can be used to meet the individual's needs for food or shelter. In-kind income is not cash but is actually food or shelter or something that can be used to obtain food or shelter.

A. Availability of income

1. Income is available when it is actually received or when the individual has a legal interest in a sum.

2. Income, which includes earned and unearned income, shall be calculated on a monthly basis regardless of whether it is received annually, semi-annually, quarterly or weekly.
- B. Earned income is payment in cash or in kind for services performed as an employee or from self-employment. Earned income includes the following:
1. Wages, which include salaries, commissions, bonuses, severance pay, and any other special payments received because of employment.
 2. Net earnings from self-employment
 3. Payments for services performed in a sheltered workshop
 4. Royalties and honoraria
- C. Earned income disregards
1. The gross amount of earned income is countable toward eligibility with the following exclusions:
 - a. \$65.00 shall be subtracted from gross earned income.
 - b. The remaining amount shall be divided in half and the resulting amount is countable income.
 - c. Any other applicable exemptions in 20 C.F.R. 416.1112. No amendments or later editions are incorporated. The Director of the Office of Medical Assistance of the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of 20 C.F.R. 416.1112; or the materials may be examined at any publications repository library.
- D. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment. Unearned income includes the following:
1. Pensions and other period payments, such as
 - a. Private pensions or disability benefits
 - b. Social Security benefits
 - c. Social Security Disability Income (SSDI)
 - d. Supplemental Security Income (SSI) payments
 - e. Workers' Compensation payments
 - f. Railroad retirement annuities
 - g. Unemployment insurance payments
 - h. Veterans benefits other than Aid and Attendance (A&A) and Unreimbursed Medical Expenses (UME).
 2. Alimony and support payments

3. Interest, dividends and certain royalties on countable resources
4. Support and maintenance in kind
5. The following are unearned income in the month received and a countable resource the following month:
 - a. Death benefits, reduced by the cost of last illness and burial
 - b. Prizes and rewards
 - c. Gifts and inheritances

E. Determining ownership of income

1. If payment is made solely to one individual, the income shall be considered available income to that individual.
2. If payment is made to more than one individual, the income shall be considered available to each individual in proportion to their interests.
3. In case of a married couple in which there is no document establishing specific ownership interests, one-half of the income shall be considered available to each spouse.
4. Income from the Community Spouse's Resource Allowance, as defined in the spousal protection rules in this volume, is income to the community spouse.

F. Income-producing property

1. Net rental income from an exempt home or a life estate interest in an exempt home is countable after the following allowable deductions:
 - a. Property taxes and insurance
 - b. Necessary reasonable routine maintenance expenses
 - c. Reasonable management fee for a professional property manager.
2. Nonbusiness property that is necessary to produce good or services essential-to self support is excluded up to \$6000 for applicants who are not applying for long-term care in a nursing facility.
3. Property used in a trade or business which is essential to self-support is excluded up to a limit of \$6000 if it produces 6% return of the excluded value. This exclusion does not apply to applicants for long term care in a nursing facility.

G. Treatment of payments from the Department of Veterans Affairs (VA) for aid and attendance (A&A) and unreimbursed medical expenses (UME)

1. Payments for aid and attendance (A&A) and unreimbursed medical expenses (UME) shall not be considered as income or be paid as patient payment for the following:
 - a. Veteran in a medical facility that is not a state veteran's medical facility
 - b. Veteran or spouse of a veteran in a state veteran's medical facility who has a spouse

or child at home

2. Payments for aid and attendance (A&A) and unreimbursed medical expenses (UME) to a veteran or spouse of a veteran in a state veteran's medical facility shall be treated as follows:

- a. Payments shall not be considered as income.
- b. Payments shall be used as patient payment to the medical facility

H. Reverse mortgages

1. In accordance with C.R.S. 11-38-110, reverse mortgages payments made to a borrower shall not be treated as income for eligibility purposes.
2. Funds remaining the following month after the payment is made will be countable as a resource.
3. Any payments from a reverse mortgage that are transferred to another individual without fair consideration shall be analyzed in accordance with the rules on transfers without fair consideration at 8.110.53 and may result in a penalty period of ineligibility.

I. Treatment of income and resources for married couples

1. The income and resources of both spouses are counted in determining eligibility for either or both spouses with the following exceptions:
 - a. If spouses share the same room in an institution, the income of the individual spouse is counted in determining his or her eligibility, and each spouse is allowed the \$2000 limit for resources.
 - b. Beginning the first month following the month the couple ceases to live together, only the income of the individual spouse is counted in determining his or her eligibility
 - c. If one spouse is applying for long term care in a nursing facility or Home and Community Based Services (HCBS), refer to the rules on Treatment of Income and Resources for Institutionalized Spouses at 8.112.

J. Income limits for eligibility for long-term care in a hospital, nursing facility Home and Community Based Services (HCBS), and the Program of Inclusive Care for the Elderly (PACE)

1. For an individual who is institutionalized in a hospital or nursing facility or receiving HCBS or PACE for a period of not less than 30 days, the income limit is three times the benefit level for Supplemental Security Income (SSI).
2. If the income exceeds three times the SSI benefit level but is below the regional average private pay rate for the nursing facility, the individual may become income eligible for long term care by establishing an income trust in accordance with the rules on income trusts at 8.110.52,B. Income trusts are not valid for establishing income eligibility for hospital care.
3. Long term care insurance benefits are not countable as income, but are payable as part of the patient payment to the nursing facility.

K. Other groups eligible for medical assistance

1. Recipients of Supplemental Security Income (SSI) and Old Age Pension (OAP) A or B with a SISC code A or B are eligible for medical assistance, not including longterm care. For long term care eligibility in a nursing facility or Home and Community Based Services (HCBS), a separate application must be submitted to the county department of social services.

8.110.51 FINANCIAL ELIGIBILITY REQUIREMENTS FOR INDIVIDUALS ELIGIBLE FOR THE COLORADO MEDICAID PROGRAM

Consideration of resources: Resources are defined as cash or other assets or any real or personal property that an individual or spouse owns. The resource limit for an individual is \$2000. For a married couple, the resource limit is \$3000. If one spouse is institutionalized, refer to Treatment of Income and Resources for Institutionalized Spouses.

A. The following resources are exempt in determining eligibility:

1. The principal place of residence which is owned by the applicant or applicant's spouse, including the home in which the individual resides, the land on which the home is located and related out-buildings.
 - a. If an individual or spouse moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence.
 - b. If an individual leaves his or her home to live in an institution, the home will still be considered the principal place of residence, irrespective of the individual's intent to return as long as the individual's spouse or dependent relative continues to live there. Dependent relative is defined as one who is claimed as a dependent for federal income tax purposes.
 - c. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.
 - d. The home will still be considered the individual's principal place of residence and retain the exemption if all of the following conditions apply:
 - 1) The individual is institutionalized.
 - 2) The individual intends to return home whether or not in fact he or she does return home.
 - 3) The intent to return home is documented in writing.
 - 4) The intent to return home applies to the home the individual or spouse was living in prior to being institutionalized or a replacement house as long as a spouse or dependent relative continues to live there. Dependent relative is defined as one who is claimed as a dependent for federal income tax purposes.
 - e. For an institutionalized individual in a nursing facility, receiving HCBS or enrolled in the PACE program, the exemption for the principal place of residence does not apply to a residence which has been transferred to a trust or other entity, such as a partnership or corporation. If the residence is transferred back into the name of the individual's name, the exemption will be regained.

- f. The principal place of residence, which is subject to estate recovery, becomes a countable resource upon the execution and recording of a beneficiary deed. The exemption can be regained if a revocation of the beneficiary deed is executed and recorded.
- 2. One automobile is totally excluded regardless of its value if it is used for transportation for the individual or a member of the individual's household. An automobile includes, in addition to passenger cars, other vehicles used to provide necessary transportation.
- 3. Household goods are not counted as a resource to an individual (and spouse, if any) if they are:
 - a. Items of personal property, found in or near the home, that are used on a regular basis; or
 - b. Items needed by the householder for maintenance, use and occupancy of the premises as a home.
 - c. Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes.
- 4. Personal effects are not counted as a resource to an individual (and spouse, if any) if they are:
 - a. Items of personal property ordinarily worn or carried by the individual; or
 - b. Articles otherwise having an intimate relation to the individual.
 - c. Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments.
 - d. Items of cultural or religious significance to the individual and items required because of an individual's impairment are also not counted as a resource.
- 5. The cash surrender value of all life insurance policies owned by an individual and spouse, if any, is a countable resource. However, if the total face value of all life insurance policies does not exceed \$1500 on any person, the cash surrender value of those policies will be excluded.
 - a. Face value is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or other special provisions.
 - b. Cash surrender value is the amount the insurer will pay to the owner upon cancellation of the policy before the death of the insured or before maturity of the policy.
 - c. Term life insurance having no cash surrender value, and burial insurance, the proceeds of which can be used only for burial expenses, are not countable toward the resource limit.
- 6. The total value of burial spaces for the applicant/recipient, his/her spouse and any other members of his/her immediate family is exempt as a resource.

- a. Burial spaces are defined as burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased. If any interest is earned on the value of an agreement for the purchase of a burial space, such interest is also exempt.
 - b. The immediate family includes the individual's spouse, minor and adult children, stepchildren, adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those persons, regardless of dependency or whether they are living in the applicant/recipient's household.
7. An applicant or recipient may own burial funds through an irrevocable trust or other irrevocable arrangement which are available for burial and are held in an irrevocable burial contract, an irrevocable burial trust, or in an irrevocable trust which is specifically identified as available for burial expenses without such funds affecting the person's eligibility for assistance. "Irrevocable" means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than the individual's burial expenses.
8. An applicant or recipient may also own up to \$1,500 in burial funds through a revocable account, trust, or other arrangement for burial expenses, without such funds affecting the person's eligibility for assistance. This exclusion only applies if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual or spouse's burial expenses. Interest on the burial funds are also excluded if left to accumulate in the burial fund. However, the \$1500 exemption is reduced by (a) the amount of any irrevocable burial funds such as are described in the preceding subparagraph, and (b) the face value of any life insurance policy whose cash surrender value is exempt. For a married couple, a separate \$1500 exemption applies to each spouse.

B. Countable resources include the following:

1. Cash or funds held by a financial institution in a checking or savings account, certificate of deposit or money market account;
2. Current market value of stocks, bonds, and mutual funds;
3. All funds in a joint account are presumed to be a resource of the applicant or client. If there is more than one applicant or client account holder, it is presumed that the funds in the account belong to those individuals in equal shares. To rebut this presumption, evidence must be furnished that proves that some or all of the funds in a jointly held account do not belong to him or her. To rebut the sole ownership presumption, the following procedure must be followed:
 - a. Submit statements from all of the account holders regarding:
 - 1) Who owns the funds.
 - 2) Why there is a joint account.
 - 3) Who has made deposits and withdrawals and how withdrawals have been

spent.

- a. Submit account records showing deposits, withdrawals and interest in the months for which ownership of funds is at issue.
 - b. Correct the account title and submit revised account records showing that the applicant or client is no longer an account holder or separate the funds to show they are solely owned by the individual.
4. Any real property that is subject to a recorded beneficiary deed and on which an estate recovery claim can be made.
5. For applications filed on or after January 1, 2006, an individual's home if the individual's equity interest in the home exceeds \$500,000 and the individual's spouse, dependent child under the age of 21, or blind or disabled child does not reside in the home.
6. Real property not exempt as the principal place of residence and not exempt as income producing property with a value of \$6000 or less, as described at 8.110.50.
 - a. When the applicant alleges that the sale of real property would cause undue hardship to the co-owner due to loss of housing, all of the following information must be obtained:
 - 1) The applicant or client's signed statement to that effect.
 - 2) Verification of joint ownership.
 - 3) A statement from the co-owner verifying the following:
 - a) The property is used as his principal place of residence.
 - b) The co-owner would have to move if the property were sold.
 - c) The co-owner would be unable to buy the applicant or client's interest in the property.
 - d) There is no other readily available residence because there is no other affordable housing available or no other housing with the necessary modifications for the co-owner if he is a person with disabilities.
 - b. Excess real property will not be included in countable resources as long as reasonable efforts to sell it have been unsuccessful. Reasonable efforts to sell means:
 - 1) The property is listed with a real estate agent at current market value.
 - 2) If owner listed, the property must be for sale at current market value, advertised and shown to the public.
 - 3) Any reasonable offer must be accepted and the owner has the burden of demonstrating that an offer was not reasonable.
 - 4) If an offer is received that is at least two-thirds of the current market value, the individual must present evidence to establish that the offer was

unreasonable.

- 5) Reasonable efforts to sell must continue and must be verified on a quarterly basis.
6. Personal property such as a mobile home or trailer or the like, that is not exempt as a principal place of residence or that is not income producing.
7. Personal effects acquired or held for their value or as an investment. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles.
8. The equity value of all automobiles that are in addition to one exempt vehicle. The equity value is the fair market value less any encumbrances. The fair market value is the average price an automobile of that particular year, make, model and condition will sell for on the open market to a private individual in the particular geographic area involved.
9. The cash surrender value of life insurance policies if the face value exceeds \$1500.
10. Promissory notes
 - a. The fair market value of a promissory note, mortgage, installment contract or similar instrument is an available countable resource.
 - b. In order to determine the fair market value, the applicant shall obtain three estimates of fair market value from a private note broker, who is engaged in the business of purchasing such notes. In order to obtain the estimates and locate willing buyers, the note shall be advertised in a newspaper with state wide circulation under business or investment opportunities.
 - c. A note or similar instrument which transferred funds or assets for less than fair market value shall be considered as a transfer without fair consideration and a period of ineligibility shall be imposed.
12. Promissory notes established on or after April 1, 2006
 - a. The value of a promissory note, loan or mortgage is an available countable resource unless the note, loan or mortgage:
 - 1) Has a repayment term that is actuarially sound based on the individual's life expectancy as found in the tables in Section 8.110.56 for annuities purchased on or after February 8, 2006;
 - 2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
 - 3) Prohibits the cancellation of the balance upon the death of the lender.
 - b. The value of a promissory note, loan or mortgage which does not meet the criteria in Section 8.110.51.B.12.a. is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is subject to the transfer without fair consideration provisions in Section 8.110.53.

C. Treatment of self-funded retirement accounts

1. The following regulations apply to self-funded retirement accounts such as an Individual Retirement Account (IRA), Keogh Plan, 401(k), 403(b) and any other self-funded retirement account.
 - a. Self-funded retirement accounts in the name of the applicant are countable as a resource to the applicant.
 - b. Self-funded retirement accounts in the name of the applicant's spouse who is living with the applicant are exempt in determining eligibility for the applicant, except as set forth in c. below.
 - c. Self-funded retirement accounts in the name of a community spouse who is married to an applicant who is applying for long term care in a nursing facility, HCBS or PACE, are countable as a resource to the applicant and may be included in the Community Spouse Resource Allowance (CSRA) up to the maximum amount allowable. The terms community spouse and CSRA are further defined in the regulations on Spousal Protection in this volume.
2. The value of a self-funded retirement account is determined as follows:
 - a. The gross value of the account, less any taxes due, is the amount that is countable as a resource, regardless of whether any monthly income is being received from the account.
 - b. If the applicant is not able to provide the amount of taxes that are due, the value shall be determined by deducting 20% from the gross value of the account.

D. Treatment of proceeds from disposition of resources

1. The net proceeds from the sale of exempt or non-exempt resources are considered available resources.
2. The net proceeds is the selling price less any valid encumbrances and costs of sale.
3. After deducting any amount necessary to raise the individual's and spouse's resources to the applicable limits, the balance of the net proceeds shall be considered available resources. In lieu of terminating eligibility due to excess resources, the client may request that the proceeds be used to reimburse the medical assistance program for previous payments for medical assistance.
4. The proceeds from the sale of an exempt home will be excluded to the extent they are intended to be used and are, in fact, used to purchase another home in which the individual, a spouse or dependent child resides, within three months of the date of the sale of the home.

E. Availability of resources and income

1. Resources and income shall be considered available both when actually available and when the applicant or client has a legal interest in a sum (including cash or equity value of a resource) and has the legal ability to make such sum available for support and maintenance.
2. If the applicant or client demonstrates with written documentation that appropriate steps are being taken to secure the resources, medical assistance shall not be delayed or terminated. Verification of efforts to secure the resources must be provided at regular

intervals as requested by the county department of social services.

3. Resources will be considered available and medical assistance shall be denied or terminated if the applicant or client refuses or fails to make a reasonable effort to secure a potential resources or income.
4. Timely and adequate notice must be given regarding a proposed action to deny, reduce or terminate assistance due to failure to make reasonable efforts to secure resources or income. If upon receipt of the prior notice, the individual acts to secure the potential resource, the proposed action to deny, reduce, or terminate assistance must be withdrawn, and assistance must be approved or continued until the resource or income is, in fact, available.
5. If the resources or income has been transferred to a trust, the trust shall be submitted for review to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on eligibility in accordance with Section 8.110.52 (10 CCR 2505-10).

8.110.52 Consideration of trusts in determining Medicaid eligibility

A. Trusts established before August 11, 1993:

1. Medicaid Qualifying Trust (MQT)

- a. In the case of a Medicaid qualifying trust, as defined in 42 U.S.C. Sec. 1396a(k), the amount of the trust property that is considered available to the applicant/recipient who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual assuming the full exercise of discretion by the trustee(s) for the distribution of the maximum amount to the applicant/recipient. This amount of property is deemed available resources to the individual, whether or not is actually received.
 - b. 42 U.S.C. Sec. 1396a(k) was repealed in 1993 and is reprinted here exclusively for purposes of trusts established before August 11, 1993. 42 U.S.C. Sec. 1396a(k) defines a Medicaid qualifying trust as "a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual."
2. This provision does not apply to any trust or initial decrees established before April 7, 1986, solely for the benefit of a developmentally disabled individual who resides in an intermediate care facility for the developmentally disabled.
 3. This provision does not apply to individuals who are receiving SSI.

B. Trusts established on or after July 1, 1994:

1. The following definitions apply to trusts established on or after July 1, 1994:

- a. Assets include all income and resources of the individual and the individual's spouse, including all income and resources which the individual or the individual's spouse is entitled to but does not receive because of action by any of the following:

- 1) The individual or the individual's spouse,
 - 2) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse, or
 - 3) Any person court or administrative body acting at the direction of or upon the request of the individual or the individual's spouse.
2. In determining an individual's eligibility for Medicaid, the following regulations apply to a trust established by an individual:
 - a. An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust, and if any of the following individuals established the trust, other than by will:
 - 1) The individual or the individual's spouse
 - 2) A person, including a court or administrative body, with legal authority to act in place of, or on the behalf of, the individual or the individual's spouse;
 - 3) A person, including a court or administrative body acting at the direction or upon the request of the individual or the individual's spouse.
 - b. In the case of a trust, the corpus of which includes assets of an individual and the assets of any other person(s), this regulation shall apply to the portion of the trust attributable to the assets of the individual.
 - c. These regulations apply without regard to the following:
 - 1) The purposes for which a trust is established;
 - 2) Whether the trustees have or exercise any discretion under the trust;
 - 3) Any restrictions on when or whether distributions may be made from the trust;
or
 - 4) Any restrictions on the use of distributions from the trust.
3. Revocable Trust
 - a. The corpus of the trust shall be considered resources available to the individual.
 - b. Payments from the trust to or for the benefit of the individual shall be considered income to the individual, and
 - c. Any other payments from the trust shall be considered assets transferred by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.
4. Irrevocable Trust
 - a. If there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the following shall apply:

- 1) The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual.
 - 2) Payments from that portion of the corpus, or income to or for the benefit of the individual, shall be considered income to the individual.
 - 3) Payments from that portion of the corpus or income for any other purpose shall be considered as a transfer of assets by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.
 - 4) Any portion of the trust from which, or any income on the corpus from which no payment could be made to the individual under any circumstances, shall be considered as a transfer of assets for less than fair market value and shall be subject to a 60 month look back period and penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume. The transfer will be effective as of the date of the establishment of the trust, or the date on which payment to the individual from the trust was foreclosed, if later. The value of the trust shall be determined by including the amount of any payments made from such portion of the trust after such date.
5. The preceding regulations for trusts established on or after July 1, 1994, do not apply to the following:

a. Income Trusts

- 1) A trust consisting only of the individual's pension income, social security income and other monthly income that is established for the purpose of establishing income eligibility for nursing facility care or Home and Community Based Services (HCBS). To be valid, the trust must meet the following criteria:
 - a) The individual's gross monthly income must be above the 300%-SSI limit but below the average cost of private nursing facility care in the geographic region in which the individual resides and intends to remain. The Colorado Department of Health Care Policy and Financing shall calculate the average rates for such regions on an annual, calendar-year basis. The geographic regions which are used for calculating the average private pay rate for nursing facility care shall be based on the Bureau of Economic Analysis Regions and consist of the following counties:

REGION I: (Adams, Arapahoe, Boulder, Broomfield, Denver, Jefferson)

REGION II: (Cheyenne, Clear Creek, Douglas, Elbert, Gilpin, Grand, Jackson, Kit Carson, Larimer, Logan, Morgan, Park, Phillips, Sedgwick, Summit, Washington, Weld, Yuma)

REGION III: (Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, El Paso, Fremont, Huerfano, Kiowa, Lake, Las Animas, Lincoln, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache, Teller)

REGION IV: (Archuleta, Delta, Dolores, Eagle, Garfield, Gunnison, Hinsdale, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel)

- b) For nursing facility clients, each month the trustee shall distribute the entire amount of income which is transferred into the trust. An amount not to exceed \$20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust.
- c) The only deductions from the monthly trust distribution to the nursing facility are the allowable deductions which are permitted for Medicaid-eligible persons who do not have income trusts. Allowable deductions include only the following:
 - 1) Personal need allowance
 - 2) Spousal income payments
 - 3) Approved PETI payments
- d) Any funds remaining after the allowable deductions shall be paid solely to the cost of the nursing facility care in an amount not to exceed the Medicaid reimbursement rate. Any excess income which is not distributed shall accumulate in the trust.
- e) No other deductions or expenses may be paid from the trust. Expenses which cannot be paid from the trust include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past-due medical bills and other debts. Trustee fees which were ordered prior to April 1, 1996 may continue until the trust terminates.
- f) For HCBS clients, the amount distributed each month shall be limited to the 300% of the SSI limit. Any monthly income above that amount shall remain in the trust. An amount not to exceed \$20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust. No other trust expenses or deductions may be paid from the trust. For the purpose of calculating Individual Cost Containment or client payment (PETI), the client's monthly income will be 300% of the SSI limit. Upon termination, the funds which have accumulated in the trust shall be paid to the Colorado Department of Health Care Policy and Financing (CDHCPF) up to the total amount of Medical assistance paid on behalf of the individual.
- g) For a court-approved trust, notice of the time and place of the hearing, with the petition and trust attached, shall be given to the county department of social services and the CDHCPF in the manner prescribed by law.
- h) The sole beneficiaries of the trust are the individual for whose benefit

the trust is established and the CDHCPF. The trust terminates upon the death of the individual or if the trust is not required for Medicaid eligibility in Colorado.

- i) The trust must provide that upon the death of the individual or termination of the trust, whichever occurs sooner, the CDHCPF shall receive all amounts remaining in the trust up to the total amount of medical assistance paid on behalf of the individual.
- j) The trust must include the name and mailing address of the trustee. The CDHCPF must be notified of any trustee address changes or change of trustee(s) within 30 calendar days.
- k) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the county department of social/human services or to the CDHCPF upon reasonable request or upon any change of trustee.
- l) The amount remaining in the trust and an accounting of the trust shall be due to the CDHCPF within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the CDHCPF if a written request is submitted within two months of the termination of the trust.
- m) The regulations in this section for income trusts shall also apply to income trusts established after January 1, 1992, under the undue hardship provisions in 26-4-506.3(3), C.R.S. and 15-14-412.5, C.R.S.

b. Disability Trusts

- 1) A trust that is established solely for the benefit of a disabled individual under the age of 65, which consists of the assets of the individual, and is established for the purpose or with the effect of establishing or maintaining the individual's resource eligibility for medical assistance and which meets the following criteria:
 - a) The individual for whom the trust is established must meet the disability criteria of Social Security.
 - b) The only assets used to fund the trust are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under *Sullivan v. Zebley*. (This provision is applicable to disability trusts established from July 1, 1994 to December 31, 2000.)
 - c) The trust is established solely for the benefit of the disabled individual by a parent, grandparent, legal guardian, or the court.
 - d) The sole lifetime beneficiaries of the trust are the individual for whose benefit the trust is established and the Colorado Department of Health Care Policy and Financing (CDHCPF).

- e) The trust terminates upon the death of the individual or if the trust is no longer required for Medicaid eligibility in Colorado.
- f) Any statutory lien pursuant to Section 26-4-403(4) must be satisfied prior to funding of the trust and approval of the trust.
- g) If the trust is funded with an annuity or other periodic payments, the CDHCPF shall be named on the contract or settlement as the remainder beneficiary up to the amount of medical assistance paid on behalf of the individual.
- h) The trust shall provide that, upon the death of the beneficiary or termination of the trust, the CDHCPF shall receive all amounts remaining in the trust up to the amount of total medical assistance paid on behalf of the individual.
- i) No expenditures may be made after the death of the beneficiary, except for federal and state taxes. However, prior to the death of the individual beneficiary, trust funds may be used to purchase a burial fund for the beneficiary.
- j) The amount remaining in the trust and an accounting of the trust shall be due to the CDHCPF within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the CDHCPF if a written request is submitted within two months of the termination of the trust.
- k) The trust fund shall not be considered as a countable resource in determining eligibility for medical assistance.
- l) [Rule 8.110.52 B 5. b. 1) I), adopted or amended on or after November 1, 2000 and before November 1, 2001 was not extended by HB 02-1203, and therefore expired May 15, 2002.]
- m) Distributions from the trust may be made only to or for the benefit of the individual beneficiary. Cash distributions from the trust shall be considered income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.
- n) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward eligibility.
- o) The trust must include the name and mailing address of the trustee. The CDHCPF must be notified of any trustee address changes or change of trustee(s) within 30 calendar days.
- p) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the county department of social/human services or to the CDHCPF upon reasonable request or upon any change of trustee.

- q) Prior to the establishment or funding of a disability trust, the trust shall be submitted for review to the CDHCPF, along with proof that the individual beneficiary is disabled according to Social Security criteria. No disability trust shall be valid unless the CDHCPF has reviewed the trust and determined that the trust conforms to the requirements of 15-14-412.8, C.R.S., as amended, and any rules adopted by the Medical Services Board.

c. Pooled Trusts

- 1) A trust consisting of individual accounts established for disabled individuals for the purpose of establishing resource eligibility for Medicaid. A valid pooled trust shall meet the following criteria:

- a) The individual for whom the trust is established must meet the disability criteria of Social Security.
- b) The trust is established and managed by a non-profit association which has been approved by the Internal Revenue Service.
- c) A separate account is maintained for each beneficiary; however, the trust pools the accounts for the purposes of investment and management of the funds.
- d) The sole lifetime beneficiaries of each trust account are the individual for whom the trust is established and the CDHCPF.
- e) If the trust is funded with an annuity or other periodic payments, the CDHCPF or the pooled trust shall be named as remainder beneficiary.
- f) The trust account shall be established by the disabled individual, parent, grandparent, legal guardian, or the court.
- g) The only assets used to fund each trust account are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under Sullivan v. Zeblev . (This provision is applicable to pooled trusts established from July 1, 1994 to December 31, 2000.)
- h) Any statutory lien pursuant to Section 26-4-403(4) must be satisfied prior to funding of the individual's trust account and approval of the joinder agreement.
- i) Following the disabled individual's death or termination of the trust account, whichever occurs sooner, to the extent that the remaining funds in the trust account are not retained by the pooled trust, the CDHCPF shall receive any amount remaining in the individual's trust account up to the total amount of medical assistance paid on behalf of the individual.
- j) The pooled trust account shall not be considered as a countable resource in determining Medicaid eligibility.
- k) Distributions from the trust account may be made only to or for the

benefit of the individual. Cash distributions to the individual from the trust shall be considered as income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.

l) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward resource eligibility.

2) If an institutionalized individual for whom a pooled trust is established is 65 years of age or older, the transfer of assets into the pooled trust creates a rebuttable presumption that the assets were transferred without fair consideration and shall be analyzed in accordance with the rules on transfers without fair consideration in this volume. This regulation is effective for transfers to pooled trusts after January 1, 2001.

C. When the individual beneficiary of an income, disability or pooled trust dies or the trust is terminated, the trustee shall promptly notify the county department of social services and the CDHCPF. To the extent required by these rules the trustee shall promptly forward the remainder of the trust property to the CDHCPF, up to the amount of medical assistance paid on behalf of the individual beneficiary.

D. Third Party Trusts

1. Third party trusts are trusts which are established with assets which are contributed by individuals other than the applicant or the applicant's spouse for the benefit of an applicant or client
2. The terms of the trust will determine whether the trust fund is countable as a resource or income for Medicaid eligibility.
 - a. Trusts which limit distributions to non-support or supplemental needs will not be considered as a countable resource. If distributions are made for income or resources, such distributions are countable as such for eligibility.
 - b. If the trust requires income distributions, the amount of the income shall be countable as income in determining eligibility.
 - c. If the trust requires principal distributions, that amount shall be considered as a countable resource.
 - d. If the trustee may exercise discretion in distributing income or resources, the income or resources are not countable in determining eligibility. If distributions are made for income or resources, such distributions are countable as such for eligibility.

E. Submission of Trust Documents and Records

1. The trustee of a trust which was established by or which benefits a Medicaid Applicant or client shall submit trust documents and records to the county department of social services and to the CDHCPF.
2. This requirement includes documents and records for income trusts, disability trusts and the joinder agreement for each pooled trust account.
3. The county department of social services shall submit any trust which is submitted with an

application or at redetermination to the CDHCPF. The county department shall determine Medicaid eligibility based on the determination of the CDHCPF as to the effect of the trust on eligibility.

F. Federally Approved Trusts

1. If an SSI recipient has a trust which has been approved by the Social Security Administration, eligibility for Medicaid cannot be delayed or denied. Individuals on SSI are automatically eligible for Medicaid despite the existence of a federally approved trust.
2. If the county department of social/human services has a copy of a federally approved trust, the county must send a copy to the CDHCPF.

8.110.53 Transfers of assets without fair consideration

A. If an institutionalized individual or the spouse of such individual disposes of assets for less than fair market value on or after the look-back date, the individual shall be subject to a period of period of ineligibility for long term care services, including nursing facility care, Home and Community Based Services (HCBS), and the Program of All Inclusive Care for the Elderly (PACE).

B. The following definitions apply to transfers of assets without fair considerations:

1. Assets include all income and resources of the individual and such individual's spouse, including all income or resources which the individual or such individual's spouse is entitled to but does not receive because of action by any of the following:
 - a. The individual or such individual's spouse,
 - b. A person, a court, or administrative body with legal authority to act on behalf of the individual or such individual's spouse, or
 - c. Any person, court or administrative body acting at the direction of or upon the request of the individual or such individual's spouse.
2. Fair market value is the value of the asset if sold at the prevailing price at the time it was transferred.
3. Fair consideration is the amount the individual receives in exchange for the asset that is transferred, which is equal to or greater than the value of the transferred asset.
4. For transfers made before February 8, 2006, the look-back date is 36 months prior to the date of application. For transfers made on or after February 8, 2006, the look-back date is 60 months prior to the date of application.
5. An institutionalized individual is one who is institutionalized in a medical facility, a nursing facility, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

C. If an institutionalized individual or such individual's spouse transfers assets without fair consideration on or after the look-back date, the transfer shall be evaluated as follows:

1. The fair market value of the transferred asset, less the actual amount received, if any, shall be divided by the average monthly private pay cost for nursing facility care in the state of Colorado at the time of application.

2. The resulting number is the number of months that the individual shall be ineligible for medical assistance. For transfers made before February 8, 2006, the period of ineligibility shall begin with the month in which the transfer occurred. For transfers made on or after February 8, 2006, the period of ineligibility shall begin on the later of the following dates:
 - a. The first day of the month in which the transfer occurred, or
 - b. The date on which the individual would be eligible for HCBS, PACE or institutional services based on an approved application for such assistance without regard to any penalty periods.
 3. The period of ineligibility shall also include partial months, which shall be calculated by multiplying 30 days by the decimal fractional share of the partial month. The result is the number of days of ineligibility. For transfers occurring on or after April 1, 2006, the result should be rounded up to the nearest whole number.
 4. There is no maximum period of ineligibility.
 5. The total amount of all of the transfers are added together and the period of ineligibility begins the first day of the month in which the resources are transferred.
 - a. If the previous penalty period has completely expired, the transfers are not added together.
 - b. If the previous penalty period has not completely expired and the first day of the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.
 6. The institutionalized individual may continue to be eligible for Supplemental Security Income (SSI) and basic Medicaid services, but shall not be eligible for medical assistance for nursing facility services, Home and Community Based Services or the Program of All Inclusive Care for the Elderly due to the transfer without fair consideration.
 7. If a transfer without fair consideration is made during a period of eligibility, a period of ineligibility shall be assessed in the same manner as stated above.
- D. Actions that prevent income or resources from being received, as set forth on the following list, which is not exclusive, shall create a rebuttable presumption that the transfer was without fair consideration:
1. Waiving pension income.
 2. Waiving a right to receive an inheritance.
 3. Preventing access to assets to which an individual is entitled by diverting them to a trust or similar device. This is not applicable to valid income trusts, disability trusts and pooled trusts for individuals under the age of 65 years.
 4. Failure of a surviving spouse to elect a share of a spouse's estate.
 5. Failure to obtain a family allowance or exempt property from an estate of a deceased spouse or parent.
 6. Not accepting or accessing a personal injury settlement.

7. Transferring assets into an irrevocable private annuity which was not purchased from a commercial company.
8. Transferring assets into an irrevocable entity such as a Family Limited Partnership which eliminates or restricts the individual's access to the assets.
9. Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony, if the benefit outweighs the cost.
10. Failure to exercise rights in a Dissolution of Marriage case, which insure an equitable distribution of marital property and income.

E. Treatment of certain assets as transfers without fair consideration

1. Promissory notes

- a. The fair market value of promissory notes is a countable resource and must be evaluated in accordance with the regulations on consideration of resources in this volume.
- b. Promissory notes with one or more of the following provisions, indicating they have little or no market value, shall create a rebuttable presumption of a transfer without fair consideration:
 - 1) An interest rate lower than the prevailing market rate.
 - 2) A term for repayment longer than the life expectancy of the holder of the note.
 - 3) Low payments.
 - 4) Cancellation at the death of the note holder.
- c. Promissory notes which have been appraised by a note broker as having little or no value shall create a rebuttable presumption of a transfer without fair consideration.

2. Promissory notes established on or after April 1, 2006

- a. Subject to the look-back date described in Section 8.110.53.B.4., for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in Section 8.110.51.B.12.a.1.-3. is the outstanding balance due as of the date of the individual's application for medical assistance for services described in Section 8.110.53.B.5.

3. Personal care services

- a. Family members who provide assistance or services are presumed to do so for love and affection, and compensation for past assistance or services shall create a rebuttable presumption of a transfer without fair consideration unless the compensation is in accordance with the following:
 - 1) A written agreement must be executed prior to the delivery of services.
 - 2) The agreement must be signed by the applicant, or a legally authorized

representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement.

3) The agreement must be dated and the signature must be notarized.

4) Compensation for services rendered must be comparable to what is received in the open market.

b. Payment for services, which were rendered previously and for which no compensation was made, shall be considered as a transfer without fair consideration.

c. Assets transferred in exchange for a contract for personal services for future assistance provided by family members or by a professional after the date of application are considered available resources.

d. A family member may provide homemaking or caregiving services prior to the date of institutionalization and may be paid at the time of rendering the services a reasonable hourly rate comparable to the prevailing market rate without the necessity of a written contract.

4. Transfers of real property into joint tenancy without fair consideration

a. If real property is transferred into joint tenancy with right of survivorship with one or more joint tenants, the amount transferred depends on the number of joint tenants to whom the property is transferred. The following are examples:

1) If the transfer is to one joint tenant, the amount transferred is equal to one-half of the value of the property at the time of the transfer.

2) If the transfer is to two joint tenants, the amount transferred is equal to two-thirds of the value.

3) If the transfer is to three joint tenants, the amount transferred is equal to three-fourths of the value of the property at the time of the transfer.

b. If the transfer is completed with two deeds or transactions, the first of which transfers a fractional share of the property into tenancy in common, and the second into joint tenancy, the amount transferred shall be determined in the same manner as set forth above.

F. No period of ineligibility will be imposed if the individual transferred the assets under any of following circumstances:

1. The asset transferred was a home and title to the home was transferred to:

a. The spouse of such individual;

b. A child of such individual who is either

1) Under the age of 21 years, or

2) Is blind or totally and permanently disabled as determined by the Social Security Administration.

c) A brother or sister

- 1) Who has an equity interest in the home and
- 2) Who was residing in such individual's home for at least one year immediately before the date that the individual becomes institutionalized.

d. A son or a daughter of such individual

- 1) Who was residing in the home for a period of at least two years immediately before the date the individual becomes institutionalized and
- 2) Who provided care to such individual by objective evidence, that permitted such individual to reside at home rather than in an institution.
- 3) Documentation shall be submitted proving that the son or daughter's sole residence was the home of the parent. The parent's attending physician(s) or professional health provider(s) during the past two years must substantiate in writing that the care was provided, and that the care prevented the parent from requiring placement in a nursing facility.

2. The assets were transferred:

- a. To the individual's spouse or to another for the sole benefit of the individual's spouse.
- b. From the individual's spouse to another for the sole benefit of the individual's spouse.
- c. To a trust which is established solely for benefit of the individual's child who is determined to be blind or totally disabled by the Social Security Administration or to that child directly for the sole benefit of the child.
- d. To a trust established solely for the benefit of an individual under 65 years of age who is determined to be blind or totally disabled by the Social Security Administration.

3. Definition of the term "for the sole benefit of," as used in the preceding exceptions to the transfer penalty rules:

- a. A transfer or a trust is considered to be for the sole benefit of the spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.
- b. To insure that the asset transferred is for the sole benefit of the spouse, blind or disabled child or disabled individual, the following criteria must be met:
 - 1) The transfer must be accomplished by a written instrument which legally binds the parties to a specified course of action and sets forth:
 - a) The conditions under which the transfer was made, and
 - b) A statement as to whom can benefit from the transfer.
 - 2) The written instrument must provide for the spending of funds or use of the transferred assets for the benefit of the individual on a basis that is

actuarially sound based on the life expectancy of the individual.

- 3) Disability trusts and income trusts, which designate the Colorado Department of Health Care Policy and Financing as the remainder beneficiary up to the amount of medical assistance paid on behalf of the individual are exempt from this requirement.
- 4) A community spouse to whom a Community Spouse Resource Allowance has been transferred does not have to provide a written document or comply with the requirement that the transfer is actuarially sound. However, the Community Spouse Resource Allowance must be for the sole benefit of the community spouse to whom it is transferred. Upon the death of the community spouse, those resources shall be made available to the surviving spouse, at least up to the amount of the elective share of the augmented estate, the family allowance and the exempt property allowance.

G. There is a rebuttable presumption the transfer without fair consideration was made for purposes of Medicaid eligibility.

1. The transfer is presumed to have been made for the purpose of obtaining eligibility or remaining eligible unless the individual provides convincing, objective evidence that the transfer was exclusively for some other purpose and the reason for the transfer did not include Medicaid eligibility. Transfers that are made to avoid the Medicaid lien or the Medicaid estate recovery program shall be included in the definition of Medicaid eligibility.
2. A subjective statement of intent or ignorance of the transfer penalty or verbal assurances that the individual was not considering Medicaid eligibility when the transfer was made are not sufficient.
3. There is a rebuttable presumption that transfers without fair consideration were made for the purpose of Medicaid eligibility in the following cases:
 - a. In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer total an amount insufficient to meet all living expenses and medical expenses reasonably expected to be incurred by the individual or the individual's spouse in the thirty-six months following the transfer. Medical expenses include the cost of long term care unless the future necessity of such care could have been absolutely precluded because of the particular circumstances.
 - b. In any case where the transfer was made on behalf of the individual or the individual's spouse, by a guardian, conservator, or agent under a power of attorney to any spouse, child, grandchild, brother, sister, niece, nephew, parent, grandparent, by birth, adoption, or marriage of the guardian, conservator, or agent under a power of attorney.
4. Convincing evidence may include, but is not limited to, verification which establishes:
 - a. That at the time of the transfer the individual could not have anticipated needing long term medical assistance due to the existence of other circumstances which would have precluded the need.
 - b. Other assets were available at the time of the transfer to meet current and future needs of the individual, including the cost of nursing facility or other

institutionalized care for a period of thirty-six months.

- c. The specific purpose for which the assets were transferred and the reason the transfer was necessary and the reason there was no alternative but to transfer the assets for less than fair market value. The presumption cannot be rebutted successfully by stating it was done for estate planning purposes or to avoid probate.
- d. When the individual had some other purpose for transferring the assets, but any expectation of establishing eligibility could reasonably be inferred to be a factor in the decision to transfer the asset, the presumption cannot be successfully rebutted.

H. Apportionment of penalty period between spouses

- 1. If a transfer results in a period of ineligibility for an individual, and the individual's spouse becomes institutionalized and is otherwise eligible for Medicaid, the period of ineligibility shall be apportioned equally between the spouses.
 - 2. If one spouse dies or is no longer institutionalized, any months remaining in the period of ineligibility shall be assigned to the spouse who remains institutionalized.
- I. If the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of a trust, the trust document shall be submitted to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on Medicaid eligibility.

J. Notice

- 1. The Colorado Department of Health Care Policy and Financing is an interested person according to 15-14-406, C.R.S. or a successor statute.
- 2. As an interested party, the department shall be given notice of a hearing in cases in which Medicaid planning or Medicaid eligibility is set forth in the petition as a factor for requesting court authority to transfer property.

K. Undue Hardship

- 1. The period of ineligibility resulting from the imposition of the transfer or the trust provisions may be waived if denial of eligibility would create an undue hardship. Undue hardship can be established only if all of the following conditions are met:
 - a. The individual is otherwise eligible;
 - b. The individual is unable to obtain medical care without the receipt of Medicaid benefits;
 - c. Application of the transfer penalty would deprive the individual of medical care such that the individual's health or life would be endangered or would deprive the individual of food, clothing, shelter or other necessities of life; and
 - d. The individual must also produce evidence to prove that the assets have been irretrievably lost, and that all reasonable avenues of legal recourse to regain possession of them has been exhausted.
- 2. Undue hardship shall not exist when the application of the trust or transfer rules merely causes the individual inconvenience or when such application might restrict his or her lifestyle but

would not put him or her at risk of serious deprivation.

3. Notice of an undue hardship exception shall be given to the applicant or client, and a determination of whether an undue hardship waiver will be granted shall be given in a timely manner. An adverse determination may be appealed in accordance with the appeal process as set forth in RECIPIENT APPEALS PROTOCOLS/PROCESS in this volume.
4. The facility in which an institutionalized individual is residing may file an undue hardship waiver application on behalf of the individual with the individual's or his or her personal representative's consent.

L. No period of ineligibility shall be assessed in any of the following circumstances:

1. Convincing and objective evidence is provided that the individual intended to dispose of the resources either at fair market value or for other valuable consideration.
2. Convincing and objective evidence is presented proving that the resources were transferred exclusively for a purpose other than to qualify or remain eligible for medical assistance.
3. All of the resources transferred for less than fair market value have been returned to the individual.
4. For assets transferred before February 8, 2006, the assets were transferred more than 36 months prior to the date of application.
5. For assets transferred before February 8, 2006, the penalty period has expired based on the following formula: The fair market value of the transferred asset is divided by the average cost of nursing facility care in the state at the time of application and the resulting number of months of ineligibility has ended prior to the date of application.

8.110.54 Treatment of Life Estates

- A. Effective July 1, 1995, for an applicant/recipient of Medicaid, and/or his/her spouse, who established a life estate on his/her residence, a transfer of assets without fair consideration may occur. A transfer of assets without fair consideration occurs when a life estate was established on the residence by the applicant/recipient of Medicaid, and/or their spouse, within 36 months from the date of Medicaid application. However, in no event shall these regulations apply to a life estate established before July 1, 1995.

The amount to be considered as a transfer of assets without fair consideration shall be computed by using equity value of the property and applying it to the life estate table contained in these rules as follows:

1. Determine the equity value of the property at the time the life estate was established. The equity value of the residential property shall be determined by obtaining the actual value and subtracting encumbrances. The actual value shall be obtained by using the actual value reported by a county assessor or from the most recent property assessment notice. If the actual value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate percentage value for residential property as established by state law to obtain the actual value.

Encumbrances include mortgages, liens, judgments, delinquent taxes, loan agreements, and other forms of indebtedness.

2. Multiply the equity value by the "Remainder" factor from the Life Estate Remainder Interest

Table contained in these rules that corresponds to the person's age at the time the life estate was established. The result is the amount to be considered as a transfer of assets without fair consideration.

When a life estate is established on the residence held by spouses in joint tenancy, the age of the youngest individual shall be used to calculate the amount of the transfer.

Once the transfer of asset amount is computed, the penalty period for transfer of assets without fair consideration is determined by using the steps in accordance with the rules at 8.110.53.C.

- B. Effective April 1, 2006, the purchase of a life estate interest in an individual's home is a transfer without fair consideration unless the purchaser resides in the home for a period of at least one year after the date of purchase.

Once the transfer of asset amount is computed, the penalty period for transfer of assets without fair consideration is determined by using the steps as explained in subsection "G" of this section.

LIFE ESTATE REMAINDER INTEREST TABLE

<u>AGE</u>	<u>REMAINDER</u>	<u>AGE</u>	<u>REMAINDER</u>
0	.02812	30	.04457
1	.01012	31	.04746
2	.00983	32	.05058
3	.00992	33	.05392
4	.01019	34	.05750
5	.01062	35	.06132
6	.01116	36	.06540
7	.01178	37	.06974
8	.01252	38	.07433
9	.01337	39	.07917
10	.01435	40	.08429
11	.01547	41	.08970
12	.01671	42	.09543
13	.01802	43	.10145
14	.01934	44	.10779
15	.02063	45	.11442
16	.02185	46	.12137
17	.02300	47	.12863
18	.02410	48	.13626
19	.02520	49	.14422
20	.02635	50	.15257
21	.02755	51	.16126
22	.02880	52	.17031
23	.03014	53	.17972
24	.03159	54	.18946
25	.03322	55	.19954
26	.03505	56	.20994
27	.03710	57	.22069
28	.03938	58	.23178

29	.04187	59	.24325
60	.25509	85	.64641
61	.26733	86	.66236
62	.27998	87	.67738
63	.29304	88	.69141
64	.30648	89	.70474
65	.32030	90	.71779
66	.33449	91	.73045
67	.34902	92	.74229
68	.36390	93	.75308
69	.37914	94	.76272
70	.39478	95	.77113
71	.41086	96	.77819
72	.42739	97	.78450
73	.44429	98	.79000
74	.46138	99	.79514
75	.47851	100	.80025
76	.49559	101	.80468
77	.51258	102	.80946
78	.52951	103	.81563
79	.54643	104	.82144
80	.56341	105	.83038
81	.58033	106	.84512
82	.59705	107	.86591
83	.61358	108	.89932
84	.63002	109	.95455

8.110.55 Annuities

A. An annuity is a contract between an individual and a commercial company in which the individual invests funds and in return is guaranteed fixed substantially equal installments for life or a specified number of years.

1. Treatment of annuities purchased prior to July 1, 1995:

- a. An annuity purchased prior to July 1, 1995 is not an available resource if it is annuitized and regular returns are being received by the annuitant. The funds received are income in the month received.
- b. If the annuity purchased by the applicant/ client or his/her spouse has not been annuitized it shall be considered an available resource regardless of the irrevocable status.

2. Treatment of annuities purchased on or after July 1, 1995.

- a. The purchase of an annuity shall be considered as a transfer of assets without fair consideration unless the following criteria are met:

- 1) The annuity is purchased from a life insurance company or other commercial

company that sells annuities as part of its normal course of business;
and,

- 2) The annuity is annuitized for the applicant/client or his/her spouse; and,
- 3) The annuity is purchased on the life of the applicant/client or his/her spouse;
and,
- 4) The annuity provides payments for a period not exceeding the annuitant's projected life.

3. Treatment of annuities purchased on or after April 1, 1998.

- a. The county department shall determine the MMMNA of the community spouse, if applicable. If the monthly payment amount provided by the annuity to the community spouse exceeds the MMMNA, the amount of the annuity which causes the monthly annuity payment to exceed the MMMNA shall be considered a transfer without fair consideration in determining the institutionalized spouse's eligibility. This subsection applies only to the extent that the transferred amount causes the CSRA to exceed the maximum.
- b. The county department shall determine if the applicant/client is receiving substantially equal installments from the annuity for the period of the annuity. If the annuity is not paid in substantially equal installments, the original purchase price of the annuity shall be considered as a transfer without fair consideration.
- c. For annuities purchased before February 8, 2006, if an annuity was purchased more than 36 months prior to the date of application, the penalty period for a transfer without fair consideration has expired. Any income received from the annuity shall be considered as income in the month received.

4. Provisions for annuities purchased on or after February 8, 2006. These provisions are in addition to those listed in 8.110.55.A.3.

- a. An applicant for HCBS, PACE or institutional services shall disclose a description of any interest the individual or his or her community spouse has in an annuity or similar financial instrument, regardless of whether the annuity or financial instrument is irrevocable or is treated as an asset.
- b. By providing HCBS, PACE or institutional services, the Department shall be a remainder beneficiary of the annuity or similar financial instrument.
- c. The county shall notify the issuer of the annuity that the Department is a preferred remainder beneficiary in the annuity for medical assistance provided to the individual. This notice shall include a statement requiring the issuer to notify the county when there is a change in the amount of income or principal that is being withdrawn from the annuity.
- d. The purchase of an annuity shall be treated as a transfer without fair consideration unless:
 - 1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual; or
 - 2) The Department is named as the remainder beneficiary in the second position

after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value; or

- 3) The annuity is an Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986; or
- 4) The annuity is part of a deemed Individual Retirement Account under a qualified employer plan as described in Section 408(q) of the Internal Revenue Code of 1986; or
- 5) The annuity was purchased with proceeds from:
 - a) An Individual Retirement Account as described in Section 408(a) of the Internal Revenue Code of 1986.
 - b) An account established by an employer or association of employers as described in Section 408(c) of the Internal Revenue Code of 1986.
 - c) A simple retirement account as described in Section 408(p) of the Internal Revenue Code of 1986.
 - d) A simplified employee pension as described in Section 408(k) of the Internal Revenue Code of 1986.
 - e) A Roth IRA as described in Section 408A of the Internal Revenue Code of 1986; or
- 6) The annuity:
 - a) Is irrevocable and nonassignable; and
 - b) Is actuarially sound; and
 - c) Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

8.110.56 Analysis of annuity to determine if purchase was a transfer without fair consideration

- A. To determine if a transfer of assets without fair consideration has occurred in the purchase of an annuity, the eligibility technician must review the annuity and:
 1. Determine the length of time of the return the annuity exceeds the reasonable life expectancy of the annuitant. The amount to be considered as a transfer of assets without fair consideration for this type of annuity shall be computed by using the Life Expectancy Tables contained in these regulations.
 - a. Determine the date on which the annuity was purchased.
 - b. Determine the amount of money used to purchase the annuity and the time period of return to the annuitant.
 - c. Determine the age of the annuitant at the time the annuity was purchased.

- d. Determine the life expectancy of the annuitant at the time the annuity was purchased from the table contained in this section of these regulations. The appropriate table for male or female must be used.
 - e. If the return from the annuity exceeds the life expectancy of the annuitant, a transfer of assets without fair consideration exists for the portion of the annuity return that exceeds the life expectancy of the annuitant.
 - f. If the return of the annuity over its lifetime is less than the original purchase price, the difference shall be considered a transfer without fair consideration.
 - g. For annuities purchased before February 8, 2006, if the annuity was purchased more than 36 months prior to the date of application, the transfer period has expired and any income shall be considered as income in the month received.
 - h. If the return is equal to or more than the original purchase price, the annuity is not a transfer without fair consideration and the money received by the annuitant from the annuity is considered as income in the month received.
2. If an irrevocable annuity is purchased by an applicant/client of Medicaid, or their his/her spouse, and the return or benefit from the annuity is transferred to a third party, a transfer of assets without fair consideration exists for the total amount of the annuity.
 3. If a revocable annuity is purchased by an applicant/client of Medicaid, or his/her spouse, the total amount invested in the annuity is considered as a countable resource.
 4. Once it has been determined that a transfer of assets without fair consideration exists, the penalty period shall be calculated by using the steps in accordance with the rules at 8.110.53.C.

LIFE EXPECTANCY TABLE – MALES FOR ANNUITIES PURCHASED BEFORE FEBRUARY 8, 2006

<u>Age</u>	<u>Life Expectancy</u>	<u>Age</u>	<u>Life Expectancy</u>
0	71.80	30	44.06
1	71.53	31	43.15
2	70.58	32	42.24
3	69.62	33	41.33
4	68.65	34	40.23
5	67.67	35	39.52
6	66.69	36	38.62
7	65.71	37	37.73
8	64.73	38	36.83
9	63.74	39	35.94
10	62.75	40	35.05
11	61.76	41	34.15
12	60.78	42	33.26
13	59.79	43	32.37
14	58.82	44	31.49
15	57.85	45	30.61
16	56.91	46	29.74
17	55.97	47	28.88
18	55.05	48	28.02

19	54.13	49	27.17
20	53.21	50	26.32
21	52.29	51	25.48
22	51.38	52	24.65
23	50.46	53	23.82
24	45.55	54	23.01
25	48.63	55	22.21
26	47.73	56	21.43
27	46.80	57	20.66
28	45.88	58	19.90
29	44.97	59	19.15

**LIFE EXPECTANCY TABLE – MALES FOR ANNUITIES PURCHASED ON OR AFTER FEBRUARY 8,
2006**

<u>Age</u>	<u>Life Expectancy</u>	<u>Age</u>	<u>Life Expectancy</u>
0	74.14	30	45.90
1	73.70	31	44.96
2	72.74	32	44.03
3	71.77	33	43.09
4	70.79	34	42.16
5	69.81	35	41.23
6	68.82	36	40.30
7	67.83	37	39.38
8	66.84	38	38.46
9	65.85	39	37.55
10	64.86	40	36.64
11	63.87	41	35.73
12	62.88	42	34.83
13	61.89	43	33.94
14	60.91	44	33.05
15	59.93	45	32.16
16	58.97	46	31.29
17	58.02	47	30.42
18	57.07	48	29.56
19	56.14	49	28.70
20	55.20	50	27.85
21	54.27	51	27.00
22	53.35	52	26.16
23	52.42	53	25.32
24	51.50	54	24.50
25	50.57	55	23.68
26	49.64	56	22.86
27	48.71	57	22.06
28	47.77	58	21.27

29	46.84	59	20.49

LIFE EXPECTANCY TABLE – FEMALES FOR ANNUITIES PURCHASED BEFORE FEBRUARY 8, 2006

<u>Age</u>	<u>Life Expectancy</u>	<u>Age</u>	<u>Life Expectancy</u>
0	78.79	30	50.15
1	78.42	31	49.19
2	77.48	32	48.23
3	76.51	33	47.27
4	75.54	34	46.31
5	74.56	35	45.35
6	73.57	36	44.40
7	72.59	37	43.45
8	71.60	38	42.50
9	70.61	39	41.55
10	69.62	40	40.61
11	68.63	41	39.66
12	67.64	42	38.72
13	66.65	43	37.78
14	65.67	44	36.85
15	64.68	45	35.92
16	63.71	46	35.00
17	62.74	47	34.08
18	61.77	48	33.17
19	60.80	49	32.27
20	59.83	50	31.37
21	58.86	51	30.48
22	57.89	52	29.60
23	56.92	53	28.72
24	55.95	54	27.86
25	54.98	55	27.00
26	54.02	56	26.15
27	53.05	57	25.31
28	52.08	58	24.48
29	51.12	59	23.67

LIFE EXPECTANCY TABLE – FEMALES FOR ANNUITIES PURCHASED ON OR AFTER FEBRUARY 8, 2006

<u>Age</u>	<u>Life Expectancy</u>	<u>Age</u>	<u>Life Expectancy</u>
0	79.45	30	50.53
1	78.94	31	49.56
2	77.97	32	48.60
3	77.00	33	47.63
4	76.01	34	46.67
5	75.03	35	45.71

6	74.04	36	44.76
7	73.05	37	43.80
8	72.06	38	42.86
9	71.07	39	41.91
10	70.08	40	40.97
11	69.09	41	40.03
12	68.09	42	39.09
13	67.10	43	38.16
14	66.11	44	37.23
15	65.13	45	36.31
16	64.15	46	35.39
17	63.17	47	34.47
18	62.20	48	33.56
19	61.22	49	32.65
20	60.25	50	31.75
21	59.28	51	30.85
22	58.30	52	29.95
23	57.33	53	29.07
24	56.36	54	28.18
25	55.39	55	27.31
26	54.41	56	26.44
27	53.44	57	25.58
28	52.47	58	24.73
29	51.50	59	23.89

.57 For the purpose of evaluating income, SSI criteria require that

- A. the first \$20 of total available unearned income (except for SSI income) must be disregarded;
- B. an additional \$65 plus 1/2 of the remainder of earned income must be disregarded;
- C. income of spouses living together is considered mutually available and must be compared to the current SSI benefit level for a couple; net income of a non-recipient spouse must be reduced by an amount up to one-half the individual SSI benefit level for unmet needs of each non-recipient child in the family;
- D. income of single persons must be compared to the current SSI benefit level for an individual (a one-third reduction applies to a person living in the household of another);
- E. unemancipated children are not subject to a one-third reduction, an amount of parental income equal to the individual or couple SSI benefit level must be allowed for the needs of the parent or parents, up to one-half the individual SSI benefit level must be allowed for the unmet needs of each non-recipient child in the family, and the remainder must be considered as income available to the applicant or recipient child. For the purposes of this rule, "unemancipated child" means (1) a child under age 18 who is living in the same household with a parent or spouse of a parent, or (2) a child under age 21 who is living in the same household with a parent or spouse of a parent, if the child is regularly attending

a school, college, or university, or is receiving technical training designed to prepare the child for gainful employment;

F. one-third of child support for the applicant/recipient child from an absent parent must be disregarded;

G. the first \$400 of gross monthly earnings, not to exceed \$1620 in a calendar year, shall be exempt from consideration as earned income of a disabled or blind child who is a student regularly attending school.

NOTE: Sections 8.110.58 - 8.110.59 deleted effective July 1, 2002.

8.110.6 OLD AGE PENSION CASES

.61 Colorado Medicaid must be provided to persons receiving OAP-A or OAP-B and SSI (SISC-B).

.611 Colorado Medicaid must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria but are not receiving a money payment (SISC-B).

.612 Colorado Medicaid must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria except for the level of their income (SISC-B).

.613 Medicaid must be provided to persons in a facility eligible for Medicaid reimbursement whose income is under 300% of the SSI benefit level and who, but for the level of their income, would be eligible for OAP "A" or OAP "B" and SSI financial assistance. This group includes persons 65 years of age or older receiving active treatment as inpatients in a psychiatric facility eligible for Medicaid reimbursement. (SISC-A)

.62 Medicaid must be provided to a person who was receiving financial assistance under OAP "A" and who lost such assistance because of the Social Security (excludes RRB) cost of living adjustment (COLA) paid in July 1977 or after. Medical assistance must also be provided to a person who loses eligibility for OAP "A" any time after July 1977 due to the receipt of Social Security benefits. The situations that require continual medical assistance are outlined as follows:

A. The person lost OAP because of a cost of living adjustment to his/her own Social Security benefits.

B. The person lost OAP because of increased income deemed from a parent or spouse due to a cost of living adjustment to Social Security benefits received by the parent or spouse.

C. The person lost OAP due to the receipt of Social Security benefits (OASDI) during the current or previous years, and would be eligible for OAP except for cost of living adjustments (COLA's) received since the initial receipt of SSA.

.63 The cost-of-living increase disregard specified in the preceding section must continue to be applied in each subsequent eligibility determination and the disregard amount then must include the increase that resulted in loss of eligibility for financial assistance plus subsequent OASDI cost-of-living increases paid to that time. This disregard must also be applied to any OASDI cost-of-living increases paid to any financially responsible individual such as a parent or spouse whose income is considered in determining the person's continued eligibility for medical assistance (see B above). This provision is retroactive to November 1985 in accordance with U.S. District Court injunction of Lynch vs. Rank. (SISC-B)

.64 To redetermine eligibility of Medicaid recipients to whom the 1977 and later cost-of-living increase disregards apply, the county must:

- A. establish whether the person received a payment under OAP and, for the same month, was entitled to a Social Security (OASDI) payment;
- B. determine the Social Security income before the loss of financial assistance;
- C. determine the current income;
- D. subtract the previous Social Security income from the current income to find the cumulative COLAs since financial assistance was lost;
- E. subtract the cumulative COLAs from the current income.

If the figure in step E is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria, such as age, resources, disability, citizenship and residency, medical eligibility must continue.

- .65 Medicaid must be provided to a person who was receiving financial assistance under OAP for August 1972 and who - except for the October 1972 Social Security (includes RRB) 20% increase amount - would currently be eligible for financial assistance. This disregard must also be applied to a person receiving medical assistance in August 1972 who was eligible for financial assistance but was not receiving the money payment and to a person receiving medical assistance as a resident in a medical institution in August 1972. (SISC-B)
- .66 The OAP-B individual included in AFDC assistance unit shall receive Medicaid as a member of the AFDC household. (SISC-B)
- .67 The Colorado Modified Medical Program provides Medical Assistance to OAP-A, OAP-B or OAP Refugees who lost their OAP financial assistance because of a cost of living adjustment other than OASDI. Examples of other sources of income are VA, RRB, PERA, etc. (SISC-C).
- .68 For the purpose of identifying the proper SISC code for persons receiving assistance under OAP "A" or OAP "B", if the person:
 - A. receives an SSI payment - the SISC code is B ;
 - B. does not receive an SSI payment but is receiving assistance under OAP "A", a second evaluation of resources must be made using the same resource criteria as specified in the section on SSI FINANCIAL ELIGIBILITY REQUIREMENTS and for those who meet these criteria - the SISC code is B for money payment and "disregard" case. A for institutional cases;
 - C. does not receive an SSI payment and does not otherwise qualify under SISC code B or A as described in item b. above - the SISC code is C.
- .69 Medicaid shall be provided retroactive to July 1, 1986, to qualified disabled widow(er)s who lost SSI and/or state supplementation due to the 1983 change in the actuarial reduction formula prescribed in Section 134 of P.L. No. 98-21.

In order for these widow(er)s to qualify, these individuals must:

- A. have been continuously entitled to Title II benefits since December 1983;
- B. have been disabled widow(er)s in January 1984;
- C. have established entitlement to Title II benefits prior to age 60;

- D. have been eligible for SSI/SSP benefits prior to application of the revised actuarial reduction formula;
- E. have subsequently lost eligibility for SSI/SSP as a result of the change in the actuarial table; and
- F. reapply for assistance prior to July 1, 1987.

8.110.7 GRANDFATHERED-IN CASES

- .71 Medicaid must be provided to aged, disabled or blind persons who are receiving mandatory state supplementary payments. Such persons are those with income below their December 1973 minimum income level (MIL).
- .72 Medicaid must be provided to a person who was eligible for medical assistance in December 1973 as an inpatient of a medical facility,
 - A. who continues to meet the December 1973 eligibility criteria for institutionalized persons. and who remains institutionalized.
- .73 Medicaid must be provided to a person who was eligible for Medicaid in December 1973 as an "essential spouse" of an AND or AB financial assistance recipient, and who continues to be in the grant and continues to meet the December 1973 eligibility criteria. Except for such persons who were grandfathered-in for continued assistance, essential spouses included in assistance grants after December 1973 are not eligible for medical assistance.

8.110.8 PERSONS RECEIVING HOME AND COMMUNITY BASED SERVICES (HCBS)

- .8 Individuals determined to be eligible for the Colorado Modified Medical Program shall not be eligible for Home & Community Based Services.
- .81 Medicaid must be provided to persons who:
 - A. except for the level of their income would be eligible for SSI;
 - B. have gross income which does not exceed 300% of the current individual SSI benefit level;
 - C. will receive services as specified in the long term care rules section on HOME AND COMMUNITY BASED SERVICES in this staff manual.
- .83 For purposes of evaluating resources, the county must apply the criteria specified in the section on SSI FINANCIAL ELIGIBILITY REQUIREMENTS.
- .84 For purposes of applying the 300% income standard, gross income means income before application of any deductions, exemptions, or disregards appropriate to the SSI program. Individuals who are eligible to receive Home and Community Based Services under the 300% income standard are eligible effective from the first day of service provision.
- .85 Income and resources of spouses living in the same household for a full calendar month or more must be considered as available to each other, whether or not they are actually contributed, and evaluated in accordance with rules contained in the section on SSI FINANCIAL ELIGIBILITY REQUIREMENTS.
- .86 Upon the completion of a determination or redetermination of eligibility, the county department shall notify the Home and Community Based Services case management agency on a State

prescribed form of the approval, denial, or termination of the case, or of income changes of clients affecting their eligibility or patient payment (PETI) obligation. For further information on assessing the PETI payments of clients with income above the Old Age Pension grant standard, refer to the section on PATIENT PAYMENT - POST ELIGIBILITY TREATMENT OF INCOME in this manual.

- .87 For individuals served in Alternative Care Facilities (ACF), income in excess of the personal needs allowance and room and board amount for the ACF shall be applied to the Medicaid charges for ACF services. The total amount allowed for personal need and room and board cannot exceed the State's Old Age Pension Standard.

8.110.9 CONSIDERATION OF ALIEN SPONSORS: DEEMING OF INCOME AND RESOURCES

- .91 All aliens who apply for Old Age Pension on or after April 16, 1988, for three (3) years after the date of admission into the United States, shall have the income and resources of their sponsors other than relatives deemed for their care. Refer to Staff Manual Volume 3 for specific instructions on deeming income and resources.

8.111 MEDICARE CATASTROPHIC COVERAGE ACT (MCCA)

8.111.1 QUALIFIED MEDICARE BENEFICIARIES (QMB)

- 8.111.10 Effective July 1, 1989, a Qualified Medicare Beneficiary is an individual who:

- A. receives Part A Medicare; and
- B. For an individual, who has resources at or below twice the SSI individual resource limit, or for a couple who has resources at or below three times the SSI individual resource limit, as described in the previous section "SSI FINANCIAL ELIGIBILITY REQUIREMENTS"; and
- C. has income at or below the percentage of the federal poverty level for the size family as mandated for QMB by federal regulations. Poverty level is established by the Executive Office of Management and Budget.

For QMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for QMB.

For QMB purposes, earned income of the applicant/recipient and/or the spouse, shall have the 65 plus 1/2 earned income disregard, in accordance with 8.110.57,B, applied before the earned income is considered toward the applicable income limit. If two or more individuals have earned income, the income of all the individuals shall be added together and the 65 plus 1/2 earned income disregard shall be applied to the total amount of earned income.

- 8.111.11 Medicare cost sharing expenses must be provided to qualified Medicare beneficiaries. This limited Medicaid package of Medicare cost sharing expenses only includes:

- A. payment of Part A Medicare premiums where applicable; and,
- B. payment of Part B Medicare premiums; and,
- C. payment of coinsurance and deductibles for Medicare services whether or not a benefit of Medicaid up to the full Medicare rate or reasonable rates as established in the State Plan.

8.111.12 Individuals may be QMB recipients only or the individual may be classified as a dual eligible.

A. A QMB-only recipient is an individual who is not eligible for other categorical assistance program due to their income and/or resources but who meets the eligibility criteria for QMB described above.

B. A dual eligible is a Medicare recipient who is otherwise eligible for Medicaid.

8.110.13 Individuals who apply for assistance as a QMB have the right to have their eligibility determined under all categories of assistance for which they may qualify.

8.111.14 All other general non-financial requirements or conditions of eligibility must also be met such as age, citizenship, residency requirements as well as reporting and redetermination requirements. These criteria are defined in the Income Maintenance Staff Manual.

8.111.15 Eligibility for QMB benefits shall be effective the month after the month of determination. Beneficiaries who submit and complete an application within the 45-day standard shall be eligible for benefits no later than the first of the month following the 45th day of application. Administrative delays shall not postpone the effective date of eligibility.

QMB benefits are not retroactive and the three month retroactive Medicaid rule does not apply to QMB benefits.

8.111.16 Clients who would lose their QMB entitlement due to annual social security cost of living adjustments (COLA) will remain eligible for QMB coverage under Medicaid, as income disregard cases, until the next year's federal poverty guidelines are published.

8.112 SPOUSAL PROTECTION - TREATMENT OF INCOME AND RESOURCES FOR INSTITUTIONALIZED SPOUSES

A. The spousal protection regulations apply to married couples where one spouse is institutionalized or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in the community.

B. For purposes of spousal protection, an institutionalized spouse is an individual who:

1. Begins a stay in a medical institution or nursing facility on or after September 30, 1989, or
2. Is first enrolled as a Medicaid client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or
3. Receives Home and Community Based Services on or after July 1, 1999.

C. A person is considered likely to remain in a medical institution, nursing facility, enrolled in the PACE program, or receiving HCBS when, at the beginning of the institutionalization there is a reasonable expectation, based on medical evidence, that he/she will remain institutionalized for at least 30 consecutive days.

D. A community spouse is defined as a spouse who:

1. Is not in a medical institution or nursing facility,
2. Is not enrolled as a Medicaid client in the Program of All Inclusive Care for the Elderly (PACE),
3. Is not receiving Home and Community Based Services (HCBS).

4. Is not in receipt of Medicaid other than coverage under a Medicare cost-sharing program such as QMB, SLMB, QI-1, or QI-2.

8.112.1 ASSESSMENT AND DOCUMENTATION OF THE COUPLE'S RESOURCES

An assessment of the total value of the couple's resources shall be completed at the time of Medicaid application or when requested by either spouse of a married couple. All non-exempt resources owned by a married couple are counted, whether owned jointly or individually. There are no exceptions for legal separation, pre-nuptial, or post-nuptial agreements.

8.112.11 CALCULATION OF THE COMMUNITY SPOUSE RESOURCE ALLOWANCE

- A. A Community Spouse Resource Allowance (CSRA) shall be allocated based on the total resources owned by the couple as of the time of Medicaid application. In calculating the amount of the CSRA, resources shall not be attributed to the community spouse based upon state laws relating to community property or the division of marital property.
 1. For persons whose Medicaid application is for an individual who meets the definition of an institutionalized spouse, the CSRA is the largest of the following amounts:
 - a. The total resources of the couple but no more than the current maximum allowance which is \$87,000 in 2001; or
 - b. The increased CSRA calculated pursuant to 8.112.24; or
 - c. The amount a court has ordered the institutionalized spouse to transfer to the community spouse for monthly support of the community spouse or a dependent family member.
 2. The resources allotted to the community spouse as the CSRA shall be transferred into the name of the community spouse and shall not be considered available to the institutionalized spouse. After the transfer of the CSRA to the community spouse, the income from these resources shall be attributed to the community spouse.
 3. The transfer of the CSRA shall be completed as soon as possible, but no later than the next redetermination. If the transfer is not completed within this time period, the resources shall be attributed to the institutionalized spouse and shall affect his/her Medicaid eligibility. Verification of the transfer of assets to the community spouse shall be provided to the county department.
 - a. The institutionalized spouse may transfer the resources allotted to the community spouse as the CSRA to another person for the sole benefit of the community spouse.
 4. If the community spouse is in control of resources attributed to the institutionalized spouse, but fails to make such resources available for his/her cost of care, this fact shall not make the institutionalized spouse ineligible for Medicaid, where:
 - a. The institutionalized spouse has assigned to the Colorado Department of Health Care Policy & Financing (CDHCPF) any rights to support from the community spouse; or
 - b. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the CDHCPF has the right to bring a support proceeding against the community spouse without such assignment; or

- c. The county determines that the denial of eligibility would work an undue hardship upon the institutionalized spouse. For the purposes of this subparagraph, undue hardship means that an institutionalized spouse, who meets all the Medicaid eligibility criteria except for resource eligibility, has no alternative living arrangement other than the medical institution or nursing facility.

8.112.12 TREATMENT OF THE HOME AND OTHER EXEMPT RESOURCES

The CSRA shall not include the value of exempt resources including the home. It is not necessary for the home to be transferred to the community spouse. The rules regarding countable and exempt resources can be found in the section "FINANCIAL ELIGIBILITY REQUIREMENTS FOR INDIVIDUALS ELIGIBLE FOR THE COLORADO MEDICAID PROGRAM". However, for Spousal Protection there is no limit to the value of household goods and personal effects and one automobile.

8.112.13 DETERMINATION OF THE INSTITUTIONALIZED SPOUSE'S RESOURCE ELIGIBILITY

The institutionalized spouse is resource eligible for Medicaid when the total resources owned by the couple are at or below the amount of the Community Spouse Resource Allowance plus the Medicaid resource allowance for an individual of \$2,000.

8.112.2 DETERMINATION OF INSTITUTIONALIZED SPOUSE'S INCOME ELIGIBILITY

The county department shall determine whether the institutionalized spouse is income eligible for Medicaid. The institutionalized spouse shall be income eligible if his/her gross income is at or below the Medicaid income limit for recipients of long-term care.

8.112.21 ATTRIBUTION OF INCOME

During any month in which a spouse is institutionalized, the income of the community spouse shall not be deemed available to the institutionalized spouse except as follows:

- A. If payment of income from resources is made solely in the name of either the institutionalized spouse or the community spouse, the income shall be considered available only to the named spouse.
- B. If payment of income from resources is made in the names of both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each spouse.
- C. If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.
- D. The above regulations of attribution of income are superseded if the institutionalized spouse can establish by a preponderance of the evidence that the ownership interests in the income are other than that provided in the regulations.

8.112.22 CALCULATING THE COMMUNITY SPOUSE'S MONTHLY INCOME NEEDS

A. The community spouse's total minimum monthly needs shall be determined as follows:

- 1. The current minimum monthly maintenance needs allowance (MMMNA), which is equal to 1/12 of the federal poverty level for a family of two and is adjusted in July of each year;
- 2. An excess shelter allowance, in cases where the community spouse's expenses for shelter exceed 30% of the MMMNA. The excess shelter allowance is computed by adding (a) and (b) together:

- a. The community spouse's expenses for rent or mortgage payment including principal and interest, taxes and insurance, and, in the case of a condominium or cooperative, any required maintenance fee, for the community spouse's principal residence; and
 - b. The larger of the following amounts: the standard utility allowance used by Colorado under U.S.C. 2014(e) of Title 7; or the community spouse's actual, verified, utility expenses. A utility allowance shall not be allowed if the utility expenses are included in the rent or maintenance charge, which is paid by the community spouse.
 - c. The excess shelter allowance is the amount, if any, that exceeds 30% of the MMMNA.
- 3. An additional amount may be approved for the following expenses:
 - a. Medical expenses of the community spouse or dependent family member for necessary medical or remedial care. Each medical or remedial care expense claimed for deduction must be documented in a manner that describes the service, the date of the service, the amount of the cost incurred, and the name of the service provider. An expense may be deducted only if it is:
 - 1. Provided by a medical practitioner licensed to furnish the care;
 - 2. Not subject to payment by any third party, including Medicaid and Medicare;
 - b. The cost of Medicare, long term care insurance, and health insurance premiums. A health insurance premium may be allowed in the month the premium is paid or may be prorated and allowed for the months the premium covers. This allowance does not include payments made for coverage which is:
 - 1. Limited to disability or income protection coverage;
 - 2. Automobile medical payment coverage;
 - 3. Supplemental to liability insurance;
 - 4. Designed solely to provide payments on a per diem basis, daily indemnity or nonexpense-incurred basis; or
 - 5. Credit life and/or accident and health insurance.
 - 4. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.
 - 5. The total that results from adding the current MMMNA and the excess shelter allowance shall not exceed the current maximum MMMNA which is \$2,175.00 for the year 2001 and is adjusted by the Health Care Financing Administration in January of each year.

8.112.23 CALCULATING THE AMOUNT OF INCOME TO BE CONTRIBUTED BY THE INSTITUTIONALIZED SPOUSE FOR THE COMMUNITY SPOUSE'S MONTHLY NEEDS

- A. The Monthly Income Allowance (MIA) is the amount of money necessary to raise the community

spouse's income to the level of his/her monthly needs, and shall be obtained from the monthly income of the institutionalized spouse. For individuals who become institutionalized on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse must be considered to have been made available to the community spouse before an MIA is allocated to the community spouse.

1. The MIA shall be the amount by which the community spouse's minimum monthly needs, which is the MMMNA, exceed his/her income from sources other than the institutionalized spouse. The community spouse's income shall be calculated by using the gross income less mandatory deductions for FICA and Medicare tax.
2. If a court has entered an order against the institutionalized spouse for monthly support of the community spouse, the MIA shall not be less than the monthly amount ordered by the court.
3. The county department shall make adjustments to the MMMNA and/or the MIA on a monthly basis for any continuing change in circumstances that exceeds \$50 a month. Continuing changes of less than \$50 in a month, and any infrequent or irregular changes, shall be considered at redetermination.

8.112.24 INCREASING THE COMMUNITY SPOUSE RESOURCE ALLOWANCE

A. The CSRA shall be increased above the maximum amount if additional resources are needed to raise the community spouse's monthly income to the level of the Minimum Monthly Maintenance Needs Allowance (MMMNA). In making this determination the items listed below are calculated in the following order:

1. The community spouse's MMMNA;
2. The community spouse's own income; and
3. The Monthly Income Allowance (MIA) contribution that the community spouse is eligible to receive from the institutionalized spouse.
4. If the community spouse's own income, and the Monthly Income Allowance contribution from the institutionalized spouse's income is less than the Minimum Monthly Maintenance Needs Allowance, additional available resources shall be shifted to the community spouse to bring his/her income up to the level of the MMMNA. The additional resources necessary to raise the community spouse's monthly income to the level of the MMMNA shall be based upon the cost of a single-premium lifetime annuity with monthly payments equal to the difference between the MMMNA and the community spouse's income. The following steps shall be followed to determine the amount of resources to be shifted:
 - a. The applicant shall obtain three estimates of the cost of an annuity that would generate enough income to make up the difference between the MMMNA and the combined community spouse's income as described above.
 - b. The amount of the lowest estimate shall be used as the amount of resources to increase the CSRA.
 - c. The applicant shall not be required to purchase the annuity in order to have the CSRA increased.
5. The CSRA shall not be increased if the institutionalized spouse refuses to make the monthly income allowance (MIA) available to the community spouse.

8.112.25 DEDUCTIONS FROM MONTHLY INCOME OF THE INSTITUTIONALIZED SPOUSE

- A. During each month after the institutionalized spouse becomes Medicaid eligible, deductions shall be made from the institutionalized spouse's monthly income in the following order.
1. A personal needs allowance or the client maintenance allowance as allowed by program eligibility.
 2. A Monthly Income Allowance (MIA) for the community spouse, but only to the extent that income of the institutionalized spouse is actually made available to, or for the benefit of, the community spouse;
 3. A family allowance for each dependent family member who lives with the community spouse.
 - a. The allowance for each dependent family member shall be equal to one third of the amount of the MMMNA and shall be reduced by the monthly income of that family member.
 - b. Family member means dependent children (minor or adult), dependent parents or dependent siblings of either spouse that are residing with the community spouse and can be claimed by either the institutionalized or community spouse as a dependent for federal income tax purposes.
 4. Allowable deductions identified in the section "POST ELIGIBILITY TREATMENT OF INCOME" .
 5. If the institutionalized spouse fails to make his/her income available to the community spouse or eligible dependent family members in accordance with these regulations, that income shall be applied to the cost of care for the institutionalized spouse.
 6. No other deductions shall be allowed.

8.112.3 RIGHT TO APPEAL

- A. Both spouses shall be informed of the following:
- (1) The amount and method by which the county department calculated the community spouse resource allowance (CSRA), community spouse monthly income allowance (MIA), and any family allowance;
 - (2) The spouses' right to a fair hearing concerning these calculations;
 - (3) The county department's conclusions with respect to the spouses' ownership and availability of income and resources, and the spouses' right to a fair hearing concerning these conclusions.
- B. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.
- C. Appeals from decisions made by the county department shall be governed by the provisions under "RECIPIENT APPEALS PROTOCOLS/PROCESS" at 10 CCR 2505-10, § 8.058.

8.121 QUALIFIED DISABLED AND WORKING INDIVIDUALS

8.121.1 Effective July 1, 1990, a Qualified Disabled and Working Individual (QDWI) is an individual who:

- A. was a recipient of federal Social Security Disability Insurance (SSDI) benefits, who continues to be disabled but lost SSDI entitlement due to earned income in excess of the Social Security Administration's Substantial Gainful Activity (SGA) threshold, and;
- B. has exhausted SSA's allowed extension of "premium-free" Medicare Part A coverage under SSDI, and;
- C. has resources at or below twice the SSI resource limit as described in the section on "SSI FINANCIAL ELIGIBILITY"; and
- D. has income less than 200% of poverty, as defined by the Executive Office of Management and Budget, or at a poverty level otherwise determined by the Health Care Financing Administration.

8.121.10 Monthly payment of Medicare Part A premiums, and any other Medicare cost-sharing expenses determined necessary by the Health Care Financing Administration (HCFA), must be made on behalf of Qualified Disabled and Working Individuals.

8.121.11 An individual may be eligible under this section only if he/she is not otherwise eligible under another medical assistance category of eligibility.

8.121.12 All other general non-financial requirements or conditions of eligibility must also be met such as citizenship and residency requirements as well as reporting and redetermination requirements. These criteria are defined in the Income Maintenance Staff Manual.

8.121.13 Eligibility for QDWI benefits shall be effective the month of determination of entitlement.

Eligibility may be retroactive only to the date as of which SSA approves an individual's application for coverage as a "Qualified Disabled and Working Individual". However, eligibility may not begin prior to 07/01/90.

8.122 SPECIAL LOW INCOME MEDICARE BENEFICIARIES

8.122.1 Effective January 1, 1993, a Special Low Income Medicare Beneficiary (SLMB) is an individual who:

- A. is entitled to Medicare Part A;
- B. For an individual, who has resources at or below twice the SSI individual resource limit, or for a couple, who has resources at or below three times the SSI individual resource limit as described in the section "SSI FINANCIAL ELIGIBILITY REQUIREMENTS";
- C. has income at or below a percentage of the federal poverty level for the family size as mandated by federal regulations for SLMB. Income limits have been defined through CY 1995, as follows: CY 1993 and 1994 100-110% of poverty, CY 1995 100-120% of poverty.

For SLMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for SLMB.

For SLMB purposes, earned income of the applicant/recipient and/or the spouse, shall

have the 65 plus 1/2 earned income disregard, in accordance with 8.110.57,B, applied before the earned income is considered toward the applicable income limit. If two or more individuals have earned income, the income of all the individuals shall be added together and the 65 plus 1/2 earned income disregard shall be applied to the total amount of earned income.

D. is not otherwise eligible for coverage under Medicaid (e.g., QMB, OAP, AND, etc.).

8.122.10 Medicaid coverage for SLMB clients is limited to payment of monthly Medicare Part B (Supplemental Medical Insurance Benefits) premiums.

8.122.11 All other general non-financial requirements or conditions of eligibility must also be met, such as citizenship and residency requirements, as well as reporting and redetermination requirements. These criteria are defined in the Income Maintenance Staff Manual.

8.122.12 Eligibility may be made retroactive up to 90 days, but may not be effective prior to 1/1/93.

8.122.13 Clients who would lose their SLMB entitlement due to annual Social Security cost-of-living adjustments (COLA) will remain eligible for SLMB coverage, as income disregard cases, through the month following the month in which the annual federal poverty levels (FPL) update is published.

8.123 MEDICARE QUALIFYING INDIVIDUALS 1

8.123.1 Eligibility for this benefit is limited by the availability of the allocation set by the Health Care Financing Administration (HCFA). Once the state allocation is met, no further benefits under this category shall be paid and a waiting list of eligible individuals shall be maintained.

8.123.11 Eligibility for QI1 benefits shall be effective the month in which application is made and the individual is eligible for benefits. Eligibility may be retroactive up to three months from the date of application, but not prior to January 1, 1998.

8.123.12 In order to qualify as a Medicare Qualifying Individual 1, the individual must meet the following:

- A. be entitled to Part A of Medicare,
- B. income of at least 120%, but less than 135% of the federal poverty level,
- C. resources may not exceed twice the SSI limit, and
- D. he/she cannot otherwise be eligible for Medicaid.

Eligibility for benefits is limited to monthly payment of Medicare Part B premiums. Payment of the premium shall be made by the department on behalf of the individual.

8.130 PROVIDER PARTICIPATION

8.130.1 DEFINITION

Requesting Agency means the United States Department of Health and Human Services, the Department, Department of Human Services, or the Medicaid Fraud Control Unit, acting through their representatives who have written or de factor designation as such.

8.130.2 MAINTENANCE OF RECORDS

8.130.2.A. Each provider shall:

1. Maintain records necessary to disclose the nature and extent of services provided to recipients including but not limited to:
 - a. Billings.
 - b. Treatment prior authorization requests.
 - c. All medical records, service reports, and orders prescribing treatment plans.
 - d. Records of items, including drugs, prescribed, ordered for, or furnished to recipients, and copies of original invoices for such items.
 - e. Records of all payments received from the Medicaid Program.
2. Maintain records, which fully substantiate or verify claims submitted for payment.
3. Furnish the records listed in 8.130.2.A.1 on request to the requesting agency.

8.130.2.B. Records of institutional providers shall include employment records, including but not limited to shift schedules, payroll records and time cards of employees.

8.130.2.C. Providers who issue prescriptions shall keep in the patient's record, the date of each prescription and the name, strength and quantity of the item prescribed.

8.130.2.D. Records must be maintained for six years unless an additional retention period is required elsewhere in 10 C.C.R. 2505-10, Sections 8.000 et seq. or in the provider agreement.

8.130.2.E. Each provider shall retain any other records created in the regular operation of business that relate to the type and extent of services provided. All records must be verifiable and must comply with generally accepted accounting principles and auditing standards.

8.130.2.F. Each entry in a medical record must be signed and dated by the individual providing the medical service.

8.130.2.G. Providers utilizing electronic record-keeping may apply computerized signatures and dates to the medical record if their record-keeping systems guarantee the following security measures:

1. Restrict application of an electronic signature to the specific individual identified by the signature. System security must prevent one person from signing another person's name.
2. Prevent alterations to authenticated (signed and dated) reports. If the provider of service chooses to supplement a previous entry, the system must only allow a new entry that explains the supplement. The provider must not be allowed to change the initial entry.
3. Printed or displayed electronic records must note that signatures and dates have been applied electronically.

8.130.2.H. At the discretion of the requesting agency, record verification may include interviews with providers, employees of providers, billing services that bill on behalf of providers, and any member of a corporate structure that includes the provider as a member.

8.130.2.I. Nothing in Section 8.130 shall negate or modify any specific record keeping requirements contained in 10 C.C.R. 2505-10, Sections 8.000 et seq. or in individual provider agreements.

8.130.3 ADVANCE DIRECTIVES

8.130.3.A. Advanced Directive means a written instruction, such as a Living Will or Durable Power of Attorney for health care, recognized under state law, whether statutory or as recognized by the courts of the state, that relates to the provision of medical care when the individual is incapacitated.

8.130.3.B. Providers shall provide adult Medicaid recipients with written information about the individual's rights under state law to accept or refuse medical treatment, the right to formulate advance directives and the providers' policies regarding the implementation of such rights as follows:

1. Hospitals, at the time of the individual's admission as an inpatient.
2. Nursing facilities, at the time of the individual's admission as a resident.
3. Providers of home health care or personal care services, in advance of the individual coming under the care of the provider.
4. Hospice programs, at the time of initial receipt of hospice care by the individual from the program.
5. Health maintenance organizations, at the time of enrollment of the individual with the organization.

8.130.3.C. The provider shall maintain written policies and procedures with respect to all adult individuals receiving medical or personal care by or through the provider organization which shall include:

1. Documentation in the individual's medical records indicating whether the individual has executed an advance directive.
2. Documentation that the individual will not be discriminated against, nor will the provision of care be conditioned on whether he/she has executed an advance directive.
3. Documentation ensuring compliance with requirements of state law respecting advanced directives.
4. Documentation in the individual's medical record substantiating the provider's reason(s) for non-compliance with an advance directive based on conscience or professional ethics.

8.130.3.D. Providers shall provide education for staff and the patient/client community on issues concerning advance directives.

8.130.4 TERMINATION

Existing contracts shall be terminated if the provider fails to disclose requested information or if any person who has an ownership or control interest in the entity, or who is an agent or managing employee of the entity, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX services program. Person with an Ownership or Control Interest means a person, corporation, partnership, joint venture or other legal entity that:

- A. Has an ownership interest equal to five percent or more in a Disclosing Entity, or
- B. Has an indirect ownership interest equal to five percent or more in a Disclosing Entity, or
- C. Has a combination of direct and indirect ownership interests equal to five percent or more in a

Disclosing Entity, or

- D. Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the Disclosing Entity if that interest equals at least five percent of the value of the property or assets of the Disclosing Entity, or
- E. Is an officer or director of a Disclosing Entity that is organized as a corporation, or
- F. Is a partner in a Disclosing Entity that is organized as a partnership.

Convicted means that a federal, state, or local court, regardless of whether an appeal from that judgment is pending, has entered a judgment of conviction.

8.170 STATE IDENTIFICATION NUMBER

- .10 As medical assistance is administered on an individual recipient basis, rather than on a household basis, the individual recipient is uniquely identified. A state assigned number is used for this purpose. This state identification number consists of an alpha (letter) prefix, followed by a six-digit number. When an individual is approved for medical assistance, the state identification number is assigned. This number is transmitted to the county department via the automated system.
- .20 The State Identification Number is the only numeric designation medical assistance providers will have, other than the name, to identify individuals. This number is required to be entered on all billing transactions.

In order to carry out this responsibility for facilitating provision of medical benefits to recipients, to properly respond to inquiries from providers, to secure benefits of medical resources other than Medicaid (see 8.061 et seq.), and for other administrative purposes, county departments are to maintain cross reference files of household and medical identification numbers.

8.180 MEDICAL IDENTIFICATION CARDS AND DURATION OF ELIGIBILITY

8.181 IDENTIFICATION

- .10 The state department will issue identification cards directly to clients who are eligible for benefits under a medical assistance program.
- .20 The providers of benefits in the Department's medical assistance programs are instructed to use the identifying information to access an automated eligibility database to obtain the client's current or previous eligibility for medical assistance for a given date of service.

8.182 MEDICAL IDENTIFICATION CARD

Each eligible client shall have a medical identification card issued from the state department's office to obtain medical services.

8.183 INSTRUCTIONS FOR HANDLING UNDELIVERED MEDICAL IDENTIFICATION CARDS

The Post Office returns all undelivered Medical Identification Cards to the county departments when recipients are deceased, no longer at that address, etc. The following steps will be taken to assure delivery of cards to the recipient.

- A. If the address shown in the envelope window is incorrect or no longer valid, the county departments are not to make the address change for remailing on the returned envelope. Counties are to open the envelope, paste a white sticker over the incorrect address, type

in the correct address, use a separate envelope with the corrected address, insert the Medical Identification Card Mailer, and remail the card and its carrier to the client's new (correct) address. (This includes out-of-state moves if the client remains eligible.)

- B. Counties shall immediately correct the address on the automated system.
- C. If the recipient is deceased, the county shall destroy the identification card and make appropriate change in the eligibility system.

8.190 ACUTE MEDICAL BENEFITS DETERMINATION

8.190.1 A client or provider may request a coverage determination for new acute medical benefits or services by submitting a written request to the Department.

8.190.1.A. Written requests shall include documentation on all the following criteria regarding the benefit or service:

1. Prescribed by a doctor of medicine or osteopathy, or an optometrist, dentist or podiatrist acting within the scope of their respective licenses;
2. A reasonable, appropriate and effective method for meeting the medical need;
3. The expected use is in accordance with current medical standards or practices;
4. Proven cost effective method of treatment;
5. Does not result in an unsafe environment or situation;
6. Not experimental, investigational and is accepted by the medical community as standard practice;
7. Primary purpose is not to enhance personal comfort or convenience; and
8. Considered to be medically necessary for the diagnosis.

8.190.2 The requestor shall be notified in writing of the Department's decision regarding coverage.

8.200 PHYSICIAN SERVICES

8.200.1 DEFINITIONS

Certified Family Planning Clinic means a family planning clinic certified by the Colorado Department of Public Health and Environment, accredited by a national family planning organization and staffed by medical professionals licensed to practice in the State of Colorado, including but not limited to, doctors of medicine, doctors of osteopathy, physicians' assistants and advanced practice nurses.

General Supervision means the procedure is furnished under the physician's overall direction and control but the physician's presence is not required during the performance of the procedure.

Medically Necessary means a covered service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

8.200.2 COVERED PHYSICIAN SERVICES

- 8.200.2.A. Physician services are authorized when the service is Medically Necessary, a benefit of Medicaid and provided by the appropriate physician specialty.
- 8.200.2.B. Physician services in regard to family planning are considered in the same manner as any other medical visit.
- 8.200.2.C. Physician services in dental care are a benefit when provided for surgery related to the jaw or any structure contiguous to the jaw or reduction of fracture of the jaw or facial bones. Service includes dental splints or other devices. A provider of dental care surgery can either be enrolled as a dentist or oral surgeon, not both.
- 8.200.2.D. Physician services in regard to foot care are a benefit when provided by a physician or licensed podiatrist.
- 8.200.2.E. Physician services in regard to vision care are a benefit.
- 8.200.2.F. Physician services in regard to laboratory testing are a benefit in accordance with 10 C.C.R. 2505-10, Section 8.660.
- 8.200.2.G. Physician services in regard to the provision of immunizations are a benefit. Vaccines provided to enrolled children shall be obtained through the Colorado Department of Public Health and Environment.
- 8.200.2.H. Physician services in regard to mental health are a benefit. Outpatient individual and individual brief counseling visits are limited to 35 visits per state fiscal year.

8.200.3 QUALIFIED NON-PHYSICIAN PRACTITIONERS ELIGIBLE TO PROVIDE PHYSICIAN'S SERVICES

- 8.200.3.A. A doctor of medicine or osteopathy shall order all medical care services or goods that are benefits of Section 8.200 except for dental, podiatry, optometric and mental health services.
- 8.200.3.B. The following requirements apply to non-physician practitioners rendering Medicaid services:

Certified registered nurse anesthetists, certified nurse practitioners, certified occupational therapists, licensed physical therapists, certified audiologists, certified speech pathologists, licensed/certified respiratory therapists and licensed physician assistants may provide services under the following conditions:

1. Services shall be rendered under the General Supervision of a physician.
2. There is appropriate consultation between the non-physician personnel who administers the service. Continuing consultation is the responsibility of the physician. Periodic review of the client's plan of care is required and shall be documented in the client's record. Periodic review shall be at the level required by the medical necessity of the patient, no less than once every two months.
3. A physician may prescribe occupational or physical therapy for clients when Medically Necessary. Clients are allowed a set number of units of occupational and physical therapy without prior authorization as established by the Department. If a client requires additional therapy, the provider shall obtain prior authorization before rendering services. Services not properly prior authorized shall not be reimbursed.

- 8.200.3.C. Reimbursement for certified registered nurse anesthetists, certified pediatric nurse practitioners, certified occupational therapists, licensed physical therapists, certified family nurse

practitioners, certified audiologists, certified speech pathologists and certified/licensed respiratory therapists shall be as follows:

1. Services rendered shall be reimbursed by the methodology described in Section 8.200.8.C.
2. Services shall be reimbursed directly to the non-physician provider unless the non-physician provider is acting within the scope of his/her contract with a physician or public or private institution or employment as a salaried employee of a physician or public or private institution.

8.200.3.D. Services provided by licensed physician assistants shall be billed through an enrolled physician.

8.200.3.E. All other non-physician practitioners shall provide services under the Direct Supervision of a physician. Direct Supervision means the physician shall be on-site during the rendering of services and immediately available to give assistance and direction throughout the performance of the service.

1. Reimbursement for other non-physician practitioners shall be made as described in Section 8.200.8.A and billed to Medicaid by the enrolled physician.
2. Reimbursement shall not be made if the practitioner is acting within the scope of their graduate education training program or as contract agents or employees of a nursing home, hospital, FQHC, clinic, home health agency, school or physician.

8.200.3.F. Supervision shall meet the specific requirements of the state laws governing each medical specialty when those supervision requirements are more stringent than the requirements contained in Section 8.200 et seq.

8.200.3.G. Licensure and required certification for non-physician providers shall be in accordance with their specific specialty practice act and with current state licensure statutes and regulations.

8.200.3.H. Certified nurse midwives shall work in coordination with a physician as described in their practice act. Reimbursements shall be made as described in Section 8.200.8.A.

8.200.3.I. Licensed dental hygienists shall be directly reimbursed for unsupervised dental hygiene services. Hygienists who serve enrolled children shall provide the child with the name of a licensed dentist. Hygienists employed by a dentist, clinic or institution shall submit claims under the employer's provider number. Reimbursements shall be made as described in Section 8.200.8.E.

8.200.4 TELEMEDICINE

8.200.4.A. Telemedicine means the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video or interactive data communication instead of in-person contact.

8.200.4.B. No enrolled managed care organization may require face-to-face contact between a provider and a client for services appropriately provided through telemedicine if the client resides in a county with a population of 150,000 or fewer residents and the county has the technology necessary for the provision of telemedicine. The use of telemedicine is not required when in-person care by a participating provider is available to an enrolled client within a reasonable distance.

8.200.4.C. Any health benefits provided through telemedicine shall meet the same standard of care as in-

person care.

8.200.5 MENTAL HEALTH

8.200.5.A. Services of licensed psychologists are a benefit. Services are not required to be under the direct supervision of a physician.

8.200.5.B. Psychology services shall be reimbursed under the same methodology as physician services described in Section 8.200.8.A.

8.200.5.C. Services ordered by a psychologist, but rendered by another provider shall be billed under the psychologist. The psychologist shall order the service and provide supervision as outlined under the Psychology Practice Act.

8.200.6 PHYSICAL EXAMINATIONS

8.200.6.A. Physical examinations are a benefit for annual preventative service, diagnosis and evaluation of disease or early and periodic screening, diagnosis and treatment as described in 10 C.C.R. 2505-10, Section 8.282. For the purpose of the adult annual preventive service benefit, annual shall mean state fiscal year.

8.200.7 CERTIFIED FAMILY PLANNING CLINICS

8.200.7.A. Laboratory services provided by Certified Family Planning Clinics shall be reimbursed if the laboratory has met all Clinical Laboratory Improvement Amendment requirements.

8.200.7.B. Services shall be rendered under the General Supervision of a physician.

8.200.7.C. The Certified Family Planning Clinic shall contact the client's PCP or managed care organization if applicable prior to rendering services that require a referral.

8.200.7.D. Clinic services shall be reimbursed under the same methodology as physician services described in section 8.200.8.A and paid directly to the clinic.

8.200.8 REIMBURSEMENT

8.200.8.A. Physician services shall be reimbursed at the lower of the following:

1. Submitted charges; or
2. Fee schedule as determined by the Department.

8.200.8.B. Physician surgery shall be reimbursed at the lower of the following:

1. Submitted charges; or
2. Fee schedule as determined by the Department.

8.200.8.C. Non-physician practitioners consisting of certified nurse midwives, certified registered nurse anesthetists, certified nurse practitioners, certified audiologists, certified speech pathologists, licensed/certified respiratory therapists, and licensed physician assistants, services shall be reimbursed at the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department.

8.200.8.D. Out patient clinical diagnostic laboratory tests preformed by a physician or independent lab shall be reimbursed at the lower of the following:

1. Submitted charges; or

2. Fee schedule as determined by the Department.

8.200.8.E. Dental services shall be reimbursed at the lower of:

1. Submitted charges; or

2. Fee schedule as determined by the Department.

8.201 TREATMENT OF ORAL MEDICAL CONDITIONS FOR ADULT CLIENTS

8.201.1 DEFINITIONS

Adult Client means an individual who is 21 years or older and eligible for medical assistance benefits.

Condition of the Oral Cavity means a problem in the oral cavity requiring treatment.

Concurrent Medical Condition means a pre-existing medically-diagnosed state that can be exacerbated by a condition present in the oral cavity.

Emergency Treatment means the need for immediate intervention by a physician, osteopath or dentist to stabilize an oral cavity condition.

Immediate Intervention or Treatment means services rendered within twelve (12) hours.

Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.

8.201.2 BENEFITS

8.201.2.A. Treatment of a Condition of the Oral Cavity for Adult Clients with a Concurrent Medical Condition is a benefit.

1. Allowable Concurrent Medical Conditions include:

a. Neoplastic disease requiring chemotherapy and/or radiation.

b. Pre and post organ transplant.

c. Pregnancy.

d. Chronic medical condition in which there is documentation that the medical condition is exacerbated by a Condition of the Oral Cavity.

8.201.2.B. Exclusions.

1. The following services/treatments are not a benefit for Adult Clients under any circumstances:

a. Preventive services to include prophylaxis, fluoride treatment and oral hygiene instruction.

- b. Treatment for dental caries, gingivitis and tooth fractures.
- c. Restorative and cosmetic procedures.
- d. Inlay and onlay restorations.
- e. Crowns.
- f. Treatment of the Oral Cavity in preparation for partial or full mouth dentures.
- g. Assessment for, delivery of dentures or subsequent adjustments to dentures and bridges.

8.201.2.C. Emergency Treatment.

1. Emergency Treatment can be provided to an Adult Client who:
 - a. Presents with an acute Condition of the Oral Cavity that requires hospitalization and or immediate surgical care.
 - b. Presents with a Condition of the Oral Cavity that would result in acute hospital medical care and or subsequent hospitalization if no Immediate Treatment is rendered.
2. Emergency Treatment provided to an Adult Client includes, but is not limited to:
 - a. Immediate Treatment or surgery to repair trauma to the jaw.
 - b. Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose.
 - c. Extraction of tooth or tooth structures associated with the Emergency Treatment of a Condition of the Oral Cavity.
 - d. Repair of traumatic Oral Cavity wounds.
 - e. Anesthesia services ancillary to the provision of emergency treatment.

8.201.3 PRIOR AUTHORIZATION REQUEST

8.201.3.A. Prior authorization is required for treatment rendered for an Adult Client with a Concurrent Medical Condition.

1. Emergency Services do not require a prior authorization before services can be rendered.
2. All prior authorization requests shall include:
 - a. Statement identifying the chronic medical condition.
 - b. Description of Condition of the Oral Cavity that is exacerbating the chronic medical condition.
 - c. Narrative describing why the recommended treatment is necessary to prevent exacerbation of the Adult Client's chronic medical condition.

8.201.4. PROVIDER REQUIREMENTS/REIMBURSEMENT

8.201.4.A. To submit claims for treatment of oral medical conditions for Adult Clients, the provider shall meet one of the following requirements:

1. Enroll as a physician and bill according to all medical billing requirements including using Current Procedural Terminology (CPT) codes.
2. Enroll as a dentist and bill according to all dental billing requirements including using Current Dental Terminology (CDT) codes.

8.205 MEDICAID MANAGED CARE PROGRAM

8.205.1 CLIENT ELIGIBILITY

8.205.1.A. A Medicaid client may choose to enroll in the Medicaid Managed Care Program in the Primary Care Physician Program or with a Managed Care Organization.

8.205.1.B. A Medicaid client who receives limited benefits and is not otherwise eligible for Medicaid, shall not be eligible to receive services through a Managed Care Organization.

8.205.1.C. In order to be eligible to be enrolled with a Managed Care Organization, a Medicaid client must live within the service area covered by the Managed Care Organization.

8.205.2 CLIENT RESPONSIBILITIES

8.205.2.A. By choosing to enroll in the Primary Care Physician Program, a client agrees to comply with the following responsibilities:

1. Select a primary care physician from those physicians participating in the Primary Care Physician Program.
2. Obtain a referral from his/her primary care physician for care provided by anyone other than his/her primary care physician. Referrals are not necessary for family planning services and emergency services as defined at 42 CFR 438.114.
3. Request any change of primary care physician from the Department or its designee.
4. Pay for any health care provided, except for family planning services and emergency services as defined at 42 CFR 438.114, when health care services are sought and received without a referral from his/her primary care physician.
5. Pay for any services received which are not Medicaid covered services.
6. Notify the primary care physician of any third party insurance, including Medicare.

8.205.2.B. By choosing to enroll with a Managed Care Organization, a client agrees to comply with the following responsibilities:

1. Select a primary care physician from those physicians available in the Managed Care Organization.
2. Follow all requirements of the Medicaid managed care program as described in the Member Handbook of the Managed Care Organization.
3. Obtain a referral from his/her primary care physician for specialty care.

4. Follow the Managed Care Organization's procedures for complaints and grievances.
5. Request any change of primary care physician from the Managed Care Organization.
6. Pay for any health care provided, except for emergency services as defined at 42 CFR 438.114, when health care services are sought and received without a referral from his/her primary care physician in the Managed Care Organization. This shall not apply where the health care services is a Medicaid covered service that is not covered by the Managed Care Organization.
7. Pay for any services received which are not Medicaid covered services.
8. Notify the Managed Care Organization of any third party insurance, including Medicare.

8.205.3 CLIENT RIGHTS AND PROTECTIONS

8.205.3.A. A client who chooses to enroll in the Primary Care Physician Program or with a Managed Care Organization shall have the following rights and protections:

1. To be treated with respect and with due consideration for his/her dignity and privacy.
2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
3. To participate in decisions regarding his/her health care, including the right to refuse treatment and the right to a second opinion.
4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
5. To obtain family planning services directly from any provider duly licensed or certified to provide such services without regard to enrollment in the Primary Care Physician Program or in a Managed Care Organization, without referral.
6. To request and receive a copy of his/her medical records and to request that they be amended or corrected, as specified in 45. CFR Part 164.
7. To exercise his/her rights without any adverse effect on the way he/she is treated.

8.205.4 CLIENT ENROLLMENT AND DISENROLLMENT

8.205.4.A. Enrollment in the managed care program shall be voluntary.

8.205.4.B. Members who are disenrolled from a managed care provider for a period of two (2) months or less shall be reenrolled with the same managed care provider upon regaining eligibility within the two (2) month period.

8.205.4.C. A client who enrolls with a managed care provider shall remain assigned to the managed care provider for a period of twelve (12) months except as otherwise provided in these rules.

8.205.4.D. A client may request disenrollment from their managed care provider without cause during the ninety (90) days following the date of their initial enrollment or the date the Department or its designee sends the notice of enrollment, whichever is later.

8.205.4.E. A client may request disenrollment without cause at least every twelve (12) months after the

date of initial enrollment with a managed care provider. A client may request disenrollment upon automatic enrollment if the temporary loss of eligibility has caused the client to miss the annual disenrollment opportunity.

8.205.4.F. A client may request disenrollment when the Department imposes intermediate sanctions as set forth in the Department's contract with the managed care provider.

8.205.4.G. A client may request disenrollment for cause at any time. Cause shall be defined as any of the following:

1. The client moves out of the managed care provider's service area.
2. The managed care provider does not, because of moral or religious objections, cover the service the client needs.
3. The client needs related services (for example, a caesarian section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the client's primary care provider or another provider determines that receiving the services separately would subject the client to unnecessary risk.
4. Administrative error on the part of the Department or its designee, the Managed Care Organization or the Primary Care Physician including, but not limited to, system error.
5. Poor quality of care, as documented by the Department.
6. Lack of access to covered services, as documented by the Department.
7. Lack of access to providers experienced in dealing with the client's health care needs, as documented by the Department.
8. The client enrolled in a Managed Care Organization with his/her physician and the physician leaves the Managed Care Organization.
9. Other reasons satisfactory to the Department.

8.205.4.H. For clients who are unable to make decisions for themselves, a family member, legal guardian or designated advocate shall be included in all decision-making concerning enrollment and disenrollment of the client.

8.205.4.I. Primary care physicians participating in the program may dismiss an enrolled client from their practice for cause at any time. The primary care physician shall give no less than 45 days notice to both the Department and the client Cause shall be defined as any of the following:

1. The client misses multiple scheduled appointments.
2. The client fails to follow the recommended treatment plan or medical instructions.
3. The primary care physician cannot provide the level of care necessary to meet the client's needs.
4. The client and /or client's family is abusive to provider and/or staff in compliance with 42 CFR 438.56(a)(2).
5. The physician moves out of the service area.

6. Other reasons satisfactory to the Department.

8.205.5 ESSENTIAL COMMUNITY PROVIDERS

8.205.5.A In order to be eligible for designation as an Essential Community Provider, the following health care providers shall be determined to have historically served medically needy or medically indigent patients and demonstrated a commitment to serve low-income and medically indigent populations who make up a significant portion of their patient population or, in the case of a sole community provider, serve the medically indigent patients within their medical capability:

1. Disproportionate share hospitals.
2. Local county and district health departments, county nursing services and regional health department operating pursuant to Title 25, C.R.S., as amended.
3. Federally Qualified Health Centers (FQHCs).
4. School based health centers that can verify that 25% of students enrolled in the school are at or below 185% of the Federal Poverty Level and that services are offered to the entire student population enrolled in the school without regard to the patient's ability to pay.
5. Family Medicine Residency Training Programs that can verify that 25 % of the patients served are at or below 185% of the Federal Poverty Level.
6. Rural Health Clinics that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
7. State certified Title X Family. Planning Agencies that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
8. Sole community providers that are not located within a metropolitan statistical area, as designated by the U.S. Office of Management and Budget, and in whose community there is no other similar type of health care and the provider can verify that it provides health care services to patients below 185% of the Federal Poverty Level within its medical capability.
9. New health care providers operating under a sponsoring or participating entity that qualifies as an Essential Community Provider.
10. Health care providers that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

8.205.6 In order to be eligible for designation as an Essential Community Provider, the provider shall waive charges or charge for services on a sliding scale for patients/families at or below 185% of the Federal Poverty Level.

8.205.7 Health care providers, except those set forth a 8.206.1(1) through (3), who seek to be designated as an Essential Community Provider, shall submit their application, including a copy of their sliding fee scale to the Department.

8.205.8 QUALIFIED PHARMACY PROVIDERS

8.205.8.A. A Managed Care Organization shall contract with qualified pharmacy providers in a manner permitting a nursing facility to continue to comply with federal Medicaid requirements of participation.

8.205.8.B. A qualified pharmacy provider shall meet all of the following requirements:

1. Employ, on a full-time basis, a pharmacist licensed by the State of Colorado.
2. Demonstrate a capability of procuring, preparing, dispensing and distributing pharmaceutical products in an institutional setting.
3. Demonstrate a capability of monitoring clients on an ongoing basis to identify, prevent and resolve drug-related problems including, but not limited to, the monitoring of drug-drug interactions and drug-allergy interactions.
4. Provide pharmaceutical consulting services twenty-four (24) hours per day.
5. Perform medication-use assessments with the assistance of a pharmacist licensed by the State of Colorado at least once each month. Such assessments shall be client-centered, ensuring that the client's medication regimen meets his or her needs.
6. Participate with the client's physicians, nurses, dieticians and other health care professionals in inter-disciplinary care planning.
7. Provide continuous pharmaceutical care and services to clients twenty-four (24) hours per day every day.
8. Reasonably respond to emergency situations and maintain an emergency kit registered with the. Colorado. State Board of Pharmacy at each nursing home.
9. Utilize appropriate unit dose or unit of issue distribution systems to ensure that clients receive proper medications, at the proper time, and at the proper dosage.
10. Demonstrate its capability to provide physician orders and medication administration records on a monthly basis.

8.205.9 PERSONS WITH SPECIAL HEALTH CARE NEEDS

8.205.9.A. Persons with Special Health Care Needs shall mean persons having ongoing health conditions that

1. Have a biologic, psychologic or cognitive basis;
2. Have lasted or are virtually certain to last for at least one year; and
3. Produce one or more of the following sequelae:
 - a. Significant limitation in areas of physical, cognitive or emotional function;
 - b. Dependency on medical or assistive devices to minimize limitation of function or activities;
 - c. In addition, for children:
 - (i) Significant limitation in social growth or developmental function;
 - (ii) Need for psychologic, educational, medical or related services over and above the usual for the child's age; or

- (iii) Special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.

8.209 MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESSES

8.209.1 GENERAL PROVISIONS

Medicaid members or their Designated Client Representatives enrolled in Managed Care Organizations (MCOs) may access and utilize the Medicaid Managed Care Grievance and Appeal Systems. The Grievance and Appeal Systems shall include a grievance process and an appeal process for handling grievances and appeals at the MCO or PIHP level and access to the State fair hearing process for appeals.

8.209.2 DEFINITIONS

Action shall mean:

1. The denial or limited authorization of a requested service, including the type or level of service;
2. The reduction, suspension or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service (except payment denials issued by a mental health prepaid inpatient health plan);
4. The failure to provide services in a timely manner; or
5. The failure to act within the timeframes provided below or the denial of a Medicaid member's request to exercise his or her right to obtain services outside the network for members in rural areas with only one MCO.

Appeal shall mean a request for review of an action.

Designated Client Representative shall mean any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services.

Fair Hearing shall mean the formal adjudication process for appeals described at 10 CCR 2505-10, § 8.057.

Grievance shall mean an oral or written expression of dissatisfaction about any matter other than an action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights.

Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

Quality of Care Complaint shall mean any grievance made in regards to the professional competence and/or conduct of a physician or other health care provider, which could adversely affect the health, or welfare of a member.

Timely Filing shall mean filing on or before the later of the following: within ten days of the MCO or PIHP postmarking the notice of action; or the intended effective date of the MCO's or PIHP's proposed action.

8.209.3 GRIEVANCE SYSTEM

8.209.3.A. The Grievance System is the overall system that includes grievances and appeals handled at the MCO and PIHP level and access to the State fair hearing process for appeals.

8.209.3.B. The MCO or PIHP shall provide a Department approved description of the grievance, appeal and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the MCO or PIHP. The description shall include:

1. The member's right to a State fair hearing for appeals.
 - a. The method to obtain a hearing, and
 - b. The rules that govern representation at the hearing.
2. The member's right to file grievances and appeals.
3. The requirements and timeframes for filing grievances and appeals.
4. The availability of assistance in the filing process.
5. The toll-free numbers that the member can use to file a grievance or an appeal by telephone.
6. The fact that, when requested by a member:
 - a. Benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and
 - b. The member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member.

8.209.3.C. The MCO or PIHP shall maintain record of grievances and appeals and submit a quarterly report to the Department.

8.209.4 APPEAL PROCESS

8.209.4.A. Notice of Action

1. The MCO or PIHP shall send the member written notice for each action. The notice shall be in writing and shall be available in English and the prevalent non-English languages spoken by members throughout the State. "Prevalent" means a non-English language spoken by a significant number or percentage of members in the service area as identified by the State.
2. The notice shall state the following:
 - a. The action the MCO or PIHP or its contractor has taken or intends to take;
 - b. The reasons for the action;
 - c. The member's or the Designated Client Representative's right to file an MCO or PIHP appeal;
 - d. The date the appeal is due;

- e. The member's right to request a State fair hearing;
- f. The procedures for exercising the right to a fair hearing;
- g. The circumstances under which expedited resolution is available and how to request it;
- h. The member's right to have benefits continue pending resolution of the appeal, and how to request that benefits be continued; and
- i. The circumstances under which the member may be required to pay the cost of these services.

3. The MCO or PIHP shall mail the notice of action within the following timeframes:

- a. For termination, suspension or reduction of previously authorized Medicaid covered services, at least ten (10) calendar days before the date of action, except in the following circumstances:
 - i) The MCO or PIHP may shorten the period of advance notice to five (5) calendar days for the date of action if:
 - 1) The MCO or PIHP has facts indicating probable fraud by the member; and
 - 2) The facts have been verified, if possible, through secondary sources.
 - ii) The MCO or PIHP may mail notice not later than the date of action if:
 - 1) The MCO or PIHP has factual information confirming the death of the member;
 - 2) The MCO or PIHP receives a clear written statement signed by the member stating that:
 - a) He or she no longer wishes services; or
 - b) Gives information that requires termination or reduction of services and indicates that he/she understands that this is the result of supplying the information;
 - iii) The member has been admitted to an institution where he/she is ineligible under the plan for further services;
 - iv) The member's whereabouts is unknown and the post office returns mail directed to him or her indicating no forwarding address;
 - v) The MCO or PIHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;
 - vi) A change in the level of medical care is prescribed by the member's physician;
 - vii) The notice involves an action made with regard to the preadmission

screening requirements of 1919(e) (7) of the Social Security Act; or

viii) Notice may be made as soon as practicable before transfer or discharge when:

- 1) The safety of individuals in the facility would be endangered;
- 2) The health of individuals in the facility would be endangered;
- 3) The resident's health improves sufficiently to allow a more immediate transfer or discharge;
- 4) An immediate transfer or discharge is required by the resident's urgent medical needs; or
- 5) A resident has not resided in the facility for 30 days.

b. For denial of payment (except for payment denials issued by a mental health prepaid inpatient health plan), at the time of any action affecting the claim.

c. For standard service authorization decisions that deny or limit services, within ten (10) calendar days.

4. If the MCO or PIHP extends the timeframe it must give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file an appeal if he or she disagrees with that decision and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the due date the extension expires.

5. For service authorization decisions not reached within ten (10) calendar days on the date the timeframes expire.

6. For expedited service authorization decisions, within three (3) days.

8.209.4.B. The member of an MCO or PIHP shall file an appeal within twenty (20) calendar days from the date of the MCO's or PIHP's notice of action.

8.209.4.C. The MCO or PIHP shall give members reasonable assistance in completing any forms required by the MCO or PIHP, putting oral requests for a State fair hearing into writing and taking other procedural steps, including, but not limited to, providing interpretive services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

8.209.4.D. The MCO or PIHP shall send the member written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution.

8.209.4.E. The MCO or PIHP shall ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, or a grievance or appeals that involves clinical issues.

8.209.4.F. The MCO or PIHP shall accept appeals orally or in writing.

- 8.209.4.G. The MCO or PIHP shall provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO or PIHP shall inform the member of the limited time available in the case of expedited resolution.
- 8.209.4.H. The MCO or PIHP shall provide the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process.
- 8.209.4.I. The MCO or PIHP shall include as parties to the appeal, the member and the designated client representative or the legal representative of a deceased member's estate.
- 8.209.4.J. The MCO or PIHP shall resolve each appeal, and provide notice as expeditiously as the member's health condition requires, not to exceed the following:
1. For standard resolution of an appeal and notice to the affected parties, ten (10) working days from the day the MCO or PIHP receives the appeal.
 2. For expedited resolution of an appeal and notice to affected parties, three (3) working days after the MCO or PIHP receives the appeal.
- 8.209.4.K. The MCO or PIHP may extend timeframes for the resolution of appeals by up to fourteen (14) calendar days:
1. If the member requests the extension; or
 2. The MCO or PIHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO or PIHP shall give the member prior written notice of the reason for delay if the timeframe is extended.
- 8.209.4.L. The MCO or PIHP shall notify the member in writing of the resolution of an appeal. For notice of an expedited resolution, the MCO or PIHP shall also make reasonable efforts to provide oral notice.
- 8.209.4.M. The written notice shall include the results of the disposition/resolution process and the date it was completed.
1. For appeals not resolved wholly in favor of the member,
 - a. The right to request a State fair hearing and how to do so;
 - b. The right to request and to receive benefits while the hearing is pending, and how to make the request; and
 - c. That the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's or PIHP's action.
- 8.209.4.N. The member of an MCO or PIHP need not exhaust the MCO or PIHP level appeal process before requesting a state fair hearing. The member shall request a state fair hearing within twenty (20) calendar days from the date of the MCO's or PIHP's notice of action.
- 8.209.4.O. In cases where the parent or guardian submits a request for a third party review to the Department of Human Services under 27-10.3-104 (1)(b) C.R.S. of the Child Mental Health Treatment Act, the member, parent or guardian and the MCO or PIHP shall have the right to request a state fair hearing. The request for the state fair hearing shall be submitted to the Office of Administrative Courts within twenty (20) calendar days from the date of the determination. The

state fair hearing shall be considered a recipient appeal.

8.209.4.P. The MCO or PIHP shall establish and maintain an expedited review process for appeals when the MCO or PIHP determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

8.209.4.Q. The MCO or PIHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

8.209.4.R. If the MCO or PIHP denies a request for expedited resolution, it shall transfer the appeal in the timeframe for standard resolution, make reasonable effort to give the member prompt oral notice of the denial and send a written notice of the denial for an expedited resolution within two (2) calendar days.

8.209.4.S. The MCO or PIHP shall provide for the continuation of benefits while the MCO or PIHP level appeal and the State fair hearing are pending if the member files the appeal timely, the appeal involves the termination, suspension or reduction of a previously authorized course of treatment, the services were ordered by an authorized provider, the original period covered by the original authorization has not expired and the member requests extension of benefits.

8.209.4.T. If at the member's request, the MCO or PIHP continues or reinstates the member's benefits while the appeal is pending, the benefits shall be continued until the member withdraws the appeal, ten days pass after the MCO or PIHP mails the notice providing the resolution of the appeal against the member, a State fair hearing office issues a final agency decision adverse to the member, or the time period or service limits of a previously authorized service has been met.

8.209.4.U. If the final resolution of the appeal upholds the MCO's or PIHP's action, the MCO or PIHP may recover the cost of the services furnished to the member while the appeal is pending to the extent that the services were furnished solely because of the requirements of this rule.

8.209.4.V. If the final resolution of the appeal reverses the MCO's or PIHP's action to deny, limit or delay services that were not furnished while the appeal was pending, the MCO or PIHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

8.209.4.W. If the final resolution of the appeal reverses the MCO's or PIHP's action to deny authorization of services and the member received the services while the appeal was pending, the MCO or PIHP must pay for those services.

8.209.5 GRIEVANCE PROCESS

8.209.5.A. The member of the MCO or PIHP shall have twenty (20) calendar days from the date of the incident to file a grievance expressing his/her dissatisfaction with any matter other than an action.

8.209.5.B. The MCO or PIHP shall send the member written acknowledgement of each grievance within two (2) working days of receipt.

8.209.5.C. The MCO or PIHP shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making and who have the appropriate clinical expertise in treating the member's condition or disease if deciding a grievance that involves clinical issues.

8.209.5.D. The MCO or PIHP shall accept grievances orally or in writing.

1. The MCO or PIHP shall dispose of each grievance and provide notice as expeditiously as the member's health condition requires, not to exceed fifteen (15) working days from the day the MCO or PIHP receives the grievance.
- 8.209.5.E. The MCO or PIHP may extend timeframes for the disposition of grievances by up to fourteen (14) calendar days:
1. If the member requests the extension; or
 2. The MCO or PIHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO or PIHP shall give the member prior written notice of the reason for delay if the timeframe is extended.
- 8.209.5.F. The MCO or PIHP shall notify the member in writing of the disposition of a grievance.
- 8.209.5.G. The written notice shall include the results of the disposition/resolution process and the date it was completed.
- 8.209.5.H. If the member is dissatisfied with the disposition of a grievance provided by the MCO or PHIP, the member may bring the unresolved grievance to the Department.
1. The Department will acknowledge receipt of the grievance and dispose of the issue.
 2. The disposition offered by the Department will be final.

8.209.6 OMBUDSMAN ASSISTANCE CONCERNING SERVICES FOR CLIENTS ENROLLED IN MANAGED CARE ORGANIZATIONS

- A. An Ombudsman under contract with the Department of Health Care Policy and Financing shall provide Ombudsman assistance concerning services for clients enrolled in Medicaid managed care organizations (MCOs).
- B. Upon request, the Ombudsman shall respond to and analyze a complaint from a client enrolled in a Medicaid managed care organization (MCO), or that client's designated client representative (DCR), by:
 1. Assisting the client or DCR to articulate the complaint, to understand the options available to resolve the complaint and his/her rights and responsibilities, and to negotiate the appropriate complaint process for his/her MCO;
 2. Acting as the client's DCR if the client requests except that the Ombudsman shall not act as the DCR in any State fair hearing as described at 10 CCR 2505-10, §8.057;
 3. Facilitating problem resolution with the MCO or its network providers;
 4. Referring clients to other agencies as appropriate, including agencies that can directly assist clients in a State fair hearing;
 5. Conducting and reporting client satisfaction studies and/or quality assessment surveys authorized by the Department to measure client experience and satisfaction with Ombudsman staff and services;
 6. Providing clients with information on the exclusions and limitations that may be imposed on care, services, equipment and supplies under the Medicaid benefits structure;

7. Having a practical understanding of all applicable provisions of Title X, Article 16, C.R.S. and Medicaid Volume 8 rules; and
8. Avoiding any relationship or circumstance which creates or gives the appearance of a conflict of interest.

8.209.7 COMPLIANCE REQUIREMENTS FOR ALL MCOS AND THE OMBUDSMAN

- A. MCOs and the Ombudsman shall recognize and ensure clients' rights to make and file complaints and to appeal adverse determinations through the complaint and appeal process for any reason.
- B. For clients with a disability, if the medical necessity of a requested procedure has not been established by the MCO, the requesting physician must be consulted in person or by telephone before a final determination is made. If the requesting physician is not available, another network provider of the client/DCR's choice shall be consulted. Such consultation shall be referenced in the notice. If the requesting physician is not available and the client/DCR does not choose another network provider within two working days of the MCO's request to make such a choice, the MCO may proceed without consultation.
- C. MCOs and the Ombudsman shall develop written procedures for accepting, processing, and responding to all complaints from Medicaid clients. For MCOs, summaries of these procedures shall be disseminated to all participating providers and shall include summaries in the Member Handbook as described in Department contract requirements. The MCO shall provide its complete complaint and appeal procedures to subcontractors and ensure subcontractor compliance with these rules and the MCO's procedures. MCOs and the Ombudsman shall obtain written approval from the Department for their internal Complaint procedures.
- D. MCOs and the Ombudsman shall establish and maintain a timely and organized system(s) for recording, tracking, and resolving Medicaid clients' complaints and appeals as specified in contract.
- E. MCOs and the Ombudsman shall confidentially maintain original records of all Complaints from Medicaid clients, including the original Complaint, action, or resolution taken by the entity, and evidence of review activities. All such information shall be archived for six (6) years from the date of the initial Complaint.
- F. MCOs shall ensure that neither cultural, expressive, or receptive communication differences negatively impact the Complaint process. MCOs shall provide services to facilitate clients' and DCRs' effective use of the Complaint process, inclusive of qualified interpreters for (1) persons with communication disabilities or differences and (2) non-English-speaking clients. The MCO shall consult with the client or the DCR about the individual or medium that will assist, and such assistance shall be at the cost of the MCO.
- G. MCOs shall provide the client, DCR, or any other person, upon written release from the client or the client's legal guardian, access to or a copy of medical records, at no cost to the client, for dates of service occurring during enrollment in the MCO. Such records shall be provided within a time frame that provides clients copies of their records prior to any decision on a Complaint or appeal, or in two weeks or less, if required by C.R.S. § 25-1-801 and 25-1-802. The MCO is only obligated to provide one copy of the client's medical records free of charge for each of the Medicaid client's Complaints.
- H. MCOs shall monitor participating network subcontractors or providers to ensure compliance with all Complaint rules and contract requirements.
- I. MCOs and the Ombudsman shall handle specific Medicaid client Complaint information in the same

way that medical record information is handled confidentially under State and Federal law and regulations.

- J. Upon request by a client, the client's DCR, or the client's provider, the MCO shall disclose its standards for denial of treatments or other benefits on the grounds that such treatment or other covered benefit is not medically necessary, appropriate, effective, or efficient.
- K. To assist clients in making inquiries and filing Complaints, MCOs and the Ombudsman shall ensure that clients and DCRs can contact them during routine business hours through a toll-free telephone number.

8.212 COMMUNITY MENTAL HEALTH SERVICES

8.212.1 ENROLLMENT

8.212.1.A. The following individuals are not eligible for enrollment in the Community Mental Health Services program:

1. Qualified Medicare Beneficiary only (QMB-only).
2. Qualified Working Disabled Individuals (QWDI).
3. Qualified Individuals 1 (QI 1).
4. Special Low Income Medicare Beneficiaries (SLMB).
5. Undocumented aliens.
6. Program of All-Inclusive Care for the Elderly (PACE).
7. Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo who are:
 - a. Found by a criminal court to be Not Guilty by Reason of Insanity (NGRI)
 - b. Found by a criminal court to be Incompetent to Proceed (ITP)
 - c. Ordered by a criminal court to the Institute for evaluation (eg. Competency to proceed, sanity, conditional release revocation, pre-sentencing).
8. Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.
9. Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are exempted from the Community Mental Health Services program while they are on TPR. TPR individuals remain under the control and care of the Institute.
10. Classes of individuals determined by the Department to require exclusion from the Community Mental Health Services program.
11. Individuals who receive an individual exemption as set forth at 8.212.2.

8.212.1.B. All other Medicaid clients shall be enrolled in the Community Mental Health Services program.

8.212.2 INDIVIDUAL EXEMPTIONS

1. A client may request to be exempt from enrollment in the Community Mental Health Services program if:
 - a. The client has a clinical relationship with a provider of mental health services that the client wishes to maintain and that provider is not part of the provider network of the behavioral health organization in the client's geographic area; or
 - b. The client and the behavioral health organization have been unable to develop a healthy working relationship and continued enrollment would not be in the best clinical interest of the client.
2. If the client requests an exemption based on Section 8.212.2.1.a:
 - a. The client shall notify the behavioral health organization of his/her request to receive necessary mental health services from the provider with whom the client has established a clinical relationship.
 - b. Within fourteen (14) calendar days of receiving notice from the client, the behavioral health organization shall determine whether it can contract with the client's chosen provider to provide necessary mental health services to the client and provide written notice to the client and the client's provider of that determination.
 - c. If the behavioral health organization is unable to approve the client's request, the notice shall:
 - i) Identify one or more providers within the behavioral health organization's network who can appropriately meet the client's mental health needs;
 - ii) Include information on the client's right to request an exemption, the process for requesting an exemption and assistance available to the client.
 - d. The client may request an exemption with the Department within fourteen (14) calendar days of the date of the notice from the behavioral health organization disapproving the client's request.
 - e. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.
3. If the client requests an exemption based on Section 8.212.2.1.b:
 - a. The client shall request an exemption from the Department.
 - b. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.
4. A client whose request for exemption has been denied by the Department has the right to appeal the determination pursuant to Section 8.057.
5. A newly Medicaid eligible client who requests an exemption shall be enrolled in the Community Mental Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.

6. A client who is enrolled in the Community Mental Health Services program and is requesting an exemption shall continue to be enrolled in the Community Mental Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.
7. A client who wants to reenroll in the Community Mental Health Services program shall notify the Department. The client will be reenrolled within thirty (30) calendar days of receipt of the client's request. The Department shall notify the client and the behavioral health organization of the reenrollment prior to the effective date of reenrollment.

8.212.3 CLIENT RIGHTS AND PROTECTIONS

8.212.3.A. A client enrolled in the Community Mental Health Services program shall have the following rights and protections:

1. To be treated with respect and with due consideration for his/her dignity and privacy.
2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.
3. To participate in decisions regarding his/her health care, including the right to refuse treatment and the right to a second opinion.
4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
5. To request and receive a copy of his/her medical records and to request that they be amended or corrected, as specified in 45 CFR Part 164.
6. To exercise his/her rights without any adverse effect on the way he/she is treated.
7. To enforce, pursuant to Section 8.209, the provisions of the community mental health services contracting regarding rights or duties owed to the client under the contract.

8.212.4 MENTAL HEALTH SERVICES

8.212.4.A. The following are required services of the Community Mental Health Services program:

1. Inpatient Hospital -- A program of psychiatric care in which the consumer remains 24 hours a day in a facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.
2. Under 21 Psychiatric -- A program of care for consumers under age 21 in which the consumer remains 24 hours a day in a psychiatric hospital, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.
3. 65 and Over Psychiatric -- A program of care for consumers age 65 and over in which the consumer remains 24 hours a day in an institution for mental diseases, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year.

4. Outpatient -- A program of care in which the consumer receives services in a hospital or other health care facility, but does not remain in the facility 24 hours a day.
5. Psychiatrist -- Services provided within the scope of practice of medicine as defined by State law.
6. Rehabilitation -- Services provided under the Rehabilitation Option of the Medicaid Program, including:
 - a. Partial Long Day -- Therapeutic contact with a consumer lasting more than four hours but less than 24 hours. Activities are programmatically linked.
 - b. Partial Short Day -- Therapeutic contact with a consumer lasting more than two hours, but no more than four hours. Activities are programmatically linked.
 - c. Group -- Therapeutic contact with more than one consumer, of up to and including two hours.
 - d. Individual -- Therapeutic contact with one consumer of more than 30 minutes, but no more than two hours. This service, in conjunction with Individual Brief services, is limited to thirty-five (35) visits per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.
 - e. Individual Brief -- Therapeutic contact with one consumer of up to and including 30 minutes. This service, in conjunction with Individual services, is limited to thirty-five (35) visits per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.
7. Psychosocial Rehabilitation -- Rehabilitative services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.
8. Case Management -- Medically necessary case management services provided in a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician.
9. Medication Management -- Monitoring of medications prescribed and consultation provided to consumers by a physician.
10. Emergency -- Services provided during a mental health emergency which involve unscheduled, immediate, or special interventions in response to crisis situation with a consumer.
11. Residential -- Any type of 24 hour care provided in a non-hospital, non-nursing home setting, where the contractor provides room, board and supervision. Residential services are appropriate for children, youth, adults and older adults who need 24 hour supervised care in a therapeutic environment.
12. School-Based Services -- Mental health services provided to school aged children and adolescents on site in their schools, with the cooperation of the schools.

8.212.4.B. Alternative services of the Community Mental Health Services program include, but are not limited to:

1. Vocational -- Services designed to help adult and adolescent consumers to gain employment skills and employment.
2. Home-Based Services for Children and Adolescents -- Therapeutic services for children/adolescents and their families provided in their homes.
3. Intensive Case Management -- Community-based services averaging more than one hour per week, provided to children with serious emotional disturbances and adults with serious mental illness who are at risk of a more intensive 24 hour placement and who need extra support to live in the community. Services may include but are not limited to mentoring.

8.212.5 EMERGENCY SERVICES

- 8.212.5.A. A client enrolled in the Community Mental Health Services program shall seek all mental health services from the behavioral health organization with which he/she is enrolled except as specified in 8.212.5.B.
- 8.212.5.B. Clients with an emergency medical condition may seek emergency services outside of the network of the behavioral health organization in which they are enrolled.
- 8.212.5.C. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention or mental health services to result in the following:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy.
 2. Serious impairment to bodily functions.
 3. Serious dysfunction of any bodily organ or part.
- 8.212.5.D. Emergency services means covered inpatient and outpatient services that are as follows:
1. Furnished by a provider that is qualified to furnish these services.
 2. Needed to evaluate or stabilize an emergency medical condition.

8.212.6 ESSENTIAL COMMUNITY PROVIDERS

- 8.212.6.A. In order to be eligible for designation as an Essential Community Provider, the following health care providers shall be determined to have historically served medically needy or medically indigent patients and demonstrated a commitment to serve low-income and medically indigent populations who make up a significant portion of their patient population or, in the case of a sole community provider, serve the medically indigent patients within their medical capability:
1. Disproportionate share hospitals.
 2. Local county and district health departments, county nursing services and regional health department operating pursuant to Title 25, C.R.S., as amended.
 3. Federally Qualified Health Centers (FQHCs).
 4. School based health centers that can verify that 25% of students enrolled in the school are at

or below 185% of the Federal Poverty Level and that services are offered to the entire student population enrolled in the school without regard to the patient's ability to pay.

5. Family Medicine Residency Training Programs that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
 6. Rural Health Clinics that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
 7. State certified Title X Family Planning Agencies that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
 8. Sole community providers that are not located within a metropolitan statistical area, as designated by the U.S. Office of Management and Budget, and in whose community there is no other similar type of health care and the provider can verify that it provides health care services to patients below 185% of the Federal Poverty Level within its medical capability.
 9. New health care providers operating under a sponsoring or participating entity that qualifies as an Essential Community Provider.
 10. Health care providers that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.
- 8.212.6.B. In order to be eligible for designation as an Essential Community Provider, the provider shall waive charges or charge for services on a sliding scale for patients/families at or below 185% of the Federal Poverty Level.
- 8.212.6.C. Health care providers, except those set forth a 8.212.6.A(1) through (3), who seek to be designated as an Essential Community Provider, shall submit their application, including a copy of their sliding fee scale to the Department.

8.213 INTEGRATED CARE AND FINANCING PROJECT

.01 DEFINITION OF THE PROJECT

The Integrated Care and Financing Project is a demonstration project designed to reduce barriers to effective care for persons in need of a variety of health care services, including preventative, ambulatory, acute, long-term and non-medical care. The project is designed for persons who are enrolled in the Medicaid program who reside in Mesa County, Colorado and persons who are dually eligible for Medicare and Medicaid who reside in Mesa County, Colorado. The goal of the project is to facilitate coordination between the Medicaid and Medicare systems by offering a broad range of health care services through a single Managed Care Organization that contracts with the Department. Client participation in the project is on a voluntary basis.

.02 LEGAL BASIS

The Integrated Care and Financing Project in Colorado is authorized by waivers of the uniformity, freedom of choice, upper payment limit, amount, duration and scope of service requirements contained in Sections 1902(a)(1), 1902(a)(23), 1902(a)(13) and 1902(a)(10)(B) of the Social Security Act. The Integrated Care and Financing Project is also authorized under State law at 26-4-122 et seq., C.R.S., as amended.

8.213.03 GENERAL DEFINITIONS

Adult Foster Care : services as defined in Section 8.483, ADULT FOSTER CARE.

Adult Foster Care Facility : a facility as defined at 8.483.21.

Adult Residential Care : services provided to Integrated Care and Financing Project clients on a 24-hour basis in non-medical facilities. Project clients may only receive Adult Residential Care services from Adult Foster Care facilities or Alternative Care Facilities that are certified by Medicaid and that have contracted to provide such residential care services through the Integrated Care and Financing Project.

Affirmative Choice : the active selection by a Dually Eligible client for participation in the Integrated Care and Financing Project or other approved health care options.

Alternative Care Facility : a facility as defined at 8.495.11.

Assigned : the process by which the Department automatically designates membership in the Integrated Care and Financing Project for Medicaid-Only clients who were enrolled in the Contractor's Medicaid Plan prior to project implementation.

Care Coordination : providing a systematic approach to the planning, integration and delivery of services through the combined effort of the Integrated Care and Financing Project client and the Care Coordination Team.

Care Coordination Team : a team comprised of the Integrated Care and Financing Project client's Care Coordinator, medical professionals such as a physician, a physician extender and/or registered nurses and non-medical professionals. The members of the Care Coordination Team shall be designated by the Contractor. The Care Coordination Team may consult other medical and non-medical professionals.

Care Coordinator : a member of the Care Coordination Team and the individual responsible for working with the Integrated Care and Financing Project client to complete a functional assessment and working with the Care Coordination Team to develop a plan of care for that client.

Direct Payments to Clients : payments to Integrated Care and Financing Project clients for Home Care Allowance, Pay Own Provider Grant, Adult Foster Care or Adult Residential Care services.

Communications Plan : a plan for conveying information about the Integrated Care and Financing Project to clients, providers, care coordinators and other interested parties.

Department : the Colorado Department of Health Care Policy and Financing.

Disenrollment : to discontinue membership in the Integrated Care and Financing Project.

Dually Eligible Clients : Medicare beneficiaries who are concurrently eligible for Medicaid.

Enrollment : to begin membership in the Integrated Care and Financing Project.

Encounter Data : data containing information about contacts between project clients and service providers regarding services rendered.

Fee-for-Service System : the traditional method of provider reimbursement in which the provider is paid according to the services rendered.

Grandfathered Integrated Care and Financing Clients or Grandfathered Clients : Medicaid eligible persons who, in the month before project implementation date, were enrolled in the Contractor's Medicaid Plan and who were receiving either Home Care Allowance payments or Adult Foster Care services at that time.

Home Care Allowance : services or payments as defined in Section 8.484 HOME CARE ALLOWANCE.

Integrated Care and Financing Project Client, or Project Client : A Medicaid only client or Dually Eligible client who is enrolled in the Integrated Care and Financing Project.

Medicaid-Only Clients : persons who are enrolled in Medicaid and who are not Medicare beneficiaries.

New Integrated Care and Financing Project Clients or New Clients : Medicaid eligible persons who, in the month before project implementation date, were not enrolled in the Contractor's Medicaid Plan, or who were enrolled in the Contractor's Medicaid Plan but were not receiving Home Care Allowance payments or Adult Foster Care services at that time. When grandfathered clients experience a lapse in Medicaid eligibility, a period of disenrollment from the Contractor's Medicaid Plan or discontinuation in Home Care Allowance payments or Adult Foster Care services, they shall be considered new clients.

Pay Own Provider (POP) Grant : a direct payment to Integrated Care and Financing Project clients for the purchase of services that are not provided by the Contractor or its subcontractors. These services and the amount of the Pay Own Provider Grant shall be determined by the Care Coordination Team in consultation with the client.

Project : the Integrated Care and Financing Project.

Project Implementation Date : date the Contractor shall begin providing Integrated Care and Financing Project services.

Quality Assurance Monitoring : a method of measuring the quality of health care services provided and client outcomes against performance standards.

Total Countable Income : income as defined in the Department of Human Services Income Maintenance Staff Manual Section 3.200, GENERAL FINANCIAL ELIGIBILITY CRITERIA (9 CCR 2503-1).

8.213.04 SERVICES PROVIDED

- A. The Contractor shall be responsible for providing Medicaid services that are currently required as basic HMO coverage as specified in Section 8.211.04.02 and as specified in the contract for Medicaid Services between the Department and the Contractor.
- B. In addition to providing Medicaid services specified in (A), the Contractor shall also be responsible for providing Medicaid long-term care services as specified in the Contract for Medicaid Services between the Department and the Contractor. Medicaid long term care services shall include: Class I and Class V nursing facility care; hospice care; Home Care Allowance; Pay Own Provider Grant; Adult Foster Care services; Alternative Care Facility services; Adult Residential Care services; and services specific to the Home and Community Based Services (HCBS) programs including services for the Elderly Blind and Disabled (HCBS-EBD), services for Persons Living with AIDS (HCBS-PLWA), services for the Children's HCBS Waiver Program (HCBS-CMW, formerly known as the Katie Beckett Waiver Program) and services for People with Brain Injury (HCBS-BI). Services specific to other Colorado Medicaid pilot programs shall be considered for inclusion as the pilot programs are developed and implemented.
- C. In addition to providing services specified in (A) and (B), the Contractor shall be responsible for providing Medicare services to Dually Eligible clients as specified in the contract for Medicare services between the Health Care Financing Administration and the Contractor.
- D. Other services may be provided to Integrated Care and Financing Project clients as deemed appropriate by the Contractor.

- E. The Contractor shall not be responsible for providing services for mental illness through the Integrated Care and Financing Project. Services for mental illness specified in Section 8.212.03, RESPONSIBILITY FOR PROVIDING SERVICES shall be provided by the Mental Health Capitation Program. The Mental Health Capitation Program shall be responsible for payment of all mental health services specified in Section 8.212.03. Services for mental illness specified in Section 8.509.12 SERVICES PROVIDED shall be provided by the Home and Community Based Services for the Mentally-Ill (HCBS-MI) program. The HCBS-MI program shall be responsible for payment of all mental health services specified in Section 8.509.12.
- F. The Contractor shall not be responsible for providing services for developmental disabilities through the Integrated Care and Financing Project. Services for developmental disabilities shall be provided by the following Home and Community Based Services (HCBS) programs: HCBS for the Children's Medical Waiver (HCBS-CMW 200) specified in Section 8.506, CHILDREN'S HOME AND COMMUNITY BASED SERVICES PROGRAM; HCBS for the Children's Extensive Support Waiver (HCBS-CES) specified in Section 8.503, DEFINITION; HCBS for the Children's Habilitation Residential Program (CHRP) specified in Section 8.508, CHILDREN'S HABILITATION RESIDENTIAL PROGRAM; HCBS for the Supported Living Services Waiver (HCBS-SLS) specified in Section 8.500.97, SERVICE DESCRIPTIONS; and HCBS for the Developmentally Disabled (HCBS-DD) specified in Section 8.500.3, PROGRAM PROVISIONS. The HCBS programs specified in this section (F) shall be responsible for payment of all services for developmental disabilities that are available under these HCBS programs.
- G. The following services shall be offered through providers that are certified by Medicaid: Class I and Class V nursing facility care; Adult Foster Care services; Alternative Care Facility services; Adult Residential Care services; adult day services; home health services; and personal care services.

8.213.05 COMPLAINT AND APPEAL PROCESS

- A. Complaints by Project clients shall be handled in accordance with the procedures and requirements described in section 8.209, entitled MEDICAID MANAGED CARE COMPLAINT AND APPEAL PROCESS.
- B. The county department of social services in the client's county of residence determines whether a Project applicant or client is financially eligible for Medicaid. Any project client may appeal matters pertaining to Medicaid financial eligibility determination according to the client appeal rights as specified in the Income Maintenance Staff Manual of the Colorado Department of Human Services.

8.213.06 ELIGIBLE PERSONS

The target population for the Integrated Care and Financing Project is defined as those persons who reside in Mesa County Colorado and who meet Medicaid financial and program eligibility requirements.

Persons who meet the following eligibility requirements may enroll in the Integrated Care and Financing Project:

- A. Persons must meet financial eligibility criteria for Medicaid in one of the following ways:
 - 1. As specified in the eligibility criteria for Medicaid as specified in Section 8.100.5, GROUPS ASSISTED UNDER THE PROGRAM;
 - 2. As specified in the eligibility criteria for 300% eligible persons in Section 8.100.5, GROUPS ASSISTED UNDER THE PROGRAM;
 - 3. As specified in the eligibility criteria for the Home Care Allowance program, Section 8.484,

HOME CARE ALLOWANCE. For all Integrated Care and Financing Project clients, Medicaid eligibility may be determined as specified in Section 8.484.20, ELIGIBILITY; or

4. As specified in the eligibility criteria for the Adult Foster Care program, Section 8.483 ADULT FOSTER CARE. For all Integrated Care and Financing Project clients, Medicaid eligibility may be determined as specified in Section 8.483.30, ELIGIBILITY.

- B. Medicare beneficiaries who are concurrently eligible for Medicaid (Dually Eligible clients) may choose to enroll in the Integrated Care and Financing Project.

8.213.07 ENROLLMENT AND DISENROLLMENT PROCESS

- A. Enrollment in and disenrollment from the Integrated Care and Financing Project for persons who are enrolled in Medicaid and who are not Medicare beneficiaries (Medicaid-Only clients) shall take place according to the following procedures:

1. Medicaid-Only clients in Mesa County may receive health care services through one of the following:
 - a. The Integrated Care and Financing Project for all health care; or
 - b. The Medicaid fee-for-service system for all health care.
2. All Medicaid-Only clients in Mesa County shall be notified in writing of the project and shall be informed of their health care options.
3. Medicaid-Only clients who were enrolled in the Contractor's Medicaid Plan in the month before project implementation shall be assigned to the project. Medicaid-Only clients may choose to disenroll from the project any time at or after project implementation.
4. Medicaid-Only clients may enroll in the project at any time during normal business hours. Enrollment for Medicaid-Only clients shall be effective immediately on the date of enrollment.
5. Enrollment in the project for Medicaid-Only clients shall not be retroactive.
6. Medicaid-Only clients may disenroll from the project at any time during normal business hours. Disenrollment for Medicaid-Only clients shall be effective the first of the month following the date of disenrollment.
7. Medicaid-Only clients who disenroll from the project may receive services in the Medicaid fee-for-service system so long as they retain Medicaid eligibility.

- B. Enrollment in and disenrollment from the Integrated Care and Financing Project for Medicare beneficiaries who are concurrently eligible for Medicaid (Dually Eligible clients) shall take place according to the following procedures:

1. Dually Eligible clients may receive health care services through one of the following:
 - a. Integrated Care and Financing Project for all health care;
 - b. The Contractor's Medicare Cost Contract for acute care and the Medicaid fee-for-service system for acute and long term care; or
 - c. Medicare/Medicaid fee-for-service system for all health care.

2. All Dually Eligible clients in Mesa County shall be notified in writing of the project and shall be informed of their health care options.
 3. Dually Eligible clients must make an affirmative choice to enroll in the project.
 4. Dually Eligible clients may enroll in the project on a monthly basis during normal business hours. Enrollment for Dually Eligible clients shall be effective according to Medicare regulations regarding enrollment.
 5. Dually Eligible clients may disenroll from the project on a monthly basis during normal business hours. Disenrollment for Dually Eligible clients shall be effective according to Medicare regulations regarding disenrollment.
 6. Dually Eligible clients who disenroll from the project have two remaining choices for health care: the Medicare Cost Contract for acute care and the Medicaid fee-for-service system for acute and long-term care; or the Medicare/Medicaid fee-for-service system for all health care.
 7. Enrollment in the project for Dually Eligible clients shall not be retroactive.
 8. Disenrollment from the project for Dually Eligible clients requires simultaneous disenrollment from the Medicare and Medicaid components of the project.
- C. Medicaid-Only and Dually Eligible clients who disenroll from the project may enroll in the Primary Care Physician Program so long as they retain Medicaid eligibility.
- D. The Contractor must not request or encourage Medicaid-Only or Dually Eligible clients to disenroll from the Integrated Care and Financing Project other than under the conditions as specified in Section 8.211.05.02, DISENROLLMENT / TERMINATION FROM A MEDICAID HMO/PHP and as specified in the contract for Medicaid services between the Department and the Contractor.

8.213.08 DIRECT PAYMENTS TO CLIENTS

To provide a comprehensive array of services to project clients, the project shall include the option of direct payments to clients and services consistent with the Home Care Allowance and Adult Foster Care programs. In order to transition clients into the project who were enrolled in the Contractor's Medicaid Plan and who were receiving Home Care Allowance or Adult Foster Care before project implementation, these clients shall be grandfathered into the project. These Grandfathered Integrated Care and Financing Project clients have the right to continue Home Care Allowance or Adult Foster Care as authorized by the Care Coordination Team. New Integrated Care and Financing Project clients shall not be eligible for Home Care Allowance or Adult Foster Care. All clients enrolled in the project may potentially receive a Pay Own Provider Grant or Adult Residential Care services as authorized by the Care Coordination Team.

Direct payments to clients who are enrolled the Integrated Care and Financing Project shall be administered according to the following procedures:

- A. Grandfathered Integrated Care and Financing Project clients receiving Home Care Allowance payments have the following options:
 1. Grandfathered clients receiving Home Care Allowance shall have the right to continue Home Care Allowance payments and services as authorized by the Care Coordination Team according to all Home Care Allowance payment and service criteria, as specified in Section 8.484.20, HOME CARE ALLOWANCE;
 2. Grandfathered clients receiving Home Care Allowance may receive services from the

Contractor and/or a Pay Own Provider Grant as authorized by the Care Coordination Team; or

3. Grandfathered clients receiving Home Care Allowance may voluntarily elect to forgo a portion or the entire amount of the Home Care Allowance payment to receive services from the Contractor and/or a Pay Own Provider Grant as authorized by the Care Coordination Team. When grandfathered clients elect to forgo the entire amount of the Home Care Allowance payment to receive services from the Contractor and/or a Pay Own Provider Grant, they shall be considered new clients.
4. The Contractor shall not be required to provide grandfathered clients receiving Home Care Allowance payments with any services that were designated to be provided using such Home Care Allowance payments.

B. Grandfathered Integrated Care and Financing Project clients receiving Adult Foster Care services have the following options:

1. Grandfathered clients receiving Adult Foster Care services have the right to receive Adult Foster Care services according to all Adult Foster Care service criteria, as specified in Section 8.483, ADULT FOSTER CARE; or
2. Grandfathered clients receiving Adult Foster Care services may voluntarily elect to forgo Adult Foster Care services to receive Adult Residential Care services from the Contractor, as authorized by the Care Coordination Team. When grandfathered clients elect to forgo Adult Foster Care services and elect to receive Adult Residential Care services from the Contractor, they are considered new clients.

C. New Integrated Care and Financing Project Clients:

1. New clients may receive services and/or a Pay Own Provider Grant as authorized by the Care Coordination Team. The Contractor shall provide services and/or a Pay Own Provider Grant to these clients. The client's total countable income is deducted from the total of the Pay Own Provider Grant authorized amount and the categorical grant standard to derive the net Pay Own Provider Grant payment to the client.
2. New clients may receive Adult Residential Care services as authorized by the Care Coordination Team. The Contractor may provide Adult Residential Care services to these clients through the Contractor's provider network. The client's total countable income is subtracted from the Adult Residential Care grant amount to derive the net payment to the client.

D. Authorization. Use and Terms of Discontinuation of Pay Own Provider Grants

1. Authorization for and amount of Pay Own Provider Grants shall be determined by the Care Coordination Team based on client need and other services available. The Contractor shall not be required to provide clients receiving Pay Own Provider Grant payments with any services that were designated to be provided using such Pay Own Provider Grant payments.
2. Pay Own Provider Grant payments shall be made directly to the client or the client's designated representative. The client or representative shall be responsible for paying the designated provider(s) the agreed amount on a regular monthly basis. No portion of the Pay Own Provider Grant may be withheld for the client's personal use. The full Pay Own Provider Grant authorization, including the client's contribution, if applicable, must be spent for services.

3. The Care Coordination Team may discontinue Pay Own Provider Grant payments if the client does not use the grant for its intended purpose or if the client's status or the client's needs change.

8.213.09 ADULT RESIDENTIAL CARE

The Care Coordination Team may authorize payment provided by the Contractor for Integrated Care and Financing Project clients receiving Adult Residential Care. Project clients may only receive Adult Residential Care services from Adult Foster Care facilities or Alternative Care Facilities that are certified by Medicaid and that have contracted to provide such residential care services through the Integrated Care and Financing Project.

A. Adult Residential Care Placement for Integrated Care and Financing Project Clients

The Care Coordination Team shall be responsible for assessment and determination of placement in Adult Residential Care as specified in Section 8.483 ADULT FOSTER CARE and Section 8.495 ALTERNATIVE CARE FACILITIES. Facilities providing Adult Residential Care to project clients shall be responsible for adhering to facility regulations as specified in Section 8.483 and Section 8.495 except for the Appropriateness of Placement criteria as specified in Sections 8.483.63 and 8.495.70 APPROPRIATENESS OF PLACEMENT.

B. Appropriateness of Placement for Integrated Care and Financing Project Clients

The Care Coordination Team is responsible for determining the appropriate placement for each resident. Only residents whose needs can be met by the facility shall be admitted to that facility. A facility shall not admit or keep any resident requiring a level of care or type of service that the facility does not provide or is unable to provide. If the facility can provide the level of care or type of service to meet the needs of all residents and no resident is at risk for self-harm or harm to others, the facility may admit and keep any resident who does not meet the Appropriateness of Placement criteria as specified in Sections 8.483.63 and 8.495.70, APPROPRIATENESS OF PLACEMENT.

8.213.10 ADMINISTRATION OF THE PROJECT

A. The Department is responsible for the following administrative functions for the project:

1. Coordinating of project monitoring and problem-solving, such as
 - a. Monitoring of contracts between Contractor and any subcontractors.
 - b. Tracking client enrollment and disenrollment, including reasons for disenrollment, and reporting that information to the Health Care Financing Administration.
 - c. Performing quality assurance monitoring of the Contractor in conjunction with the Health Care Financing Administration.
2. Administering enrollment and disenrollment of project clients.
3. Calculating Integrated Care and Financing Project capitation rates.
4. Assuring that sufficient access to care and network capacity are available to potential enrollees for all services provided through the project.
5. Coordinating administrative functions, such as

- a. Quality assurance monitoring that is designed to work in conjunction with the Department's HMO Quality Management Program.
 - b. Project research and evaluation.
 - c. Performing necessary modifications of the Department's data systems for operation, monitoring and evaluation of the project.
- 6. Reviewing and approving, in conjunction with the Health Care Financing Administration, of the communications plan for enrolled clients developed by the Contractor, including all marketing materials.
 - 7. Reviewing and approving, in conjunction with the Health Care Financing Administration, of the communications plan for Medicaid clients developed by Mesa County Options for Long Term Care.

B. The Contractor is responsible for the following administrative functions:

- 1. Providing services required under the Integrated Care and Financing Project as specified in Section 8.213.04 SERVICES PROVIDED.
- 2. Developing and implementing a Care Coordination Team.
- 3. Actively participating in care coordination as a member of the Care Coordination Team.
- 4. Conducting provider education regarding the project.
- 5. Providing encounter data to the Department regarding enrolled clients as defined by the approved Section 1115 waiver for the Integrated Care and Financing Project.
- 6. Providing an annual listing of all primary and specialty physicians participating in the project as requested by the Department and the Health Care Financing Administration.
- 7. Providing data regarding quality assurance and outcomes as requested by the Department and the Health Care Financing Administration.
- 8. Establishing quality assurance standards and systems as needed in addition to the existing HMO Quality Management Program. The Contractor is responsible for coordinated quality assurance monitoring of nursing facilities and assisted living facilities as agreed with the Colorado Department of Public Health and Environment.
- 9. Providing necessary data and reporting as requested by the Department for the purpose of monitoring and evaluation of the project.
- 10. Participating in project problem solving with the Department, Mesa County Options for Long Term Care, clients and client advocacy groups.
- 11. Designing and implementing a communications plan for project clients and providers, subject to review and approval by the Department and the Health Care Financing Administration.
- 12. Cooperating with project evaluation contractors.

C. Mesa County Options for Long Term Care is responsible for the following administrative functions:

- 1. Participating in client eligibility determination for Medicaid services in accordance with

Medicaid eligibility rules.

2. Providing contracted services as specified in the contract between Mesa County Options for Long Term Care and the Contractor including, but not limited to, intake, assessment and care coordination.
3. Actively participating in care coordination as a member of the Care Coordination Team.
4. Participating in a communications plan for project clients, providers and interested parties, subject to review and approval by the Department and the Health Care Financing Administration.
5. Designing and implementing a communications plan for Medicaid clients in Mesa County subject to review and approval by the Department and the Health Care Financing Administration.
6. Maintaining and modifying a database related to project service coordination.
7. Providing necessary data and reporting as requested by the Department for the purpose of monitoring and evaluation of the project.

8.213.11 CAPITATION: RATE SETTING METHODOLOGY

The Department is responsible for computing capitation rates for the project. The Department shall provide capitation payments to the Contractor for Medicaid acute and long-term care services. Capitation payments for Medicare services shall be paid directly to the Contractor by the Health Care Financing Administration. The computation of capitation rates is based on the following methodologies:

- A. The computation of capitation rates for Medicaid acute care services, including risk adjustment, is based upon Department capitation methodology as specified in Section 8.211.09, RATE SETTING.
- B. The computation of capitation rates for Medicaid long-term care services is based upon the average Medicaid fee-for-service costs for long-term care services in Mesa County by category of eligibility and long-term care status, inflated to the contract period. The contractor shall receive a capitation rate reflecting nursing facility and community care expenditures for clients meeting the nursing home level of care as assessed by the Uniform Long Term Care Client Assessment Instrument (ULTC-100) and approved by the Peer Review Organization (PRO). The Contractor shall be paid at a separate rate for clients not meeting the nursing home level of care. The long-term care capitation rates include costs for the Home Care Allowance and Adult Foster Care programs. The long-term care capitation rates are computed at 95% of the Medicaid fee-for-service costs.
- C. Costs for services provided by Mesa County Options for Long Term Care are computed at 100% of the Mesa County Options for Long Term Care (Single Entry Point) costs for project clients based on projected enrollment and inflated to the contract period.
- D. The computation of capitation rates for Medicare services is based upon the weighted-average Medicare fee-for-service and the Contractor's per capita costs in Mesa County by age category and demographic status, inflated to the contract period. The Medicare capitation rates are computed at 95% of the weighted-average Medicare costs.

8.213.12 COORDINATION OF HEALTH CARE SERVICES: CARE COORDINATION TEAM

The Contractor is responsible for coordination and provision of covered health care services to all

Integrated Care and Financing Project clients in the following manner:

- A. Service coordination and authorization shall be conducted by the Care Coordination Team in consultation with the client. Coordination and authorization of services shall take place through the development of a care plan for each project client.
- B. The Care Coordination Team shall attempt to maintain and/or improve client well being, reduce use of institutional care when appropriate and increase client functional independence when these goals are shared by the client.
- C. The Care Coordination Team shall consider the client's requests regarding services and situations planned and provided through the project.
- D. To the extent possible, the Care Coordination Team shall work with the client's Primary Care Physician and other referral sources for medical service management.
- E. The Care Coordination Team shall obtain consultation and involvement of medical and non-medical experts as needed to assist the Care Coordination Team and to assist in the provision of services to the client.
- F. The principal duties of the Care Coordination Team include, but are not limited to, the following:
 - 1. Evaluating information provided by the client, the client's family, the primary care physician, other providers, the Care Coordinator and client assessments;
 - 2. Preparing detailed care plans in consultation with the client to address the client's needs and to arrange for medical and non-medical services to meet those needs;
 - 3. Assuring that all planned services are appropriate, that all services are provided in a timely, cost-effective manner and that all services meet quality of care standards;
 - 4. Consulting with the client regarding all planned services;
 - 5. Monitoring the client's health care outcomes and modifying care plans in consultation with the client to address the client's needs and to achieve desired results;
 - 6. When appropriate, utilizing preventative care services, seeking to avoid unnecessary institutionalization and unnecessary use of emergency services;
 - 7. Exploring innovative ways of improving the delivery of integrated acute and long term care; and
 - 8. When appropriate, coordinating with programs funded by the Older Americans Act.
- G. The Contractor shall provide a copy of each client's care plan to the client. The Care Coordinator shall make every attempt to assure that the client and/or the client's designated representative agrees with the care plan as authorized by the Care Coordination Team.
- H. The Care Coordination Team shall consider assessment information from the Uniform Long Term Care Client Assessment Instrument (ULTC-100) and/or the Brain Injury Waiver Assessment for project clients as directed by the Department.
- I. The Contractor and Mesa County Options for Long Term Care shall share client information in a timely manner for the purposes of screening, assessment, monitoring and reporting.

8.213.13 CLIENT RIGHTS AND RESPONSIBILITIES

In order to implement Care Coordination that produces the maximum potential benefit for each project client, the Care Coordination Team and the client shall assure the protection of the following client rights and responsibilities regarding the project:

- A. The client and/or the client's designated representative has the right to be fully informed of the client rights and responsibilities regarding the project;
- B. The client and/or the client's designated representative has the responsibility to participate in the care planning process, however the client and/or the client's designated representative has the right to choose not to participate;
- C. The client and/or the client's designated representative has the right to receive a copy of the care plan approved by the Care Coordination Team;
- D. The client and/or the client's designated representative has the responsibility of seeking to understand the care plan authorized by the Care Coordination Team;
- E. The client and/or the client's designated representative has the right to agree or disagree with the authorized care plan. The client and/or the client's designated representative shall sign the authorized care plan to signify agreement;
- F. The client and/or the client's designated representative has the responsibility to communicate to the Care Coordinator and/or the Care Coordination Team any disagreements regarding the proposed or authorized care plan;
- G. The client and/or the client's designated representative has the right to speak with the Care Coordination Team and attend Care Coordination Team meetings related to the client's care;
- H. The client and/or the client's designated representative has the right to request that the Care Coordination Team make changes in the proposed or approved care plan;
- I. The client and/or the client's designated representative has the right to be informed of the client's responsibilities regarding HMO membership as specified in this Staff Manual. PREPAID CAPITATED PROGRAMS; and
- J. The client has the financial responsibility for any project services received that are not authorized by the Contractor, except for emergency services defined by Medicare regulations for dual eligible clients and Medicaid regulations at 8.206.23,L.

8.213.14 QUALITY ASSURANCE

- A. The following quality assurance goals shall be pursued through the project:
 - 1. Improvement of access to medical and non-medical health care services for project clients;
 - 2. Improvement of the quality of medical and non-medical health care services to insure that clients receive services appropriate to their needs; and
 - 3. Development of positive client outcomes and client satisfaction with services received through the project.
- B. The project shall maintain a quality assurance monitoring system that shall work in conjunction with the Department's Quality Management Program. The project's quality assurance system shall

involve the following functions:

1. The Department shall monitor and review the Contractor's performance in the areas of service delivery and client satisfaction. In monitoring the Contractor, the Department shall use encounter data and data regarding client complaints, disenrollments and satisfaction. The Department shall also consider other data sources, including information regarding HMO accreditation status and HMO performance measures.
2. The Department shall perform analysis of encounter data provided by the Contractor as defined by the approved Section 1115 waiver for the Integrated Care and Financing Project.
3. The Department shall utilize the Medical Management Information System, Client Oriented Information Network, Mesa County Options for Long Term Care client data base and the Integrated Long Term Care Database to track client costs and service utilization and to make program adjustments in a timely manner.
4. The Contractor shall maintain a timely and organized system for recording, tracking and resolving clients' complaints, including informal and formal grievance procedures.
5. Clients enrolled in the project may be asked to participate in a client satisfaction survey to be analyzed by the Department.

8.213.15 PROJECT EVALUATION

The Integrated Care and Financing Project shall be evaluated to assess the extent to which the project has met intended objectives. The evaluation shall be conducted with the combined efforts of the Department and an evaluation contractor. The evaluation shall assess the project's effectiveness on client access to care, service utilization, client outcomes and costs.

8.214 INTEGRATED CARE AND FINANCING PROJECT-DENVER METRO AREA

8.214.01 DEFINITION OF THE PROJECT

The integrated Care and Financing Project in the Denver Metro Area is a demonstration project designed to reduce barriers to effectively care for persons in need of a variety of health care services, including preventative, ambulatory, acute, long-term and non-medical care. The Project is designed for persons who are enrolled in the Medicaid program or are Dual Eligible for Medicare and Medicaid, meet the Nursing Facility Level of Care and reside in the Denver Metro Area. The goal of the Project is to facilitate coordination between the Medicaid and Medicare systems by offering a broad range of health care services through a single Managed Care Organization that contracts with the Department. Client participation in the Project is on a voluntary basis.

8.214.02 LEGAL BASIS

The Integrated Care and Financing Project in the Denver Metro Area is authorized in the Colorado Medicaid State Plan under Section 1915(a) [42 U.S.C. 1396n] of the Social Security Act. The Integrated Care and Financing Project is also authorized under Colorado State law at 26-4-122, C.R.S., as amended.

8.214.03 GENERAL DEFINITIONS

Adult Foster Care : services as defined in Section 8.483 ADULT FOSTER CARE.

Affirmative Choice : the active selection by an eligible client to participate in the Integrated Care and

Financing Project or other approved health care options.

Care Coordination : providing a system of health care services that is integrated, client-centered, collaborative, comprehensive, non-fragmented and inter-disciplinary through the combined effort of the Integrated Care and Financing Project client and/or the Designated Client Representative and the Care Coordination Team.

Care Coordination Team : a team comprised of the Integrated Care and Financing Project client and/or Designated Client Representative, a Care Coordinator, medical professionals such as a physician, a physician extender and/or registered nurses, and non-medical professionals. The Contractor shall designate the members of the Care Coordination Team. The Care Coordination Team may consult with other medical and non-medical professionals.

Care Coordinator : the member of the Care Coordination Team who is responsible for working with the Integrated Care and Financing Project client and/or the Designated Client Representative and service providers to develop a seamless package of care in which primary, acute and long-term care service needs are met. The Care Coordinator shall work with the Care Coordination Team to develop an understandable and rational plan of care for the client.

Communications Plan : a plan for conveying information about the Integrated Care and Financing Project to clients, providers, care coordinators and other interested parties.

Contractor : a Managed Care Organization that enters into a contract with the Department to provide and/or arrange comprehensive health care services to Integrated Care and Financing Project clients.

Denver Metro Area : the five-county Denver metropolitan area that is participating in the Integrated Care and Financing Project, including Adams, Arapahoe, Denver, Douglas and Jefferson Counties.

Department : the State of Colorado Department of Health Care Policy and Financing.

Designated Client Representative (DCR) : shall mean any person authorized in writing by the client or the client's legal guardian to represent his or her interests related to complaints or appeals about medical assistance benefits. The authorization shall include the name, address, and phone number of the Designated Client Representative so he/she can be contacted during the complaint and appeal process. The Designated Client Representative shall not have access to medical records or specific details of the complaint, if related directly to the client's health care, unless the client or client's legal guardian has signed a formal release for medical information.

Disenrollment : to discontinue membership in the Integrated Care and Financing Project.

Dual Eligible Client : a Medicare beneficiary who is concurrently eligible for Medicaid.

Enrollment : to begin membership in the Integrated Care and Financing Project.

Enrollment Facilitator : an independent, objective facilitator acting under the supervision of the Department, which informs clients of the managed care choices in their area through appropriate sources of information and counseling.

Encounter Data : data generated by Health Maintenance Organization (HMO) processed claims for services rendered by network providers to Project clients as specified in Section 8.205.11 (G) MEDICAID MANAGED CARE SYSTEM DEFINITIONS.

Fee-for-Service System : the traditional method of provider reimbursement in which the provider is paid according to the services rendered.

Home Care Allowance : services or payments as defined in Section 8.484 HOME CARE ALLOWANCE.

Integrated Care and Financing Project : Client or Project Client: a Medicaid-Only client or Dual Eligible client who is enrolled in the Integrated Care and Financing Project, meets the Nursing Facility Level of Care and is eighteen (18) years of age or older.

MCO Contract : the Contract between the Managed Care Organization (MCO) Contractor and the Department to provide enrolled Medicaid clients covered services as defined in the contract, the signature sheet and exhibits, or any supplements, amendments, endorsements or riders annexed to the original.

Medicaid-Only Client : a person who is enrolled in Medicaid, is not a Medicare beneficiary, meets the Nursing Facility Level of Care and is eighteen (18) years of age or older.

Project : the Integrated Care and Financing Project.

Project Implementation Date : the date the Contractor shall begin providing Integrated Care and Financing Project services.

Quality Assurance Monitoring : a method of measuring the quality of health care services provided and client outcomes against performance standards.

8.214.04 SERVICES PROVIDED

- A. The Contractor shall be responsible for providing Medicaid services that are currently required as basic MCO coverage as specified in Section 8.205.4 BASIC COVERAGE REQUIREMENTS and in the MCO Contract.
- B. In addition to providing Medicaid services specified in (A), the Contractor shall also be responsible for providing Medicaid long-term care services as specified in the MCO Contract. Medicaid long-term care shall include services specific to the Home and Community Based Services (HCBS) waiver programs, Class I and Class V nursing facility care, and hospice care as specified in Section 8.550 HOSPICE SERVICES. HCBS waiver programs shall include: services for the Elderly, Blind and Disabled as specified in Section 8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED (HCBS-EBD) GENERAL PROVISIONS; services for Persons Living with AIDS as specified in Section 8.496 HOME AND COMMUNITY BASED SERVICES FOR PERSONS LIVING WITH AIDS (HCBS-PLWA) GENERAL PROVISIONS; services for the Mentally Ill as specified in Section 8.509 HOME AND COMMUNITY BASED SERVICES FOR THE MENTALLY ILL (HCBS-MI); and services for people with Brain Injury as specified in Section 8.515 HOME AND COMMUNITY BASED SERVICES FOR PEOPLE WITH BRAIN INJURY (HCBS-BI). Services specific to other Colorado Medicaid pilot programs shall be considered for inclusion as the pilot programs are developed and implemented.
- C. In addition to providing services specified in (A) and (B), the Contractor shall be responsible for providing Medicare Parts A and B services to Dual Eligible Clients as specified in the contract for Medicare services between the Health Care Financing Administration and the Contractor.
- D. In addition to providing services specified in (A), (B) and (C), the Contractor shall be responsible for providing client assessment, developing care plans and monitoring client outcomes for long-term care.
- E. Other services may be provided to Integrated Care and Financing Project clients as deemed appropriate by the Contractor.
- F. The Contractor shall not be responsible for providing services for mental health and developmental disabilities through the Integrated Care and Financing Project. Services for mental health care

shall be provided by the Mental Health Capitation Program as specified in Section 8.212 MENTAL HEALTH CAPITATION PROGRAM. Services for developmental disabilities shall be provided by Intermediate Care Facilities for the Mentally Retarded and certain Home and Community Based Services (HCBS) wavier programs. The HCBS waiver programs include the following: the Children's Medical Waiver (HCBS-CMW 200) as specified in Section 8.507 CHILDREN'S MEDICAL WAIVER; the Children's HCBS Waiver as specified in Section 8.506 CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM; the Children's Extensive Support Waiver (HCBS-CES) as specified in Section 8.503 DEFINITION; the Children's Habilitation Residential Program (CHRP) as specified in Section 8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM; the Supported Living Services Waiver (HCBS-SLS) as specified in Section 8.500.97 SERVICE DESCRIPTIONS; and the Developmentally Disabled (HCBS-DD) as specified in Section 8.500.3 PROGRAM PROVISIONS. The HCBS programs specified in this section (F) shall be responsible for payment of all services for developmental disabilities that are available under these HCBS programs.

- G. The following services shall be offered through providers that are certified by Medicaid: Class I and Class V nursing facility care; Alternative Care Facility services; adult day services; and home health services.

8.214.05 COMPLAINT AND APPEAL PROCESS

- A. Complaints by Project clients shall be handled in accordance with the procedures and requirements described in Section 8.209, entitled MEDICAID MANAGED CARE COMPLAINT AND APPEAL PROCESS.
- B. The county department of social services in the client's county of residence determines whether a Project applicant or client is financially eligible for Medicaid. Any Project client may appeal matters pertaining to Medicaid financial eligibility determination according to the client appeal rights as specified in the Income Maintenance Staff Manual of the Colorado Department of Human Services.

8.214.06 ELIGIBLE PERSONS

The target population for the Integrated Care and Financing Project is defined as those persons who reside in the Denver Metro Area and who meet Medicaid financial and program eligibility requirements.

Persons who meet the following eligibility requirements may enroll in the Integrated Care and Financing Project:

- A. Medicaid-Only clients, Medicaid beneficiaries who are not eligible for Medicare, must meet the financial and program eligibility criteria for Medicaid in the following ways:
1. Medicaid eligibility criteria as specified in Section 8.100.5 GROUPS ASSISTED UNDER THE PROGRAM; or
 2. 300% eligibility criteria as specified in Section 8.100.5 GROUPS ASSISTED UNDER THE PROGRAM; and
 3. Nursing Facility Level of Care as specified in Section 8.401 LEVEL OF CARE SCREENING GUIDELINES; and
 4. Be eighteen (18) years of age or older.
- B. Dual Eligible clients, Medicare Part A and B beneficiaries who are concurrently eligible for Medicaid, must meet the program eligibility criteria in the following ways:

1. Nursing Facility Level of Care as specified in Section 8.401 LEVEL OF CARE SCREENING GUIDELINES; and
2. Be eighteen (18) years of age or older.

8.214.07 ENROLLMENT AND DISENROLLMENT PROCESS

A. Enrollment in and disenrollment from the Integrated Care and Financing Project for Medicaid-Only clients, persons who are enrolled in Medicaid and who are not Medicare beneficiaries, shall take place according to the following procedures:

1. Medicaid-Only clients must make an affirmative choice to enroll in the Project.
2. Medicaid-Only clients may enroll in the Project at any time during normal business hours through the enrollment facilitator. Enrollment for Medicaid-Only clients shall be effective the first day of the month following the month in which a selection by the client is made.
3. Upon voluntary enrollment in a Managed Care Organization, clients eligible for services through the Project shall remain assigned to the Managed Care Organization for a period of six (6) months as specified in Section 8.207.24 MINIMUM PERIOD OF CLIENT ENROLLMENT IN MANAGED CARE OPTIONS.
4. Medicaid-Only clients may disenroll from the Project within the first ninety (90) days for any reason through the enrollment facilitator during normal business hours. After the first ninety (90) days, disenrollment shall be for good cause only as specified in Section 8.207.32 GOOD CAUSE DISENROLLMENT FROM A MANAGED CARE ORGANIZATION OR PRIMARY CARE PHYSICIAN PROGRAM. Disenrollment for Medicaid-Only clients shall be effective the first of the month following the date of disenrollment.
5. Medicaid-Only clients may disenroll from the Project within the first ninety (90) days of enrollment without cause. Clients will be required to make an alternate Managed Care Organization choice prior to the disenrollment becoming effective as specified in Section 8.207.31 GUARANTEED DISENROLLMENT PERIOD. Such disenrollment will nullify a client's access to the six (6) month guaranteed coverage as specified in Section 8.207.23 GUARANTEED ELIGIBILITY IN MANAGED. CARE ORGANIZATIONS.
6. Medicaid-Only clients must voluntarily disenroll from the Project by notifying the enrollment facilitator no later than the fifteenth (15th) of the month in order for the disenrollment to take effect on the first day of the month following the month in which the disenrollment was granted and ensure clients receive appropriate community placement.

B. Enrollment in and disenrollment from the Integrated Care and Financing Project for Dual Eligible clients, Medicare beneficiaries who are concurrently eligible for Medicaid, shall take place according to the following procedures:

1. All Dual Eligible clients in the Denver Metro Area shall be notified in writing upon implementation of the Project and shall be informed of their health care options.
2. Dual Eligible clients must make an affirmative choice to enroll in the Project.
3. Dual Eligible clients must assign their Medicare and Medicaid to the ICFP contracted HMO.
4. Dual Eligible clients may enroll in the Project on a monthly basis during normal business hours through the enrollment facilitator. Enrollment for Dual Eligible clients shall be effective

according to Medicare and Medicaid regulations regarding enrollment.

5. Dual Eligible clients may disenroll from the Project on a monthly basis during normal business hours. Disenrollment for Dual Eligible clients shall be effective according to Medicare and Medicaid regulations regarding disenrollment.
 6. Disenrollment from the Project for Dual Eligible clients requires simultaneous disenrollment from the Medicare and Medicaid components of the Project.
- C. Medicaid-Only and Dual Eligible clients who disenroll from the Project may enroll in the Medicaid Managed Care Program, the Medicaid fee-for-service system, or the Primary Care Physician Program so long as they retain Medicaid eligibility.
- D. The Contractor must not request or encourage Medicaid-Only or Dual Eligible clients to disenroll from the Integrated Care and Financing Project other than as specified in the contract for Medicaid services between the Department and the Contractor.
- E. The enrollment facilitator shall be authorized by the Department to process requests for enrollment and disenrollment for the Project.

8.214.08 HOME CARE ALLOWANCE

Integrated Care and Financing Project clients shall have the right to continue receiving Home Care Allowance as authorized by the Care Coordination Team.

- A. Project clients receiving Home Care Allowance prior to enrollment in the project shall have the right to continue Home Care Allowance payments and services as specified in Section 8.484.20 HOME CARE ALLOWANCE.
- B. Home Care Allowance payments received by the client must be used to continue to reimburse the current Home Care Allowance service provider, or be paid to a newly selected, suitable service provider as determined in consultation with the Care Coordination Team.
- C. Home Care Allowance clients may elect at any time to discontinue receiving Home Care Allowance payments in order to receive services from the Contractor.
- D. When Home Care Allowance clients elect to forgo their Home Care Allowance payments and the Home Care Allowance case is closed, they shall not be eligible to re-apply for Home Care Allowance so long as they continue to receive services through the Project.
- E. Project clients who were not eligible to receive Home Care Allowance payments prior to enrollment in the Integrated Care and Financing Project shall not be eligible to apply for the Home Care Allowance program so long as they continue to be enrolled in the Project.
- F. If a Project client applies for and receives Home Care Allowance payments after enrollment in the Project, the County Department of Social/Human Services shall be notified to discontinue Home Care Allowance payments to the client.
- G. The Contractor shall not be required to provide Home Care Allowance clients with any services that are provided using Home Care Allowance payments.

8.214.09 ADULT FOSTER CARE

Integrated Care and Financing Project clients shall have the right to continue receiving Adult Foster Care as authorized by the Care Coordination Team.

- A. Project clients receiving Adult Foster Care prior to enrollment in the project shall have the right to continue Adult Foster Care services as specified in Section 8.483 ADULT FOSTER CARE.
- B. Adult Foster Care payments received by the client must be used to continue to reimburse the current Adult Foster Care service provider, or be paid to a newly selected, suitable service provider as determined in consultation with the Care Coordination Team.
- C. Adult Foster Care clients may elect at any time to discontinue receiving Adult Foster Care payments in order to receive services from the Contractor.
- D. When Adult Foster Care clients elect to forgo their Adult Foster Care services and the Adult Foster Care case is closed, they shall not be eligible to re-apply for Adult Foster Care so long as they continue to receive services through the Project.
- E. Project clients who were not eligible to receive Adult Foster Care payments prior to enrollment in the Integrated Care and Financing Project shall not be eligible to apply for the Adult Foster Care program so long as they continue to be enrolled in the Project.
- F. If a Project client applies for and receives Adult Foster Care services after enrollment in the Project, the County Department of Social/Human Services shall be notified by the Contractor to discontinue Adult Foster Care payments to the client.
- G. The Contractor shall not be required to provide Adult Foster Care clients with any services that are provided by the Adult Foster Care Facility.

8.214.10 ADMINISTRATION OF THE PROJECT

- A. The Department is responsible for the following administrative functions related to the Project:
 - 1. Overseeing the Project and problem solving as follows:
 - a. Monitoring contracts between a Contractor and a subcontractor.
 - b. Tracking client enrollment and disenrollment, including reasons for disenrollment through the enrollment facilitator.
 - c. Performing quality assurance monitoring of the Contractor.
 - 2. Calculating the Integrated Care and Financing Project Medicaid acute and long-term care capitation rates.
 - 3. Assuring that sufficient access to care and network capacity is available to potential enrollees for all services provided through the Project.
 - 4. Coordinating administrative functions as follows:
 - a. Monitoring quality assurance with the current standards and systems used by the Department's Quality Assurance Section, along with a separate system that shall be implemented by Project staff.
 - b. Evaluating and conducting research on the Project.
 - c. Performing necessary modifications of the Department's data systems for operation, monitoring and evaluation of the Project.

5. Reviewing and approving the communications plan developed by the Contractor within thirty (30) days.
6. Reviewing and approving, in conjunction with the Health Care Financing Administration, all marketing materials developed by the Contractor.

B. The Contractor is responsible for the following administrative functions related to the Project:

1. Providing services required under the Integrated Care and Financing Project as specified in Section 8.214.04 SERVICES PROVIDED.
2. Developing and implementing a Care Coordination Team for each client.
3. Actively participating as a member of each client's Care Coordination Team.
4. For clients who are enrolled in the Project and need long-term care services, the Contractor shall perform the long-term care screening, the Uniform Long Term Care Client Assessment Instrument (ULTC-100), and care planning services.
5. Conducting provider and member education on the Project.
6. Providing an annual listing of all primary and specialty physicians participating in the Project as requested in the Department's MCO Contract.
7. Providing an annual listing of long-term care service providers as specified in Section 8.214.04 (B) and (E).
8. Providing data regarding quality assurance and outcomes as requested by the Department.
9. Establishing quality assurance standards and systems as needed in addition to those used by the Department's Quality Assurance Section. The Contractor is responsible for coordinated quality assurance monitoring of nursing facilities and assisted living facilities as agreed with the Colorado Department of Public Health and Environment.
10. Providing necessary data and reporting as requested by the Department for the purpose of monitoring and evaluation of the Project.
11. Participating in project problem solving with the Department, clients and client advocacy groups.
12. Designing and implementing a communications plan for Project clients and providers, subject to review and approval by the Department.
13. Cooperating with project evaluation contractors.
14. Maintaining and modifying a database related to project service coordination.
15. Designing a detailed care plan format for Project clients and providers, subject to review and approval by the Department.

8.214.11 COORDINATION OF HEALTH CARE SERVICES: CARE COORDINATION TEAM

The Contractor is responsible for coordination and provision of covered health care services to all Integrated Care and Financing Project clients in the following manner:

- A. Service coordination and authorization shall be conducted by the Care Coordination Team in consultation with the client and/or the Designated Client Representative. Coordination and authorization of services shall take place through the development of a care plan for each Project client.
- B. The Care Coordination Team shall attempt to maintain and/or improve client well being, reduce use of institutional care when appropriate and increase client functional independence when these goals are shared by the client and/or the Designated Client Representative.
- C. The Care Coordination Team shall consider the client and/or Designated Client Representative's requests regarding service delivery and services provided through the Project.
- D. To the extent possible, the Care Coordination Team shall work with the client's Primary Care Physician and other referral sources for medical service management.
- E. The Care Coordination Team shall obtain consultation and involvement of medical and non-medical experts as needed to assist the Care Coordination Team and to assist in the provision of services to the client.
- F. The principal duties of the Care Coordination Team include, but are not limited to, the following:
 - 1. Evaluating information provided by the client, the Designated Client Representative, the client's family and/or the client's primary care provider, as well as the primary care physician, other providers, the Care Coordinator and client assessments.
 - 2. Preparing detailed care plans in consultation with the client and/or the Designated Client Representative to address the client's needs and to arrange for medical and non-medical services to meet those needs.
 - 3. Assuring that all planned services are appropriate, that all services are provided in a timely, cost-effective manner and that all services meet quality of care standards.
 - 4. Consulting with the client and/or the Designated Client Representative regarding all planned services.
 - 5. Monitoring the client's health care outcomes and modifying care plans in consultation with the client and/or the Designated Client Representative to address the client's needs and to achieve desired results.
 - 6. When appropriate, utilizing preventative care services, seeking to avoid unnecessary institutionalization and unnecessary use of emergency services.
 - 7. Exploring innovative ways of improving the delivery of integrated acute and long-term care.
 - 8. When appropriate, coordinating with programs funded by the Older Americans Act.
- G. The Contractor shall provide a copy of each client's care plan to the client. The Care Coordinator shall make a reasonable attempt to assure that the client agrees with the care plan as authorized by the Care Coordination Team.
- H. Any Project client may attend Care Coordination Team meetings to discuss matters that impact the client's access to, satisfaction with, or the quality of services, treatments or providers authorized or denied by the Care Coordination Team. However to use the complaint and appeal process, a client must follow the procedures specified in Section 8.209 MEDICAID MANAGED CARE COMPLAINT AND APPEAL PROCESS.

- I. Any Project client may make a request to change his/her Care Coordinator or other members of the Care Coordination Team in writing to the Care Coordination Team. The Care Coordination Team will review the request, make a written determination within ten (10) days, and send out the determination within one (1) day. All written determinations shall comply with Section 8.209.2 NOTICES REQUIRED OF MANAGED CARE ORGANIZATIONS DURING THE INTERNAL APPEAL PROCESS. If the client is dissatisfied by the determination, a complaint for an adverse event may be filed as specified in Section 8.209 MEDICAID MANAGED CARE COMPLAINT AND APPEAL PROCESS.
- J. The Care Coordination Team shall provide assessment information consistent with the Uniform Long Term Care Client Assessment Instrument (ULTC-100) and/or the Brain Injury Waiver Assessment for Project clients as directed by the Department.
- K. If a client voluntarily disenrolls from the Project, the Care Coordination Team shall ensure that the client receives appropriate community placement.
- L. The Contractor and other service providers shall share client information in a timely manner for the purposes of screening, assessment, care coordination, monitoring and reporting.
- M. The Contractor shall protect the confidentiality of client records.

8.214.12 CLIENT RIGHTS AND RESPONSIBILITIES

In order to implement Care Coordination that yields the maximum potential benefit for each Project client, the Care Coordination Team, the client and/or the Designated Client Representative shall assure the protection of the following client rights and responsibilities regarding the Project.

- A. The client and/or the Designated Client Representative has the right to be fully informed of the client rights and responsibilities regarding the Project.
- B. The client and/or the Designated Client Representative has the responsibility to actively participate in the care planning process by communicating specific health care needs and working to fulfill those needs with the Care Coordination Team. However, the client and/or the Designated Client Representative has the right to choose not to participate.
- C. The client and/or the Designated Client Representative has the right to receive a copy of the care plan approved by the Care Coordination Team.
- D. The client and/or the Designated Client Representative has the responsibility of seeking to understand the care plan authorized by the Care Coordination Team.
- E. The client and/or the Designated Client Representative has the right to agree or disagree with the authorized care plan. The client and/or the Designated Client Representative shall sign the authorized care plan to signify agreement.
- F. The client and/or the Designated Client Representative has the responsibility to communicate to the Care Coordinator and/or the Care Coordination Team any disagreements regarding the proposed or authorized care plan.
- G. The client and/or the Designated Client Representative has the right to speak with the Care Coordination Team and attend Care Coordination Team meetings related to the client's care.
- H. The client and/or the Designated Client Representative has the right to request that the Care Coordination Team make changes in the proposed or approved care plan and the specific needs contained within the care plan.

- I. Any Project client may make a request to change his/her Care Coordinator or other members of the Care Coordination Team in writing to the Care Coordination Team. The Care Coordination Team will review the request make a written determination within ten (10) days and send out the determination within one (1) day. All written determinations shall comply with Section 8.209.2 NOTICES REQUIRED OF MANAGED CARE ORGANIZATIONS DURING THE INTERNAL APPEAL PROCESS. If the client is dissatisfied by the determination, a complaint for an adverse event may be filed as specified in Section 8.209 MEDICAID MANAGED CARE COMPLAINT AND APPEAL PROCESS.
- J. The client and/or Designated Client Representative has the right to be made fully aware of the Project's complaint and appeals process.
- K. The client and/or the Designated Client Representative has the right to be informed of the client's responsibilities regarding HMO membership as specified in Section 8.206.23 CLIENT RESPONSIBILITY IN THE MEDICAID MANAGED CARE SYSTEM.
- L. The client has the financial responsibility for any project services received that are not authorized by the Contractor, except for emergency services defined by Medicare regulations for Dual Eligible Clients and Medicaid regulations as specified in Section 8.205.4 BASIC COVERAGE REQUIREMENTS and Section 8.205.11 (C) DEFINITIONS.

8.214.13 QUALITY ASSURANCE

- A. The following quality assurance goals shall be pursued through the Project:
 - 1. Improvement of access to medical and non-medical health care services for Project clients;
 - 2. Improvement of the quality of medical and non-medical health care services to insure that clients receive services appropriate to their needs; and
 - 3. Development of positive client outcomes and client satisfaction with services received through the Project.
- B. The Project's quality assurance system shall involve the following components:
 - 1. The current quality assurance monitoring system utilized by the Department's Quality Assurance Section that monitors and reviews the Contractor's performance in the areas of service delivery and client satisfaction. In monitoring the Contractor, the Department's Quality Assurance Section shall use encounter data, client satisfaction surveys, as well as other data regarding client complaints and disenrollments. The Department's Quality Assurance Section may also consider other data sources, including information regarding HMO accreditation status and HMO performance measures.
 - 2. A separate quality assurance monitoring system that shall be implemented by Project staff to monitor and review the Contractor's performance with regard to quality assurance goals specific to the Project. This separate system shall work in conjunction with the current system used by the Department's Quality Assurance Section.
 - 3. Project staff shall utilize the Medicaid Management Information System, Client Oriented Information Network, the Integrated Long Term Care Database, and Health Care Financing Administration Medicare data to track client costs and service utilization and to make program adjustments in a timely manner.
 - 4. The Contractor shall maintain a timely and organized system for recording, tracking and resolving clients' complaints, including informal and formal complaint procedures as

specified in Section 8.214.05 COMPLAINT AND APPEALS PROCESS.

5. Clients enrolled in the Project may be asked to participate in a client satisfaction survey to be analyzed by Project staff and/or the Department's Quality Assurance Section.

8.214.14 PROJECT EVALUATION

The Integrated Care and Financing Project shall be evaluated to assess the extent to which the Project has met intended objectives. The evaluation shall be conducted with the combined efforts of the Department and an evaluation contractor. The evaluation shall assess the Project's effectiveness on client access to care, service utilization, client outcomes and costs.

8.220 COMPETITIVE PROCUREMENT AND SELECTIVE CONTRACTING, INCLUDING GLOBAL FEE PAYMENT PROGRAMS

This section of Staff Manual Volume 8 describes Medicaid competitive procurement and selective contracting.

8.221 GENERAL PROVISIONS

The Colorado Department of Health Care Policy and Financing (the State) may enter into contracts to provide a range of health care benefits identified in the State Plan to persons determined eligible for medical care under Title XIX of the Social Security Act (Medicaid). The Department under provisions of State and Federal law and regulation, and contingent upon Federal waiver(s), may elect to competitively procure and/or selectively contract for organ and other transplant services.

A. Transplant Services

1. The Department, after consultation with affected groups, may issue Requests for Proposals from providers to contract with the State for the provision of certain organ transplants and related services. A limited number of contracts may be executed with providers whose proposals demonstrate that they are qualified to provide adequate access to quality services, and whose price proposals are most advantageous to the State.
2. Effective on or after July 1, 1995 the Department may contract with selected providers under a global fee arrangement for transplant services related to heart, lung, liver, kidney, and bone marrow transplants. Under these contracts providers will receive a single payment for all services related to the transplant procedure, and a monthly case management fee as the Primary Care Physician for six months following the transplant. The following services are included under the global transplant payment:
 - a. Patient access to the transplant network
 - b. Provision of general assistance and education for the transplant patient and families or attendants
 - c. Transplant procedures
 - d. All services required by a transplant patient including organ acquisition, physician services, and certain non-hospital post-transplant care for a period not to exceed 6 months.
 - e. Related transportation for patients and necessary family member(s) or attendant(s)
3. The method of payment to be used for transplants under this program will be an inclusive rate

per discharge.

4. All transplant services will be prior authorized as described in 8.317.
5. All transplant services will be subject to Quality Assurance review by the Peer Review Organization as described at 8.312.12., and as required under provisions of the Federal waiver and/or specific contract provisions of the competitively procured transplant program.

8.280 EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT)

8.280 DEFINITIONS

- .01 Department shall be defined as the Department of Health Care Policy and Financing (HCPF).
- .02 Department's Designated Entity shall be defined as an agency whose function is to reimburse, coordinate, provide or prior authorize EPSDT services for Medicaid-enrolled children.
- .03 Diagnosis shall be defined as the determination of the nature or cause of physical or mental disease or abnormality through the evaluation of health history, physical and developmental examination, laboratory tests and x-rays.
- .04 Health Maintenance Organization (HMO) shall be defined as a prepaid health plan contracted with the Department that provides comprehensive health care.
- .05 Managed Care Organization (MCO) shall be defined as an entity contracting with the Department that provides, delivers, arranges for, pays for or reimburses the costs of health care services through the child's use of health care providers managed by, owned by, under contract with, or employed by the entity.
- .06 Medically necessary, or medical necessity, shall be defined as a Medicaid service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the child's needs.

8.281 EPSDT ELIGIBILITY

.01 ELIGIBILITY

To receive EPSDT services, the child shall be:

- A. Enrolled in Medicaid; and
- B. Under the age of 21.

.02 NOTIFICATION OF ELIGIBILITY

A. General Guidelines:

1. All Medicaid-enrolled children and their parents or legal guardians shall be informed about the services included in the EPSDT benefit and how these services may be accessed.
2. Notification shall be defined as the process of informing Medicaid-enrolled clients,

their parents or legal guardians, about the services included in the EPSDT benefit and how those services may be accessed. A combination of oral or written methods must be used, within 60 days following the date of the Medicaid eligibility determination. Oral notifications shall include face-to-face meetings, discussions or telephone conversations.

3. Written communications shall be prepared in a format using clear non-technical language and at a 6th grade reading level whenever possible.
 4. Written and oral information shall be culturally appropriate and provided in a manner and format appropriate for children, or their parents or legal guardians, who have limited English proficiency or sensory impairments.
- B. Responsibility for notification and information about EPSDT, shall be provided to children and their parents or legal guardians by County Departments of Human/Social Services, and a written notification from the child's HMO if the child is enrolled in managed care.

.03 RE-NOTIFICATION

Re-Notification of EPSDT benefits shall occur at least annually and shall be completed by the County Departments of Human/Social Services for children/families not enrolled in a HMO or by HMOs for children/families enrolled in their organization.

8.282 SERVICES/BENEFITS

.01 SCREENINGS

- A. A screening shall be defined as the use of procedures to determine a child's mental and physical growth progress, and in particular, to identify a disease or abnormality and the need for more definitive study and treatment of possible physical or emotional problems.
- B. Screenings shall include comprehensive health assessments that are performed soon after birth or as early as possible in a child's life and repeated at prescribed periodic intervals of time through the age of 20 as described in the Periodicity Schedule.
 1. The Periodicity Schedule describes the intervals at which preventive physical, sensory, developmental and behavioral screening, including vision, hearing and dental services shall be performed for enrolled children through the age of 20, as recommended by the American Academy of Pediatrics.
 2. A copy of the Periodicity Schedule may be obtained from the American Academy of Pediatrics website at <http://www.aap.org> or from the Department's EPSDT Benefit Coordinator.
- C. Screenings shall be performed in a culturally sensitive and age appropriate manner by, or under the supervision of, a participating Medicaid provider qualified to furnish primary medical and health care services, including:
 1. The child's Primary Care Physician (PCP) who is a health care professional, licensed to practice medicine (e.g., an M.D. or D.O.) or a facility with a licensed physician on staff.
 2. Local organized County Health Department and/or local County Nursing Service when performed by a registered nurse under the supervision of a physician;

3. Community Health Center physician; or
4. Another Medicaid provider including physicians' assistant or nurse practitioner.

D. The components of an EPSDT screen shall include:

1. A detailed health and development history including growth and development milestones.
2. A comprehensive unclothed physical examination.
3. An assessment of the following:
 - a) Vision;
 - b) Hearing;
 - c) Mouth, oral cavity and teeth (shall not replace a full oral screen by a dentist);
 - d) Mental/behavioral health;
 - e) Nutritional status;
 - f) Cardiovascular and respiratory function;
 - g) Genital status; and
 - h) Gastrointestinal status.
4. Immunizations to bring a child current with the schedule recommended and approved annually by the Advisory Committee on Immunization Practices (ACIP). Current information about approved immunizations is found at the Center for Disease Control website at <http://www.cdc.gov>
5. Any appropriate age-specific screening or laboratory tests at intervals recommended by the American Academy of Pediatrics:
 - a) Laboratory tests must include lead toxicity tests for all children who shall be tested at twelve (12) and twenty-four (24) months of age, or any child through age 6 not previously tested; and
 - b) If the blood lead measures equal to or greater than 10 micrograms per deciliter of blood (ug/dL) as identified by a finger-stick sample, it shall be followed by a venous sample to confirm the results of the first test.
6. A developmental assessment shall include a range of activities to determine whether a child's emotional and developmental processes fall within a normal range of achievement according to the child's age group and cultural background. This assessment shall include: self-help and self-care skills; gross and fine motor development; communication skills or language development; social-emotional development; cognitive skills; and appropriate mental/behavioral health screening.
7. Health Education including anticipatory guidance shall include:

- a) Counseling provided by a qualified health care professional to the parent or legal guardian of a child during any visit. Such counseling includes information about what to expect developmentally and behaviorally from the child;
- b) Health education and counseling based on the results of the screening process and shall be required for parents or guardians, and children;
- c) Age appropriate, culturally specific education, designed to assist the parent or guardian to understand what to expect in terms of the child's development;
- d) Information about the child's nutritional needs, physical growth, mental development and care for current conditions shall be provided, as well as information about the timeframe for the next exam; and
- e) Information about the benefits of healthy lifestyles and practices.

.02 PERIODIC EXAMINATIONS

- A. The recommended frequency of follow-up examinations is outlined in the Periodicity Schedule.
- B. The intervals in the schedule as found at <http://www.aap.org> indicate the minimum frequency in performing the various procedures as recommended by the American Academy for Pediatrics and local medical review, and for which payment can be provided under the Colorado Medicaid EPSDT benefit.

.03 INTER-PERIODIC EXAMINATIONS

Inter-periodic visit shall be any health care that occurs outside the periodic preventive care screening exam such as a further diagnosis, evaluation, acute or sick care visit.

.04 RESULTS OF SCREENINGS AND INTER-PERIODIC EXAMINATIONS

Results shall be recorded in the child's medical record. Documentation shall include at a minimum the following components:

- A. Identified problems and negative findings on the initial and periodic EPSDT medical screenings;
- B. Documentation of further diagnostic studies and/or treatments needed and date ordered;
- C. Referral from a child's PCP to obtain medically necessary specialty services through another Medicaid provider specified by the PCP. Referrals must be obtained before services are rendered to ensure reimbursement by the Department.
- D. Referrals to other health care providers or facilities are covered if:
 - 1. The child receives a referral from the provider who documents the reason for the referral, including the name of the provider;
 - 2. Referred to a participating Medicaid provider;
 - 3. The diagnosis is identified as a result of an EPSDT screening or inter-periodic exam;

and

4. The services are medically necessary.

E. A referral to a dentist twice a year, starting no later than age one.

1. A physician's oral exam during a visit shall not be a substitute or replacement for a dental exam.

2. A PCP or Medicaid-enrolled physician referral to the dentist may be a verbal referral and does not require completion of a referral form.

F. Clients may self-refer without a referral from their PCP for routine vision, dental or mental health services; and hearing services provided by the Health Care Program for Children with Special Needs, through the Colorado Department of Public Health and Environment.

.05 DIAGNOSIS AND TREATMENT

A. GENERAL GUIDELINES:

1. Diagnosis and treatment are a covered benefit if the services are:

a) For a defect, illness or condition which has been:

(i) Newly discovered by the screening or inter-periodic exam;

(ii) Previously identified but not treated; or

(iii) Previously identified and treated, but is shown to have increased in severity or continues to require treatment.

b) Medically necessary and are reasonably expected to correct or ameliorate defects which include physical, dental or mental illness conditions;

c) In accordance with generally accepted standards of medical practice;

d) Clinically appropriate in terms of type, frequency, site and duration; and

e) Not primarily for the convenience of the child, parent or legal guardian, physician, or other health care provider.

B. Vision services for Medicaid-enrolled children may be provided by an ophthalmologist, optometrist or optician. These services include testing, diagnosis, and treatment for visual defects, and eyeglasses if medically necessary.

1. Services may require prior authorization by the Department's Designated Entity or the child's HMO if the child is enrolled in managed care.

a) If the child is not enrolled in an HMO, providers shall refer to the Fiscal Agent's provider manuals, billing instructions and Medicaid bulletins for further information about vision services requiring prior authorization.

b) If the child is enrolled in an HMO, the provider shall contact the child's HMO for information about the HMO's prior authorization requirements for vision services.

2. Eyeglasses dispensed by an optician shall be a benefit only when ordered by an ophthalmologist or an optometrist.
3. Vision benefits include one or two single or multi-focal clear glass lenses, one standard frame; repair or replacement of plain eyeglasses due to broken frames or lenses; dispensing fee and materials.
4. Replacement glasses shall be provided when:
 - a) The glasses are medically necessary;
 - b) There is a change in the prescription; or
 - c) The glasses are damaged to the extent that repairs are not cost effective.
5. Contact lenses or orthoptic vision treatment services shall be a benefit only when prior authorized by the Department or the child's HMO if enrolled in managed care.

C. Audiological benefits include identification, diagnostic evaluation and treatment for children with hearing impairments. Conditions treated may be either congenital or acquired. Conditions treated may be provided by board certified otolaryngologists, audiologists, speech pathologists and certified and licensed Colorado Home Intervention Program (CHIP) early interventionists or other approved providers. Services shall include, but are not limited to:

1. Audiological evaluation;
2. Hearing aids including:
 - a) Purchase, maintenance, repairs and accessories;
 - b) Selection, testing and fitting of hearing aides for children with bilateral or unilateral hearing loss; and
 - c) Auditory training in the use of hearing aids.
3. Therapy for children with hearing impairments;
4. Family-focused, home-based, early language intervention for children, birth to three, with a hearing loss through the Colorado Home Intervention Program (CHIP).

a.

D. Dental Services

1. Diagnostic and treatment services available for Medicaid-enrolled children shall include, but are not limited to:
 - a) Routine periodic oral examinations to be provided no more than once every six (6) months (180 days) unless there is medical necessity and the service is prior authorized;
 - b) Radiographs;
 - c) Preventive services;

- d) Restorations;
- e) Endodontics;
- f) Periodontics;
- g) Prosthodontics, fixed and removable; and
- h) Oral surgery.

2. Emergency dental services shall be defined as those services necessary to control bleeding, relieve pain, eliminate acute infection; operative procedures which are required to prevent pulpal death and the imminent loss of teeth; treatment of injuries to the teeth or supporting structures; and palliative therapy for pericoronitis associated with impacted teeth.

3. Orthodontic services are available for children with congenital, severe developmental or acquired handicapping malocclusions when the orthodontist's documented medical necessity is confirmed by pre-treatment case review.

- a) Orthodontist completes and submits a handicapping malocclusion orthodontic assessment, documented medical necessity and treatment plan.
- b) Treatment plan benefits are available after the Department's Designated Entity has reviewed each case for medical necessity, the specific requirements of an unusually severe handicapping malocclusion and approved the appropriateness of treatment plan for the client.
- c) Orthodontic services are considered as part of a single, individual course of treatment accomplished over time.

E. Family Planning Services shall be in accordance with Section 8.730 through Section 8.733, and include family planning counseling, treatment and follow-up, information on birth control, including insertion and removal of approved contraceptive devices, and measurement for contraceptive diaphragms.

1. Obstetrical Services shall include:

- a) Prenatal care services; and
- b) Physician or nurse-midwife services in pregnancy, labor, birth and 60 days postpartum.

F. Lead Blood Level diagnosis and follow-up shall include:

- 1. Retesting to confirm the diagnosis;
- 2. Reporting high blood lead levels to the provider and to the Colorado Department of Public Health and Environment, which will provide case management including:
 - a) Routine reminders for follow-up tests;
 - b) Home investigation to determine the source of the lead poisoning; and
 - c) Nutritional counseling and laboratory work to test for iron deficiency.

G. Wrap-around services include:

1. Those services not included in the client's HMO benefit package, but which are covered by Medicaid; or
2. Services that exceed coverage limitations under the contract between the HMO and the Department and are billed to the Medicaid Fiscal Agent.

H. Other health care services may include Expanded EPSDT benefits in addition to those offered in the State Plan, if the need for such services is identified during an EPSDT visit, the services are medically necessary and meet the requirements at Section 8.284.05.

I. EPSDT Extraordinary Home Health Services are those services available to Medicaid enrolled children if the child needs care above the daily home health units, services are to be provided outside the home, skilled personal care is needed and meet the requirements at Section 8.284.06.

.06 EPSDT OUTREACH AND CASE MANAGEMENT

A. EPSDT outreach and case management shall be defined as facilitating and maintaining the child's contact with a comprehensive and continuous health care service source.

B. EPSDT outreach and case management shall be offered and provided to Medicaid-enrolled children receiving health services within 60 days, and shall include:

1. Informing Medicaid-enrolled children, their parents and/or legal guardians about the EPSDT benefit and encourage their participation in the program;
2. Educating families on the importance of preventive health care;
3. Assisting children/families in selecting a primary care provider. Children without a primary care provider shall be informed of the choices of PCP and/or HMOs available to them and how to notify the Enrollment Broker of their choice, as described in Section 8.207 through Section 8.207.5;
4. Assisting in arranging EPSDT screening appointments, inter-periodic examinations, dental appointments, or non-emergent medical transportation if such assistance is required;
5. Verifying follow-up of appointments to determine whether the child kept the appointment, and whether services were received within a reasonable time period. If the appointment was not kept, efforts shall be made to assist with the rescheduling of a second screening appointment; and
6. Assisting in identifying the names and locations of health care providers from whom the services may be obtained, and scheduling services when there is a need for further diagnosis or treatment.

C. Case managers shall perform notification and outreach to include instructing Medicaid-enrolled children and their families to understand:

1. The need for early detection of disease or disability;
2. Where and when EPSDT screening takes place and what the screening visit entails;

3. Screening is not enough to prevent or treat disease and that diagnostic and treatment services must be acquired when recommended;
 4. Assistance in arranging and getting to medical, dental and mental health care can be provided if needed; and
 5. EPSDT is a voluntary program.
- D. Medicaid-enrolled children and their families shall be informed of how to obtain a listing of the names and locations of primary care providers (PCP) or HMOs available within the child's area.
- E. Medicaid-enrolled children and families shall be informed about how and when to access emergency transportation services, that non-emergent medical transportation assistance is available if needed, and how such transportation may be accessed if necessary.

8.283 PROVIDER REQUIREMENTS/RESPONSIBILITIES

- .01 Medicaid providers offering EPSDT screening, diagnostic and treatment services shall assure that services provided meet the Federal and State minimum standards for ESPDT services.
- .02 Providers shall be responsible for verifying Medicaid eligibility and managed care enrollment status prior to rendering services.
- .03 If services require prior authorization, providers shall be responsible for obtaining appropriate prior authorization and meeting the documentation requirements of the Department's Designated Entity or the child's HMO.
- .04 Providers shall be responsible for documenting the results of EPSDT screening, inter-periodic examinations, diagnostic and treatment encounters, and completing appropriate screening and claim forms.

8.284 PRIOR AUTHORIZATIONS

- .01 GENERAL GUIDELINES:
 - A. Prior authorization shall be approved from the Department's Designated Entity for reimbursement of specific health care services based on a review of medical information and a finding that the services are both medically necessary and covered benefits of the Medicaid program.
 - B. Providers shall obtain Prior Authorization of services when required from the Department's Designated Entity or the child's HMO.
 1. Fee-for-service providers shall contact the Fiscal Agent to obtain information about services requiring prior authorization.
 2. If the child is enrolled in an HMO, providers may obtain information from the child's HMO about services that require prior authorization and network providers that may be utilized.
 3. If services are approved, the child, or the parent or legal guardian, the physician; and care providers shall receive an authorization letter describing the services and the specific provider which has been authorized.

C. It is the responsibility of the provider to obtain prior authorization.

1. The child's provider shall determine medically necessary treatment and enumerate those services that require prior authorization on the Medicaid claim form.
2. This form, and applicable x-rays and/or other evidence of medical necessity, shall be sent to the Fiscal Agent for prior authorization review.
3. The Fiscal Agent shall review the treatment proposed, verify the medical necessity of services proposed and approve or deny authorization of treatment.

D. In order to obtain prior authorization, all EPSDT services shall be ordered by the child's Primary Care Physician, dentist or provider designated by the PCP.

E. Prior authorization of services is not a guarantee of payment if the child is not a Medicaid-eligible child on the date the services are rendered.

.02 VISION SERVICES

Requests for authorization of glasses and/or contacts shall be submitted to the Fiscal Agent or the child's HMO.

.03 AUDIOLOGICAL and ORTHODONTIC SERVICES

Requests for authorization of covered audiological or orthodontic services shall be submitted to the Department's Fiscal Agent.

.04 DENTAL SERVICES

- A. Prior authorization is a requirement for reimbursement for specific dental services, as determined by the Department. Such services are a reimbursable benefit only if authorized by the Fiscal Agent or the child's HMO if the child is enrolled in managed care and there is a concurrent medical condition.
- B. A child may present to a dentist with a dental emergency requiring immediate care and/or treatment without prior authorization.
 1. Such emergency care and/or treatment is a benefit of EPSDT only to the extent that treatment is necessary for the control of bleeding, immediate relief of pain, or elimination of acute infection.
 2. Emergency services exceeding limits established by the Department shall be subject to post payment review.

.05 EPSDT EXPANDED SERVICES

- A. Expanded EPSDT are services not provided under the State Plan but are available to Medicaid-enrolled children.
- B. If expanded EPSDT services are requested, a copy of the EPSDT screening results identifying the medical need for the particular service shall be attached to the request for prior authorization. In addition to the requirements described at Section 8.282.05(I), expanded EPSDT services shall meet these requirements:
 1. The service is in accordance with generally accepted standards of medical practice;

2. The service is clinically appropriate in terms of type, frequency, extent, site and duration;
3. The service provides a safe environment or situation for the child;
4. The service is not experimental or investigational and is generally accepted by the medical community for the purpose stated;
5. The service is not primarily for the convenience of the child, the child's parents or legal guardians, the physician or other health care provider; and
6. The service is cost effective.

.06 EPSDT EXTRAORDINARY HOME HEALTH SERVICES

- A. EPSDT extraordinary home health services are covered services above and beyond those provided under the State Plan but available to EPSDT clients, from birth through 20 years of age, as a wrap-around benefit through Medicaid fee-for-service, if it is medically necessary.
- B. Requests for authorization of EPSDT extraordinary home health services shall be submitted to the Department's Designated Entity.
- C. If the child has a skilled need that meets the home health rules and requires care above the daily cost limits:
 1. The home health agency shall submit a prior authorization request to exceed the daily cap; and
 2. Medical documentation shall be required to verify that the extra services are skilled and medically necessary.
- D. If the child requires a home health provider to render care outside of the home, the home health agency must submit a request for prior authorization and documentation justifying why the required skilled services need to take place outside of the home.

8.285 REIMBURSEMENT

.01 GENERAL GUIDELINES:

- A. Reimbursement shall be in accordance with the regulations for pricing physician services as reflected at Section 8.200 for all EPSDT medical screening, diagnostic and treatment services.
- B. No reimbursement shall be made for services requiring prior authorization unless such authorization has been obtained.
- C. Providers shall not bill nor receive payment from the child, his/her family, or relative, and shall abide by all other applicable regulations of the Medicaid program.
- D. Medicaid shall be the payer of last resort. Enrolled children are not entitled to have Medicaid reimbursement made on their behalf if all, or any part of, the items or services are covered by private insurance, Workmen's Compensation, third party liability, or any federal, state, county, municipal or private benefit systems for which the eligible person is qualified.

.02 VISION BENEFITS

- A. Pricing of vision care benefits shall be in accordance with the regulations for pricing physician services as contained in Section 8.200 and Medicaid bulletins or as established by provider contracts with the child's HMO.
- B. When the child or parent or legal guardian desires options that have additional costs, the amount reimbursed by the Department for standard frames and clear glass lenses shall be applied to the total cost of these services. This shall also apply to repair or replacement of broken eyeglasses.
 - 1. The provider shall be permitted to charge the child for the difference between the retail price of the service and the amount paid by Medicaid.
 - 2. Providers must notify the child and the child's parent or legal guardian or the child's designated client representative in writing of the difference and obtain the signature of the child or the child's parent or guardian or designated client representative indicating agreement to pay the additional costs.

8.290 SCHOOL HEALTH SERVICES

8.290.1 DEFINITIONS

Care Coordination Plan means a document written by the District that describes how the District coordinates client services across multiple providers to assure effective and efficient access to service delivery and prevent duplication of services.

Disability means a physical or mental impairment that substantially limits one or more major life activities.

Individualized Plan means an Individualized Education Plan or Individualized Family Services Plan developed pursuant to the federal Individuals with Disabilities Education Act, an Accommodation Plan developed pursuant to Section 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C., Section 794 or an Individualized Health Services Plan developed in accordance with "The Procedure Guidelines for Health Care of Students with Special Needs in the School Setting" published by the Colorado Department of Education.

Local Services Plan (LSP) means a document written by the District that describes the types and the costs of services to be provided with the reimbursed federal funds.

Medically at Risk means a client who has a diagnosable physical or mental condition having a high probability of impairing cognitive, emotional, neurological, social, or physical development.

Medically Necessary service means a benefit service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury or disability and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

Qualified Health Care Professional means an individual who is registered, certified or licensed by the Department of Regulatory Agencies as a health care professional and who acts within the profession's scope of practice. In the absence of state regulations, a qualified health care professional means an individual who is registered or certified by the relevant national professional health organization.

Transportation means transportation service necessary to provide a client with access to Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) Medicaid services.

8.290.2 ELIGIBILITY

8.290.2.A. An eligible client shall be:

1. Enrolled in Medicaid,
2. Enrolled in a public school of a participating District and
3. Under the age of 21.

8.290.2.B. A person with a disability or who is Medically at Risk is eligible for targeted case management benefits as set forth in §8.290.3.C when he or she receives a referral for or services according to an Individualized Plan.

8.290.3 SERVICES, BENEFITS AND LIMITATIONS

8.290.3.A. EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT) Services

1. EPSDT services shall meet the requirements at 10 C.C.R. 2505-10, Section 8.280 et seq.
2. EPSDT rehabilitation services shall be services to reduce physical or mental disability and which may improve physical or mental health level. Rehabilitation services shall be recommended by a physician or other licensed practitioner of the healing arts.
3. EPSDT services shall not be for academic assessment.
4. Except for services delivered pursuant to the federal Individuals with Disabilities Education Act or Section 504 of the federal Rehabilitation Act of 1973, the District shall not claim reimbursement for EPSDT services to clients enrolled in health maintenance organizations that would normally be provided for clients by their health maintenance organization.

8.290.3.B. Transportation shall be required on the client's Individualized Plan or shall be for EPSDT screens provided during the normal school day at non-school locations. Transportation shall be to and from a client's place of residence and the school, or the site of a Medicaid reimbursable service if the service is not provided at the school.

8.290.3.C. Targeted Case Management Services (TCM)

1. TCM services shall be services to assist the individual client who is Medically at Risk to access needed medical, social, educational, and other services.
2. TCM services may include:
 - a. Individualized strengths and needs assessment,
 - b. Needs-based service planning that provides an individualized written, comprehensive service plan based on needs identified in the assessments,
 - c. Service coordination, monitoring and advocacy,
 - d. Crisis assistance planning.
3. Targeted case management services shall not include:

- a. Program activities of the District that do not meet the description of the TCM benefit,
- b. Administrative activities necessary for the operation of the District,
- c. Diagnostic, treatment or instructional services, including academic testing, or
- d. Services that are an integral part of another service already reimbursed by Medicaid.

8.290.4 PROVIDER STANDARDS

8.290.4.A. The District shall have a Department approved Local Services Plan to obtain a contract with the Department.

8.290.4.B. Individual EPSDT service providers employed by or subcontracted by the District shall be Qualified Health Care Professionals. The following providers are considered qualified:

- 1. Occupational therapy assistants certified by the National Board for Certification of Occupational Therapy when providing services according to the standards of practice described in the American Journal of Occupational Therapy (December 1998),
- 2. Physical therapy assistants when providing services pursuant to Section 12-41-101, C.R.S. , *et seq.* , and
- 3. Health technicians when providing skilled nursing services under the delegation clause of Section 12-38-101, C.R.S., *et seq.*

8.290.4.C. The District shall have a Care Coordination Plan approved by the Department for the delivery of TCM services.

8.290.4.D. The District shall complete and submit to the Department a Care Coordination Plan for the delivery of TCM services. The District shall have a representative group of parents and community-based providers, including the local public health department, EPSDT case managers and any existing school-based health centers to assist in developing the Care Coordination Plan.

Included in the care coordination plan is the provision for coordination of benefits and case management across multiple providers to:

- 1. Achieve service integration, monitoring, and advocacy,
- 2. Provide needed medical, social, educational, and other services,
- 3. Ensure that services effectively complement one another and
- 4. Prevent duplication of services.

8.290.4.E. Individual TCM providers shall be Qualified Health Care Professionals or shall meet the qualifications established by the Colorado Department of Education to develop and implement Individualized Plans or services under the Individuals with Disabilities Education Act.

8.290.5 COORDINATION OF CARE

8.290.5.A. The District shall coordinate the provision of care with the client's primary health care provider for routine and preventive health care.

8.290.5.B. The District shall refer clients to their primary care provider, health maintenance organization

or managed care provider for further diagnosis and treatment that may be identified as the result of an EPSDT screen or service.

8.290.5.C. When the client is receiving Medicaid services from other health care providers and the District, the District shall coordinate medical care with the providers to ensure that service goals are complementary and mutually beneficial to the client or shall show cause as to why coordination did not occur.

8.290.5.D. When the client of the targeted population is receiving case management services from another provider agency as the result of being members of other covered targeted groups, the District shall ensure that case management activities are coordinated to avoid unnecessary duplication of services.

8.290.5.E. The District shall inform a family receiving case management services from more than one provider that the family may choose one lead case manager to facilitate coordination.

8.290.6 REIMBURSEMENT

8.290.6.A. The District shall obtain from the client or the client's guardian a written informed consent to submit Medicaid claims on behalf of the client.

8.290.6.B. The District shall abide by the Third Party Liability rule at 10 C.C.R. 2505-10, Section 8.061.2.23.

8.290.6.C. Rates

1. Transportation rates are based on special transportation cost information received from the Department of Education.
2. Rates, other than transportation rates, are developed according to Department methodology based on averaged costs to Districts for providing services. Costs are the salary and fringe benefits of qualified providers, direct support and indirect support.
3. The District shall provide salary and fringe benefits cost data for use in rate setting as part of the required independent audit report submitted annually to the Department of Education.
4. The District shall periodically participate in a time study to determine the direct support rate.
5. The indirect support rate is a standard rate published annually by the Department of Education.

8.290.6.D. Payment

1. The District shall submit a claim for each benefit service provided for each client.
2. The District shall receive reimbursement on a fee for service basis.
3. The District shall receive the federal share of the determined rate, not to exceed 100% of the federal match rate, as payment.

8.290.7 CERTIFICATION OF MATCH

The District shall certify to the Department that it has expended local and state monies to provide Medicaid services in an amount sufficient to meet the nonfederal share of expenditures claimed for federal financial participation.

8.300 HOSPITAL SERVICES

- .10 Hospital services are a benefit of the Medicaid Program and Include those items and services which are ordinarily furnished by a hospital for the care and treatment of inpatients provided under the direction of a physician.

Inpatient hospital services are a benefit under the Modified Medical Program.

- .11 Inpatient hospital services which are defined as experimental by the Medicare program are not a benefit of the Medicaid Program.
- .12 Inpatient hospital services which are not a covered benefit of the Medicare program are not a benefit of the Medicaid Program.
- .13 For Medicaid approved benefits, Medicare patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities.
- .14 For Medicaid approved benefits, patients (having Medicaid primary coverage) may receive treatment at any participating Colorado Medicaid hospital facility.
- .15 The Peer Review Organization (PRO) may evaluate medical data related to benefit coverage for conformance of benefits to community medical standards. The Department may approve PRO recommendations for modifications to benefit coverage.
- .16 The published standards of the Department of Health and Human Services which comprise the Medicare benefits and exclusions described above are based upon 42 USC 1395y, 42 CFR Part 409, and the Medicare Intermediary Manual/Claims Processing/Part 3. No amendments or later additions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Foundation for Medical Care P.O. Box 17300 1260 S. Parker Road Denver,
Colorado 80217-0300 or

Manager, Health and Medical Services Colorado Department of Social Services 1575
Sherman Street Denver, Colorado 80203

Reimbursement for surgical procedures will be subject to the stipulations set forth in the reimbursement for surgery section.

- .20 Acute inpatient hospital psychiatric care is a benefit of the Medicaid Program for eligible recipients when provided as an integral service of a participating Medicaid general hospital. Acute inpatient hospital psychiatric care is a benefit of the Modified Medical Program.
- .30 Psychiatric hospital services are reimbursed by the methodology established in 8.374. Such services, except as described herein, are limited to forty-five (45) days per State fiscal year and include:
- A. bed and board, including special dietary service, in a semi-private room to the extent available;
 - B. professional services, including those of physicians, physical therapists, either voluntary or paid hospital employees, interns, residents, or other physicians in training in the hospital and general nursing services;
 - C. laboratory services, therapeutic or diagnostic services involving use of x-ray, radium or

radioactive isotopes, emergency room, drugs, whole blood or equivalent quantities of packed red cells, medical supplies, equipment and appliances as related to care and treatment of a psychiatric diagnosis in the hospital.

The forty-five (45) day limit shall not apply to clients who are receiving psychiatric hospital services as a result of a court order requiring the psychiatric hospital services.

8.301 HOSPITAL DEFINITION

A hospital is an institution which:

- A. is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the purpose of medical diagnosis, treatment, and care of an injured, disabled, or sick person;
- B. is not primarily established for the care and treatment of mental diseases;
- C. is licensed by the Colorado Department of Health, and is approved as meeting the standards established for such licensing;
- D. is qualified to participate under Title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation.

8.302 MEDICAID PARTICIPATING HOSPITAL: REQUIREMENTS

To be a participating hospital in the Medicaid Program, an institution must:

- A. be certified for participation under the Medicare Program;
- B. for non-PPS providers, have in effect a negotiated prospective reimbursement rate with the Department, see 8.350, et seq.;
- C. have an approved Application for Participation with the Department;
- D. a hospital located outside of Colorado which is more accessible to Medicaid clients who require inpatient hospital services than a hospital within the State, can provide services to Colorado Medicaid clients. The Office of Medical Assistance will be free to make the proximity determination. For inpatient services, these hospitals will be paid the average Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services. For outpatient services, these hospitals will be paid 70% of billed charges. Consideration of additional benefit will be made on a case by case basis in accordance with the supporting documentation submitted by the out-of-state hospital; or
- E. a Qualified Indian Health Services hospital located outside the State of Colorado may apply for recognition as a provider under Colorado's Medicaid Program. This is pursuant to Public Law No. 94-437, the Indian Health Care Improvement Act, which makes 100% federal financial participation available for payment of inpatient hospital services, outpatient hospital services and emergency transportation to persons who are Indians with a legal tribal affiliation and who are eligible to receive Colorado Medical Assistance benefits. Reimbursement shall be in accordance with the Colorado Title XIX approved State Plan except where insufficient cost data is available in which case payment shall be in accordance with the requirements of the Office of Management and Budget.

Institutions which fail to meet the above requirements shall be eligible to provide emergency

hospital services under the Medicaid Program, and shall be classified as non- participating Medicaid Hospitals. Inpatient payment shall be 90% of the Colorado urban or rural DRG payment rate. Outpatient services shall be paid at 60% of billed charges.

8.303 EMERGENCY CARE

Emergency care is defined as a medical condition (including active labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: (a) Placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Emergency care services are exempt from Primary Care Provider referral.

Medical Screening Examination is defined as screening of sick, wounded, or injured persons in the emergency room to determine whether the person has an emergency medical condition. An appropriate medical screening examination (including ancillary services routinely available to an emergency treatment facility) must be available to any individual who comes to the emergency treatment facility for examination or treatment of a medical condition and on whose behalf the examination or treatment is requested.

Disputed Denial: A disputed denial occurs when an authorization for treatment or coordination of care is denied by the primary care provider or a non-physician provider under the PCP's supervision and the emergency physician disagrees with the PCP or non-physician provider's clinical assessment or decision about the recipient's clinical management.

The recipient must return to his/her PCP for further treatment, follow up, referral (if necessary) or other medical services.

Claims submitted for medical screening examination or emergency services, as defined above, do require an emergency indicator code, but do not require a referral from the Primary Care Provider to assure reimbursement.

If an emergency treatment facility or licensed medical professional has made an attempt to contact the primary care provider to coordinate medical care and the primary care provider has not returned the call within 30 minutes, it shall be documented in the patient's medical record, and the Managed Care Hotline shall be notified that the primary care provider failed to return the call.

All claims submitted without the proper primary care physician referral will be denied unless documentation is available demonstrating the primary care physician was unavailable to obtain the proper referral.

Any claim submitted as an emergency care service when non-emergent care was provided is subject to payment recovery.

A claim may be submitted for emergency services when there is a disputed denial. The Managed Care Hotline must be notified when a disputed denial occurs. Any claim submitted as a disputed denial is subject to review by the Department, the Department's peer review organization and may result in payment recovery.

8.304 SURGERY BENEFITS

Reimbursement for surgery will be authorized upon certification by the attending physician that surgical treatment is medically necessary at that time. Surgeries are medically necessary at that time if delay could reasonably result in placing the client's health in jeopardy, deterioration in the person's condition or causing other serious medical consequences and/or serious impairment of bodily functions. This will apply to inpatient and outpatient settings. This regulation is effective for surgeries provided during the time period February 15, through June 30, 1988.

8.305 NON-PARTICIPATING HOSPITALS

A non-participating hospital is a hospital which does not meet the requirements of 8.302, above. A non-participating hospital may receive payment for inpatient hospital services if:

- A. the services meet the definition of emergency care;
- B. the services are covered benefits under the Medicaid Program;
- C. the hospital agrees on an individual case basis not to charge the recipient, or the recipient's relatives, for items and services which are covered benefits of the Medicaid Program, and to return any monies improperly collected for such covered items and services.

8.310 INPATIENT HOSPITAL SERVICES

8.311 EXTENT OF INPATIENT HOSPITAL SERVICES

- .10 All Medicaid clients admitted to a participating Medicaid hospital pursuant to the provisions of 8.312, et seq., may receive inpatient hospital services (as described in 8.300) for as many days as determined medically necessary by the client's attending physician and by the PRO for the duration of the client's Medicaid eligibility.
- .20 A Colorado non-participating hospital shall be considered a participating hospital only when the services provided to a Medicaid client qualify as emergency services (see 8.303), and they have contacted the Medicaid Program to obtain a provider number.
- .30 Hospitals located outside Colorado shall be deemed participating hospitals for purposes of providing services to eligible clients who require emergency services while temporarily absent from Colorado (or in the case of PRO prior authorization approval per Departmental policy), if said hospital meets the definition of a hospital in 8.301.
- .40 The primary source of payment for a Medicaid client who has health or other insurance covering all or any part of the costs for inpatient hospital services shall be such insurance. In such instances, Medicaid will be the payor of last resort.

For Medicaid clients who are eligible for Title XVIII (Medicare) benefits, the inpatient hospital services benefit shall run concurrently with Medicare benefits. When Medicare benefits are exhausted and a medical need remains for inpatient hospital services, Medicaid will provide payment for continued inpatient hospital services as a benefit, provided the continuing need for medical services meets criteria for approval.

8.312 INPATIENT HOSPITAL ADMISSIONS/REVIEW OF MEDICAL NECESSITY OF SERVICES

- .10 To establish administrative controls and procedures on the expenditure of allocated (Medicaid) funds for clients' hospital services, and to meet the requirements of Section 1903(i)(4) of Title XIX of the Social Security Act, the following procedures govern review of medical necessity for hospital services, length of stay for inpatient admissions, and the care delivered in non-hospital settings.
- .11 All participating hospitals shall participate in the Hospitalization Review Program administered by a Professional Review Organization (PRO).
- .12 The Hospitalization Review Program conducted by the PRO may include (but not be limited to):
 - A. Preadmission review for inpatient admissions selected by frequency and intensity of services;

- B. Admission and Continued stay review for selected Non-Prospective-Payment System (Non-PPS) inpatient admissions;
- C. Second opinion review for selected inpatient and outpatient procedures;
- D. Prior authorization for selected inpatient and outpatient procedures, and elective out-of-state treatment;
- E. Retrospective admission and continued stay review of non-PPS admissions. Retrospective admission, DRG validation, and quality of care review of Prospective Payment System (PPS) admission;
- F. A random sample of day outliers, readmissions, and transfers on a retrospective basis; and,
- G. Quality review for HMO facilities.

8.313 REVIEW OF ADMISSION AND CONTINUED STAY

- .10 Effective July 1, 1993, the PRO shall initiate admission and continued stay review in selected non-PPS hospitals subject to departmental approval. The PRO may deny inpatient days, not meeting acute care, rehabilitation care or psychiatric criteria, concurrently or retrospectively.
- .11 The hospital, after PRO notification of intent to perform continued stay review, shall be responsible for notifying the PRO of a Medicaid client's admission to the hospital. This notification shall occur on the day of admission, or if the admission is not on a scheduled review day of the PRO, on the first scheduled review day following the client's admission.
- .12 The PRO shall examine the medical record and compare the documentation in the record against the appropriate PRO approved hospitalization criteria.
- .13 If criteria for hospitalization are not met at any point in the hospitalization (i.e., at the point of admission review or continued stay review) the PRO may cause payment for hospitalization to be denied.
 - A. When a court-ordered psychiatric inpatient admission does not meet the medical necessity criteria established for Psychiatric Acute Care by the PRO, such stay may be denied by the PRO Physician Advisor (PA).
 - B. When a court-ordered psychiatric inpatient admission is denied by the PRO PA, the provider shall submit the type of bill as an outpatient claim in order to recover ancillary costs. The billing claim form will reflect the denied admission days as "non-covered days" and will be reimbursed at the prescribed outpatient rate.
- .14 During continued stay review prior to issuing a denial of admission or continued hospitalization the PRO shall attempt to contact the attending physician and discuss the need for hospitalization. The PRO decision shall be based on documentation contained in the medical record.
- .15 The documentation shall, at a minimum, meet all guidelines required under 42 C.F.R. Part 466, Part 473 and Part 476 (1992). The Department may fulfill these requirements or parts thereof through contract with the designated professional standards review organization as allowed under 42 C.F.R. 431.630, October 1992 edition. No amendments or later editions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following address, or may be examined at any State Publications Depository Library.

Manager, Office of Medical Assistance Colorado Department of Health Care Policy and Financing

1575 Sherman Street, Denver, Colorado 80203.

Documentation shall be sufficient to substantiate the nature and extent of services provided.

8.314 RETROSPECTIVE REVIEW

- .10 Retrospective review will be performed on a sample basis following the client's discharge from the hospital. Retrospective review will determine if the care provided was medically necessary, of adequate medical quality, and if the billing information provided to the fiscal agent was accurate.

Retrospective review may result in all or part of the stay being denied, and/or may affect the DRG assignment for the hospital stay. Retrospective review may result in recovery of all or part of the payment for a hospital stay. At the time of post-payment retrospective denial, the PRO will inform the provider that the Department will make an adjustment to recover the payment.

In the case of outliers (i.e., hospital stays exceeding a predetermined number of days), retrospective review may result in the denial of all or a portion of outlier days.

- .11 Retrospective review may be performed for the purpose of monitoring physician or hospital utilization patterns or it may be performed as a type of corrective action for an identified problem provider or client.

8.315 PREADMISSION REVIEW

- .10 Preadmission review may be conducted for elective rehabilitation hospital and rehabilitation distinct part unit admissions. The preadmission review process requires that at least 7 days prior to admission to the hospital, the client's attending physician shall contact the PRO and initiate a request for preadmission authorization. The attending physician shall contact the PRO and describe the client's condition. The coordinator shall review the information provided by the attending physician. If criteria for admission are met, the admission shall be approved by the PRO. The PRO shall notify the attending physician, the client, and the hospital in writing regarding the result of the review.
- .11 If criteria for hospitalization are not met, the PRO review coordinator shall refer the case to the PRO physician reviewer who shall review the documentation obtained and make a determination as to medical necessity for admission. The physician reviewer may contact the attending physician to discuss the case prior to issuing a denial notification. If an approved PRO preadmission review form is not available in the hospital admission office for any admission requiring preadmission review, and the admission is not specified as an emergency by the attending physician, the client shall be admitted at the financial risk of the hospital and physician.
- .12 Preadmission denial, or failure to obtain preadmission approval, may result in recovery of payment(s) made to the hospital and/or physician. Denial of payment may also result if the review did not occur when specified or if the information provided for review was not accurate.

8.316 SECOND OPINION REVIEW

- .10 Subject to Departmental approval, the PRO shall provide a second opinion review program for selected procedures. The hospital and/or physician shall be advised in advance of such required review. The second opinion process requires the client's attending physician to obtain a second opinion confirming medical necessity for the selected procedure (on either an inpatient or outpatient basis) in order for payment to be made by Medicaid to the physician and/or the hospital. Providers shall be advised of selected procedures by Medicaid Bulletin. Providers will be notified of changes in selected procedures. Whenever feasible, this notification will occur 60 days prior to the effective date of review.

- .11 Second opinion review may be performed in conjunction with preadmission review or independent of preadmission review.
- .12 Physicians wishing to schedule one of the selected procedures shall contact the PRO at least 2 weeks prior to the performance of the procedure. A PRO review coordinator shall review documentation from the physician to determine whether criteria for performance of the procedure are met. If criteria are not met then one of the following shall occur:
 - A. Review coordinator shall contact the client and provide him/her with the name(s) of physicians who shall be willing to provide a second opinion as to the medical necessity of the procedure and shall advise the attending physician of this action; or
 - B. Review coordinator shall refer the case to a physician reviewer for reviewer for consideration of the medical necessity of the procedure.
- .13 If a second confirming opinion is not obtained prior to the procedure being performed, and after review the procedure is found to be medically unnecessary, the Department will recover payment for that procedure and notify the provider. A Notice of Denial shall be provided to the client by PRO.
- .14 Documented emergency cases are exempted from this requirement.

8.317 PRIOR AUTHORIZATION REVIEW

- .10 Effective March 1, 1992, prior authorization review shall be performed by the PRO for all inpatient elective (non-emergent) care occurring out- of- state, all covered transplants (except corneal or kidney) or when extraordinary elective treatment and/or procedures are identified by the department. Hospital treatment and procedures requiring prior authorization are listed in provider bulletins. All documented emergency cases, regardless of location, are exempt from prior authorization, but are subject to PRO retrospective review.
- .11 The provider (not the client) shall contact the PRO by telephone, or in writing, and provide information required by the PRO concerning the patient's medical condition. Subsequent to the initial contact with the PRO, the provider shall also submit any additional information required to complete the prior authorization process.
- .12 When a request for prior authorization is received by the PRO, the registered nurse review coordinator (RNRC) shall conduct the prior authorization review, utilizing established PRO review screening criteria described in 8.317.15. The RNRC will have one working day to respond to the provider (physician or hospital) if the screening guidelines are met and the requested treatment/procedure is approved. If screening guidelines are not met, the RNRC must refer the case to a PRO physician reviewer (PR), who will conduct an independent medical evaluation, based on his/her professional medical knowledge and experience, and make a final determination. If PR review is required, the PRO shall have a maximum of five working days to respond to the provider.
- .13 When the prior authorization request is for out-of-state elective care or for covered transplants, the PRO shall notify the provider and the client of the determination within the same specifications for timeliness referred to in 8.317.12. For extraordinary elective treatment and/or procedures identified by the Department, the PRO shall send notification to the Department within five working days. The Department will then notify the provider and the client by telephone or by placing written notice in the mail no later than two days after notification is received from the PRO.
- .14 The prior authorization reconsideration and formal appeal process for clients is described in 8.318.15.

Provider appeals are addressed in 8.318.16 and in 8.050, Provider Appeals.

.15 PRO REVIEW CRITERIA

A state plan for medical assistance shall provide such methods and procedures as are necessary to guard against unnecessary utilization of care. For this purpose, the State is required to contract with a federally-approved utilization and quality control peer review organization (PRO). (Stipulations of the Social Security Act - Section 1902(a)(30)((A), (B), (C))). No later amendments to or editions of the Social Security Act are incorporated. Copies of these standards or portions thereof are available for public inspection during normal business hours and will be provided at cost from the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

PRO review screening criteria are developed by health professionals relying on professional expertise, prior experience, and the professional literature. These criteria are used to determine the quality, medical necessity, and appropriateness of a health care procedure, treatment or service under review. (Title 42 CFR, Part 466, Subpart A.) No later amendments to or editions of Title 42 CFR are incorporated. Copies of these standards or portions thereof are available for public inspection during normal business hours and will be provided at cost from the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

The PRO shall maintain review criteria development committees for the purpose of revising and/or developing review screening criteria to be utilized for the approval or denial of specific Medicaid benefits. Any new or revised criteria must be approved by the PRO Board of Directors, and shall be reviewed on an approximately yearly basis to assure continuing appropriateness. The Department shall also evaluate and approve all criteria used in the review of Medicaid services.

8.318 ADMINISTRATIVE DENIAL AND APPEAL PROCEDURES

.10 DENIAL AS A RESULT OF PREADMISSION AND PRIOR AUTHORIZATION REVIEW

A denial notification shall be issued by the PRO if justification for admission is not indicated from the documentation provided by the attending physician. A denial notification shall be provided to the attending physician and the client, which shall include the reason for the determination; a statement informing the parties and their representatives of their right to appeal the denial; the location, procedure, and time frame for filing an appeal request; and, a brief statement concerning the duties and functions of the PRO under the act.

.11 DENIAL AS A RESULT OF CONTINUED STAY REVIEW

During continued stay review a denial decision may not be made unless the PRO has made a reasonable attempt to contact the client's attending physician to discuss the review in question. If the PRO makes the decision to deny medical necessity of either admission or continued stay, the PRO shall provide a written notice of denial of Medicaid payment to the client (or next of kin, guardian, or sponsor, if the client is expected to be unable to comprehend the notice) to the attending physician or other attending health care practitioners, the hospital, and the Department. The notice shall include the reason for the denial, the date after which the stay in the hospital will not be approved as being medically necessary or appropriate, and those items specified under 8.318.10 above.

.12 DENIAL AS A RESULT OF RETROSPECTIVE REVIEW

- A. If upon review of the medical record the PRO physician advisor does not find justification for medical necessity for hospitalization, a Notice of Denial shall be issued to the client, attending physician and the hospital. The notice shall include those items specified under 8.318.10 above.
- B. The denial of medical necessity may result in denial and recovery of payment to the hospital and/or the physician. In the case of post-payment retrospective denial, the Department will proceed to recover payment upon notification of the denial decision by the PRO. Payment may be denied if review is being performed as a form of corrective action. The hospital and/or the physician shall not pursue collection from the client for the denied payment.

8.318.13 DENIAL AS A RESULT OF ADMINISTRATIVE ERROR

If a provider does not comply with the PRO request to provide required medical information within 30 calendar days, the claim will be denied and the provider will have an additional 30 calendar days to provide the required information. If after 60 calendar days the required information is not received, the PRO will notify the Department. Upon receiving this notice the Department will initiate recovery of payment and notify the provider.

.14 DENIAL AS A RESULT OF BILLING ERROR

During retrospective review, when the PRO identifies a billing error which has resulted in incorrect payment, the PRO will notify the provider that the Department will correct the billing information and adjust the payment.

.15 APPEALS OF PRO REVIEW DECISIONS

A. PRO Reconsideration Process

1. The reconsideration process available through the PRO is the first step in filing a formal client appeal. The client or his/her representative may initiate the process by contacting the PRO office. The attending physician or the hospital may appeal on the client's behalf. If the request for reconsideration is made within 24 hours or one working day of the issuance of the denial of admission or continued stay, and the client remains hospitalized, the PRO shall complete the reconsideration process within 24 hours of request.
2. The reconsideration process shall consist of an independent review of the medical record by one or more peer physicians who were not involved with the original denial decision.
3. Parties to the denial as stated above shall be notified verbally by PRO of the results of the reconsideration process. This shall be followed by a written notification.

B. Formal Client Appeal

1. A second step is available in the client appeal process, if the patient is dissatisfied with the decision of the PRO reconsideration panel. The patient or his/her representative may appeal to (the State Department of) General Support Services for a fair hearing before an independent State Administrative Law Judge. Appeals of prior authorization, preadmission or continued stay denials may be filed by the attending physician or the hospital only on behalf of the patient, as formal client appeals, and shall not duplicate appeals filed by the patient. A written request must be made to General Support Services of

Administration within 60 calendar days of the date of the PRO reconsideration panel notification. This written request may be filed with either:

- a. the PRO following instructions contained in the notification documents; or
- b. directly with General Support Services, Division of Administrative Hearings.

The PRO shall forward said appeal to General Support Services, Office of Administrative Courts, for hearing pursuant to Section 24-4-105, C.R.S.

2. The Administrative Law Judge shall conduct the hearing as provided in Section 8.058, STATE HEARINGS. S/he shall prepare and enter an Initial Decision which the State Department shall serve upon each party. The Office of Appeals of the State Department, as designee of the Executive Director, shall review the Initial Decision and enter a Final Agency Decision affirming, modifying, reversing, or remanding the Initial Decision.

If the Final Agency Decision is adverse to the patient, he/she, or his/her representative, shall have a right to judicial review pursuant to Section 24-4-106, C.R.S.

8.318.16 APPEAL OF RETROSPECTIVE DENIALS (PROVIDER APPEALS)

If payment to the provider for covered services rendered to an eligible client is denied due to failure to comply with provisions of the Medical Assistance Program, law and/or appropriate rules, the provider is precluded from collecting payment from the Medicaid client (8.012 Prohibition of Charges to Recipients). Federal regulations at Title 42 CFR Section 447.25, Acceptance of State Payment. No later amendments to or editions of 42 CFR Section 447.25 are included. Copies are available for public inspection during normal business hours and will be provided at cost upon request to the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

.17 DISCHARGE PLANNING

The PRO may perform such services as may be appropriate to assist the attending physician and the participating hospital in identifying, at the earliest reasonable opportunity during the eligible person's hospital stay, situations which may require discharge planning, and in planning for the eligible person's health needs after discharge, including but not limited to the recommendation of appropriate post-hospital accommodations.

.18 SELECTION OF REVIEW METHODOLOGY

The PRO, with Department approval, is responsible for determining the review methodology to be used for specific providers or specific procedures, and shall notify providers accordingly.

8.318.19 CORRECTIVE ACTION

- A. Corrective action shall be recommended when documentation is presented which indicates a chronic problem of inappropriate utilization or questionable quality of care. A decision regarding whether corrective action should be initiated shall then be made.
- B. Corrective action may include, but is not limited to: provider education, intensified review, required consultation, mandatory preadmission review, second opinion review, and retrospective review. The provider, and the client, when appropriate, shall be notified when corrective action is to be initiated.

Satisfactory resolution of the identified problem shall result in the corrective action being lifted. If corrective action does not result in resolution of the problem, sanction activity shall be initiated, as defined under the fraud and abuse section of the rules.

.20 AGENCY RECONSIDERATION

The Department may require the PRO to reconsider an initial review decision resulting in either approval or denial. In the case of a request for reconsideration the Department shall communicate the request within 15 working days of the review decision. Upon receipt of the Department's direction to reconsider, the PRO will convene a reconsideration panel to perform an independent review of the medical record by peer physicians who were not involved with the original decision. The PRO will communicate the findings of this reconsideration review to the attending physician, the hospital (if necessary), the client, and the Department within 15 working days of the request.

8.319 HOSPITALIZATION AND EXTENSIONS CONCERNING NEWBORN INFANTS

Medical assistance payments on behalf of the newborn shall extend only for the period of the mother's hospitalization with a single exception; that medical necessity exists for the infant to remain hospitalized. In such cases, the hospitalization for the infant certification and approval for additional days of hospital care, and to the infant's own eligibility for medical assistance following the mother's discharge.

Continued stay of healthy newborns for any other reason after the mother's discharge is not a benefit under the medical assistance program.

8.320 DIALYSIS

The Colorado Medical Assistance Program will provide payment for dialysis treatments to individuals who have established eligibility for public assistance purposes in Colorado. Such individuals must be eligible in all respects under the provisions of 8.100, et seq.

8.321 INPATIENT HOSPITAL (ACUTE DIALYSIS)

Payments may be made to licensed participating hospitals for the provision of dialysis treatments to an eligible recipient who is an inpatient of the hospital only in those cases where hospitalization is required for:

- A. An acute medical condition for which dialysis treatments are required; and
- B. Any other medical condition for which the Medical Assistance Program provides payment when the eligible recipient receives regular maintenance treatment on an outpatient dialysis program; and
- C. Placement or repair of the dialysis route ("shunt", "cannula").

8.322 OUTPATIENT DIALYSIS

Outpatient dialysis treatments are a benefit of the Medical Assistance Program when provided by a separate unit within a hospital or a free standing dialysis treatment center approved for participation by the Colorado State Department of Health Care Policy and Financing. A dialysis treatment center is defined as a health institution or a department of a licensed hospital, which is planned, organized, operated and maintained to provide outpatient treatment by means of dialysis and/or training for home use of dialysis equipment. Other conditions of participation are those entered into specifically in the agreement with the Department of Health Care Policy and Financing (Department).

.10 AUTHORIZATION FOR OUTPATIENT DIALYSIS

No payments shall be made on behalf of eligible recipients for the provision of outpatient dialysis treatments unless a physician licensed to practice in the State of Colorado certifies the medical need for regular chronic dialysis treatments exists.

Dialysis treatment centers or free-standing dialysis units shall permit the Department to review any records for Medicaid patients upon request.

.11 Payments for Medicaid outpatient dialysis shall continue when documentation certifies that outpatient dialysis treatment must continue because:

- A. training of the eligible recipient to perform self-treatment in the home environment is contraindicated; or,
- B. the eligible recipient is not a proper candidate for self-treatment in a home environment; or,
- C. the home environment of the eligible recipient contraindicates self-treatment; or,
- D. the eligible recipient is awaiting a kidney transplant.

8.323 HOME (CHRONIC DIALYSIS)

The high costs of dialysis treatments and the budgetary limitations of the Medicaid program require that all Medicaid patients be considered for the most cost efficient method of dialysis based upon their individual medical diagnosis and condition. Such treatments include home dialysis and peritoneal methods of dialysis.

The participating separate dialysis unit within a hospital or free-standing dialysis treatment center shall be responsible for the maintenance of all equipment and necessary fixtures required for home dialysis and provisions of all supplies.

8.324 PAYMENT FOR DIALYSIS TREATMENTS

.10 INPATIENT HOSPITAL

Payment for inpatient hospital dialysis treatment shall be included as part of the DRG rate.

.20 OUTPATIENT AND HOME TREATMENT

Any facility providing regularly scheduled outpatient or chronic dialysis treatments at a free-standing facility or billing for supplies necessary to perform the various types of home dialysis treatments shall apply for a separate Medicaid provider number from the fiscal agent. Such provider number shall be designated solely for the purpose of claims submission for dialysis services.

The amount of payment for regularly scheduled routine outpatient dialysis or necessary supplies to perform home dialysis treatments, when provided by a separate unit within a hospital or a free standing dialysis treatment center approved for participation by the Colorado State Department of Health Care Policy and Financing, shall be based on the lesser of the unit's specific Medicare rate or the Medicare composite rate ceiling.

The amount of payment for non-routine outpatient dialysis treatments, when provided by a separate unit within a hospital or free standing dialysis treatment center, shall be based upon the Medicaid fee schedule.

There is no reimbursement for home dialysis, only for supplies necessary to accomplish home dialysis.

8.325 REIMBURSEMENT FOR ALL ROUTINE AND NON-ROUTINE ANCILLARY DIALYSIS SERVICES

Ancillary services performed as part of the routine dialysis treatment shall be considered as part of the composite rate and billed on the UB-92 claim form.

Non-routine ancillary services performed outside the dialysis treatment shall be reimbursed separately and billed on the Colorado 1500 claim form. This claim form requires the provider use the appropriate HCPCS codes designated for the service provided.

8.325.10 Laboratory Services

All routine laboratory services performed by a dialysis treatment facility, with the designation as a certified clinical laboratory, or as a certified independent laboratory are included as part of the dialysis treatment reimbursement. All routine tests must be performed by the facility, with designation as a certified clinical laboratory, and reimbursed as part of the composite rate or performed by a certified independent outside laboratory and billed to the facility performing the dialysis treatment.

The following required procedures constitute routine laboratory services that are considered medically necessary. These laboratory tests are included as part of the dialysis service reimbursement.

Per Treatment

Hematocrit

Weekly

Prothrombin time for patients on anti-coagulant therapy Serum Creatinine

BUN

Monthly

HCT

Dialysate Protein

CBC Sodium

Potassium

CO₂

Serum Calcium

Specimen Collection

Serum Potassium

Total Protein

All Hematocrit and Clotting time tests

Monthly

Hgb

Alkaline Phosphatase

Magnesium

LDH

Serum Albumin

Serum Bicarbonate

Serum Chloride

Serum Phosphorous

SGOT

Drugs considered part of the routine dialysis treatment:

Heparin

Mannitol

Saline

Pressor Drugs

Antiarrhythmics

Protamine

Glucose

Dextrose

Antihistamines

Antihypertensives

Drugs considered non-routine:

Antibiotics	Anabolics
Hematinics	Sedatives
Analgesics	Tranquilizers
Muscle Relaxants	

Nonparenteral items may not be billed separately by the dialysis center, but may be billed directly to Medicaid by the supplier. Nonparenteral items administered during the dialysis treatment are reimbursed as part of the composite rate.

8.330 OUTPATIENT HOSPITAL SERVICES

Outpatient hospital services are those diagnostic, therapeutic, rehabilitative, preventive, and palliative items and services furnished by or under the direction of a physician to an eligible person who is an outpatient in a participating hospital. Routine and annual physical examinations are not a benefit of the program unless determined necessary based on medical necessity. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals. Outpatient hospital services are a benefit of the Modified Medical Plan.

8.331 DEFINITIONS

“Outpatient” means a patient who is receiving professional services at a participating hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-a-day basis.

“Diagnostic services” means any medical procedures or supplies recommended by a physician within the scope of his/her practice under state law, to enable him/her to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

“Rehabilitative services” mean any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

“Preventive services” mean services provided by a physician within the scope of his/her practice under state law to: (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and, (3) promote physical and mental health and efficiency.

“Palliative services” mean any medical services recommended by a physician within the scope of his/her practice under state law, for the purpose of affording a recipient relief from the symptoms of a condition or disease.

“Therapeutic services” means any medical service provided by a physician within the scope of his/her practice under state law, in the treatment of disease.

8.332 PAYMENT

Outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare charge to cost ratio percent less 28 percent (28%). A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Outpatient hospital services which are defined as experimental by the Medicare program are not a benefit of the Medicaid Program. Outpatient hospital services which are not a covered benefit of the Medicare program are not a benefit of the Medicaid program. Extraordinary situations, based upon PRO

recommendation and Department approval, will be reviewed for exception to these benefit limitations.

The published standards of the Department of Health and Human Services which comprise the Medicare benefits and exclusions described above are based upon 42 USC 1395y, 42 CFR Part 409, October 1991 edition, and the Medicare Intermediary Manual/Claims Processing/Part 3. No amendments or later editions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Foundation for Medical Care P.O. Box 17300 1260 S. Parker Rd. Denver, Colorado
80217-0300 or

Manager, Health and Medical Services Colorado Department of Social Services 1575 Sherman
St. Denver, Colorado 80203

OUTPATIENT CLINICAL LABORATORY TESTS

Medicaid reimbursement for clinical diagnostic laboratory tests performed by certified outpatient hospital clinical laboratories may not exceed 60 percent (60%) of the Medicare prevailing charge fee schedule or the Medicaid fee schedule, whichever is lower.

OUTPATIENT ANATOMICAL LABORATORY TESTS

Outpatient anatomical laboratory tests are reimbursed on an interim basis from the Medicaid fee schedule. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost, or Medicaid fee schedule.

8.332.10 OUTPATIENT PREPROCEDURE AND PRETREATMENT REVIEW

The purpose of preprocedure review and pretreatment review is to confirm the medical necessity and the appropriateness of the selected outpatient procedures and treatments. The PRO shall provide, upon direction from the Department: 1) a preprocedure review program for selected outpatient surgical, medical and radiographic procedures; and 2) a pretreatment review for planned outpatient psychiatric and substance abuse disorder treatments. Physicians and hospitals shall be advised, in advance of selected procedures and treatments requiring PRO review by Medicaid Bulletin.

The purpose of preprocedure review and pretreatment review is to confirm the medical necessity and the appropriateness of the selected outpatient procedures and treatments. The PRO shall provide, upon direction from the Department: 1) a preprocedure review program for selected outpatient surgical, medical and radiographic procedures; and 2) a pretreatment review for planned outpatient psychiatric and substance abuse disorder treatments. Physicians and hospitals shall be advised, in advance of selected procedures and treatments requiring PRO review by Medicaid Bulletin.

.11 OUTPATIENT PREPROCEDURE REVIEW PROCESS

Upon direction from the Department the preprocedure review process shall involve the following procedures: A physician planning to perform one of the selected outpatient surgical medical and radiographic procedures which requires preprocedure review must contact the PRO at least 2 weeks prior to admission and provide the required information relative to the scheduled procedure. A PRO RN Review Coordinator (RNRC) will review the information from the physician to determine whether or not criteria for the procedure are met. If criteria are met, then the RNRC will confirm the procedure. If criteria are not met, then the following will occur:

A. The RNRC will refer the case to a Physician Reviewer (PR) for consideration of the medical

necessity and appropriateness of the planned procedure.

- B. If the PR does not confirm the plan of care, then the RNRC will contact the patient and provide him/her with the names of two physicians who are willing to provide a second opinion as to the medical necessity and appropriateness of the planned procedure. If the second opinion physician confirms the procedure, then the review process is complete. The PRO will notify the patient, the attending physician, and the hospital of the outcome of this action.
- C. If the second opinion does not confirm the planned procedure, then the patient may request a third opinion. When the request is received, the RNRC facilitates the third opinion as described in the preceding paragraph.
- D. If the third opinion confirms the procedure, then the review process is complete. The PRO will notify the patient, attending physician, and the hospital as above. If the third opinion physician does not confirm the procedure, then the review process is complete and the procedure is not confirmed. The PRO will notify the patient, the attending physician, and the hospital.

8.332.12 OUTPATIENT PRETREATMENT REVIEW PROCESS

Upon direction from the Department, the pretreatment review process shall involve the following procedures: A physician planning to treat one of the selected psychiatric or substance abuse disorders in an outpatient setting must contact the PRO within 2 weeks for approval of the treatment plan and to provide the PRO the required information relative to the current patient status. A PRO RN Review Coordinator (RNRC) will review the information provided to determine whether or not criteria for the planned treatment are met. If criteria are met, then the RNRC confirms the plan for care. If the criteria are not met, then the RNRC will refer the case to a PRO Physician Reviewer who will use his/her best medical judgement to decide whether or not the plan of care is appropriate and demonstrates medical necessity. If he/she agrees with the plan of care, then he/she will approve the planned treatment. If he/she does not agree with the plan of care, then the treatment is denied. The PRO will notify the patient and attending physician of the denial, including the procedure for appeal.

- .13 Denial and appeal as a result of outpatient pretreatment review shall be processed as described in 8.318.10 through 8.318.18.
- .14 It is assumed that emergency care for the selected psychiatric/substance abuse disorders would be treated in the acute care setting.
- .15 OUTPATIENT PREPROCEDURE AND PRETREATMENT REVIEW PAYMENT

Unless specifically approved by the Department, providers will receive NO reimbursement for outpatient claims submitted for payment where appropriate PRO review is not obtained by the facility or when the required PRO review is not documented appropriately.

Documented emergency care is exempt from the second opinion and pretreatment review process. All emergency care may be reviewed retrospectively by the PRO to validate the medical necessity and appropriateness of the procedures or the treatments performed.

8.333 OUTPATIENT PSYCHIATRIC SERVICES

8.333.10 DEFINITION OF OUTPATIENT AND CLINICS

- 1. Outpatient Psychiatric hospital services mean preventive, diagnostic, therapeutic, rehabilitative, or

palliative services that:

- (a) Are furnished to outpatients;
- (b) Are furnished by or under the direction of a physician; and
- (c) Are furnished by an institution that:
 - (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
 - (ii) Meets the requirements for participation in Medicare.

2. Clinic outpatient psychiatric services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

- (a) Are provided to outpatients;
- (b) Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and
- (c) Are furnished by or under the direction of a physician.

8.333.20 EVALUATION

1. Effective September 13, 2002, 10 C.C.R. 2505-10, Section 8.333.10 shall not apply to recipients enrolled in and receiving mental health services through the Mental Health Capitation Program.
2. An intake evaluation for any recipient entering an organized program or course of psychiatric treatment shall be completed. Evaluation is defined as a written assessment that evaluated the recipient's mental condition, and based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate. The evaluation team shall include a physician and an individual experienced in diagnoses and treatment of mental illness. The evaluation team shall certify that the program is appropriate to meet the recipient's treatment needs and shall be made part of the medical records.

8.333.20 EVALUATION (Continued)

3. The evaluation team shall periodically review and update the recipient's Plan of Care (PoC) (as defined in 8.333.30) in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team shall perform such reviews every 90 days and the reviews shall be documented in detail in the patient records, kept on file and made available as requested for State or Federal audit purposes.

Audits for the purpose of medical necessity for the services rendered shall be conducted by the Department of Health Care Policy and Financing or its designee.

8.333.30 DOCUMENTATION

1. Each recipient receiving outpatient psychiatric services in an outpatient or clinic setting shall have an individual, written, Plan of Care (PoC), designed to improve the patient's condition to the point that participation in the program is no longer necessary. Treatment objectives must be included in the PoC and a description of:

- a. The treatment regimen: The specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives;
 - b. A projected schedule for service delivery: This includes the expected frequency and duration of each type of planned therapeutic session or encounter; the type of personnel that shall be furnishing the services; and a projected schedule for completing re-evaluations of the patient's condition and updating the PoC;
 - c. Re-evaluations of treatment objectives that shall be scheduled no less than once every six months; and
 - d. The written PoC which shall be developed and be entered into the patient's record prior to any billings for service being submitted for reimbursement.
2. The outpatient program shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, shall consist of material which includes:
 - a. the specific services rendered;
 - b. the date and actual time the services were rendered;
 - c. who rendered the services;
 - d. the setting in which the services were rendered;
 - e. the amount of time it took to deliver the services;
 - f. the relationship of the services to the treatment regimen described in the PoC;
 - g. updates describing the patient's progress.

Clinics that are licensed by Department of Human Services, Mental Health Services are exempt from the above specific documentation standards and shall be required to adhere to the documentation standards required by the licensing authority. But deviations shall be documented in the medical record. For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC shall be documented in the patient's record. Similarly, a detailed explanation, shall be documented for a medical or remedial therapy session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

If the documentation standards required above are not met, that service is subject to recoupment and/or State and Federal administrative or civil action.

8.333.40 REIMBURSEMENT

Outpatient hospitals and clinics shall bill on the appropriate claim forms to receive reimbursement.

8.340 GRADUATE MEDICAL EDUCATION (GME) AND DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS TO HOSPITALS FOR MEDICAID MANAGED CARE

Effective for inpatient discharges and outpatient dates of service after October 1, 1997. graduate medical education (GME) costs for Medicaid managed care clients shall be paid directly to qualifying hospitals.

rather than to managed care organizations (MCOs).

8.341 GME for Medicaid Managed Care - Inpatient Services

- .10 The hospital cost report used for the most recent rebasing shall be used to determine the Medicaid inpatient GME cost per day for each hospital that has graduate medical education costs in its fee-for-service base rate. Each hospital's GME cost per day shall be computed when hospital rates are recalculated each year.
- .20 MCOs shall provide to the Department inpatient days, by hospital, for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
- .30 The Medicaid managed care inpatient days for each hospital shall be the total of the inpatient days for each hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the inpatient GME reimbursement for each hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each hospital by June 30th of each year.
- .40 MCOs other than Mental Health Assessment and Services Agencies (MHASAs) shall provide to the Department inpatient days, by hospital, for discharges from October 1, 1997 through December 31, 1997. This data shall be used for the purpose of calculating the GME reimbursement for the first partial year covered under this new methodology. (MHASA days are not included for this partial period since GME was still included in the payment to MHASAs.) If the MCOs are unable to provide this data by April 30, 1998, the reimbursement will be calculated using one quarter of the MCO inpatient hospital days at each hospital for the 1997 calendar year. This initial inpatient GME payment to hospitals shall be made by June 30, 1998.

8.342 GME for Medicaid Managed Care - Outpatient Services

- .10 The hospital cost report used for the most recent rebasing shall be used to determine the outpatient GME cost to charge ratio for each hospital that has a graduate medical education program. Each hospital's GME cost per day shall be computed when hospital rates are recalculated each year.
- .20 MCOs shall provide to the Department outpatient charges for Medicaid clients, by hospital, for outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
- .30 The Medicaid managed care outpatient charges for each hospital shall be the total of the outpatient charges for each hospital received from the MCOs for each quarter. That total shall be multiplied by 72 percent of outpatient charges to determine the outpatient GME reimbursement for each hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each hospital by June 30th of each year.
- .40 MCOs other than MHASAs shall provide to the Department outpatient charges, by hospital, for outpatient dates of service from October 1, 1997 through December 31, 1997. This data shall be used for the purpose of calculating the GME reimbursement for the first partial year covered under this new methodology. (MHASA charges are not included for this partial period since GME was still included in the payment to MHASAs.) If the MCOs are unable to provide this data by April 30, 1998, the reimbursement shall be calculated using one quarter of the outpatient hospital charges at each hospital for the 1997 calendar year. This initial inpatient GME payment to hospitals shall be made by June 30, 1998.

8.350 PAYMENT OF HOSPITAL COSTS FOR NON-PPS PROVIDERS AND UNITS

This section provides the method by which the payment rate for costs of medical care provided by exempt providers to eligible clients shall be determined. This method shall be referred to as “The Hospital Rate System.”

In summary, these rules provide that:

- a. For exempt (non-PPS) providers, the rate of payment for services rendered during the twelve month period corresponding with the State's fiscal year (7/1 – 6/30) shall be determined and agreed upon by both the provider and the Department of Health Care Policy and Financing.
- b. For exempt (non-PPS) providers, the prospective rates may be established in accordance with the established accounting principles and regulations utilized for the determination of reimbursement to providers as provided for by Title XVIII, with the exception that prospective rather than historic expenses will provide the basis for payment. Title XVIII regulations shall be utilized as guidelines. This method of payment will not exceed that produced under available Title XVIII methods of apportionment of such costs.
- c. The establishment of prospective rates shall be supported by current and predicted costs derived through an appropriate budget and accounting system.
- d. Absolute and comparative performance measurements shall be based upon the direct costs of patient care which shall include approved research projects and educational activities only. In addition, any comparative evaluations shall reflect the provider's size, geographic location, and scope of services.
- e. In order to provide incentives for the efficient and economical utilization of provider resources, the payment rate agreed upon by provider and the Department of Health Care Policy and Financing shall be neither retroactively increased to reflect unforeseen patient costs nor retroactively decreased as a result of efficient provider operation. However, gains accruing to the provider as a result of a suspension of those patient services which were included in the setting of the prospective rate may be subject to a reduced adjustment.
- f. Provision is made for the Department to consider establishing a mechanism for determining emergency adjustments of prospectively determined rates.
- g. Provision is made for the Department to consider establishing a mechanism of administrative review of any prospective rate which cannot be agreed upon by the Department of Health Care Policy and Financing and provider.

8.351 METHODS FOR DETERMINING RATES FOR EXEMPT PROVIDERS

.10 As used in this section, 8.351, unless the context otherwise requires, the following definitions shall apply:

- (1) “Add-ons” - This consists of a significant increase in a budgeted departmental cost that exceeds the consumer price index (CPI) and which can be justified on the basis of being a new or expanded service, a price increase, or case mix change. It is understood that rate modifiers, as described in the consent decree, are considered to be synonymous with add-ons. Further details regarding add-ons are found in the consent decree.
- (2) “Consent Decree” - Settlement of Colorado Hospital Association, et al. v. State of Colorado, et al., D.C. Colorado, 76-F, 140, December 13, 1977. These rules, as modified by the consent decree, are applied in determining rates for Medicaid provider hospital.
- (3) “Retroactive” - Increases incurred in years prior to the budget year. Exception: the

Department may consider add-ons incurred in the current (most recent contract) year if such expenses were unforeseen and therefore not budgeted. Increases which were budgeted but not requested will not be considered as retrospective add-ons.

- (4) "Significant Increase" - An increase in the cost of goods and services over the CPI which results in a minimum increase of \$.20 per diem or \$2,000 per year in total inpatient Medicaid payment, based on the most recent annual Medicaid days.

.20 The provider shall submit an approved budget which provides the basis for any add-ons requested prior to the submission of same to the Department of Health Care Policy and Financing. All information supplied by provider is deemed to be confidential.

a. The provider's proposed budget shall be submitted 60 days prior to the beginning of the State's fiscal year and shall be accompanied by the add-on request, where applicable. If an approved budget is not available May 1, the provider shall not submit an interim budget. No penalty is imposed for late budget submittal other than a possible delay in the effective date of a new rate. No per diem can be offered until an approved budget is received. The add-on request shall be accompanied by all required documentation. Documentation shall be sufficient to prove the merits of the add-on, including its relation to patient care as defined by Medicare. The Department reserves the right to request any additional information considered necessary to justify the add-on request. Provider shall propose a prospective payment rate for the next operating period. No add-ons requests shall be accepted after August 1.

b. If no add-on requests accompany the approved budget, the Department shall offer the hospital a rate computed by applying the appropriate CPI to the provider's previous contract rate.

The participation agreement shall become effective on the date of receipt by the Department or the beginning of the State's fiscal year, whichever is later.

c. The CPI used shall be the CPI W-U.S. for the 12 month period ending 90 days prior to the beginning of the State's new fiscal year.

d. If add-ons are requested, the two parties can begin negotiations. Should it appear that no agreement can be reached before the beginning of the State's fiscal year, the CPI rate will be offered. When accepted, then a participation agreement for the CPI increase only shall be signed to become effective on the date of signature or the State's fiscal year, whichever is later, and shall remain effective until such time as it is replaced by a participation agreement for a final rate based upon approved add-on requests.

e. Negotiations with respect to add-ons may continue as follows: If there is no agreement with respect to the add-ons within 60 days from the beginning of the State's fiscal year (July 1), the provider shall receive written notice from the Department that it is required to proceed within the scope of the following four options.

(1) Sign a participation agreement for the Department's offer;

(2) File a request for a rate review board hearing. Whatever rate is then decided upon would become effective the date the contract is signed, or such other date, as recommended by the rate review board and approved by the Executive Director.

(3) Continue to negotiate for an additional 20 days (to Sept. 18). A final offer shall be issued by the Department on or before 10 days (to September 28). The provider shall either sign a contract or request rate review. Rate review shall be requested within fifteen (15) days (to October 13). If rate review is requested after October

13 it shall be denied; or

(4) Withdraw from participation in the Medicaid Program.

- f. A provider and/or the Department of Health Care Policy and Financing shall be able to request changes in rates when major events that have a fiscal impact occur which were unpredictable or were uncontrollable by the provider and which would require a rate change to meet the financial requirements of the provider.

The Department of Health Care Policy and Financing shall act upon such a request within a thirty-day period after receipt of the request.

- g. A possible basis for denial of add-ons includes, but is not limited to: projects which do not foster cost containment and which do not improve patient care, in accordance with Medicare regulations, or projects which would significantly increase a hospital's per diem in excess of that of its peers, or projects which are not required as a medical necessity. Return on equity and increases in hospital property costs caused by re-evaluation of assets are not allowable add-ons. Retroactive issues shall not be considered for add-ons in the prospective budget year.

8.352 REVIEW PROCEDURES CARRIED OUT BY THE DEPARTMENT

Upon receipt of materials from providers, the Department of Health Care Policy and Financing shall:

Review submitted material for completeness and request additional information if necessary.

Review cost components of the rate to determine significant changes, i.e., addition or deletion of departments determine changes in rates resulting from such additions or deletions.

Equate the proposed expenses/rate with prior rate by removing or adding the expenses of the departments in question.

Review the components of the proposed rate. Salary, other supplies and expense, professional fees shall be evaluated for their change as related to appropriate wage and price indices.

Approve the rate if the changes fall within limits defined above.

Review additional information as provided. Approve as a result of extenuating circumstances or disapprove request.

Calculate a counter proposed rate on all rates which are disapproved.

8.353 RATE REVIEW BOARD

- .10 The Rate Review Board shall consist of six (6) members who shall be appointed by the Executive Director, Department of Health Care Policy and Financing, and shall serve thereon at the pleasure of said Executive Director. Three of the said six (and three alternate members) members shall be members of the staff of the Department of Health Care Policy and Financing. Three of the said six (and three alternate members) members shall be selected from the membership of the Colorado Hospital Association. The total membership of the Board shall be seven (7) members. Such seventh member (and one alternate for said seventh member) shall be selected by the six above said and duly appointed members from candidates submitted by any such member or any other person making known his desire for such membership.

- .20 The principle function of the Rate Review Board shall be to assist the Department of Health Care

Policy and Financing in determination of rates to be paid individual hospitals as described and set forth in these rules.

.30 The board also shall function in performing administrative reviews as set forth in 8.354.

8.354 ADMINISTRATIVE REVIEW

A request for rate review board hearing (see 8.351.20) shall necessitate the following steps:

- a. The Department of Health Care Policy and Financing shall designate, within a period of thirty (30) days, a date upon which provider may appear before the Department of Health Care Policy and Financing Hospital Rate Administrative Review Board. Such appearance date shall not be later than sixty (60) days following the request for hearing unless otherwise agreed to by the hospital and the Department.
- b. The Board shall not consider any evidence of add-on requests that were denied because of noncompliance with the rules of the Department. The Board shall be bound by the rules and regulations of the Department in its deliberations and recommendations to the Executive Director.
- c. Provider shall place before the Board evidence it deems to be good and sufficient to warrant purchaser's acceptance of the proposed rate. Department of Health Care Policy and Financing shall, at the same time, state evidence it deems good and sufficient to warrant acceptance of the counter proposal. All review shall be open to the public and shall be conducted informally insofar as an orderly presentation will permit. The Board shall only consider evidence presented or introduced at the review which is within the scope of the rules of the Department. A full and complete record shall be kept of the proceedings. Cost of attendance shall be borne by the provider.
- d. For purposes of conducting reviews, five (5) members of the Board constitute a quorum, one of whom must be the chairman or vice chairman. No Board member shall hear any matter in which he has an interest, nor shall he represent either party at the review. Either Department of Health Care Policy and Financing or the subject provider may challenge any Board member in writing, served upon the Board Chairman five (5) days in advance of any scheduled review, and if the Board shall find merit in the challenge, it shall excuse the challenged member.
- e. Within thirty (30) days after the review, the Review Board shall render its decision, in writing, to both parties. The rate designated by the Review Board shall be recommended to the Executive Director for his consideration. The Executive Director shall issue a final decision to the provider within thirty (30) days after receiving the Rate Review Board's recommendations. A final offer based on this decision shall be made to the provider within seven (7) days after the decision has been issued. Copies of such decision shall be kept on file by the Board.
- f. Department has exclusive right to set rates for hospital vendors. Department may allow vendors to request adjustments in rates as provided herein. The Medical Services Board may, in its discretion, review rates. A vendor has no vested right to participate in the Medicaid program. Any vendor by applying to participate agrees to accept the rate determined after the procedures set out herein, and should he not be able to accept the rates so determined, shall withdraw from participating. In such an event, if the negotiations have extended into the vendor's new fiscal period, final settlement for services provided during such new fiscal period shall be on the basis of 90 percent of allowed charges.

8.355 FORMS TO BE USED CONCERNING THE PAYMENT RATE FOR HOSPITALS

The instructions set forth in 8.350 – 8.355.10 et seq. are designed to allow Colorado hospitals to prepare an estimate of per diem patient costs in their next fiscal year in accordance with Section 8.351 through

8.355.80.

These instructions are designed to be used by those hospitals which currently do not prepare budgets. They are not complete, in the sense that they do not provide for the budgeting of either patient revenue or capital expenditures, but instead concentrate only upon hospital expenses and adjustment to expenses.

.10 PATIENT DAY STATISTICS

- .11 The purpose of this form is to establish a level of service for the hospital's budget year. Specifically, the level of service shall be considered as the number of patient days that are anticipated in the next year.
- .12 The form provides for the patient days by month for the current and budget years for up to seven patient categories and nursery. The categories of patient type are neither meant to be all inclusive nor are they meant to be mandatory. No doubt many hospitals do not have their patient statistics kept in this manner. A minimum breakdown of patient days, however, shall be by Nursery and Other.
- .13 In the space provided in "Current Year", enter by month the patient days, broken down into as many categories as possible. This information should be available from medical records for the current year through the end of last month. Then, using knowledge of existing medical trends, and both recent and anticipated changes in the community, changes in the hospital facilities, or other items which would affect the level of hospital service, such as seasonal trends, predict by month the number of patient days for the remainder of the current year and for the budget year. The estimate shall be broken into the same categories as the existing statistics.
- .14 Total each column and row ("foot" and "crossfoot").

8.355.20 PAYROLL BUDGET WORKSHEET

- .21 This form may be used, if desired, to estimate the amount of the salaries to be paid in the budget year. This form need not be returned to the Department. By Department, list each full-time employee and then each part-time employee. Leave several spaces after each department.
- .22 From each employee's earnings record, enter in column 4 the earnings paid to date. From the number of pay periods remaining in the year, estimate each employee's earnings for the rest of the year and enter this in column 5. Be certain to reflect that each employee may have been given a raise or will soon receive one in the calculation of the remaining wages.
- .23 If additional employees are to be added before year end, enter their position description in column 2, and in column 3 enter their start date, the number of pay periods they are expected to be employed through the rest of the year, and their expected annual earnings. In column 4, enter the wages to be paid that employee. Place an asterisk by those positions which are new. The cross total of columns 4 and 5 should be placed in column 6.
- .24 Total columns 4, 5 and 6.
- .25 For each position listed at year end, determine the increases, if any, that will be paid in the budget year. For example, recognize that a \$100 merit increase which is due halfway through the year will only cause a \$50 increase in earnings. For all positions which have not been newly created this year, add columns 6, 7 and 8 across to determine the budget

year wages (column 9). For those positions which have been added this year (not new employees filling existing positions), add the estimated annual wages entered in column 3 to columns 7 and 8 to obtain budget year wages.

- .26 For each new position, if any, to be created in the budget year, enter the position description in column 2, and in column 3, enter the start date, number of pay periods, and estimated annual earnings for the position. Enter the anticipated wages to be paid the employee in column 9.
- .27 Total columns 7, 8 and 9.
- .28 In columns 10 and 11 respectively, enter 5.2% of column 9 not to exceed \$468, and enter 3.1% of column 9 not to exceed \$130. Total columns 10 and 11.

8.355.30 PAYROLL SUMMARY

From the Payroll Budget Worksheet, enter the estimated wages to be paid in the current year and the wages expected in the budget year. Also enter the number of employees expected at the end of both the current and budget year.

Total columns 2 through 5.

8.355.40 SUPPLIES AND SERVICES

- .41 This form shall be used for all expenses other than payroll and payroll taxes, and medical professional fees.
- .42 In column 2, enter the expenses corresponding to the description in column 1 for the year to date. In column 3, estimate the expenses for the remainder of the year. This may be done in either of two ways. If the first portion of the year has been representative of the year's activity, annualize the rest of the year, i.e., if nine months of actual expenses have been recorded, place the figure 1.33 (12/9) in column 3 and multiply column 2 by 3 to obtain the year's expense (column 4). If activity in the first portion of the year has not been representative, either because expenses have been too high or there is an unusual expense still to be incurred, estimate the remaining expense based upon the particular situation. Add columns 2 and 3 for those expenses which were not annualized and place the total in column 4.
- .43 Based upon historic trends and upon the forecast of patient days, estimate the expenses for the budget year, and place them in column 5.

8.355.50 MEDICAL PROFESSIONAL FEES

Procedures for completion of this form should correspond to those for completing Worksheet C - Supplies and Services.

8.355.60 ADJUSTMENTS TO EXPENSES

The captions and the intent of this form correspond to the captions and the intent of schedules A-5 of Form SSA-1562. The procedure for completing this form is the same procedure used in Worksheet C and Worksheet D.

8.355.70 YEAR EXPENSE SUMMARY

Two forms should be submitted, one for the current year, and one for the budget year, identify by

lining out "budget" or "current" as applicable. Enter by department, in Columns 2 through 5, the expenses calculated for the applicable year. These expenses come forward from Schedules B-1, C, and D. Enter the total of Columns 2 through 5 in Column 6. Enter the adjustments from Worksheet E in Column 7 and subtract Column 7 from Column 6 to obtain net expenses.

8.355.80 HOSPITAL EXPENSE SUMMARY

Figures for the current year and the budget year carry forward from Columns 8 of Schedules F.

8.355.90 Modification of payment to exempt non-prospective payment (non-PPS) hospitals (including free-standing psychiatric hospitals) effective with dates of services on or after December 15, 1989.

1. For purposes of payment, exempt hospitals will not be considered to be in any of the peer group categories developed for prospective payment system (PPS) hospitals. Exempt hospitals (including free standing psychiatric hospitals) will be paid a per diem for inpatient hospital services. Exempt hospitals and exempt units are also eligible for the major teaching hospital and disproportionate share payments as described in 8.356.20.
2. Effective for dates of service on or after July 1, 1991, exempt hospitals will receive modifications to per diem rates via the add-on development process described in 8.351 through 8.355. The maximum amount of any rate increase granted to a facility's per diem rate shall be a 7% annual limit.
3. In July 1993, the maximum amount of any add-on granted to a facility's per diem rate shall be no more than the weighted average increase in the base rates of participating PPS hospitals. This exemption from the 7% annual limit shall be in effect only for state fiscal year 1994 and for every third year thereafter when PPS base rates are recalculated.
4. An exempt hospital advisory committee will be convened by the department, consisting of representatives of the department and the hospital industry, to include but not be limited to:
 - a. representatives of psychiatric facilities,
 - b. representatives of state facilities,
 - c. the Colorado Hospital Association.

The purpose of this committee is to advise the department on issues related to future modification to the rate structure and other issues of relevance to non-PPS inpatient hospital financing and delivery of health care services. The department will attempt to assure statewide geographic representation in the selection of committee members.

8.356 PAYMENTS FOR IMPATIENT HOSPITAL SERVICES

.10 General Provisions

The payment method described in this section will apply to all Colorado participating hospitals, effective with dates of service on or after December 15, 1989 (unless otherwise specified).

.20 Definitions

1. **Diagnosis Related Group (DRG):** A patient classification that reflects clinically cohesive groupings of inpatient hospitalizations that utilize similar amounts of hospital resources.

The Medicare grouping methodology will be used as a base for the DRG payment system. The Department has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid.

2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the client's admission to the hospital.
3. Relative Weight: A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases: Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The Department shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.
4. Base Rate:

An estimated cost per Medicaid discharge.

For PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by reducing the Medicare base rate by a set percentage equally to all PPS Hospitals. This percentage will be determined by the Department based on the available funds appropriated by the General Assembly.

For the purpose of rate setting effective on July 1 of each fiscal year, the Medicare base rate used will be the Medicare base rate effective on October 1 of the previous fiscal year adjusted for inflation. For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty Medicaid discharges in the previous fiscal year, the Medicare base rate used will be the average Medicare base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty Medicaid discharges in the previous fiscal year. The inflation factor will be the CMS hospital market basket index used to inflate the Medicare base rates relative to the fiscal year for which the Medicaid base rates are effective.

Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge for Nursery, Neo-Natal Intensive Care Units, and Graduate Medical Education.

Pediatric Specialty Hospitals may receive an additional adjustment factor to account for the specialty care provided. This adjustment factor will be determined by the Department during the rate setting process.

For PPS Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate will be set as a cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal

year. This Medicaid base rate may be adjusted by an equal percent for all hospitals within the peer group. This percentage will be determined by the Department as required by the available funds appropriated by the General Assembly. Beginning April 1, 2004, acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries shall receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.

Hospital specific Medicaid base rates are adjusted annually (rebased) and are effective each July 1. The Medicaid base rate will be adjusted during the fiscal year, if necessary to adjust for appropriations available to the Department. Providers will be notified of the Medicaid base rate and any adjustment factors 60 days prior to any modifications.

5. Exempt Providers and Units: Those hospitals and units within hospitals which are designated by the Department to be exempt from the DRG-based prospective payment system (PPS).

The Department may designate facilities as exempt or non-exempt providers. Non-exempt providers shall be reimbursed using the DRG-based prospective payment system (PPS).

6. Hospital Peer Groups: The grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups are defined as follows:

- a. Pediatric Specialty Hospitals: All hospitals providing care exclusively to pediatric populations.
- b. Rehabilitation and Specialty-Acute Hospitals: All hospitals providing rehabilitation or specialty-acute care (hospitals with average lengths of stay greater than 25 days).
- c. Rural Hospitals: Colorado hospitals not located within a federally designated metropolitan statistical area (MSA).
- d. Urban Hospitals: All Colorado hospitals in MSAs, including those in the Denver MSA. Also included would be the rural referral centers in Colorado, as defined by HCFA. 42 U.S.C. Section 1395 WW(D)(5)(C)(I), 42 C.F.R. Sections 412.90(C) and 412.96.

Facilities which do not fall into the peer groups described in a. will default to the peer groups described in b. through d. based on geographic location.

7. Outlier Days: The days in a hospital stay which occur after the trim point day. The trim point day is that day which would occur 1.94 standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations will be adjusted to maintain budget neutrality when changes are made to the DRG payment system. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.
8. Major Teaching Hospital Allocations: Effective October 1, 1993, hospitals shall qualify for additional payment when they meet the criteria for being a major teaching hospital, and when their Medicaid days combined with indigent care days (days of care provided under Colorado's indigent care program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available.

a. Criteria

A major teaching hospital is defined as a Colorado hospital which meets the following criteria:

1. maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s.
2. maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed.
3. meets the department's eligibility requirement for disproportionate share payment.

b. Payment Formula

The additional major teaching payment rate is calculated as follows:

$$\text{MTHR} = ((\text{ICD} + \text{MD})/\text{TPD}) \times \text{MIAF}$$

where:

MTHR = major teaching hospital rate

ICD = indigent care days

MD = Medicaid days

MIAF = medically indigent adjustment factor

<u>I/R FTE's (7/1/91 to 6/30/92)</u>	<u>MIAF</u>
110 to 150	1.1590
151 to 190	1.4909

Payment calculation for hospitals which qualify for the additional major teaching hospital payment shall be as follows:

- a. Based upon data available at the beginning of each fiscal year, Colorado shall determine each hospital's ICD, MD and TPD. ICD will be extracted from the most recent available Colorado Indigent Care Program interim report to the Colorado General Assembly, submitted by the University of Colorado Health Sciences Center. MD and TPD will be extracted from the most recently available Colorado Acute and Rehabilitation Hospital Utilization Data Report of the Colorado Hospital Association. In addition, each hospital's Medicaid payment for the previous fiscal year shall be estimated.
- b. Multiply the Medicaid payment by the calculated MTHR to determine the additional major teaching hospital payment.
- c. Payment shall be made monthly.

9. Disproportionate Share Hospital Adjustment:

- a. Federal regulations require that hospitals which provide services to a disproportionate

share of Medicaid recipients shall receive an additional payment amount to be based upon the following minimum criteria:

- 1) Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and
- 2) A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.

In the case where a hospital is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

- 3) Number 2) above does not apply to a hospital in which:

- a) the inpatients are predominantly under 18 years of age; or
- b) does not offer non-emergency obstetric services as of December 21, 1987.

The Medicaid inpatient utilization rate for a hospital shall be computed as the total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.

The low income utilization rate shall be computed as follows:

- a) The fraction (expressed as a percentage)

(I) the numerator of which is the sum (for a period) of (i) total revenues paid the hospital for patient services under a State Plan under this title and (ii) the amount of the cash subsidies for patient services received directly from state and local governments, and (II) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

- b) A fraction (expressed as a percentage)

(I) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (I) (ii) of subparagraph a) (of Section 1923 of the Social Security Act) in the period reasonably attributable to inpatient hospital services, and (II) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (b)(I) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a state plan approach under this title).

b. Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a Low Income Payment defined in section 8.903 of these regulations.

Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive a Low Income Shortfall payment.

The total available funds for the Low Income Shortfall payment equals the percentage of Self Pay Days plus Other Paid Days of those providers who qualify for the Low income Shortfall payment compared to all other Medicaid Inpatient Hospital providers multiplied by the General Fund appropriated by the General Assembly to Safety-Net Provider Payments. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low-Income Shortfall payment for the specific provider.

- c. Disproportionate share amounts shall be based upon the recalculated base rate for affected facilities (prospectively determined annually in conjunction with base rate changes). The percentage of Medicaid patients in each facility used to calculate the appropriate disproportionate share payments (if any) shall be based upon the most recent Colorado Hospital Association Data Bank information available, information from hospitals not participating in the Data Bank, and from Health Maintenance Organizations and/or Prepaid Health Plans describing total patient days and Medicaid days. Data will be subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care.

- d. Effective January 1, 1991, an additional Disproportionate Share Adjustment payment method shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share Hospital criterion of Medicaid inpatient hospital services utilization rate of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for third party payments), less Colorado Indigent Care Programs patient payments and Colorado Indigent Care Programs reimbursements.

For each hospital which qualifies under this section D. these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. The basis for this calculation will be information published by the Colorado Indigent Care Programs in its most recent annual report available before rate setting by the Department for each upcoming state fiscal year. The Colorado Indigent Care Programs costs, patient payments, and program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Programs, subject to validation through the use of data from the Department, the

Colorado Foundation for Medical Care, and/or independent audit.

Effective July 1, 1993. Component 1 shall be superseded by a Disproportionate Share Adjustment payment method (herein described as Component 1a) under which the above cost data will be inflated forward from the year of the most recent available Colorado Indigent Care Program report available before rate setting (using the CPI-W. Medical Care for Denver) through June 30 of the fiscal year payment period.

Effective for the period from June 1, 1994 to June 30, 1994, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by the percent of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements, that will allow the State to approach but not exceed the State's Federal Fiscal Year 1994 Disproportionate Share Hospital allotment as published in the May 2, 1994 Federal Register. If these reimbursements exceed the federal allotment limits, they will be recovered proportionately from all participating hospitals.

Effective for the period from July 1, 1994 to June 30, 1995, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by 200% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

Effective June 1 through June 30, 1995, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 200% of the hospital's reported Colorado Hospital Association bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report available before rate setting by the Department, inflated from the year of the annual report to June, 1995 using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, and reduced by estimated patient payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

Effective from July 1, 1998, through September 30, 1998, and from October 1, 1998 through September 30, 1999, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by

estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of \$93 million in Federal Fiscal Year 1998, and \$85 million in Federal Fiscal Year 1999. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

Effective from September 1, 2000, through September 30, 2000, each government hospital will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. These payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of \$79 million in Federal Fiscal Year 2000. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share payments. This payment will apply to any government disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State. Effective June 1, 2001, this bad debt Disproportionate Share Adjustment payment to government hospitals is extended to an annual basis, and is subject to the Federal Funds limits of the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The limit for 2001 is \$81.765 million. These payments are subject to approval and appropriation by the General Assembly.

Effective July 1, 1995, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department.

This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

- e. Effective retroactively to July 1, 1991, the department will reimburse disproportionate share hospitals for the reasonable costs associated with administrative outstationing eligibility functions. The reimbursement will occur in the following manner:

Disproportionate share hospitals will submit on an extra line on the Medicaid Cost Report (related to Worksheet A - Trial Balance) the Administrative and

General pass through direct costs associated with outstationing activities. This additional retrospective reimbursement will be separately identified on the Medicaid Settlement Sheet.

Payment. for taking of the initial applications and initiating the process of determining Medicaid eligibility, shall be made to recognize these provider administrative costs. This outstationing payment shall be made based upon actual cost with a reasonable cost per application limit to be established by the Department, based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case, shall reimbursement exceed a maximum cap of \$60,000 per facility per year for all administrative costs associated with outstationing activities.

- f. Effective October 1, 1991 through September 30, 1992, a separate separate Component 2 Disproportionate Share Adjustment payment method shall apply for all hospitals eligible to receive reimbursement for services provided to Colorado Medicaid patients. These payments shall be made in addition to all other Medicaid payments. Hospitals which serve a higher proportion of low income care will receive a higher disproportionate share adjustment. The additional disproportionate share payments are based upon and are proportional to historical Medicaid Program payments and Colorado Indigent Program payments. The calculation shall be based upon the most recent Colorado Hospital Association Data Bank information available regarding the amount of uncompensated care provided, excluding discounts for contractual allowances made to third party payers, and the most recently published Colorado Indigent Care Program Annual Report.

To provide funding for this payment adjustment, all Colorado hospitals will be assessed 10% of their own specific Medicaid revenues for the previous state fiscal year. Failure of the provider to pay the assessment shall result in the Department withholding Component 2 disproportionate share payment. The disproportionate share payment for Component 2 is based upon the amount of previous year's historical Medicaid and Medically Indigent payment. This is expressed in the following formula and payment schedule:

$$\frac{\text{Uncompensated Inpatient Care Ratio}}{\text{Uncompensated I/P care revenue*}} = \text{UICR}$$

$$\frac{\text{Total I/P care revenue}}{\text{Total I/P care revenue}} = \text{UICR}$$

* The total of bad debt and charity care revenue

The UICR is used to array facilities to determine the level of uncompensated care. Based upon the level of uncompensated care, facilities will receive from 10% to 60% of their uncompensated care historical cost base (which is defined as .50 of Medically Indigent payment and .10 of Medicaid payment for the previous fiscal year).

Increased Historical
UICR

Cost Base (HCB)

0.00 – 0.029	Level 1	10%
0.30 – 0.049	Level 2	10%
0.050 – 0.079	Level 3	30%
0.080 – 0.109	Level 4	40%
0.110 – 0.169	Level 5	50%
0.170+	Level 6	60%

Component 2 Payment is determined as follows:

HCB = Increased Historical Cost Base

$X = .10 \times \text{Medicaid Payment}$

$Y = .50 \times \text{Medically Indigent Payment}$

Component 2 Payment = $HCB \times X + Y$

Hospitals qualifying under both the Component 1 and Component 2 disproportionate share methodology, as described in Sections D and # above, may receive only the greater of the Component 1 or Component 2 payment adjustments.

- g. Based upon historical data for the period July 1, 1986 through June 30, 1989, an additional Disproportionate Share Adjustment payment (herein described as Component 3) will be made effective on October 1, 1991, to any disproportionate share hospitals meeting the current Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share Hospital criterion of Medicaid inpatient hospital services utilization rate of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the state (as described above in this subsection. Disproportionate Share Hospital Adjustment, paragraph (A)). Hospitals meeting this criterion shall be eligible for an additional Disproportionate Share payment adjustment as follows:

Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for third party payments), less Colorado Indigent Care Programs patient payments and Colorado Indigent Care Programs reimbursements.

For each hospital which qualifies under Component 3, these amounts will be calculated based upon historical data (for the period July 1, 1986 to June 30, 1989) and paid in a single payment. The basis for this calculation will be information published by the Colorado Indigent Care Programs in its annual reports, which would have been available before each applicable state fiscal year period. The Colorado Indigent Care Programs costs, patient payments, and program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Programs, subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care, and/or independent audit.

- h. Effective July 1, 1994, an additional disproportionate share payment adjustment method will apply to any outstate disproportionate share hospitals meeting the

Medicaid inpatient utilization rate formula.

1) Eligibility for Outstate Disproportionate Share Hospital Payments.

These hospitals are defined as those hospitals which meet the disproportionate share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one percent of total patient days. Providers who are not participating in the Colorado Indigent Care Program are excluded from receiving this adjustment. Also excluded are Specialty Indigent Care Program providers, which are defined by the Colorado Indigent Care Program as those providers which either offer unique specialized services or serve a unique population. Outstate hospitals are defined by the Colorado Indigent Care Program as those Colorado hospitals that are outside the City and County of Denver, and who participate in the Colorado Indigent Care Program.

Effective July 1, 2001, Outstate Disproportionate Share hospitals which do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition will be separated into the Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals. Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are owned by a state, county or local government entity. Non-Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are not owned by a state, county or local government entity.

These hospitals must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. The obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.

Hospitals must participate in the Colorado Indigent Care Program, and must meet the separate annual audit requirements of the Colorado Indigent Care Program; and must supply data per the Colorado Indigent Care Program guidelines on total charges, total third party collections, total patient liability, and write-off charges to the Colorado Indigent Care Program. Hospitals meeting these criteria shall be eligible for an additional disproportionate share payment adjustment as follows:

2) Reimbursement.

a) Percent of Uncompensated Care.

Each facility will receive a payment proportional to its uncompensated medically indigent costs, as calculated by the Colorado Indigent Care

Program. The percent of uncompensated care that will be reimbursed depends on the annual amount appropriated by the State Legislature to the Colorado Medically Indigent Program for Outstate hospitals. Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals may have a different calculated total reimbursement percentage of uncompensated costs.

b) Calculation of Uncompensated Costs.

These uncompensated costs will be calculated by taking total medically indigent charges, subtracting total third party collections and total patient liability to obtain write-off charges, and then multiplying write-off charges by the cost-to-charge ratio as defined by the Colorado Indigent Care Program, to calculate medically indigent write-off costs. The cost-to-charge ratio is defined by the Colorado Indigent Care Program as that cost-to-charge ratio calculated using the most recently submitted Medicare Cost Report for each hospital.

3) Method of Payment.

a) Basis of Payment.

For each hospital which qualifies under this section, these payments for indigent care costs will be calculated based upon prospective data provided by the Colorado Indigent Care Program. The basis for this calculation will be the projected reimbursement for the current fiscal year as calculated by the Colorado Indigent Care Program.

b) Payment Limits

The DSH payment will not exceed uncompensated costs as defined in the Social Security Act, Section 1923(g)(1)(A). Adjustments will be made to the monthly payments based on interim recalculations performed by the Colorado Indigent Care Program.

c) Frequency of Payment.

Payment will be made on a monthly basis.

11. Family Medicine Residency Training Program: A hospital qualifies as a teaching hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Commission on Family Medicine and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the major teaching hospital program, it is not eligible for this program, unless the facility is a university hospital. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Training Program will be \$213,195. Effective July 1, 1999, the annual payment for each Family Medicine

Residency Training Program will be \$228,379. The annual payment will change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

8.356.30 Subject to the fiscal agent's implementation of the DRG payment system, PPS hospitals will receive DRG-based payment for inpatient hospital stays no sooner than April 1, 1988.

.31 The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the client was treated, surgical procedures involved, and complication of the illness. Every DRG is assigned a relative weight, average length of stay, and trim point, based upon data obtained from states operating Medicaid DRG systems and upon Colorado-specific data as they become available. The DRG relative weight will be multiplied by the base rate for the each hospital to generate the base payment amount.

.32 Abbreviated patient stays will be paid as follows:

- A. The hospital will receive the full DRG payment for all patient deaths and cases in which the patient left against medical advice.
- B. Subject to Department approval, in cases involving transfers to, from or between PPS hospitals, PPS facilities excluding rehabilitation and specialtyacute hospitals will be paid a DRG per diem for each day based upon the full DRG payment, divided by the average length of stay for the DRG (up to a maximum of the full DRG payment). These discharges may also qualify for outlier payment when the length of stay exceeds the DRG trim point.
- C. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility.

8.356.40 ADJUSTMENTS FOR OUT OF STATE PROVIDERS

- A. Payment for out-of-state and non-participating Colorado hospital inpatient services shall be at a rate equal to 90% of the average Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services.
- B. The state agency may reimburse a higher payment rate (than 90% of the average Colorado other urban or rural DRG payment rate) for non-emergent services when needed services are not available in Colorado hospitals. Non-emergent inpatient medical care rendered at an out-of-state hospital to a Colorado Medicaid client must be prior authorized by the State Department of Health Care Policy and Financing, based upon review and recommendation by the PRO. For non-DRG payment, the out-of-state hospital will be paid at a rate mutually agreed upon by the parties involved.

Payment shall in no case exceed 100% audited Medicaid costs as determined by the Department and/or its agent.

In no case shall payment exceed \$1,000,000 per admission.

Prior to authorization for payment, the PRO will review to determine the medical necessity of the treatment. Payment will be made only for the specific treatment(s) approved by the PRO as medically necessary and for complications occurring during the

hospital stay which are directly related to the illness under treatment. All subsequent readmissions must be independently reviewed by the PRO and receive separate authorization for payment. The out-of-state hospital will be responsible for providing the PRO (on a bimonthly basis) medical records necessary for PRO review. Non-compliance with a PRO request for medical records will result in denial of reimbursement.

8.356.50 BASE RATES FOR NEW PPS FACILITIES

- A. Beginning July 1, 1996, claims for clients admitted to pediatric specialty hospitals will be reimbursed under the DRG payment system.
- B. Claims for clients admitted to rehabilitation and specialty-acute hospitals which are designated as non-exempt providers beginning July 1, 1997 shall be reimbursed using the DRG payment system.
- C. The Department shall assign any new PPS facilities which become providers during the year to the appropriate peer group. The new facility shall submit budgeted cost data to the Department for consideration. The Department shall consider this data and/or cost and rate data for similar facilities in determining the initial reimbursement rate for new PPS facilities. If a new facility does not submit adequate budgeted cost data, the Department may assign a new PPS facility a rate equal to the lowest rate in the peer group to which the facility is assigned.
- D. When changes occur at a Medicaid provider which affect the health facility license or scope of operations attributed to that provider number, the Department shall determine whether a rate adjustment is necessary based on the resulting impact on costs. Examples of such changes include but are not limited to mergers and consolidations, acquisitions, expansions of services to existing facilities, and changes in ownership involving multi-campus hospitals. The Department may use hospital cost report data and may require the provider to submit additional historical and/or budgeted costs for the operating locations involved in order to determine the rate adjustment. If the provider does not submit adequate historical or budgeted cost data, the Department may adjust the rate to the lowest rate in the peer group to which the provider is assigned.

The Department shall adjust rates for the changes described in this section only to the extent that such changes improve efficiency. The rate resulting from the changes shall be no higher than the rate paid prior to the change. The Department may reflect anticipated efficiencies of changes by discounting existing rates for the cost savings.

Changes which are limited to inpatient hospital services shall not be considered significant if the change in total beds is less than 5 (five) percent of the facility's certified beds prior to the change. If the change involved outpatient hospital services, the provider shall submit budgeted cost information for the Department to use in determining whether the change will significantly impact costs. The Department will determine the necessary rate adjustment for significant changes based on this data.

8.356.60 MEDICAID DATA

All hospitals participating in the Medicaid program will submit Medicaid and total hospital utilization, statistical and financial data to the Colorado Hospital Association Data Bank Program. If a hospital does not report to the Colorado Hospital Association data base, the Department will send the required format for reporting this data.

8.356.70 DRG ADVISORY COMMITTEE

The DRG Advisory Committee shall meet periodically, but no less frequently than annually, to provide advisory input to the department on the DRG payment system. This input shall include, but not be limited to:

1. Base Rate Determination
2. Relative weight adjustment
3. Changes in basic grouping methodology
4. Other aspects of the DRG payment system.

8.358 PATIENT PAYMENT CALCULATION FOR NURSING FACILITY CLIENTS WHO ARE HOSPITALIZED

When an eligible client is admitted to the hospital from a nursing facility, the nursing facility shall, at the end of the month, apply all of the available patient payment to the established Medicaid rate for the number of days the client resided in the nursing facility. The nursing facility shall notify the county department of any amount of patient payment that applies. Form AP-5615 shall be used to notify the county. An allowed exception to the usual five (5) day completion requirement is that the AP-5615 for hospitalized clients may be completed at the end of the month. If the nursing facility has calculated an excess amount, the county will notify the hospital and the State Department of Health Care Policy and Financing of the amount. The nursing facility shall transfer the excess amount to the hospital and this payment will be shown as a patient payment when the hospital submits a claim to the Medicaid Program.

- .10 When a patient, who is not a transfer from a nursing facility, is admitted to the hospital and it appears the patient may be eligible for medical assistance, the hospital shall notify the county department. If the patient subsequently qualifies for assistance on the basis of institutionalization (see 8.110.31(B)) the county department will compute the income available to the individual. Except for deductions as allowed under the section Nursing Facility/Hospitalized Recipient Income, all income available to the individual must be applied to the cost of medical care. The hospital will show this as third party payment when submitting a claim to the Medicaid Program.
- .20 The hospital is responsible for collecting the correct amount of patient payment due from the client, his family, or representatives. Failure to collect patient pay, in whole or in part, does not allow the hospital to bill the Medical Assistance Program.
- .30 The hospital shall advise the responsible county department when the client is ready for discharge.

8.373 INPATIENT PSYCHIATRIC CARE FOR INDIVIDUALS UNDER THE AGE OF 21

Inpatient psychiatric care is a benefit of the Medicaid Program for individuals eligible for Medicaid benefits under the age of 21 only when (A) provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals, or in a facility or program accredited by the Joint Commission of Accreditation of Hospitals; (B) services are provided under the direction of a physician and involve active treatment which a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, or prevent further regression so that the services will no longer be needed; and (C) are provided prior to the date such individual attains age 21, or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, (i) the date such individual no longer requires such services or (ii) if earlier, the date such individual attains 22.

In addition to these requirements, these facilities shall comply with all the federal federal requirements for inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs as specified in 42 C.F.R. 441.150, et seq., October 1992 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Manager, Health and Medical Services, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, CO 80203-1714. The Department may fulfill these requirements or parts thereof through contract with the designated professional standards review organization as allowed under 42 C.F.R. 431.630, October 1992 edition. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Foundation for Medical Care P.O. Box 17300 1260 So. Parker Road Denver, CO 80217-0300 or Manager, Health and Medical Services Colorado Department of Health Care Policy and Financing 1575 Sherman Street Denver, CO 80203

8.373.05 COMMUNITY MENTAL HEALTH SYSTEM REFERRAL FOR INPATIENT PSYCHIATRIC CARE RENDERED TO PATIENTS UNDER AGE 21

When inpatient psychiatric care is provided to Medicaid clients under age 21 at a hospital (other than a state institution) reimbursed by per-diem rates, the Community Mental Health Center (CMHC) referral system shall apply:

A. Admission Notification Assessment

When a Medicaid enrolled individual under age 21 is admitted to an inpatient hospital for psychiatric care, the hospital shall notify the PRO, by telephone, of the admission within 24 hours. The PRO shall notify the CMHC in the patient's service area of responsibility by telephone and writing within 48 hours of notification.

1. The CMHC will determine if the client's condition warrants assessment, and what alternative services are available. If, after notification, the CMHC staff determines an assessment is necessary, such assessment shall occur within 10 working days from the date of notification. The CMHC staff will assess the client's medical condition/service needs, document the assessment in the hospital medical record, and participate in development of the disposition plan.
2. Exception: If the Medicaid client admitted to the hospital is enrolled in the Mental Health Assessment and Service Agency (MHASA) program, procedures established by that program for notification and coordination of care shall be followed.

B. In hospitals where inpatient psychiatric care is provided to Medicaid clients under age 21 at a hospital (other than a state institution) reimbursed by per diem rates, PRO retrospective review shall assess the medical necessity for admission and for the number of paid days, in accordance with 8.314.10.

C. In the event of denial of any or all of the client's stay, the appeal process for clients and/or providers is described at 8.318.12.

8.373.20 ELIGIBILITY

With the exception of determination that a child is deprived of parental support or care and school attendance, a person's eligibility for this program shall be determined under AFDC rules. See the Medical Assistance Eligibility section regarding needy persons under 21.

Determining eligibility for the "Under 21 Psychiatric Program" must include a determination of whether the person, individually or through his family, is covered by medical insurance or has other "third party"

medical resources which must be used prior to benefit coverage under Medicaid. Except for an amount reserved for personal needs, all income available to the individual must be applied to the costs of medical care. When such individual has no income, a personal needs payment may be made if the individual is eligible as an eligible member of an AFDC household.

8.373.30 ELIGIBILITY AND INITIAL CERTIFICATION PROCESS

1. The admitting facility shall refer those persons deemed potentially eligible for benefits to the county department of social services of the county in which the facility is located or the county of jurisdiction for the client if different and known to the facility. The referral shall include medical data: diagnosis, prognosis, treatment plan, and long and short-range treatment goals. Such referral should contain as much personal and financial data as possible to enable the county department quickly to undertake and complete eligibility determination.
2. The referral information concerning medical data shall immediately be forwarded by the county department to the Peer Review Organization for purposes of securing certification of the need for inpatient psychiatric care.
3. At the time of such submittal, the county department shall initiate application and eligibility determination process. County departments shall work cooperatively with the facility concerning the securing of application.
4. The State Department promptly shall furnish the county department with the result of its review, certifying, as applicable, the child's need for care. See Section - Extension Certification concerning extensions.
5. The county department shall complete its eligibility determination process and notify the applicant, in accordance with standard procedures therefor (Form PA-75 or PA-78). If the Peer Review Organization fails to certify the child as requiring inpatient care, this reason shall be set forth as the primary reason for denial in the recipient notice.
6. The facility shall advise the responsible county department of any changes in income or circumstances affecting eligibility or payment by the individual client in care. The client (parent or guardian if client is a minor) also has responsibility to provide such information to the county department.
7. Procedures and entries concerning reporting are set forth in the Financial and Medical Eligibility Reporting Manual.

8.373.40 EXTENSION CERTIFICATION

Such individuals admitted to a long - term inpatient psychiatric facility with a psychiatric diagnosis are limited to an initial length of stay of up to 30 days. The attending physician (psychiatrist) may request authorization for additional inpatient treatment if, in his opinion, additional active psychiatric treatment in a long-term inpatient psychiatric facility can be expected to result in amelioration of the diagnosed condition.

Such extensions beyond the initial 30 days must be certified by the Office of Medical Assistance, Department of Social Services. Signature is required on each Extension Form MED-177 which states the current medical records have been reviewed and the client's psychiatric condition warrants continued inpatient active treatment. Certification shall be made on the 25th day of care and every 30 days thereafter. Extensions of psychiatric diagnosis(es) beyond the initial 30 days shall be granted only in those cases where the attending physician (psychiatrist) determines that the client can be expected to make a satisfactory recovery through the application of active treatment. Failure to maintain properly signed Certification Form MED-177 for current period of care on client's chart will result in recovery of Medicaid funds.

Medicaid records are subject to audit by staff of the Department of Health Care Policy and Financing or its authorized representative.

Extension certification shall be made before the patient enters into each succeeding period of inpatient care. This applies to all persons eligible for Medicaid regardless of status of application until eligibility is denied or the client is discharged, whichever occurs first. Appropriate prior notice rules are applicable.

8.373.50 INSPECTION OF CARE

These facilities shall be surveyed under the Colorado Department of Public Health and Environment's Inspection of Care Program. Failure to satisfy the Inspection of Care requirements shall cause the Department to institute corrective action as it deems necessary.

8.373.60 BILLING PROCEDURES

Billing procedures for the Under 21 Psychiatric Program shall be issued by the Medicaid Fiscal Agent. Such billing procedures shall be approved by the Office of Medical Assistance and, as a minimum, shall include the following provisions:

1. All necessary client identification and statistical data as required to maintain necessary and proper medical records.
2. The billing form shall certify that extension certification was made as described under Extension Certification above.
3. Any income the client receives while an inpatient in a long-term care psychiatric facility shall be shown as another resource. Such income shall be applied toward the payment of the client's hospital care.
4. For a facility licensed as a psychiatric hospital, the rate of payment shall be that rate as determined in accordance with procedures contained in the PAYMENT OF HOSPITAL COSTS Section of this staff manual less any third-party resources, including patient payments.
5. For facilities not licensed as a psychiatric hospital, the initial payment shall be \$2710, until such time as a Medicaid cost report is filed according to procedures defined in FORM MED-13: GENERAL INFORMATION, MED-13: DEPARTMENT RESPONSIBILITIES AND FORM MED-13: NURSING FACILITY RESPONSIBILITIES.

Reimbursement for subsequent periods shall be determined according to procedures described in Computation of Individual Reimbursement Rate and Determination of Maximum Reimbursement Rate of the LONG TERM CARE - REIMBURSEMENT Section of these regulations. For purposes of reimbursement, all psychiatric facilities included under the Under 21 Psychiatric Program which are not licensed as hospitals shall constitute a single class of facilities.

6. Third-party payments are made first. Medicaid payment is made after other resources are exhausted.

Modification to billing procedures necessitated by new or additional requirements of the Medicaid Program shall be authorized by the Office of Medical Assistance of the Department of Health Care Policy and Financing.

8.374 PAYMENT FOR INPATIENT SERVICES AT FREE STANDING PSYCHIATRIC HOSPITALS

- .10 Payment for inpatient care provided to Medicaid clients under age 21 in free standing psychiatric hospitals (excluding state institutions) shall be limited to the following institutions:

Centennial Peaks Hospital Cleo Wallace Center La Plata Psychiatric Hospital

This limitation applies to the licensed beds available at each institution as of October 10, 1988. Effective June 1, 1991, for the facilities listed in this section, the Department may impose contractual limits on beds by means of the hospital participation agreements subject to the provisions of 8.374.30.

- .20 Effective October 10, 1988, payment rates for these institutions have been established by the Department on the basis of historical Medicaid payment rates and Medicaid payment rates and evaluation of hospital information concerning the relationship between hospital costs and patient length of stay. The following per diem rates will be in effect as of October 10, 1988:

Day 1 through Day 7:	\$330
Day 8 through remainder of care at acute level:	\$239
Days certified awaiting appropriate transfer:	\$ 67

These rates will be increased initially on July 1, 1989, by the CPI-W. Effective December 15, 1989, these free standing psychiatric hospital rates will be updated annually by the methodology described in 8.355.90. The annual inflator may be adjusted by the Department.

- .30 The Department shall conduct an annual assessment to include:

- A. The appropriateness of the geographic location of these beds relative to patient needs for access.
- B. The appropriateness of the number of beds available, relative to patient needs and accessibility.

Based upon results of this annual assessment the Department shall determine the appropriateness of maintaining the contractual relationships in effect 10/30/88 with psychiatric hospitals (excluding state institutions) providing care for persons under 21 years of age, and if necessary, modify these contractual relationships relative to the number of beds eligible for reimbursement.

Based upon results of this assessment the Department may also issue a Request for Proposal in order to obtain provider contracts for the number and geographic location of beds deemed appropriate.

- .31 Federal statute requires that Certification of Need (CON) be performed for all hospital inpatient care provided to Medicaid clients in Colorado Free Standing Psychiatric Hospitals. Payment for inpatient claims submitted by Free Standing Psychiatric Hospitals will be denied if the Colorado Foundation for Medical Care (CFMC) determines that the facility has not complied with Departmental CON documentation.

The CON is performed by the hospital's internal review team. The CFMC denial will be administrative and not subject to appeal.

8.375 SWING-BED HOSPITALS

.10 DEFINITIONS

"Swing-Bed Hospital" is a hospital participating in Medicare and Medicaid that has an approval from the

federal government to provide skilled and/or intermediate care services.

“Routine SNF Services” and “Routine ICF Services” are those services required to be provided by nursing facilities participating in the Medicaid program as part of their per diem rate.

“Ancillary Services” are services which are not required to be provided by nursing facilities participating in the Medicaid program within their per diem rate, but which are reimbursable services under the Medicaid program. These include but are not limited to: laboratory and x-ray services, and prescription drugs.

.20 APPLICATION PROCESS

Hospitals which intend to designate swing-beds for the Medicaid program must apply to the Colorado Department of Public Health and Environment for certification of swing-beds and to the Colorado Department of Health Care Policy and Financing for participation as a provider of skilled and/or intermediate nursing facility services.

The following requirements must be met for participation as a swing-bed hospital:

1. Hospitals must meet state regulations with respect to certificates of need.
2. Hospitals must have fewer than 50 inpatient acute care beds excluding newborn bassinets and beds in special care units: i.e., ICU, CCU, EDRD, etc. (does not apply to hospitals approved on a demonstration basis by the U.S. Department of Health and Human Services.)
3. Hospitals are not located in an area of the state designated as “urbanized” by the most recent official census published by the Federal Bureau of the Census. (Does not apply to hospitals approved on a demonstration basis by the U.S. Department of Health and Human Services.)
4. Hospitals must have a current valid Medicare agreement. Hospitals on “deferred termination” status are not eligible nor are hospitals with a waiver of 24-hour RN coverage.

8.375.30 PAYMENT RATES

Payment for swing-bed services will be made at the average rate per patient day paid to Class I nursing facilities for services furnished during the previous calendar year.

Payment for routine skilled nursing facility and intermediate care facility services may not exceed the rates charged for the same services to private pay residents or residents with other sources of income.

Oxygen provided to swing-bed patients will be paid at the same rate currently paid to skilled nursing facilities and intermediate care facilities in addition to payments made for routine services.

Clients shall be required to contribute all patient income minus the personal needs amount to the cost of their skilled or intermediate nursing care. Collection as well as determination of the patient income amount shall be in accordance with the section of this manual entitled “Patient Income and Possessions.”

.40 CLAIM SUBMISSION

Hospitals shall submit claims for swing-bed routine services and oxygen on nursing facility claim forms provided by the fiscal agent.

Ancillary services shall be billed separately on the appropriate claim form.

.50 SERVICES FURNISHED WITHIN THE PER DIEM RATE

Hospitals providing skilled nursing facility and/or intermediate care facility services in swing-beds must furnish the same services, supplies and equipment within the per diem rate which skilled nursing facilities and intermediate care facilities, excluding intermediate care facilities/mentally retarded, are required to provide.

Clients and/or their families or guardians shall not be charged for any of these required items or services.

8.375.60 PATIENTS' RIGHTS

Hospitals providing skilled nursing facility or intermediate care facility services to swing-bed patients shall adhere to the patient's rights requirements for skilled nursing facilities and intermediate care facilities contained in the Department of Public Health and Environment regulations including:

The right to be transferred or discharged only for medical reasons or his/her welfare, or that of other patients, or for nonpayment for his/her stay and the right to be given reasonable advance notice of any transfer or discharge, except in the case of an emergency as determined by professional staff.

However, if the hospital wishes to establish limited lengths of stay in its swing-beds, it will be considered to have protected this patient right if the patient signs a notice of the conditions of such stay at the onset of his/her intermediate care facility or skilled nursing facility care.

.70 PERSONAL NEEDS FUNDS AND PATIENT PAYMENTS

Swing-bed hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance with the requirements established for nursing facilities in the section entitled "Patient Income and Possessions."

.80 PRIOR AUTHORIZATION OF SWING-BED CARE BY THE PEER REVIEW ORGANIZATION

All Medicaid patients shall be prior authorized and subject to the continued stay review processes of the Peer Review Organization in accordance with the criteria and procedures found in the section of this manual entitled "Long Term Care - General."

The long term care Single Entry Point system consists of Single Entry Point agencies, representing geographic districts throughout the state, for the purpose of enabling persons in need of long term care to access appropriate long term care services.

Legal Authority

Pursuant to C.R.S. 26-4-522, the state department is authorized to provide for a statewide Single Entry Point system.

8.390.1 DEFINITIONS

- A. Agency Applicant means a legal entity seeking designation as the provider of Single Entry Point agency functions within a Single Entry Point district.
- B. Assessment means a comprehensive *evaluation* with the client and appropriate collaterals (such as family members, advocates, friends and/or caregivers) and an evaluation by the case manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding resources.
- C. Care Planning means the process of identifying with the client and appropriate collaterals, goals and client choices for the care needed, services needed, appropriate service providers, and client co-

payment, based on the client assessment and knowledge of the client and of community resources.

- D. Case Management means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic reassessment of such client's needs.
- E. Corrective Action Plan means a written plan which includes the specific actions the agency shall take to correct non-compliance with standards, and which stipulates the date by which each action shall be completed.
- F. Department shall mean the Colorado Department of Health Care Policy and Financing.
- G. Failure To Satisfy The Scope Of Work means incorrect or improper activities or inactions by the Single Entry Point agency in terms of its contract with the Department.
- H. Financial Eligibility means an individual meets the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources.
- I. Functional Needs Assessment means a comprehensive *evaluation* with the client and appropriate collaterals (such as family members, friends and/or caregivers) and a written evaluation on a state prescribed form by the case manager, with supporting diagnostic information from the client's medical provider, to determine the client's level of functioning, service needs, available resources, potential funding resources, and medical necessity for admission or continued stay in certain long term care programs.
- J. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long term care client assessment.
- K. On-Going Case Management means the evaluation of the effectiveness and appropriateness of services, on an on-going basis, through contacts with the client, appropriate collaterals, and service providers.
- L. Private Pay Client means an individual for whom reimbursement for case management services is received from sources other than a state administered program, including the individual's own financial resources.
- M. Program means a publicly funded program including, but not limited to, Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), Medicaid nursing facility care, and case management services funded through the Older Americans Act (Title III-B)
- N. Reassessment means a comprehensive *evaluation* with the client and appropriate collaterals and an evaluation by the case manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding resources.
- O. Resource Development means the study, establishment, and implementation of additional resources or services which will extend the capabilities of community long-term care systems to better serve

long-term care clients and clients likely to need long-term care in the future.

- P. Single Entry Point means the availability of a single access or entry point within a local area where a current or potential long-term care client can obtain long-term care information, screening, assessment of need, and referral to appropriate long-term care programs and case management services.
- Q. Single Entry Point District means two or more counties, or a single county, that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of long term care services.
- R. Single Entry Point Agency means the organization selected to provide case management functions for persons in need of long term care services within a Single Entry Point District. Single Entry Point agencies may function as a Utilization Review Contractor.
- S. State Designated Agency means a single entry point agency designated to perform specified functions that would otherwise be performed by the county department(s) of social services.
- T. Utilization Review Contractor shall mean an entity or entities contracted with the Department of Health Care Policy and Financing to provide assessment, case management, training, monitoring, and/or utilization control for the following programs: Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), Home and Community-Based Services for Persons with Mental Illness (HCBS-MI), Children's Home and Community Based Services, Medicaid nursing facility care, Program for All Inclusive Care for the Elderly (PACE), Estate Recovery, Private Duty Nursing (PDN), Children's Extensive Support, Hospital Back-up and PASARR. Single Entry Points are one type of Utilization Review Contractor.
- U. Utilization Management shall mean the use of techniques designed to approve or deny admission or continued stay in selected long term care programs, based on the clinical necessity, amount and scope, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques applicable to this Section 8.390 include prospective review/prior authorization, certification, concurrent review, or retrospective review.

8.390.2 SINGLE ENTRY POINT CLIENTS

Persons shall access the above listed long term care programs through the single entry point agency that serves the single district in which they reside.

- .21 Client characteristics. An individual who desires access to long term care services shall meet the following criteria:
 - A. The individual shall require skilled, maintenance and/or supportive services; and
 - B. The individual has functional impairment in activities of daily living (ADL), and/or a need for supervision, necessitating long term care services provided in a nursing facility, a residential alternative, or the individual's home; and
 - C. If the individual has a primary diagnosis of developmental disability or mental illness, the individual's needs are primarily for long term care services, in accordance with specific program eligibility criteria; and
 - D. The individual receives or is eligible to receive medical assistance (Medicaid) and/or financial assistance under one or more of the following programs: Old Age Pension, Aid to Blind,

Aid to Needy Disabled, Supplemental Security Income, or Colorado Supplemental, or as a 300% eligible, as defined at 8.485.50 below, receiving long term care services in a nursing facility or through one of the Home and Community-Based Services programs listed below at 8.390.22.

- .22 Clients of publicly funded programs. Single Entry Point agencies shall provide case management to clients of publicly funded long term care programs including, but not limited to, Medicaid nursing facility care, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), Home Care Allowance, Adult Foster Care, and Older American's Act case management services.
- .23 Utilization Review Contractors shall be authorized to provide Utilization Management to clients of publicly-funded long term care including, but not limited to, Medicaid nursing facility care, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), Program for All-Inclusive Care for the Elderly (PACE), Children's Home and Community Based Services, Estate Recovery, Home and Community-Based Services for People with Mental Illness (HCBS-MI), Private Duty Nursing (PDN), PASARR, Hospital Back-up and Children's Extensive Support Waiver.
- .24 Program-specific eligibility criteria. Authorization to receive services through a publicly funded program shall be in accordance with the program's eligibility criteria.

8.391 SINGLE ENTRY POINT DISTRICT DESIGNATION

.10 Changes in Single Entry Point District Designation

- A. In order to change Single Entry Point designation, a county or district shall submit an application to the Department, six months prior to commencement date of the proposed change. The application shall include the following information:
 - a. The geographic boundaries of the proposed Single Entry Point district;
 - b. Assurances that the proposed district meets all criteria set forth in Department rules for Single Entry Point district designation;
 - c. The designation of a contact person for the proposed district; and
 - d. A resolution supporting the application passed by the county commissioners of each county or parts of counties in the proposed district.
- B. The application shall be approved provided the proposed district meets the Single Entry Point district designation requirements.

.11 District Designation Requirements

Single Entry Point districts shall meet the following requirements:

- A. Counties composing a multi-county district shall be contiguous.
- B. A single county may be designated a district provided the county serves a monthly average of 200 or more clients from the following community-based programs: Adult Foster Care, Home Care

Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), and/or Older American's Act case management services.

- C. Multi-county districts shall not be required to serve a minimum number of clients.
- D. Each district shall have at least one full-time case manager employed by the Single Entry Point agency that serves the district.
- E. Each district shall assure adequate staffing by the district's Single Entry Point agency to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.

NOTE: Section 8.391.12 was deleted effective December 2, 2002.

8.391.20 SINGLE ENTRY POINT AGENCY SELECTION

- A. Except as otherwise provided herein, upon a change in Single Entry Point district designation or upon expiration of the district's existing Single Entry Point agency contract, a Single Entry Point district may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the Single Entry Point agency for the district. Once the Single Entry Point functions in a district are provided through a contract between the Department and an entity other than as listed above, the Single Entry Point agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.
- B. The agency selected by the Single Entry Point district shall serve as the Single Entry Point agency for the district unless the agency selected by the district has previously had its Single Entry Point agency contract terminated by the Department.
- C. The Single Entry Point district's selection shall be delivered to the Department no less than sixty (60) days prior to the effective date of the change in district designation or expiration of the contract with the district's existing Single Entry Point agency.
- D. If the Single Entry Point district has not delivered to the Department its selection within the timeframe specified in subsection (3) of this rule, the Single Entry Point agency for the district shall be selected by the Department pursuant to applicable state statutes and regulations.

NOTE: Sections 8.391.21 - 8.391.38 were deleted effective December 2, 2002.

8.392 FINANCING OF THE SINGLE ENTRY POINT SYSTEM

8.392.1 Single Entry Point agencies shall be established as separate administrative units for the purpose of providing case management services.

8.392.2 REIMBURSEMENT METHODOLOGY

- A. Reimbursement for Single Entry Point functions shall be determined by the number of counties included in a district and by the number of clients served, subject to the availability of funds.

- 1. A Single Entry Point agency that serves a multi-county district shall annually receive a base amount for each county included in the district, plus an amount for each client served, to be determined annually by the Department.

2. A Single Entry Point agency that serves a district composed of only one county shall not receive the base amount, but shall receive an amount for each client served each year.
3. The amount for each client shall be based on the number of clients served in one or more of the following programs: Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People With Brain Injury (HCBS-BI), and Older American's Act case management services.

8.392.3 COST ALLOCATION

- A. The Department shall make monthly payments to each designated Single Entry Point agency using a methodology which shall be specified in the contract between the state and the agency.
- B. At year end, each Single Entry Point agency's allowable costs shall be reconciled with the agency's allocation. Reimbursement for allowable expenditures shall be made to the extent of the district's allocation. In the event a district's allocation is greater than its allowable expenditures, the district shall remit any overpayment.
- C. Allowable agency expenditures are those which the Department deems allowed or required, in accordance with the following federal rules: CFR Title 45, Part 74, Appendix C; Office of Management and Budget Circular A-87, January 1981; and U.S. Department of Health and Welfare, December 1976, Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government (OASC-10). This rule does not include later amendments to or editions of the incorporated material. Copies are available for public inspection during regular business hours, and may be obtained at cost or examined from the Director of the Office of Accounting and Purchasing, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, CO; or may be examined at any State Publications Depository Library.
- D. Single Entry Point agencies may be audited by representatives of the Department, its designee, and/or independent audit firms, in accordance with state and federal rules.
- E. Pre-audits made in the Department may result in reducing the Single Entry Point agency's reimbursement by the amount of any incorrect payments. Post audits made by the field audit staff verify the correctness of payments and may result in additional adjustments in reimbursement.
- F. Single Entry Point agencies shall maintain documentation to support the actual costs of operation. Quarterly reports submitted to the Department shall document time expended by employees on specified programs, in accordance with a state prescribed time analysis method.
- G. For Utilization Management functions, the Department shall make monthly payments to each designated Single Entry Point agency using a methodology which shall be specified in the contract between the Department and the agency.

8.392.4 PRIVATE PAY CLIENTS

Single Entry Point agencies shall provide case management services to private pay clients within

two years from agency start-up.

- A. The Single Entry Point agency must serve private pay clients who are able to make payment in full on a fee-for-service basis and may serve private pay clients on a sliding fee basis.
- B. If the Single Entry Point agency chooses to serve private pay clients on a sliding fee basis, the Single Entry Point agency shall be responsible for obtaining supplemental funds to cover the cost of case management services for these clients.
- C. The Single Entry Point agency shall establish separate accounting cost centers for the reporting of private pay clients as separate and distinct from clients of publicly funded programs.
- D. The services provided to private pay clients shall be subject to the same standards as apply to clients who are recipients or applicants for state administered programs, including the collection of comparable client specific data.

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1 ADMINISTRATION OF A SINGLE ENTRY POINT AGENCY

The single entry point agency shall be required by federal or state statute, or by mission statement, by-laws, articles of incorporation, contracts, or rules and regulations which govern the agency, to comply with the following standards:

- A. The Single Entry Point agency shall serve persons in need of long term care services, regardless of impairment or disability, in accordance with program criteria, except that persons in need of specialized assistance such as services for developmental disabilities or mental illness may be referred by a Single Entry Point agency to programs under the Colorado Department of Human Services;
- B. The Single Entry Point agency shall have the capacity to accept multiple funding source public dollars;
- C. The Single Entry Point agency shall have the capacity to file for and receive payment from private insurance carriers, and charge and collect fees for services from clients;
- D. The Single Entry Point agency shall have the capacity to contract with individuals, with for-profit entities, and with not-for-profit entities to provide some or all Single Entry Point functions;
- E. The Single Entry Point agency shall have the capacity to receive funds from public or private foundations and corporations; and
- F. The Single Entry Point agency shall be required to publicly disclose all sources and amounts of revenue.

.11 Community advisory committee.

The Single Entry Point agency shall, within thirty (30) days of designation, establish a community advisory committee for the purpose of providing public input and guidance for Single Entry Point agency operation.

- A. The membership of the community advisory committee shall include, but not be limited to, regional representation from the district's county commissioners, area agencies on aging, medical professionals, long term care service providers, long term care ombudsman, human service agencies, county government officials, and long term care consumers.

- B. The community advisory committee shall provide public input and guidance to the Single Entry Point agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall Single Entry Point agency operations, service quality, client satisfaction, and other related professional problems or issues.

.12 Personnel system.

The Single Entry Point agency shall have a system for recruiting, hiring, evaluating, and terminating employees.

- A. Single Entry Point agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.
- B. The Single Entry Point agency shall maintain written job descriptions for all positions.

.13 Accounting system.

The Single Entry Point agency shall follow generally accepted accounting practices and comply with all rules and regulations for accounting practices set forth by the State.

- A. In addition, the Single Entry Point agency shall assure the following:

- 1. Funds are used solely for authorized purposes;
- 2. All financial documents are filed in a systematic manner to facilitate audits;
- 3. All prior years' expenditure documents are maintained for use in the budgeting process and for audits; and
- 4. Records and source documents are made available to the Department, its representative, or an independent auditor for inspection, audit, or reproduction during normal business hours.

- B. The Single Entry Point agency shall be audited annually and shall submit the final report of the audit to the Department within six months after the end of the state's fiscal year. The Single Entry Point agency shall assure timely and appropriate resolution of audit findings and recommendations.

.14 Liability insurance coverage.

The Single Entry Point agency shall maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements for contract agencies.

.15 Information management.

The Single Entry Point agency shall, in a format specified by the State, be responsible for the collection and reporting of summary and client-specific data including but not limited to information and referral services provided by the agency, program eligibility determination, financial eligibility determination, care planning, service authorization, resource development, fiscal accountability, and, if applicable, utilization management.

- A. The Single Entry Point agency shall have computer hardware and software, compatible with the Department's computer systems, and with such capacity and capabilities as prescribed by the Department.

- B. The Single Entry Point agency shall have adequate staff support to maintain a computerized information system in accordance with the Department's requirements.

.16 Recordkeeping.

The Single Entry Point agency shall maintain client records in accordance with program requirements, including the documentation of all case activities, the monitoring of service delivery, and service effectiveness. If applicable, the client's designated representative (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation. If the client is unable to sign a form requiring his/her signature due to a medical condition, any mark that the client is capable of making will be accepted in lieu of a signature. If the client is not capable of making a mark, the signature of a family member or other person designated to represent the client will be accepted.

.17 Confidentiality of information.

The Single Entry Point agency shall protect the confidentiality of all applicant and recipient records in accordance with State statute (CRS 26-1-114 as amended). Release of information forms obtained from the client must be signed and dated, and shall be renewed at least annually. or sooner if providers change. Fiscal data, budgets, financial statements and reports which do not identify clients by name or number are open records.

.18 Client rights.

The Single Entry Point agency shall assure the protection of the client's rights as defined by the Department under applicable programs.

- A. The Single Entry Point agency shall assure that the following rights are preserved for all clients of the Single Entry Point agency, whether the client is a recipient of a state administered program or a private pay client:

1. The client and/or the client's designated representative is fully informed of the client's rights and responsibilities;
2. The client and/or the client's designated representative participates in the development and approval, and is provided a copy, of the client's care plan;
3. The client and/or the client's designated representative selects service providers from among available and appropriate providers in the client's Single Entry Point district;
4. The client and/or the client's designated representative has access to a uniform complaint system provided for all clients of the Single Entry Point agency; and
5. The applicant or client who applies for or receives publicly funded benefits and/or the applicant's or client's designated representative has access to a uniform appeal process, which meets the requirements of Section 8.393.26, when benefits or services are denied or reduced and the issue is appealable.

- B. At least annually, the Single Entry Point agency shall survey a random sample of clients to determine their level of satisfaction with services provided by the agency.

1. The random sample of clients shall constitute ten (10) clients or ten percent (10%) of the Single Entry Point agency's average monthly caseload, whichever is higher.
2. If the Single Entry Point agency's average monthly caseload is less than ten (10) clients, all

clients shall be included in the survey.

3. The client satisfaction survey shall conform to guidelines provided by the Department.
 4. The results of the client satisfaction survey shall be made available to the Department and shall be utilized for the Single Entry Point agency's quality assurance and resource development efforts.
- C. The Single Entry Point agency shall assure that consumer information regarding long term care services is available for all clients at the local level.

.19 Access

There shall be no physical barriers which prohibit client participation, in accordance with the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.

- A. The Single Entry Point agency shall not require clients to come to the agency's office in order to receive assessments, utilization management services, or case management services.
- B. The Single Entry Point agency shall comply with anti-discriminatory provisions, as defined by federal and Department rules.
- C. The functions to be performed by a Single Entry Point (SEP) agency shall be based on a case management model of service delivery.

8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

- A. The Single Entry Point agency shall provide case management and, if applicable, Utilization Management services in compliance with standards established by the Department.
- B. The Single Entry Point agency shall provide sufficient staff to meet all performance standards. In the event a Single Entry Point agency sub-contracts with an individual or entity to provide some or all service functions of the Single Entry Point agency, the sub-contractor shall serve the full range of Single Entry Point programs. Subcontractors must abide by the terms of the Single Entry Point agency's contract with the Department, and are obligated to follow all applicable federal and state rules and regulations. The Single Entry Point agency is responsible for subcontractor performance.
- C. Protective services. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence and/or the local law enforcement agency.
- D. Pilot Projects. Effective July 1, 2001, the Single Entry Points shall be permitted under a pilot project administered by the Department to perform the following activities as negotiated under agreement with the Department:
 1. Approve authorizations for admission and continued stay into the Home and Community Based Services - Elderly, Blind, and Disabled (HCBS-EBD) and Home and Community Based Services - Persons Living with AIDS (HCBS-PLWA) Programs.
 2. Approve authorizations for admission and continued stay into nursing facilities, Program of All-Inclusive Care for the Elderly, the Brain Injury Program, and the Home and Community Based Services - Mentally Ill program. Such authorization shall only be permitted when both the SEP and the provider submitting the request for authorization agree to

voluntarily participate in the pilot. Such agreement from the provider shall be indicated on the provider's official letterhead, signed by a representative of the provider legally authorized to act on behalf of the provider, and submitted to the SEP and the Department.

3. Approvals made pursuant to §8.393.2 D (1) and (2) shall follow 8.401.15 A.
4. Submit data as necessary to support the structure of long term care data systems.

.21 Intake/screening/referral

- A. The intake/screening/referral function of a Single Entry Point agency shall include, but not be limited to, the following activities:
 1. The completion of Part A of the Department prescribed Long Term Care Single Entry Point Intake Form;
 2. The provision of information and referral to other agencies as needed;
 3. The determination of the appropriateness of a referral for a comprehensive long term care client assessment;
 4. The identification of potential payment source(s), including the availability of private funding resources; and
 5. The implementation of a Single Entry Point agency procedure for prioritizing urgent inquiries.
- B. If a referral to Single Entry Point long term care services is determined to be appropriate, Part B of the Intake Form shall be completed with the applicant or applicant's representative, within two (2) working days of the completion date on the screening form (Part A).
- C. When long term care services are to be reimbursed through one or more of the publicly-funded long term care programs administered by the Single Entry Point system, the Single Entry Point staff shall:
 1. Verify the applicant's current financial eligibility status, or
 2. Refer the applicant to the county department of social services of the client's county of residence for application, or
 3. Provide the applicant with financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides, and
 4. Document follow-up on return of forms.
- D. The determination of the applicant's financial eligibility shall be completed by the county department of social services for the county in which the applicant resides.
- E. The notification of applicants at the time of their application for publicly funded long term care services that they have the right to appeal actions of the Single Entry Point agency, the Department of Health Care Policy and Financing, or contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.
- F. Single Entry Point staff shall obtain the client's or representative's signature on the Intake Form.

.22 Assessment

- A. The county department shall notify the Utilization Review Contractor/Single Entry Point (URC/SEP) case manager of the Medicaid application date for the client upon receipt of the Part I and II of the Medicaid application. The county shall not notify the SEP/URC for clients being discharged from a hospital or nursing facility or Long Term Home Health. The URC/SEP case manager shall complete the ULTC 100.2 assessment within the following time frames:
1. For an individual who is not being discharged from a hospital or a nursing facility, the client evaluation shall be completed within ten (10) working days.
 2. For a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the URC/SEP case manager shall complete the evaluation within five (5) working days after notification by the nursing facility.
 3. For a resident who is being admitted to the nursing facility from the hospital, the URC/SEP case manager shall complete the evaluation within two (2) working days after notification.
 4. For a client who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the URC/SEP case manager shall complete the evaluation within five (5) working days after notification.
 5. For a client who that is being transferred from a hospital to an HCBS program, the URC/SEP case manager shall complete the evaluation within two (2) working days after notification.
- B. The URC/SEP case manager shall complete the ULTC 100.2 assessment. Assessment instrument shall be completed for individuals eligible to receive services through the following programs:
1. Medicaid nursing facility care
 2. Home and Community-Based Services for the Elderly, Blind, and Disabled (HCBS-EBD);
 3. Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA);
 4. Adult Foster Care;
 5. Home and Community Based Services - Brain Injury
 6. Home and Community Based Services - Mentally Ill
 7. Home and Community Based Services - Children's
 8. Consumer Directed Attendant Support (CDAS)
 9. Long term home health
 10. In-home services provided by the Older American's Act when the individual is in need of case management services
- C. The ULTC-100.2 may be completed for clients who are able to pay for case management services with private resources. Any completed ULTC 100.2 shall be kept on file at the URC/SEP agency, but copies need not be sent to the Department unless specifically requested.
- D. The URC/SEP case manager shall conduct the following activities for a comprehensive client

assessment:

1. Obtain diagnostic information from the client's medical provider for clients in nursing facilities, HCBS Programs for mentally ill, Persons Living With Aids (PLWA) and brain injured.
2. Determine the client's functional capacity during an evaluation, with observation of the client and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section 10 C.C.R. 2505.10 §8.484.20 C.
3. Determine the length of stay for nursing facility clients using the Nursing Facility Length of Stay Assignment Form in accordance with 10.C.C.R. 2505.10 §8.402.15.
4. Determine the need for paid care on the ULTC 100.2 during the evaluation. For HCA clients, the need for paid care score shall be used to determine the monthly HCA authorized amount in accordance with Section 10 C.C.R.-2505-10 §8.484.2.
5. Determine if the HCA services provided by the caregiver living with the client are above and beyond the workload of the normal family/household routine. If services are not beyond normal family/household routine, the client may not be scored as needing paid care for that service. Examples of normal family/household routine are cooking a meal for the members of the household with no special prescribed diet for the client; housekeeping for the members of the household with no heavy housekeeping for the client; washing the client's laundry with the laundry of other members of the household when there is no incontinence or illness which precludes washing household and client clothing together, shopping and running errands for the household when there is no article which has been prescribed for the health or personal care of the client and which necessitates a separate trip.
6. For HCA, score children age zero (0) through thirteen (13) years in both functional capacity and need for paid care according to the following age appropriate criteria:
 - a. Toileting: A child age 0 to 36 months will not be scored for bowel and bladder incontinence.
 - b. Mobility and Positioning: A child age 0 to 36 months will not be scored for mobility and positioning.
 - c. Dressing: A child age 0 to 60 months will not be scored for dressing.
 - d. Bathing and hygiene: A child 0 to 60 months will not be scored for bathing and hygiene.
 - e. Eating: A child 0 to 48 months will not be scored for eating.
 - f. Transfers: A child 0 to 48 months will not be scored for transfers. A child 0 to 60 months will not be scored for car seat, highchair, or crib transfers.
7. Determine the ability and appropriateness of the client's caregiver(s) and family to provide the client assistance in activities of daily living;
8. Determine the client's service needs, taking into consideration services available, or already being received, from all funding sources;
9. If the client is a resident of a nursing facility, determine the feasibility of de-institutionalization;

10. If an out-of-home placement is required, review placement options based on the client's needs, the potential funding sources, and the availability of resources within the district including, but not limited to, an adult foster care facility, an alternative care facility, a nursing facility, or another residential alternative;
11. Determine and document, on the Care Plan, client preferences in program selection;
12. Assist the client in the completion of applications for Single Entry Point administered long term care programs, if appropriate;
13. Maintain appropriate documentation for certification of program eligibility, if required for entrance into a program; or to submit such documentation to the Utilization Review Contractor, if applicable, and
14. Refer the client to alternative services, if the client does not meet the eligibility requirements for a long term care program administered by the Department.

D. The case manager shall complete the following activities for discharges from nursing facilities:

1. For all discharges from nursing facilities to community placements through Single Entry Point agencies:
 - a. The nursing facility shall contact the Single Entry Point agency in the district where the nursing facility is located to inform the Single Entry Point agency of the discharge if placement into community services is being considered.
 - b. The nursing facility and the Single Entry Point case manager shall coordinate the discharge date, and where placement into the Home Care Allowance or Adult Foster Care programs are being considered, the completion of a new ULTC-100 to use for assessment and care planning. The case manager shall be responsible for completion of the form.
2. When placement into the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program, or the Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) program is being considered, the Utilization Review Contractor shall determine the remaining length of stay.
 - a. The Utilization Review Contractor/, in accordance with 8.486.35, ASSESSMENT-DEINSTITUTIONALIZATION, shall send the Single Entry Point agency a copy of page 1 of the current nursing facility ULTC-100 indicating discharge to HCBS with an assigned length of stay using the end date that was assigned to the nursing facility.
 - b. The nursing facility and the URC/SEP agency case manager shall coordinate the discharge date, and where placement into the Home Care Allowance or Adult Foster Care programs are being considered, the completion of a new ULTC 100.2 to use for assessment and care planning. The case manager shall be responsible for completion of the form.
3. When placement into the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program, or the Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) program is being considered, the URC/SEP agency shall . complete a new ULTC-100.2 if the current ULTC 100's completion date is older than six (6) months. The assessment results shall be used to determine level of care and the new length of stay.

- a. The URC/SEP agency shall send the Statewide Utilization Review Contractor a copy of the current nursing facility ULTC 100.2 indicating discharge to HCBS with an assigned length of stay and new end date.
 - b. The nursing facility ULTC 100.2 used by the URC/SEP agency to certify HCBS eligibility shall be kept in the case record. In addition, a copy must be sent to the income maintenance technician at the county department of social services, and a copy must be sent to the Department or its agent with the HCBS prior authorization request.
- 4. If placement into the Home Care Allowance program or the Adult Foster Care program is being considered, notification shall be sent to the income maintenance technician at the county department of social services.
- 5. For referrals to other programs or services, the URC/SEP case manager shall use the ULTC 100.2 for eligibility, care planning, Utilization Management, or referral, as appropriate.
- E. For HCBS-EBD or HCBS-PLWA clients already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the URC/SEP case manager shall coordinate the admission date with the facility. . The case manager shall contact the Statewide Utilization Review Contractor to conduct a PASARR screening. If appropriate, the URC/SEP agency shall assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ULTC 100 is not older than six (6) months..

.23 Care planning

- A. The URC/SEP case manager shall develop the care plan after completing the client assessment and prior to the arrangement for services. The URC/SEP case manager shall complete the care plan (including all required paperwork) within fifteen (15) working days after determination of program eligibility.
- B. The nursing facility shall be responsible for developing a care plan for the nursing facility client.
- C. Care planning shall include, but not be limited to, the following tasks:
 - 1. The identification and documentation of care plan goals and client choices;
 - 2. The identification and documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider, and services needed but not available;
 - 3. The determination of client co-payment and documentation of client choices, in accordance with program requirements;
 - 4. The formalization of the care plan agreement, including appropriate signatures, in accordance with program requirements;
 - 5. The authorization for services, in accordance with program directives, including cost containment requirements;
 - 6. The prior authorization of Long Term Home Health Services, pursuant to 8.527.11.
 - 7. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision, and formalizing provider agreements in accordance with program rules;

8. The completion of program requirements for authorization of services;
9. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community;
10. The explanation of complaint procedures to the client;
11. The explanation of appeals process to the client.

D. Prudent purchase of services:

1. The case manager shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.
2. When services are available to the client at no cost from family, friends, volunteers, or others, these services shall be utilized before the purchase of services, providing these services adequately meet the client's needs.
3. When public dollars must be used to purchase services, the case manager shall encourage the client to select the lowest cost provider of service when quality of service is comparable.
4. The case manager shall assure there is no duplication in services provided by single entry point programs and any other public or privately funded services.

.24 On-going case management

A. The major goals of on-going case management shall be to:

1. Monitor the quality of care provided to clients;
2. Identify changes in the client's needs that may require a full reassessment or a change in the care plan;
3. Identify and resolve any problems with service delivery; and
4. Make changes in service plans as appropriate to client needs.

B. The case manager shall assure quality of care by monitoring service providers, the appropriateness of services provided, the amount of care, the timeliness of service delivery, client satisfaction, and the safety of the client, and by taking corrective actions as needed.

C. On-going case management shall include, but not be limited to, the following tasks:

1. Review of the client's care plan and service agreements;
2. Contact with the client concerning the client's satisfaction with services provided;
3. Contact with service providers concerning service coordination, effectiveness and appropriateness, as well as concerning any complaints raised by the client or others;
4. Contact with appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client or others;
5. Conflict resolution and/or crisis intervention, as needed;

6. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;
 7. Notification of appropriate enforcement agencies, as needed; and
 8. Referral to community resources as needed.
- D. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or misutilization of any public assistance benefit, and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services rules (Staff Manual Volume 3, Section 3.810) and Department of Health Care Policy and Financing (Staff Manual Volume 8, Section 8.076).
- E. The case manager shall contact the client at least quarterly, or more frequently as determined by the client's needs or as required by the program.
- F. The case manager shall review the ULTC100 and the Care Plan with the client every six months. The review shall be conducted by telephone or at the client's place of residence, place of service or other appropriate setting as determined by the client's needs.
- G. The case manager shall contact the service providers to monitor service delivery as determined by the client's needs or as required by the specific service requirements.

.25 Reassessment

- A. The case manager shall commence a regularly scheduled reassessment at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a reassessment of a client within twelve (12) months of the initial client assessment or the previous reassessment. A reassessment shall be completed sooner if the client's condition changes or if required by program criteria.
- B. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the ULTC 100.2. When a new ULTC 100.2 is completed for a HCA or AFC client, a copy shall be sent to the county department of social services and to the Department within thirty (30) days of the reassessment.
- C. Reassessment shall include, but not be limited to, the following activities:
1. Obtain diagnoses from the client's medical provider at least annually, or sooner if the client's condition changes or if required by program criteria;
 2. Assess client's functional status face-to-face at the client's place of residence.
 3. Review care plan, service agreements, and provider contracts or agreements;
 4. Evaluate service effectiveness, quality of care, and appropriateness of services;
 5. Verify continuing Medicaid eligibility, other financial and program eligibility;
 5. Annually, or more often if indicated, complete new care plan and service agreements;
 7. Inform the client's medical provider of any changes in the client's needs;
 8. Maintain appropriate documentation, including type and frequency of long term care services the client is receiving for certification of continued program eligibility, if required by the

program for a continued stay review.

9. Refer client to community resources as needed and develop resources for the client if the resource is not available within the client's community; and
 10. Submit appropriate documentation for authorization of services, in accordance with program requirements.
- D. The URC/SEP agency shall be responsible for completing reassessments of nursing facility clients. A reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status or if the client requests a reassessment.

.26 Case Recording/Documentation

- A. The Single Entry Point agency shall maintain records, including a copy of the intake form, on every individual for whom an intake was completed. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the Single Entry Point agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.
- B. The Single Entry Point agency shall maintain client case records on each Single Entry Point client.
- C. The case record shall include:
1. Identifying information, including the client's state identification (Medicaid) number and social security number (SSN);
 2. All State-required forms; and
 3. Documentation of all case management activity required by these regulations.
- D. Case management documentation shall meet all the following standards:
1. Documentation must be legible;
 2. Entries must be written at the time of the activity or shortly thereafter;
 3. Entries must be dated according to the date of the activity, including the year;
 4. Entries must be made in permanent ink;
 5. The client must be identified on every page;
 6. The person making each entry must be identified;
 7. Entries must be concise, but must include all pertinent information;
 8. All information regarding a client must be kept together, in a logical organized sequence, for easy access and review by case managers, supervisors, program monitors and auditors; and
 9. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact, or is a judgment or conclusion on the part of anyone.

10. All persons and agencies referenced in the documentation must be identified by name and by relationship to the client.
 11. All forms prescribed by the Department shall be completely and accurately filled out by the case manager.
 12. Whenever the case manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the Single Entry Point agency's control, the circumstances shall be documented in the case record. These circumstances shall be taken into consideration upon monitoring of Single Entry Point agency performance. However, under no circumstances shall continued stay review ULTC-100 forms be backdated by the utilization review contractor, according to Section 8.486.33, ASSESSMENT, or late PAR revisions be approved by the State or its agent, according to Section 8.485.93, STATE PRIOR AUTHORIZATION OF SERVICES.
- E. Summary recording to update a case record shall be done at least every six months or whenever a case is transferred from one Single Entry Point agency to another, or when a case is closed. The location of the six-month summary within the case file may be determined by the Single Entry Point agency, however, the location must be consistent across client files.

.27 Completion of Single Entry Point Forms

- A. The Notice of Services Status (LTC-803) form, or an Advisement Letter, shall be sent for all applicable programs at the time of initial eligibility, when there is a significant change in the client's payment or services, an adverse action, or at the time of discontinuation. The Single Entry Point client shall receive a copy of the LTC-803, or Advisement Letter, and a copy shall be placed in the client's case record.
- B. The ULTC-100 shall be completed at the time of initial assessment and when there is a significant change in the client's condition, and shall be updated at each six-month summary recording.

For the AFC and HCA Programs, the original ULTC-100 shall be sent to the Department at the time of the initial assessment and each annual reassessment. For HCBS Programs, and admissions to nursing facilities from the community, the original ULTC-100 copy shall be sent to the Utilization Review Contractor, as applicable, or kept by the Single Entry Point agency. A copy shall be placed in the client's case record. At the six-month record update, if there are changes in the client's condition which significantly change the payment or services amount, a copy of the ULTC-100 must be sent to the Department or the Utilization Review Contractor, as applicable or kept by the Single Entry Point agency.

- C. When receiving a ULTC-100 from other entities, including but not limited to nursing facilities and hospitals, for utilization management activities, the Utilization Review Contractor shall review the completeness of the ULTC-100. If such ULTC-100 is not sufficiently complete, according to Department-approved criteria, to conduct the utilization management review, then the Utilization Review Contractor shall notify the originating entity within two business days of receipt that the ULTC-100 is incomplete and that a review will not be completed without the requested additional information.

8.393.28 A. DENIALS/DISCONTINUATIONS

Clients shall be denied or discontinued from services under publicly funded programs administered by the Single Entry Point system if they are determined ineligible due to any of the reasons below. Clients shall be notified of the action and appeal rights as follows:

1. Financial Eligibility

The income maintenance technician shall notify the client of denial for reasons of financial eligibility, and shall inform the client of appeal rights in accordance with Section 8.057. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the State.

2. Level of Care and Target Group

- a. Home and Community-Based Services Programs, and nursing facility admissions from the community:

The Utilization Review Contractor shall notify the client of denial for reasons related to determination of level of care and target group eligibility, and shall inform the client of appeal rights in accordance with Section 8.057. The case manager shall not make judgments as to eligibility regarding level of care or target group, and shall refer all clients who request a utilization review to the utilization review contractor

- b. Home Care Allowance and Adult Foster Care Programs:

The Single Entry Point agency shall notify the applicant on the State-prescribed form [LTC-803] of the denial and appeal rights, and the case manager shall attend the appeal hearing to defend a denial or discontinuation, when:

- 1) Home Care Allowance functional capacity and/or Need For Paid Care scores do not meet minimum requirements.
- 2) The applicant does not meet the Appropriateness for Placement Criteria for Adult Foster Care

3. Receipt of Services

The Single Entry Point agency shall notify the client, via the LTC-803, of the denial and appeals rights, and shall attend the appeal hearing to defend the denial or discontinuation, when:

- a. The client has not received services for one month;
- b. The applicant has two (2) times in a thirty (30) day consecutive period, refused to schedule an appointment for assessment, 6 month visit or after an inter-district transfer, or, has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period;
- c. The client or authorized representative refuses to use the Home Care Allowance or Adult Foster Care payment to pay for services, or uses the payment for services not identified in the service agreement; or
- d. The client or authorized representative refuses to sign the Intake form, Care Plan form, Release of Information form, or other forms as required to receive services.

4. Institutional Status

The Single Entry Point agency shall notify the client of denial or discontinuation, via the

LTC-803, when the case manager determines that the client does not meet the following program eligibility requirements. The case manager shall attend the appeal hearing to defend the denial or discontinuation, when:

- a. The client is not eligible to receive services while a resident of a nursing facility, hospital, or other institution.
- b. The client who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.
- c. An applicant for Home Care Allowance (HCA) is residing in an Adult Foster Care or Alternative Care Facility; or a client receiving HCA has resided in such a facility more than thirty (30) days.

5. Cost-Effectiveness/Service Limitations

The Single Entry Point agency shall notify the client of denial or discontinuation, via the LTC-803 form, when the case manager determines that the client cannot be safely served given the type and/or amount of services available, or, if applicable, is not eligible due to the cost of Home Health and HCBS services exceeding the individual cost containment amount determined at 8.485.61 E. The case manager shall attend the appeal hearing to defend the denial or discontinuation action.

To support a denial or discontinuation for safety reasons related to cost-effectiveness or insufficient services being available, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and which will satisfy the burden of proof required of the case manager making the denial.

- 8.393.28 B. 1. In the case of denial or discontinuation, the case manager shall provide appropriate referrals to other community resources, as needed, within one (1) working day of discontinuation.
2. The case manager shall notify all providers on the case plan within one (1) working day of discontinuation.
 3. The case manager shall notify the Utilization Review Contractor on a Department-prescribed form within thirty (30) calendar days of discontinuation for all HCBS Programs.
 4. If a case is discontinued before an approved HCBS Prior Authorization Request (PAR) has expired, the case manager shall submit to the Department or its fiscal agent, within five (5) working days of discontinuation, a copy of the current PAR form on which the end date is adjusted (and highlighted in some manner on the form); and the reason for discontinuation shall be written on the form.

8.393.28 C. ADVISEMENT LETTERS

When clients are denied or discontinued from publicly funded programs administered by the Single Entry Point agency, for reasons not related to the eligibility requirements at Section 8.393.28 D, the Single Entry Point agency shall follow the procedures below:

1. Death

Clients who die shall be discontinued from the program, effective upon the day after the date of death. No advisement letter shall be sent when the basis for discontinuation is death of the client.

2. Move Out of State

Clients who move out of Colorado shall be discontinued effective upon the day after the date of the move. The case manager shall send the client a State-prescribed Advisement Letter advising the client that the case has been closed. Clients who leave the state on a temporary basis, with intent to return to Colorado, according to Income Maintenance Staff Manual Section 3.140.2, RESIDENCE, shall not be discontinued unless one or more of the other eligibility criteria are no longer met.

3. Voluntary Withdrawal from the Program

Clients who voluntarily withdraw from a program shall be discontinued from the program effective upon the day after the date on which the client's request is documented, or the date on which the client enters a nursing facility, other long term care institution, or another HCBS program. The case manager shall send the client a State-prescribed Advisement Letter advising the client that the case has been closed.

4. Residing in an Unlicensed Personal Care Boarding Home

When a client is residing in an unlicensed personal care boarding home, the case manager after confirming with the Colorado Department of Public Health and Environment that the facility is unlicensed, shall inform the client and client's designated representative, if any, of the need to relocate within thirty (30) days in order to continue to receive services. The case manager shall deny or discontinue the client from the publicly funded program effective the thirty-first (31st) day after advising the client of the need to relocate, by sending the client an Advisement Letter advising the client that the case has been closed.

8.393.28 D. The Single Entry Point agency shall notify the income eligibility section of the appropriate county department of social services:

1. At the same time that it notifies the applicant or client of the adverse action;
2. When the applicant or client has filed a written appeal with the Single Entry Point agency; and
3. When the applicant or client has withdrawn the appeal or a final agency decision has been entered.

8.393.28 E. When the Single Entry Point agency conducts an assessment of the applicant's or client's functional capacity on the Uniform Long Term Care Client Assessment Instrument for review by the utilization review contractor, the assessment is not an adverse action which is directly appealable. The applicant's or client's right to appeal arises only when notice of adverse action is given by the Utilization Review Contractor regarding denial of certification for applicable long term care programs. The appeal process is governed by the provisions of Section 8.059.12, titled "Appeals Related to the Utilization Review Contractors" in this Staff Manual.

8.393.28 F. The Single Entry Point agency shall provide information to applicants and clients regarding their appeal rights when applicants apply for publicly funded long term care services or whenever the client requests such information, whether or not adverse action has been taken by the Single Entry Point agency.

8.393.29 COMMUNICATION

In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

- A. The case manager shall inform the income maintenance technician of any and all changes effecting the client's participation in Single Entry Point agency-administered programs, including changes in income, within one working day after the case manager learns of the change. The case manager shall provide the technician with copies of the first page of all (utilization review contractor) approved ULTC-100 forms within one working day after receipt from (utilization review contractor).
- B. If the client has an open adult protective services case at the county department of social services, the case manager shall keep the client's caseworker informed of the client's status and shall participate in mutual staffing of the client's case.
- C. The case manager shall inform the client's physician of any significant changes in the client's condition or needs.
- D. The case manager shall report to the Colorado Department of Public Health and Environment any congregate facility which is not licensed.
- E. The Single Entry Point agency.

8.393.295 UTILIZATION MANAGEMENT

In addition to any utilization management requirements specified elsewhere in these rules, the Single Entry Point Agency, if assuming utilization management duties, or another Utilization Review Contractor, as applicable, shall be responsible for the following:

- A. For Utilization Management Activities Using a Functional Needs Assessment
 - 1. The Utilization Review Contractor logs in Functional Needs Assessment Reviews completed by the Single Entry Point agency and Functional Needs Assessments Reviews received from other entities on the same day as completion/receipt on the Department approved log form.
 - 2. If a ULTC 100.2 is complete, scoring must be completed with in three (3) business days for hospital discharge and brain injury reviews, all other reviews must be completed within ten (10) business days of receipt.
 - 3. The Utilization Review Contractor determines if the score indicates that client should be approved or disapproved for admission or continued stay to an applicable long term care program and notes recommendation in case file.
 - 4. If the assessment indicates approval, the Utilization Review Contractor assures that approval is noted and that the appropriate parties are notified, including requesting client, client's designated representative, if applicable, and requesting provider.
 - 5. If the assessment indicates denial, the Utilization Review Contractor shall notify the appropriate parties. Such notification shall include directions for filing an appeal with the Division of Administrative Hearings pursuant to Section 8.057.

If the client or client's designated representative appeals, the Utilization Review Contractor shall process such request, according to Recipient Appeals 8.057.

8.393.3 INTERCOUNTY AND INTERDISTRICT TRANSFER PROCEDURES

.31 Intercounty transfers.

Single Entry Point agencies shall complete the following procedures to transfer case management clients to another county within the same Single Entry Point district:

- A. Notify the income maintenance technician of the client's plans to relocate to another county and the date of transfer, and instruct the technician to follow the procedures for intercounty transfers (Department of Human Services, Staff Manual, Volume 3, Section 3.140.3).
- B. If the client's current service providers do not provide services in the area where the client is relocating, make arrangements in consultation with the client for new service providers.
- C. If the client is moving from one county to another county to enter an Alternative Care Facility, forward copies of the following client records to the Alternative Care Facility, prior to the client's admission to the facility:
 - 1. Uniform Client Assessment Instrument (ULTC-100), certified by a Utilization Review Contractor,
 - 2. Client Payment Form for Alternative Care Facility clients; and
 - 3. Verification of Medicaid eligibility status.

.32 Interdistrict transfers.

Single Entry Point agencies shall complete the following procedure in the event a client transfers from one Single Entry Point district to another Single Entry Point district:

- A. The transferring Single Entry Point agency shall contact the receiving Single Entry Point agency by telephone and give notification that the client is planning to transfer, negotiate a transfer date, and provide information.
- B. If the transfer is from one county to another county, the transferring Single Entry Point agency shall notify the income maintenance technician of the client's plan to transfer and the transfer date, and instruct the technician to follow procedures for intercounty transfers (Section 3.140.3, Volume 3; and Section 8.110.39, Volume 8). The receiving Single Entry Point agency shall coordinate the transfer with the income maintenance technician of the new county.
- C. The transferring Single Entry Point agency shall forward copies of the client's case records, including forms required by the publicly funded program, to the receiving Single Entry Point agency prior to the relocation, if possible, or in no case later than five (5) working days after the client's relocation.
- D. If the client is moving from one Single Entry Point district to another Single Entry Point district to enter an Alternative Care Facility, the transferring Single Entry Point agency shall forward copies of client records to the Alternative Care Facility, prior to the client's admission to the facility, in accordance with the procedures for intercounty transfers.
- E. The receiving Single Entry Point agency shall complete a face-to-face meeting with the client and a case summary update within ten (10) working days after notification of the client's relocation, in accordance with assessment procedures for Single Entry Point agency clients.
- F. The receiving single entry point agency shall review the care plan and ULTC-100, and change or

coordinate services and providers as necessary.

- G. If indicated by changes in the care plan, the receiving Single Entry Point agency shall revise the care plan and service authorization forms as required by the publicly funded program.
- H. Within thirty (30) calendar days of the client's relocation, the receiving Single Entry Point agency shall forward to the Department, or its designee, revised forms as required by the publicly funded program.

8.393.4 STAFFING OF A SINGLE ENTRY POINT AGENCY

.41 Staffing patterns.

The Single Entry Point agency shall provide staff for the following functions: receptionist/clerical, administrative/ supervisory, case management, and medical consulting services.

- A. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, assisting Single Entry Point agency staff with clerical duties, and entering data into an information management system.
- B. The administrative/supervisory function of the Single Entry Point agency shall include, but not be limited to, supervision of staff, training and development of agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, review and signing of all HCA and AFC ULTC-100s, resource development, marketing, liaison with the Department, and, as needed, providing case management services in lieu of the case manager.
- C. The case management function shall include, but not be limited to, all of the case management functions previously defined for Single Entry Point case management services, as well as resource development, and attendance at staff development and training sessions.
- D. Effective October 1, 2001, the contracted medical consultant services functions shall include, but not be limited to, an employed or contracted physician and/or registered nurse who shall provide consultation to Single Entry Point agency staff regarding medical and diagnostic concerns and long term home health prior authorizations.

.42 Qualifications of staff.

The Single Entry Point agency's supervisor(s) and case manager(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

- A. Case managers shall have at least a bachelor's degree in one of the human behavioral science fields (such as human services, nursing, social work, psychology, etc.).
- B. An individual who does not meet the minimum educational requirement may qualify as a Single Entry Point agency case manager under the following conditions:
 - 1. The determination as to the qualification as a case manager shall be made jointly by the Single Entry Point agency and the Department;
 - 2. Experience as a caseworker or case manager with the long term care client population, in a private or public social services agency may substitute for the required education on a year for year basis; and

3. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.
- C. The case manager shall be required to demonstrate competency in all of the following areas:
1. Knowledge of and ability to relate to populations served by the Single Entry Point agency;
 2. Client interviewing and assessment skills;
 3. Knowledge of the policies and procedures regarding public assistance programs;
 4. Ability to develop care plans and service agreements;
 5. Knowledge of long term care community resources; and
 6. Negotiation, intervention, and interpersonal communication skills.
- D. The Single Entry Point agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of long term care.

.43 Functions of the case manager.

The Single Entry Point agency's case manager(s) shall be responsible for all case management services provided by the Single Entry Point agency including: information and referral, intake/screening/referral, assessment of clients, development of care plans, on-going case management, monitoring of clients, reassessments, resource development for individual clients, and case closure.

- A. The case manager shall contact the client at least once within each quarterly period, or more frequently if warranted by the client's condition.
- B. The case manager shall have a face-to-face contact with the client at least every six months, or more frequently if warranted by the client's condition, updating the Uniform Long Term Care Client Assessment Instrument and placing a copy in the client file.
- C. The case manager shall reassess the client annually, or more frequently if warranted by the client's condition or if required by program criteria, completing a new Uniform Long Term Care Client Assessment Instrument.
- D. The case manager shall monitor the services provided to the client, and shall monitor the contract between the client and the provider when required by the publicly funded program.
1. The case manager shall monitor the quality of care provided, and
 2. The case manager shall monitor the health and safety of the client.
- E. The following criteria may be used by the case manager to determine the client's level of need for case management services:
1. Availability of family, volunteer, or other support,
 2. Overall level of functioning,
 3. Mental status or cognitive functioning,
 4. Duration of disabilities,

5. Whether the client is in a crisis or acute situation,
6. The client's perception of need and dependency on services, and
7. The client's move to a new housing alternative, if applicable,

.44 Functions of the Single Entry Point agency supervisor

Single Entry Point agencies shall provide adequate supervisory staff who shall be responsible for:

- A. Supervisory case conferences with case managers, on a regular basis;
- B. Review and signing of all HCA and AFC ULTC-100s: and regular, systematic review of case records and other case management documentation, on at least a sample basis;
- C. Communication with the Department when technical assistance is required by case managers, and the supervisor is unable to provide answers after reviewing the regulations;
- D. Allocation and monitoring of staff to assure that all standards and time frames are met in a reasonable percentage of cases; and
- E. Assumption of case management duties when necessary.

.45 Training of Single Entry Point agency staff.

Single entry point agency staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for Single Entry Point agencies.

- A. Prior to agency start-up, the Single Entry Point agency staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:
 1. Background information on the development and implementation of the Single Entry Point system;
 2. Mission, goals, and objectives of the Single Entry Point system;
 3. Regulatory requirements and changes or modifications in federal and state programs;
 4. Contracting guidelines, quality assurance mechanisms, and certification requirements; and
 5. Federal and state requirements for the Single Entry Point agency.
- B. During the first three years of agency operation, in addition to an agency's own training, the Department or its designee will provide in-service and skill development training for Single Entry Point agency staff on an annual basis. Thereafter, the Single Entry Point agency will be responsible for in-service and staff development training.

8.393.5 RESOURCE DEVELOPMENT

.51 Resource development committee.

The Single Entry Point agency shall assume a leadership role in facilitating the development of local resources to meet the long term care needs of clients who reside within the Single Entry Point district served by the Single Entry Point agency.

- A. Within 90 days of the effective date of the initial contract, the Single Entry Point agency's community advisory committee shall appoint a resource development committee.
- B. The membership of the resource development committee shall include, but not be limited to, representation from the following local entities: area agencies on aging, county departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards for the developmentally disabled, vocational rehabilitation agencies, and long term care consumers.
- C. In coordination with the resource development efforts of the area agency(ies) on aging that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.
 - 1. The resource development plan shall include:
 - a. An analysis of the long term care resources available within the Single Entry Point district;
 - b. Gaps in long term care resources within the Single Entry Point district;
 - c. Strategies for developing needed resources: and
 - d. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support, and a time frame for accomplishing stated objectives.
 - C. 2. The data generated by the Single Entry Point agency's information and referral, intake/screening/referral, client assessment, documentation of unmet client needs, resource development for individual clients, and data available through the Department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.
- D. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the Department.

.52 Certification of service providers.

The Single Entry Point agency shall be responsible for the certification of adult foster care facilities within the Single Entry Point district, in accordance with Department rules for adult foster care (Section 8.483, et seq., of this Staff Manual).

8.393.6 PROVISION OF DIRECT SERVICES

.61 Waiver criteria.

The Single Entry Point agency may be granted a waiver by the Department to provide direct services provided the agency complies with the following:

- A. The Single Entry Point agency shall document at least one of the following in a formal letter of application for the waiver:
 - 1. The service is not otherwise available within the Single Entry Point district or within a sub-region of the district; and/or

2. The service can be provided more cost effectively by the Single Entry Point agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or subregion of the district.
- B. The Single Entry Point agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report, at such time and on a form as prescribed by the Department, which includes a cost comparison of the service with other service providers in the area in order to document continuing cost effectiveness.
 - C. The Single Entry Point agency shall assure the Department that efforts have been made, and will continue to be made, to develop the needed service within the Single Entry Point district or within the sub-region of the district, as a service external to the Single Entry Point agency. The Single Entry Point agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.
 - D. The direct service provider functions and the Single Entry Point agency functions shall be administratively separate.
 - E. In the event other service providers are available within the district or sub-region of the district, the Single Entry Point agency case manager shall document in the client's case record that the client has been offered a choice of providers.

8.394 ACCOUNTABILITY MECHANISMS FOR SINGLE ENTRY POINT AGENCIES

8.394.1 PERFORMANCE BASED CONTRACT

A Single Entry Point agency shall be bound to the terms of the contract between the agency and the Department, including quality assurance standards and compliance with the Department's rules for Single Entry Point agencies and for publicly funded programs.

8.394.2 CERTIFICATION OF SINGLE ENTRY POINT AGENCIES

A Single Entry Point agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.

- A. Certification as a Single Entry Point agency shall be based on an evaluation of the agency's performance in the following areas:
 1. The quality of the services provided by the agency;
 2. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;
 3. The agency's performance of administrative functions, including reasonable costs per client, timely reporting, managing programs in one consolidated unit, on-site visits to clients, community coordination and outreach, and client monitoring;
 4. Whether targeted populations are being identified and served;
 5. Financial accountability, and
 6. The maintenance of qualified personnel to perform the contracted duties.
- B. The Department or its designee shall conduct reviews of the Single Entry Point agency.

- C. At least sixty (60) days prior to expiration of the previous year's certification, the Department shall notify the Single Entry Point agency of the outcome of the review, which may be approval, provisional approval, or denial of certification.

.21 Provisional approval of certification.

In the event a Single Entry Point agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of clients.

- A. The agency will receive notification of the deficiencies and a request to submit a corrective action plan to be approved by the Department. Upon receipt and review of the corrective action plan, at the Department's option, a second sixty-day provisional certification may be approved.
- B. The Department or its designee shall provide technical assistance to facilitate corrective action.

.22 Denial of certification.

In the event certification as a Single Entry Point agency is denied, the procedure for Single Entry Point agency termination or nonrenewal of contract shall apply (Section 8.391.22).

NOTE: Sections 8.394.3–8.394.4 were deleted effective December 2, 2002.

8.400 LONG TERM CARE

- .10 Long term care includes nursing facility care as part of the standard Medicaid benefit package, and Home and Community Based Services provided under waivers granted by the Federal government.
- .101 Nursing facility services and Home and Community Based Services are benefits only under Medicaid. Nursing Facility Services and Home and Community Based Services are non-benefits under the Modified Medical Program.
- .102 State only funding will pay for nursing facility services for October 1988 and November 1988 for clients under the Modified Medical Program who were residing in a nursing facility October 1, 1988. This is intended to give clients time to qualify for Medicaid.
- .103 Until the implementation of SB 03-176 a legal immigrant, as defined in 26-4-103(8.5), C.R.S., who received Medicaid services in a nursing facility or through Home and Community Based Services for the Elderly, Blind and Disabled on July 1, 1997, who would have lost Medicaid eligibility due to his/her immigrant status, shall continue to receive services under State funding as long as he/she continues to meet Medicaid eligibility requirements.
- .104 If a nursing facility client, who is only eligible for the Modified Medical Program, is making a valid effort to dispose of excess resources but legal constraints do not allow the conversion to happen by December 1, 1988, the client may have 60 additional days to meet SSI eligibility requirements.
- .11 Standard Medicaid long term care services are services provided in:
- Skilled care facilities (SNF)
 - Intermediate care facilities (ICF)

- Intermediate care facilities for the mentally retarded (ICF/MR)

- .12 Home and Community Based Services under the Medicaid waivers include distinct service programs designed as alternatives to standard Medicaid nursing facility or hospital services for discrete categories of clients. These programs are Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based Services for the Developmentally Disabled (HCBS-DD); Home and Community Based Services for those inappropriately residing in nursing facilities (OBRA '87); and, Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA).
- .13 Unless specified by reference to the specific programs described above, the term Home and Community Based Services where it appears in these rules and regulations shall refer to the programs described herein above, and the rules and regulations within this section shall be applicable to all Home and Community Based Services programs.
- .14 Nursing facilities are prohibited from admitting any new client who has mental illness or mental retardation, as defined in 8.401.18 Determination Criteria for Mentally Ill and Developmentally Disabled unless that client has been determined to require the level of services provided by a nursing facility as defined in 8.401.19.
- .15 Clients eligible for Home and Community Based Services are eligible for all Medicaid services including home health services.
- .16 Target Population Definitions. For purposes of determining appropriate type of long term services, including home and community based services, as well as providing for a means of properly referring clients to the appropriate community agency, the following target group designations are established:
 - A. Developmentally Disabled - includes all clients whose need for long term care services is based on a diagnosis of Developmental Disability and Related Conditions, as defined in Section 8.401.18.
 - B. Mentally Ill - includes all clients whose need for long term care is based on a diagnosis of mental disease as defined in Section 8.401.18.
 - C. Functionally Impaired Elderly - includes all clients who meet the level of care screening guidelines for SNF or ICF care, and who are age 65 or over. Clients who are mentally ill, as defined in Section 8.401.18. shall not be included in the target group of Functionally Impaired Elderly, unless the person's need for long term care services is primarily due to physical impairments that are not caused by any diagnosis included in the definition of mental illness at 8.401.18, and determined by Utilization Review Contractor from the medical evidence.
 - D. Physically Disabled or Blind Adult - includes all clients who meet the level of care screening guidelines for SNF or ICF care, and who are age 18 through 64. Clients who are developmentally disabled or mentally ill, as defined in 8.401.18, shall not be included in the Physically Disabled or Blind target group, unless the person's need for long term care services is primarily due to physical impairments not caused by any diagnosis included in the definition of developmental disability or mental illness at 8.401.18, as determined by Utilization Review Contractor from the medical evidence.
 - E. Persons Living with AIDS - includes all clients of any age who meet either the nursing home level of care or acute level of care screening guidelines for nursing facilities or hospitals, and have the -diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may

alternatively request to be designated as any other target group for which they meet the definitions above.

- .17 Services in Home and Community Based Services programs established in accordance with federal waivers shall be provided to clients in accordance with the Utilization Review Contractor determined target populations as defined herein above.

8.401 LEVEL OF CARE SCREENING GUIDELINES

- .01 The client must have been found by the Utilization Review Contractor to meet the applicable level of care guidelines for the type of services to be provided.
- .02 The Utilization Review Contractor shall not make a level of care determination unless the recipient has been determined to be Medicaid eligible or an application for Medicaid services has been filed with the county department of social services.
- .03 Payment for skilled (SNF) and intermediate nursing home care (ICF) and Home and Community Based Services will only be made for clients whose functional assessment and frequency of need for skilled and maintenance services meet the level of care guidelines for long term care.
- .04 Payment for care in an intermediate care facility for the mentally retarded (ICF/MR) will only be made for developmentally disabled clients whose programmatic and/or health care needs meet the level of care guidelines for the appropriate class of ICF/MRs. Payment for Home and Community Based Services for the Developmentally Disabled will only be made for developmentally disabled clients who meet the level of care guidelines for long term care services for the developmentally disabled.
- .05 Services provided by nursing facilities are available to those clients that meet the guidelines below and are not identified as mentally ill or mentally retarded by the Determination Criteria for Mentally Ill and Developmentally Disabled in 8.401.18.

8.401.1 GUIDELINES FOR LONG TERM CARE SERVICES (CLASS I SNF AND ICF FACILITIES, HCB-EBD, HCBS-MI, HCBS-BI, Children's HCBS, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP, HCBS-PLWA, and Long Term Home Health)

- .11 The guidelines for long term care are based on a functional needs assessment in which individuals are evaluated in at least the following areas of activities of daily living:
- Mobility
 - Bathing
 - Dressing
 - Eating
 - Toileting
 - Transferring
 - Need for supervision
- .12 Skilled services shall be defined as those services which can only be provided by a skilled person such as a nurse or licensed therapist or by a person who has been extensively trained to perform that service.

.13 Maintenance services shall be defined as those services which may be performed by a person who has been trained to perform that specific task, e.g., a family member, a nurses aide, a therapy aide, visiting homemaker, etc.

.14 Skilled and maintenance services are performed in the following areas:

- Skin care
- Medication
- Nutrition
- Activities of daily living
- Therapies
- Elimination
- Observation and monitoring

.15 A. The Utilization Review Contractor shall certify as to the functional need for the nursing facility level of care. A Utilization Review Contractor reviews the information submitted on the ULTC 100.2 and assigns a score to each of the functional areas described in subsection 8.401.11 above. The scores in each of the functional areas are based on a set of criteria and weights approved by the State which measures the degree of impairment in each of the functional areas. When the score in a minimum of two ADLs or the score for one category of supervision is at least a (2), the Utilization Review Contractor may certify that the person being reviewed is eligible for nursing facility level of care.

B. The Utilization Review Contractor's review, shall include the information provided by the functional assessment screen.

C. A person's need for basic Medicaid benefits is not a proper consideration in determining whether a person needs long term care services (including Home and Community Based Services).

D. The ULTC 100.2 shall be the comprehensive and uniform client assessment process for all individuals in need of long-term care, the purpose of which is to determine the appropriate services and levels of care necessary to meet clients' needs, to analyze alternative forms of care and the payment sources for such care, and to assist in the selection of long-term care programs and services that meet clients' needs most cost-efficiently.

LONG TERM CARE ELIGIBILITY ASSESSMENT

General Instructions: To qualify for Medicaid long-term care services, the recipient/applicant must have deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision.

ACTIVITIES OF DAILY LIVING

I. BATHING

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

ADL SCORING CRITERIA

- ☐ 0=The client is independent in completing the activity safely.
☐ 1=The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone.
☐ 2=The client requires hands on help or standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity.
☐ 3=The client is dependent on others to provide a complete bath.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments : ☐ Pain ☐ Visually Impaired ☐ Limited Range of Motion ☐ Weakness ☐ Balance Problems ☐ Shortness of Breath ☐ Decreased Endurance ☐ Falls ☐ Paralysis ☐ Neurological Impairment ☐ Oxygen Use ☐ Muscle Tone ☐ Amputation	☐ Open Wound ☐ Stoma Site Supervision: ☐ Cognitive Impairment ☐ Memory Impairment ☐ Behavior Issues ☐ Lack of Awareness ☐ Difficulty Learning ☐ Seizures Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

Comments:

II. DRESSING

Definition: The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.

ADL SCORE CRITERIA

- ☐ 0= The client is independent in completing activity safely.
☐ 1=The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days.
☐ 2= The client needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time.
☐ 3= The client is totally dependent on others for dressing and undressing

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments : ☐ Pain ☐ Sensory Impairment ☐ Limited Range of Motion ☐ Weakness ☐ Balance Problems ☐ Shortness of Breath ☐ Decreased Endurance ☐ Fine Motor Impairment ☐ Paralysis ☐ Neurological Impairment ☐ Bladder Incontinence ☐ Bowel Incontinence ☐ Amputation ☐ Oxygen Use ☐ Muscle Tone	☐ Open Wound Supervision: ☐ Cognitive Impairment ☐ Memory Impairment ☐ Behavior Issues ☐ Lack of Awareness ☐ Difficulty Learning ☐ Seizures Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

Comments:

III. TOILETING

Definition: The ability to use the toilet, commode, bedpan or urinal. This includes transferring on/off the toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing.

ADL SCORE CRITERIA

- ☐ 0=The client is independent in completing activity safely.
☐ 1=The client may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.
☐ 2=The client needs physical assistance or standby with toileting, including bowel/bladder training, a bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environment clean.
☐ 3=The client is unable to use the toilet. The client is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The client may or may not be aware of own needs.

Due To: (Score must be justified through one or more of the following conditions)

<u>Physical Impairments:</u> ☐ Pain ☐ Visual Impairment ☐ Limited Range of Motion ☐ Weakness ☐ Shortness of Breath ☐ Decreased Endurance ☐ Fine Motor Impairment ☐ Paralysis ☐ Neurological Impairment ☐ Bladder Incontinence ☐ Bowel Incontinence ☐ Amputation ☐ Oxygen Use ☐ Physiological defect ☐ Balance ☐ Muscle Tone ☐ Impaction	☐ Ostomy ☐ Catheter <u>Supervision Need:</u> ☐ Cognitive Impairment ☐ Memory Impairment ☐ Behavior Issues ☐ Lack of Awareness ☐ Difficulty Learning ☐ Seizures <u>Mental Health:</u> ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

Comments:

IV. MOBILITY

Definition: The ability to move between locations in the individual's living environment inside and outside the home. Note: Score client's mobility without regard to use of equipment.

ADL SCORE CRITERIA

- ☐ 0=The client is independent in completing activity safely.
☐ 1=The client is mobile in their own home but may need assistance outside the home.
☐ 2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home.
☐ 3=The client is dependent on others for all mobility.

Due To: (Score must be justified through one or more of the following conditions)

<u>Physical Impairments:</u> ☐ Pain ☐ Sensory Impairment ☐ Limited Range of Motion ☐ Weakness ☐ Shortness of Breath ☐ Decreased Endurance ☐ Fine or Gross Motor Impairment ☐ Paralysis ☐ Neurological Impairment ☐ Amputation ☐ Oxygen Use ☐ Balance ☐ Muscle Tone	<u>Supervision Need:</u> ☐ Cognitive Impairment ☐ Memory Impairment ☐ Behavior Issues ☐ Lack of Awareness ☐ Difficulty Learning ☐ Seizures ☐ History of Falls <u>Mental Health:</u> ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

Comments:

V. TRANSFERRING

Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices for transfers. Note: Score client's mobility without regard to use of equipment.

ADL SCORE CRITERIA

- ☐0=The client is independent in completing activity safely.
☐1=The client transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed.
☐2=The client transfer requires standby or hands on assistance for safety; client may bear some weight.
☐3=The client requires total assistance for transfers and/or positioning with or without equipment.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments: ☐ Pain ☐ Sensory Impairment ☐ Limited Range of Motion ☐ Weakness ☐ Balance Problems ☐ Shortness of Breath ☐ Falls ☐ Decreased Endurance ☐ Paralysis ☐ Neurological Impairment ☐ Amputation ☐ Oxygen Use	Supervision Need: ☐ Cognitive Impairment ☐ Memory Impairment ☐ Behavior Issues ☐ Lack of Awareness ☐ Difficulty Learning ☐ Seizures Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

Comments:

VI. EATING

Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew and swallow food. **Note:** If a person is fed via tube feedings or intravenously, check box 0 if they can do independently, or box 1, 2, or 3 if they require another person to assist.

ADL SCORE CRITERIA

- ☐0=The client is independent in completing activity safely
- ☐1=The client can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment.
- ☐2=The client can feed self but needs standby assistance for frequent gagging, choking, swallowing difficulty, or aspiration resulting in ~~need~~ need for medical intervention. The client needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person.
- ☐3=The client must be totally fed by another person; must be fed by another person by stomach tube or venous access.

Due To: (Score must be justified through one or more of the following conditions)

<u>Physical Impairments:</u> ☐ Pain ☐ Visual Impairment ☐ Limited Range of Motion ☐ Weakness ☐ Shortness of Breath ☐ Decreased Endurance ☐ Paralysis ☐ Neurological Impairment ☐ Amputation ☐ Oxygen Use ☐ Fine Motor Impairment ☐ Poor Dentition ☐ Tremors ☐ Swallowing Problems ☐ Choking ☒ Aspiration	☐ Tube Feeding ☐ IV Feeding <u>Supervision Need:</u> ☐ Cognitive Impairment ☐ Memory Impairment ☐ Behavior Issues ☐ Lack of Awareness ☐ Difficulty Learning ☐ Seizures <u>Mental Health:</u> ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

Comments:

VII. SUPERVISION

Definition: The need for supervision is indicated by a significant impairment in Behavior and/or Cognition/Memory.

A. Behaviors (Wandering/Disruptive/Self-Injurious/Resistive to care/Self-neglect)

Scoring Criteria

- ☐ 0=The client demonstrates appropriate behavior; there is no concern.
- ☐ 1=The client exhibits some inappropriate behaviors but not resulting in injury to self, others and/or property. The client may require redirection. Minimal intervention is needed.
- ☐ 2=The client exhibits inappropriate behaviors that put self, others or property at risk. The client requires more than verbal redirection to interrupt inappropriate behaviors. The client needs medication assistance, monitoring, supervision or is unable to make safe decisions.
- ☐ 3=The client exhibits behaviors resulting in physical harm for self or others. The client requires extensive supervision to prevent physical harm to self or others.

Due To: (Score must be justified through one or more of the following conditions)

<u>Physical Impairments:</u> ☐ Medication Management ☐ Chronic Medical Condition ☐ Acute Illness ☐ Pain ☐ Neurological Impairment ☐ Choking ☐ Sensory Impairment ☐ Communication Impairment (not inability to speak English) <u>Mental Health:</u> ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia ☐ Mood Instability	<u>Supervision needs:</u> ☐ Short Term Memory Loss ☐ Long Term Memory Loss ☐ Agitation ☐ Aggressive Behavior ☐ Cognitive Impairment ☐ Difficulty Learning ☐ Memory Impairment ☐ Verbal Abusiveness ☐ Constant Vocalization ☐ Sleep Deprivation ☐ Self-Injurious Behavior ☐ Impaired Judgment ☐ Disruptive to Others ☐ Disassociation ☐ Wandering ☐ Seizures ☐ Self Neglect

Comments:

B. Memory/Cognition Deficit

Scoring Criteria

- ☐ 0= Independent no concern
- ☐ 1= The client can make safe decisions in familiar/routine situations, but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.
- ☐ 2= The client requires consistent and ongoing reminding and assistance with planning, or requires regular assistance with adjusting to both new and familiar routines, including medication assistance and monitoring or requires ongoing supervision or is unable to make safe decisions, or cannot make his/her basic needs known.
- ☐ 3= The client needs help most or all of time. Medications must be administered for the client.

Due To: (Score must be justified through one or more of the following conditions)

<u>Physical Impairments:</u> ☐ Metabolic Disorder ☐ Medication Reaction ☐ Acute Illness ☐ Pain ☐ Neurological Impairment ☐ Alzheimer's/Dementia ☐ Sensory Impairment ☐ Chronic Medical Condition ☐ Communication Impairment (does not include ability to speak English) ☐ Abnormal Oxygen Saturation ☐ Fine Motor Impairment <u>Supervision Needs:</u> ☐ Disorientation ☐ Cognitive Impairment ☐ Difficulty Learning ☐ Memory Impairment	☐ Self-Injurious Behavior ☐ Impaired Judgment ☐ Unable to Follow Directions ☐ Constant Vocalizations ☐ Perseveration ☐ Receptive Expressive Aphasia ☐ Agitation ☐ Disassociation ☐ Wandering ☐ Lack of Awareness ☐ Seizures <u>Mental Health:</u> ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia ☐ Mood Instability

Comments:

8.401.18 PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) AND SPECIALIZED SERVICES FOR MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS

.181 Purpose of Program

- A. The PASARR program requires pre-screening or reviewing of all clients who apply to or reside in a Medicaid certified nursing facility regardless of:
 - 1. The source of payment for the nursing facility services; or
 - 2. The individual's or resident's diagnosis.
- B. The purpose of the PASARR Level I Identification screening is to identify for further review, all those clients seeking nursing facility admission, for whom it appears a diagnosis of mental illness or mental retardation is likely.
- C. The purpose of the PASARR Level II evaluation is to evaluate and determine whether nursing facility services are needed, whether an individual has mental illness or mental retardation and whether specialized mental health or mental retardation services are needed.

.182 Definitions

A. Mental Illness

- 1. [Removed per S.B. 03-088, 26 CR 7]
- 2. A major mental disorder is defined as: A primary diagnosis of schizophrenic, paranoid, major affective, schizoaffective disorders or other psychosis.
- 3. An individual is considered to not have mental illness if he/she has:
 - a. a primary diagnosis of dementia (including Alzheimer's disease or a related disorder); or
 - b. a non-primary diagnosis of dementia (including Alzheimer's disease or a related disorder) without a primary diagnosis of serious mental illness, or mental retardation or a related condition.

B. Mental Retardation and Related Conditions

[Removed per S.B. 03-088, 26 CR 7]

- 1. Mental Retardation refers to significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental years.
- 2. The provisions of this section also apply to individuals with "related conditions," as defined by 42 C. F. R. § 435.1009 (2000) which states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:
 - a. It is attributable to:
 - 1) Cerebral palsy or epilepsy; or
 - 2) Any other condition, other than mental illness, found closely related to mental

retardation. These related conditions result in impairment of general intellectual functioning or adaptive behavior similar to individuals with mental retardation, and require treatment or services similar to those required for these individuals.

- b. It is manifested before the individual reaches age 22.
- c. It is likely to continue indefinitely.
- d. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - 1) Self-care,
 - 2) Understanding and use of language,
 - 3) Learning,
 - 4) Mobility,
 - 5) Self-direction or
 - 6) Capacity for independent living.”

8.401.183 Requirements for the PASARR Program

- A. The Level of Care determination and the Level I screening reviews shall be required by the Utilization Review Contractor prior to admission to a Medicaid certified nursing facility.
- B. The Utilization Review Contractor admission start date (the first date of care covered by Medicaid) shall be assigned after the required Level II PASARR evaluation is completed and the Utilization Review Contractor certifies the client is appropriate for nursing facility care. The admission start date for individuals who do not requiring a Level II evaluation shall be the date that the Initial Screening and Intake Form and Professional Medical Information pages from the ULTC 100.2 are faxed to the Single Entry Point.
- C. Individuals other than Medicaid eligible recipients, who require a Level II evaluation, shall have the Level II evaluation prior to admission. The Level II contractor shall perform the evaluation. The Level II contractor can be a qualified mental health professional, a corporation that specializes in mental health, the community mental health center, or the community centered board.
- D. The Level II contractor shall conduct a review and determination for individuals or clients found to be mentally ill or retarded who have had a change in mental health or developmental disabled status.
- E. PASARR findings, as related to care needs, shall be coordinated with the nursing facility federally prescribed, routine Resident Assessments (Minimum Data Set) requirements. These requirements are described at 42 C.F.R., §483.20 (October 1, 2000 edition). No amendments or later editions are incorporated. Copies are available for inspection at the following address: Health and Medical Services, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714.

8.401.184 Nursing Facilities Responsibilities Under the PASARR Program

- A. The Utilization Review Contractor/Single Entry Point shall complete the Level I screening on the

functional assessment form for Medicaid clients. The nursing facility shall complete the Level I screening for non-Medicaid individuals admitted from the community or pay source change. The hospital shall complete the Level I for non-Medicaid individuals admitted to nursing facility from the hospital. Medicaid Level I information is on the Level I screen in the ULTC-100.2 and is submitted to the Utilization Review Contractor with the rest of the Level of Care information. Private pay Level I information that indicates the resident may be mentally ill or mentally retarded is submitted to the Utilization Review Contractor as well on the ULTC-100.2.

- B. Nursing facility staff shall be trained in which diagnoses, medications, history and behaviors would result in a positive finding in a Level I screening (e.g., a Yes response to a psychiatric diagnosis or history).
- C. Following review of information on the Functional Assessment form, the Utilization Review Contractor determines whether a Level II evaluation is necessary and notifies the facility.
- D. If a Level II evaluation is necessary, the facility and the Level II contractor shall assure that the Level II is completed. Level II PASARR evaluations shall be done at no cost to the individual or facility by the Level II contractor for that geographic area.
- E. If the individual is determined to be mentally ill or mentally retarded as a result of the Level II, the nursing facility shall retain the results of the Level II in the resident's charts. The Level II evaluation shall be updated when the resident's condition changes. The Level II evaluations must be kept current in the resident's charts.
- F. If a Level II evaluation is not required, documentation must be completed on the reasons a Level II one was not done and retained in the resident's chart.
- G. The resident's chart shall contain the following information:
 - 1. The psychiatric evaluation and/or Colorado Assessment Review form (COPAR);
 - 2. The findings; and
 - 3. The determination letter (from either mental health or mental retardation authorities).
- H. The nursing facility shall assure that the diagnoses are current and accurate by reconciling in the resident's record any diagnoses conflicting with the PASARR Level II diagnosis.
- I. The nursing facility is responsible to arrange for services based on service recommendations from the Level II evaluation.
- J. Nursing Facilities may contact the local community mental health centers or community center boards to make arrangements for the provisions of Specialized Services as indicated on the Level II reviews. Furthermore, nursing facilities are prohibited from providing Specialized Services.

.185 The State Survey and Certification Process

- A. The State Survey and Certification Process will be used to determine whether the resident had the following:
 - 1. A comprehensive Level I and Level II assessment;
 - 2. An appropriate care plan; and
 - 3. Specialized treatment, if needed.

- B. The Department of Public Health and Environment shall conduct the PASARR program surveys in accordance with the Agency Agreement between Department of Public Health and Environment and the Department.

.186 Responsibilities of the Utilization Review Contractor in Determining Level of Care

- A. For private pay and nursing facility residents on admission with indications of mental illness or mental retardation, the Utilization Review Contractor shall first determine appropriate admission to a nursing facility through the following process:
1. A Level of Care review;
 2. The Level I identification screen verification;
 3. A Categorical determination, if appropriate; and
 4. A Level II referral, if appropriate.
- B. A nursing facility placement shall be considered appropriate when the following conditions are met:
1. An individual's needs are such that he or she passes the Level of Care screen for admission and the individual is seeking Medicaid reimbursement; and
 2. The Level I and II screens indicate nursing facility placement is appropriate.

8.401.19 LEVEL I IDENTIFICATION SCREEN

- .191 The Level I Screen criteria shall be as follows:

- A. The Level I Screen, used by the Utilization Review Contractor to identify those who may be mentally ill shall, be applied under the following conditions:
1. The individual has a diagnosis of mental illness as defined above; and/or
 2. The individual has a recent (within the last two years) history of mental illness, as defined above; and/or
 3. A major tranquilizer, anti-depressant or psychotropic medication has been prescribed regularly without a justifiable diagnosis of neurological disorder to warrant the medication; and/or
 4. There is presenting evidence of mental illness (except a primary diagnosis of Alzheimer's disease or dementia) including possible disturbances in orientation, affect, or mood, as determined by the Utilization Review Contractor.
- B. The Level I Screen, used by the Utilization Review Contractor to identify those who may be mentally retarded or individuals with related conditions, shall be applied under the following conditions:
1. The individual has a diagnosis of mental retardation or related conditions as defined above; and/or
 2. There is a history of mental retardation or related conditions, as defined above, in the individual's past; and/or

3. There is presenting evidence (cognitive or behavior functions) of mental retardation or related conditions; and/or
4. The individual is referred by an agency that serves individuals with mental retardation or related conditions, and the individual has been determined to be eligible for that agency's services.

.192 When the results of the Level I Screen indicate the individual may have mental illness or mental retardation or related conditions, the individual must undergo the additional PASARR Level II evaluation specified below, unless one or more of the following is determined by the Utilization Review Contractor:

A. There is substantial evidence that the individual is not mentally ill or mentally retarded; or

B. A categorical determination is made that:

1. The individual has:

- a. A primary diagnosis of dementia, including Alzheimer's Disease or a related disorder;
- b. The above must be substantiated based on a neurological examination.

2. The individual is terminally ill (i.e., the physician documents that the individual has less than six months to live).

3. An individual is in need of convalescent care.

a. Convalescent care is defined as:

- 1) A discharge from an acute care hospital;
- 2) An admission for a prescribed, limited nursing facility stay for rehabilitation or convalescent care; and
- 3) An admission for a medical or surgical condition that required hospitalization.

b. If an individual is determined to need convalescent care, the Utilization Review Contractor must follow-up to determine if the individual still needs convalescent care (and the following must occur, including):

- 1) A referral shall be made for a Level II evaluation if the individual remains in the nursing facility for longer than 60 days;
- 2) The above referral shall be made to the appropriate community mental health center or community centered board or other designated agencies; and
- 3) The individual shall receive a Level II evaluation within 10 calendar days of the referral.

4. An individual is severely ill.

a. An individual is considered severely ill if he or she is:

- 1) comatose;
- 2) ventilator dependent;
- 3) in a vegetative state.

b. The following PASARR criteria must be met when an individual is severely ill:

- 1) A Mental Health referral shall be made and a Level II evaluation shall be completed if the individual no longer meets the above criteria as determined by the Utilization Review Contractor.
- 2) A Mental Retardation Level II referral shall be made and an evaluation shall be completed within 60 days of admission, even if the individual meets the above criteria as determined for severely ill by the Utilization Review Contractor.

5. Emergency procedure in C.R.S. § 27-10-101, et. seq., shall supersede the PASARR process. When the State Mental Health authorities, pursuant to C.R.S. § 27-10-101, et. seq., determine that an individual requires inpatient psychiatric care and qualifies under the emergency procedures for a hold and treat order, this procedure shall supersede the PASARR determination process.

.193 For individuals or residents who may have mental illness or mental retardation as determined through the Level I screen and who are referred by the State authorities or designees for a PASARR Level II evaluation, the following applies:

- A. The designated agencies completing the Level I screen shall send a written notice to the individual or resident and to his or her legal representative stating the Level I findings.
- B. The Level I notice to the individual or resident shall be required if the Level I findings result in a referral for a Level II evaluation.
- C. The Level I findings are not an appealable action.

.194 Categorical determinations which may delay a Level II referral shall not prevent the nursing facility from meeting the psychosocial, physical and medical needs of the resident.

.195 Categorical Determinations may be applied only if an individual is in no danger to him/herself or others.

8.401.20 LEVEL II PASARR EVALUATION

.201 The purpose of the Level II evaluation is to determine whether:

- A. Each individual with mental illness or mental retardation requires the level of services provided by a nursing facility.
- B. An individual has a major mental illness or is mentally retarded.
- C. The individual requires a Specialized Services program for the mental illness or mental retardation.

.202 Basic Requirements for LEVEL II PASARR Evaluations and Determinations include:

- A. The State Mental Health authority shall make determinations of whether individuals with mental illness require specialized services that can be provided in a nursing facility as follows:
 - 1. The determination must be based on an independent physical and mental evaluation.
 - 2. The evaluation must be performed by an individual or entity other than the State Mental Health authority.
- B. The State Mental Retardation authority shall conduct both the evaluation and the determination functions of whether individuals with mental retardation require specialized services that can be provided in nursing facilities.
- C. The PASARR Level II contractor shall complete the evaluation within 10 working days of the referral from the Utilization Review Contractor.
- D. PASARR determinations made by the State Mental Health or Mental Retardation authorities cannot be countermanded by the Department through the claims payment process or through other utilization control/review processes, or by the State Department of Public Health and Environment, survey and certification agency, or by any receiving facility or other involved entities.
- E. The Final Agency action by the Department may overturn a PASARR adverse determination made by State Mental Health or Mental Retardation authorities.
- F. Timely filing of PASARR billings from providers is 120 days.

.203 An individual meets the requirements of a Depression Diversion Screen.

- A. A Depression Diversion Screen shall be applied under the following conditions:
 - 1. Depression is the only Level I positive finding (i.e. a depression diagnosis is the only Yes checked on the Level I screen); and
 - 2. The Utilization Review Contractor or the PASARR Level II Contractor for that geographic area shall make the determination of need for a Depression Diversion Screen.
- B. The nursing facilities are not authorized to apply the Depression Diversion Screen.
- C. When a non-major mental illness depression is validated as the only Level I positive finding through the Depression Diversion Screen, a complete Level II referral and evaluation is not required unless the individual's condition changes.

.204 Appeals Hearing Process for the PASARR Program

- A. A resident has appeal rights when he or she has been adversely affected by a PASARR determination as a result of the Level II evaluation made by the State Mental Health or Mental Retardation authorities either at Pre- admission Screening or at Annual Resident Review.
- B. Adverse determinations related to PASARR mean a determination made in accordance with sections 1919(b)(3)(F) or 1919(e)(7)(B) of the Social Security Act that:
 - 1. The individual does not require the level of services provided by a Nursing Facility;

and/or

2. The individual does or does not require Specialized Services for mental illness or mental retardation.
- C. Appeals of Level of Care determination are processed through the Appeals section related to the Utilization Review Contractor's Level of Care process in Staff Manual Volume 8 §8.059.12.
- D. For adverse actions related to the need for Specialized Services, the individual or resident affected by the mental illness or mental-retardation determination may appeal through procedures established for appeals in the Recipient Appeals and Hearings section of Staff Manual Volume 8 §8.059.17.

.205 The Level II PASARR Evaluation Process

- A. The Utilization Review Contractor shall refer all Medicaid clients and private pay individuals who require a Level II evaluation, to the PASARR Level II contractor.
 1. The PASARR Level II contractor shall complete the Level II evaluation..
 2. The State Medicaid program shall pay for the private pay evaluations.
 3. Nursing facilities shall not complete the Level II evaluation.
 4. The findings of these evaluations shall be returned to the Utilization Review Contractor for review and referral to the State Mental Health and/or Mental Retardation authorities for final review and determination.
- B. Evaluations shall be adapted to the cultural background, language, ethnic origin and means of communication used by the individual.
- C. The Level II Mental Illness Evaluation for Specialized Services shall consist of the following:
 1. A comprehensive medical examination of the individual. The examination shall address the following areas:
 - a. A comprehensive medical history;
 - b. An examination of all body systems; and
 - c. An examination of the neurological system which consists of an evaluation in the following areas:
 - 1) Motor functioning;
 - 2) Sensory functioning;
 - 3) Gait and deep tendon reflexes;
 - 4) Cranial nerves; and
 - 5) Abnormal reflexes.
 - d. In cases of abnormal findings, additional evaluations shall be conducted by

appropriate specialists; and

- e. If the history and physical examinations are not performed by a physician, then a physician must review and concur with the conclusions and sign the examination form.
2. A psychosocial evaluation of the individual, which at a minimum, includes an evaluation of the following:
 - a. Current living arrangements;
 - b. Medical and support systems; and
 - c. The individual's total need for services are such that:
 - 1) The level of support can be provided in an alternative community setting; or
 - 2) The level of support is such that nursing facility placement is required.
3. A Functional Assessment shall be completed on the individual's ability to engage in activities of daily living.
4. A comprehensive psychiatric evaluation, at a minimum, must address the following areas:
 - a. A comprehensive drug history is obtained on all current or immediate past utilization of medications that could mask symptoms or use of medications that could mimic mental illness;
 - b. A psychiatric history is obtained;
 - c. An evaluation is completed of intellectual functioning, memory functioning, and orientation;
 - d. A description is obtained on current attitudes, overt behaviors, affect, suicidal or homicidal ideation, paranoia and degree of reality testing (presence and content of delusions, paranoia and hallucinations); and
 - e. Certification status under provisions at 27-10-101, C.R.S., et.seq. and need for in-patient emergency psychiatric care shall be assessed. If an individual qualifies under the emergency provisions in the statute, emergency proceedings shall be considered. This action shall supersede any PASARR activity.
5. If the psychiatric evaluation is performed by a professional other than a psychiatrist, then a psychiatrist's countersignature shall be required.
6. The Mental Health evaluation shall identify all medical and psychiatric diagnoses which require treatment, and should include copies of previous discharge summaries from the hospital or nursing facility charts (during the past two years).
7. The Mental Health determination process shall insure that a qualified mental health professional, as designated by the State, must validate the diagnosis of mental illness and determine the appropriate level of mental health services needed.

D. The Level II Mental Retardation or related conditions evaluation for Specialized Services shall consist of the following:

1. A comprehensive medical examination review so that the following information can be identified:
 - a. A list of the individual's medical problems;
 - b. The level of impact on the individual's independent functioning;
 - c. A list of all current medications; and
 - d. Current responses to any prescribed medications in the following drug groups:
 - 1) Hypnotics,
 - 2) Anti-psychotics (neuroleptics),
 - 3) Mood stabilizers and anti-depressants,
 - 4) Antianxiety-sedative agents, and
 - 5) Anti-Parkinsonian agents.
2. The Mental Retardation process must assess:
 - a. Self-monitoring of health status;
 - b. Self-administering and/or scheduling of medical treatments;
 - c. Self-monitoring of nutrition status;
 - d. Self-help development such as: toileting, dressing, grooming, and eating);
 - e. Sensorimotor development such as: ambulation, positioning, transfer skills, gross motor dexterity, visual motor/perception, fine motor dexterity, eye-hand coordination, and extent to which prosthetic, orthotic, corrective or mechanical supportive devices improve the individual's functional capacity);
 - f. Speech and language (communication) development, such as: expressive language (verbal and nonverbal), receptive language (verbal and nonverbal), extent to which non-oral communication systems improve the individual's functional capacity, auditory functioning, and extent to which amplification devices (e.g., hearing aid) or a program of amplification improve the individual's functional capacity);
 - g. Social development, such as: interpersonal skills, recreation-leisure skills, and relationships with others;
 - h. Academic/educational development, including functional learning skills;
 - i. Independent living development such as: meal preparation, budgeting and personal finances, survival skills, mobility skills (orientation to the neighborhood, town, city), laundry, housekeeping, shopping, bed making,

care of clothing, and orientation skills (for individuals with visual impairments); and

j. Vocational development, including present vocational skills;

k. Affective development (such as: interests, and skills involved with expressing emotions, making judgments, and making independent decisions); and

l. Presence of identifiable maladaptive or inappropriate behaviors of the individual based on systematic observation (including, but not limited to, the frequency and intensity of identified maladaptive or inappropriate behaviors).

3. The Level II Mental Retardation evaluation shall insure that a psychologist, who meets the qualifications of a qualified mental retardation professional completes the following:

a. The individual's intellectual functioning measurement shall be identified; and

b. The individual's mental retardation or related condition shall be validated.

4. The Level II Mental Retardation evaluation shall identify to what extent the individual's status compares with each of the following characteristics, commonly associated with need for specialized services including:

a. The inability to:

1) Take care of most personal care needs;

2) Understand simple commands;

3) Communicate basic needs and wants;

4) Be employed at a productive wage level without systematic long term supervision or support;

5) Learn new skills without aggressive and consistent training;

6) Apply skills learned to a training situation to other environments or settings without aggressive and consistent training; or

7) Demonstrate behavior appropriate to the time, situation or place, without direct supervision.

b. Demonstration of severe maladaptive behavior(s) which place the individual or others in jeopardy to health and safety;

c. Inability or extreme difficulty in making decisions requiring informed consent; and

d. Presence of other skill deficits or specialized training needs which necessitate the availability of trained mental retardation personnel, 24 hours per day, to teach the individual functional skills.

5. The Mental Retardation evaluation shall collect information to determine whether the

individual's total needs for services are such that:

- a. The level of support may be provided in an alternative community setting; or
- b. The level of support is such that nursing facility placement is required.

6. The Mental Retardation evaluation shall determine whether the mentally retarded individual needs a continuous Specialized Services program.

.206 PASARR Findings from Level II Evaluations

A. PASARR Level II findings shall include the following documentation:

1. The individual's current functional level must be addressed;
2. The presence of diagnosis, numerical test scores, quotients, developmental levels, etc. shall be descriptive; and
3. The findings shall be made available to the family or designated representatives of the nursing facility resident, the parent of the minor individual or the legal guardian of the individual.

B. PASARR Findings from the Level II Evaluations shall be used by the Utilization Review Contractor in making determinations whether an individual with mental illness or mental retardation is appropriate or inappropriate for nursing facility care, and

C. The individual shall be referred back to the Utilization Review Contractor for a determination of the need for long term care services if at any time it is found that the individual is not mentally ill or mentally retarded, or has a primary diagnosis of dementia or Alzheimer's disease or related disorders or a non-primary diagnosis of dementia (including Alzheimer's disease or a related disorder) without a primary diagnosis of serious mental illness, or mental retardation or a related condition.

D. The results of the PASARR evaluation shall be described in a report by the State Mental Health or Mental Retardation authorities, which includes:

1. The name and professional title of the person completing the evaluation, and the date on which each portion of the evaluation was administered.
2. A summary of the medical and social history including the individual's positive traits or developmental strengths and weaknesses or developmental needs.
3. The mental health services and/or mental retardation services required to meet the individual's identified needs;
4. If specialized services are not recommended, any specific services identified which are of a lesser intensity than specialized services required to meet the evaluated individual's needs;
5. If specialized services are recommended, the specific services identified required to meet each one of the individual's needs; and
6. The basis for the report's conclusions.

E. Copies of the evaluation report will be made available to:

1. The individual and his or her legal representative;
2. The appropriate state authorities who make the determination;
3. The admitting or retaining nursing facility;
4. The individual's attending physician; and
5. The discharge hospital, if applicable.

.207 PASARR Determinations from the Level II Evaluation

A. Determinations which may result in admissions and/or specialized services shall include:

1. If an individual meets the level of care and needs the level of services provided in a nursing facility, as determined by the Utilization Review Contractor, and is determined not mentally ill or mentally retarded, the individual may be admitted to the facility.
2. If an individual does not meet the level of care (as determined by the Utilization Review Contractor), and is determined to not be mentally ill or mentally retarded through the PASARR determination and is not seeking Medicaid reimbursement, the individual may be admitted to the facility.
3. If the determination is that a resident or applicant for admission to a nursing facility requires BOTH the nursing facility level of care and specialized mental health or mental retardation services, as determined by the Utilization Review Contractor and the State Mental Health and Mental Retardation authorities:
 - a. The individual may be admitted or retained by the nursing facility; and
 - b. The State Mental Health or Mental Retardation authorities shall provide or arrange for the provision of specialized services needed by the individual while he or she resides in the nursing facility.
4. Nursing facilities admitting residents requiring specialized mental health or mental retardation services shall be responsible for assuring the provisions of services to meet all the resident needs identified in the Level II evaluations. The provisions of services shall be monitored through the State's survey and certification process.

B. Determinations which may result in denial of admission include:

1. If an individual does not require nursing facility services and is seeking Medicaid reimbursement, the individual cannot be admitted to the nursing facility.
2. If the determination is that an individual requires neither the level of services provided in a nursing facility nor specialized services, the nursing facility shall:
 - a. Arrange for the safe and orderly discharge of the resident from the facility; and
 - b. Prepare and orient the resident for the discharge.
 - c. Provide the resident with a written notice of the action to be taken and his or her grievance and appeal rights under the procedure found at section 25-1-120, C.R.S. entitled "Nursing and intermediate care facilities - rights of

patients”.

C. If the determination is that a resident does not require nursing facility services but requires specialized services, the following action shall be taken:

1. For long term residents who have resided continuously in a nursing facility at least 30 months before the date of the first annual review determination and who require only specialized services, the nursing facility, in cooperation with the resident's family or legal representative and care givers, shall complete the following:
 - a. The resident shall be offered the choice of remaining in the facility or receiving services in an alternative appropriate setting; and
 - b. The resident shall be informed of institutional and non-institutional alternatives; and
 - c. The effect on eligibility for Medicaid services shall be clarified if the resident chooses to leave the facility, including the effect on readmission to the facility; and
 - d. The provision of specialized services shall be provided for, or arranged regardless of the resident's choice of living arrangements.
2. For short term residents who require only specialized services and who have not resided in a nursing facility for 30 continuous months before the date of PASARR determination, the nursing facility, in conjunction with the State Mental Health or Mental Retardation authority, in cooperation with the resident's family or legal representative and caregivers, shall complete the following:
 - a. The safe and orderly discharge of the resident from the facility shall be arranged;
 - b. The resident shall be prepared and oriented for the discharge; and
 - c. A written notice shall be given to the resident notifying him or her of the action to be taken and of his or her grievance and appeal rights.
 - d. The provision of specialized services shall be provided or arranged, regardless of the resident's choice of living arrangements.

D. Any individual with mental illness, determined through the PASARR process, to be in need of in-patient psychiatric hospitalization, shall not be admitted to the nursing facility until treatment has been received and the individual certified as no longer needing in-patient psychiatric hospitalization.

8.401.21 SPECIALIZED SERVICES FOR MENTALLY ILL AND MENTALLY RETARDED

.211 Specialized Services shall include the following requirements:

- A. Community Mental Health Centers and Community Centered Boards shall be authorized by the State to provide specialized services to individuals in Medicaid nursing facilities.
- B. These services shall be reimbursed by the Medicaid program to the community mental health centers or community centered boards through Department of Institutions. The cost of these services shall not be reported on the Nursing Facility cost report.

- C. Specialized services may be provided by agencies other than community mental health centers or community centered boards or other designated agencies on a fee for service basis, but the cost of these services shall not be included in the Medicaid cost report or the Medicaid rate paid to the nursing facility.
- .212 Specialized Services for Individuals with Mental Illness shall be defined as services, specified by the State, which include:
- A. Specified services combined with the services provided by the nursing facility, resulting in a program designed for the specific needs of eligible individuals who require the services.
 - B. An aggressive, consistent implementation of an individualized plan of care.
- .213 Specialized services shall have the following characteristics:
- A. The specialized services and treatment plan must be developed and supervised by an interdisciplinary team which includes a physician, a qualified mental health professional and other professionals, as appropriate.
 - B. Specific therapies, treatments and mental health interventions and activities, health services and other related services shall be prescribed for the treatment of individuals with mental illness who are experiencing an episode of severe mental illness which necessitates supervision by trained mental health personnel.
- .214 The intent of these specialized services is to:
- A. Reduce the applicant or resident's behavioral symptoms, that would otherwise necessitate institutionalization.
 - B. Improve the individual's level of independent functioning.
 - C. Achieve a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.
- .215 Levels of Mental Health services shall be provided, as defined by the State, including Enhanced and General Mental Health services.
- .216 Specialized Services for Individuals with Mental Retardation shall be defined as a continuous program for each individual which includes the following:
- A. An aggressive, consistent implementation of a program of specialized and generic training, specific therapies or treatments, activities, health services and related services, as identified in the plan of care.
 - B. The individual program plan includes the following:
 - 1. The acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and
 - 2. The prevention or deceleration of regression or loss of current optimal functional status.

8.401.4 GUIDELINES FOR INSTITUTIONS FOR MENTAL DISEASES (IMD's)

.41 DEFINITION

“Institution for Mental Diseases” (IMD) as defined in the Medicaid regulations at 42 C.F.R. 435.1009, is an institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

.42 CRITERIA USED FOR DETERMINATION OF IMD STATUS

The primary criteria for the determination of the IMD status of an institution is that more than fifty percent (50%) of all patients in the facility have primary diagnoses of major mental illness as determined by the Level II Pre-Admission Screening and Annual Resident Review (PASARR) process which is verified by the Utilization Review Contractor.

The State has defined the following diagnostic codes contained in the DSM IV as valid for the purpose of determining whether an individual has a “mental disease”:

295.10 through 295.90

296.0 through 296.9

297.10

298.9

300.40

301.13

[Removed per S.B. 03-088, 26 CR 7]

Additional criteria applied for the purpose of IMD determination are as follows:

- A. The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases;
- B. The facility is accredited as a psychiatric facility by the Joint Commission for Accreditation for Health Care Organizations (JCAHCO);
- C. The facility is under the jurisdiction of the state's mental health authority;
- D. The facility specializes in providing psychiatric/psychological care and treatment as ascertained through a review of patients' records; and
- E. The current need for institutionalization for more than 50 percent of all patients in the facility results from major mental diseases.

Facilities that meet the primary “50%” criterion at a minimum are at serious risk of being classified as an IMD by the State and federal government. However, facilities meeting any lesser criteria may or may not be at risk of being identified as an IMD.

The assurance that a facility is not an IMD is included in all nursing facility contracts.

.43 FFP DISALLOWANCE

FFP is not available for any medical assistance under Title XIX for individuals between the ages of 21 and 65 who are patients in an IMD. The Department of Social Services, in cooperation with the Departments of Health and Institutions, will monitor long term care facilities to determine whether any facility has a census of primary psychiatric patients in excess of fifty percent (50%) of its total census. Facilities whose psychiatric census approaches this fifty percent (50%) limit will be so notified by the Department. Should an on-site review by the Department document a psychiatric census in excess of fifty percent (50%) of total census in a facility, Medicaid reimbursement shall be denied for all residents between the ages of 21 and 65 until the Department determines that the facility is no longer an IMD.

.44 ADMINISTRATIVE PROCEDURES AND REQUIREMENTS

In order to determine whether a nursing home facility is an IMD the following administrative procedures and requirements are necessary:

- A. All nursing homes shall indicate on the patient's medical record the primary, secondary and tertiary diagnoses (as applicable) of all their patients, Medicaid and private pay. All medical records shall contain this information no later than three calendar months after the effective date of this regulation.
- B. All nursing homes shall report discharges to the Utilization Review Contractor. Discharge information shall include the name of the person, state identification number if applicable, discharge destination, date, payment source Utilization Review Contractor and primary and secondary diagnoses. Discharges of all patients shall be reported within one week of discharge. Discharge is defined to mean death, transfers, discharge to home, and absent without leave.
- C. Colorado Department of Public Health and Environment shall use the medical records diagnosis information to determine the percentage of patients with mental diseases. In cases where the percentage is higher than 40%, a notice of the potentially high percentage shall be sent to the Department and Utilization Review Contractor.
 - d. (1) In cases where the percentage is over 40% and less than 50% the nursing home will be instructed by the Department to provide admission data and discharge data on all private pay as well as Medicaid patients to the Utilization Review Contractor. The admission and discharge data is necessary on all patients so that the entire psychiatric census of the facility can be determined and monitored by the Utilization Review Contractor.
 - (2) In cases where the percentage of psychiatric patients appears to be exceeding or about to exceed 50%, the Department may instruct the Utilization Review Contractor to deny admission authorization for Medicaid patients with psychiatric diagnoses. The facility shall be notified of the Department's intent to limit admissions to only non-psychiatric patients at least five (5) days in advance of the action. The facility may appeal this action in accordance with the regulations entitled PROVIDER APPEALS AND HEARINGS.
 - e. (1) In cases where the percentage of psychiatric patients in the census of the facility is over fifty (50) percent, and/or the facility meets some of the other criteria, the Department shall conduct an audit of the facility to determine if it is primarily engaged in the care and treatment of persons with mental diseases (i.e. an institution for mental diseases). The basis of such a finding shall be the criteria described in the regulations. This audit shall be conducted with assistance from the Colorado Department of Public Health and Environment and shall include medical personnel with the necessary qualifications to determine the primary characterization of a facility.
 - e. (2) Should the audit indicate a finding that the facility is an Institution for Mental Disease, then all Medicaid funding for patients between the ages of 21 and 65 shall be denied. Furthermore, should the audit indicate the facility has been an IMD for a period of time

prior to the time the audit was undertaken, the facility shall refund to the Medicaid program one hundred percent (100%) of the payments for patients between the ages of 21 and 65. Under no circumstances shall the refund extend to periods of time before the effective date of the GUIDELINES FOR INSTITUTIONS FOR MENTAL DISEASES, issued April, 1987.

- f. The Department shall make arrangements with the Medicaid patients of the facility determined to be an IMD to do any of the following:
- (1) Relocate Medicaid patients between the ages of 21 and 65 in accordance with the regulations entitled NURSING HOME RESIDENT/CLIENT RELOCATION PLAN.
 - (2) Relocate a sufficient number of psychiatric patients from the facility so as to reduce the facility's psychiatric census to below 50%. Such relocation shall be completed in accordance with the NURSING HOME RESIDENT/CLIENT RELOCATION PLAN.
- g. A nursing home facility determined to be an IMD may appeal such a finding in accordance with the regulations entitled PROVIDER APPEALS AND HEARINGS. In cases where the administrative law judge issues a stay of the agency's action to terminate Medicaid payments to a provider, such an order of stay shall clearly indicate that should the State's IMD finding be correct, the facility shall repay the State one hundred percent (100%) of Medicaid payments it received during the period of the stay. In order to assure that such a payment shall be made, the administrative law judge shall require the facility to post a bond in the amount of one hundred percent (100%) of the anticipated nursing home payment for each month the stay is in effect.

8.401.50 GUIDELINES FOR CLASS V REHABILITATION FACILITIES

Section deleted

8.402 ADMISSION PROCEDURES FOR LONG TERM CARE

8.402.01 PRE-ADMISSION REVIEW (NOT FOR DEVELOPMENTAL DISABILITIES)

When a physician wishes to obtain skilled or maintenance services for a client, he/she, or his/her designee, shall contact the regional Utilization Review Contractor (URC). The Utilization Review Contractor will request and record information about the client's condition and the proposed treatment plan.

In order to promote the most appropriate placement of developmentally disabled clients when skilled or maintenance services are sought, the physician shall, unless an emergency admission as defined at §8.402.20 is required, refer the client to the Residential Referral and Placement Committee (RR/PC) for the area served by the Community Centered Board (CCB) where the client resides. Class I services shall be authorized by the Utilization Review Contractor only when the following requirements have been met:

- a. The RR/PC determines in collaboration with the physician and the client or the client's designated representative that Intermediate Care Facilities for the Mentally Retarded (ICF/MR) services or services available through Home and Community Based Services for the Developmentally Disabled (HCB-DD) are not appropriate to meet the health care needs of the client.
- b. ICF/MR or HCB-DD services are not available if such services are appropriate.
- c. The physician and the client or the client's designated representative chooses Class I services in preference to services available specifically for developmentally disabled clients, and

the client meets the level of care criteria for these services.

Referrals by physicians of developmentally disabled clients for Class I services without review by the RR/PC will not be certified by the Utilization Review Contractor for Medicaid reimbursement. Clients for whom ICF/MR or HCB-DD services are appropriate as defined in §8.401.18, subject to the physician's and the client's or the client's designated representative concurrence, shall be referred immediately to the Utilization Review Contractor and to the appropriate Community Centered Board under the provisions at §8.405.

- .02 After reviewing the information taken from the physician or his designee, the Utilization Review Contractor shall assign a target group designation based upon the primary reason for which long-term care services are needed. The Utilization Review Contractor shall follow the target group designations established at §8.402.32(A) through §8.402.32(D).

8.402.10 ADMISSION PROCEDURES FOR CLASS I NURSING FACILITIES

- .11 The URC/SEP shall certify a client for nursing facility admission after a client is determined to meet the functional level of care and passes the PASARR Level 1 screen requirements for long term care. However, the URC/SEP shall not certify a client for nursing facility admission unless the client has been advised of long term care options including Home and Community Based Services as an alternative to nursing facility care.
- .12 The medical provider must complete the necessary documentation prior to the client's admission.
- .13 The ULTC 100.2 and other transfer documents concerning medical information as applicable, must accompany the client to the facility.
- .14 The nursing facility or hospital shall notify the URC/SEP agency of the pending admission by faxing or emailing the Initial Screening and Intake Form. The date the form is received by the URC/SEP agency shall be the effective start date if the client meets all eligibility requirements for Medicaid long-term care services.
- .15 The URC/SEP case manager shall determine the client's length of stay using the Nursing Facility Length of Stay Assignment form developed by the Department. The length of stay shall be less than a year, one year or indefinite. All indefinite lengths of stay shall be approved by the case manager's supervisor.
- .16 The URC/SEP agency shall notify in writing all appropriate parties of the initial length of stay assigned. Appropriate parties shall include, but are not limited to, the client or the client's designated representative, the attending physician, the nursing facility, the Fiscal Agent, the appropriate County Department of Social/Human Services, the appropriate community agency, and for clients within the developmentally disabled or mentally ill target groups, the Department of Human Services or its designee.
- .17 Beginning November 1, 2003, the nursing facility shall be responsible for tracking the length of stay end date so that a timely reassessment is completed by the URC/SEP.
- .18 The Statewide Utilization Review Contractor will determine the start date for nursing facility services. The start date of eligibility for nursing facility services shall not precede the date that all the requirements (functional level of care, financial eligibility, disability determination) have been met.

8.402.30 ADMISSION PROCEDURES FOR HOME AND COMMUNITY BASED SERVICES

- .31 When the client meets the level of care requirements for long term care, is currently living in the community, and could possibly be maintained in the community, the URC/SEP agency shall

immediately communicate with the appropriate community agency, according to the URC/SEP agency-determined target group, for an evaluation for alternative services. The URC/SEP agency shall forward a copy of the worksheet plus a State prescribed disposition form to the agency either immediately after the telephone referral, or in place of the telephone referral.

- .32 Based upon information obtained in the pre-admission review, the URC/SEP case manager shall make the referral to the appropriate community agency based on the client's target group designation, as defined below:
- A. Individuals determined by the URC/SEP agency to be in the Mentally Ill target group, regardless of source, shall be referred to the appropriate community mental health center or clinic.
 - B. Individuals determined by the Utilization Review Contractor to be in the Functionally Impaired Elderly target group or the Physically Disabled or Blind target group shall be referred to the appropriate Single Entry Point agency for evaluation for Home and Community Based Services for the Elderly, Blind or Disabled (HCBS-EBD).
 - C. Individuals identified by the Utilization Review Contractor to be in the Developmentally Disabled target group shall be referred to the appropriate Community Centered Board.
 - D. Individuals determined by the Utilization Review Contractor to be in the Persons Living with AIDS target group shall be referred to the appropriate single entry point agency for evaluation for Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) or HCBS-EBD.
 - E. The Utilization Review Contractor shall notify any clients referred to case management agencies of the referral, the provisions of the program, and shall inform them of the complaint procedures.
- .33 The case management agency or community mental health center or clinic shall complete an evaluation for alternative services within five (5) working days of the referral by the Utilization Review Contractor.
- .34 Single Entry Point agencies shall conduct the evaluation in accordance with the procedures at §8.485 through §8.486.501.
- .35 Community Centered Boards shall conduct the evaluation in accordance with procedures at §8.500.
- .36 Community mental health centers and clinics shall conduct the evaluation in accordance with Standards/Rules and Regulations for Mental Health 2 C.C.R., 502-2 and Rules and Regulations Concerning Care and Treatment of the Mentally Ill, 2 C.C.R., 502-1.
- .37 If the community agency develops an approved plan for long term care services, the Utilization Review Contractor will approve 1 certification for long term care services and the client shall be placed in alternative services. Following receipt of the fully completed ULTC 100.2, the Utilization Review Contractor will review the information submitted and make a certification decision. If certification is approved, the Utilization Review Contractor shall assign an initial length of stay for alternative services. If certification is denied, the decision of the Utilization Review Contractor may be appealed in accordance with §10 CCR 2505-10, Sections 8.05710 CCR 2505-10, Sections 8.057 through § 10 CCR 2505-10, Sections 8.057.8.
- .38 If the appropriate community agency cannot develop an approved plan for long term care services, the Utilization Review Contractor will approve certification for long term care services and utilize the procedure for nursing home admissions described previously in this section.

8.402.40 ADMISSION TO NURSING FACILITY WITH REFERRAL FOR COMMUNITY SERVICES

- .41 When a client who meets the level of care requirements for long term care is currently hospitalized but could possibly be maintained in the community, certification shall be issued. The client may be placed in the nursing facility, given a short length of stay and immediately referred to the appropriate community agency for evaluation for alternative services in accordance with the procedure described in the preceding section.

8.402.50 DENIALS (ALL TARGET GROUPS)

- .51 When, based on the pre-admission review, the client does not meet the level of care requirements for skilled and maintenance services, certification shall not be issued. The client shall be notified in writing of the denial.
- .52 If the Utilization Review Contractor denied long term care certification based upon the information on the ULTC 100.2, written notification of the denial shall be sent to the client, the attending physician, and the referral source (hospital, nursing facility, etc.).

If the information provided on the ULTC 100.2 indicates the client does meet the level of care requirements, the Utilization Review Contractor shall proceed with the admission and/or referral procedures described above.

- .53 Denials of certification for long term care may be appealed in accordance with the procedures described at § 10 CCR 2505-10, Sections 8.057 through § 10 CCR 2505-10, Sections 8.057.8.
- .54 Denial of designation into a specifically requested target group may also be appealed in accordance with § 10 CCR 2505-10, Sections 8.057 through § 10 CCR 2505-10, Sections 8.057.8.

8.402.60 CONTINUED STAY REVIEWS: SKILLED AND MAINTENANCE SERVICES

- .61 The Utilization Review Contractor shall authorize all skilled nursing facility and intermediate care facility services, Home and Community Based Services for the Elderly, Blind or Disabled, and mental health clinic services when such services are appropriate and necessary for eligible clients. The Utilization Review Contractor may also limit the period for which covered long term care services are authorized by specifying finite lengths of stay, and may perform periodic continued stay reviews, when appropriate, given the eligibility, functional and diagnostic status of any eligible Client.
- .62 Continued stay reviews shall, at a minimum, be conducted as frequently as necessary for the purpose of reviewing and re-establishing eligibility for all Home and Community Based Services waiver programs, in accordance with all applicable statutes, regulations and federal waiver provisions.
- .63 The frequency of the continued stay reviews and the determination of length of stay for nursing facilities may be conducted for the purpose of program eligibility. The process for these decisions will be prescribed in criteria developed by the Department.
- .64 Continued stay reviews for long term care clients receiving HCB-EBD or mental health clinic services may be conducted more frequently at the request of the case manager or the Community Mental Health Center (CMHC).
- .65 The Continued Stay Review will follow the same procedures found at §8.401.11–.17(H) and if applicable, §8.485.61(B)(3).
- .66 As a result of the continued stay review, the Utilization Review Contractor shall renew or deny

certification.

8.403 LONG TERM CARE - SERVICES TO THE DEVELOPMENTALLY DISABLED

Long term care services for the developmentally disabled include institutional services available through Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and Home and Community Based Services for the Developmentally Disabled (HCB-DD). These specialized services are available to Medicaid eligible clients who meet the target group designation for the developmentally disabled, and meet the level of care guidelines described below.

8.403.1 LEVEL OF CARE GUIDELINES FOR LONG TERM CARE SERVICES FOR THE DEVELOPMENTALLY DISABLED

Level of care guidelines for programs for the developmentally disabled are used to determine if the profile of a client's programmatic and/or medical needs are appropriate to a specific ICF/MR nursing home class or equivalent set of HCB-DD services.

.11 Clients shall be certified for admission to a specific class of ICF/MR or equivalent set of HCB-DD services based on the following criteria:

A. Minimum/Moderate - developmentally disabled clients who exhibit the following characteristics:

1. Have deficiencies in adaptive behavior that preclude independent living and require a supervised sheltered living environment;
2. Need supervision and training in self help skills and activities of daily living, but do not display excessive behavior problems which are disruptive to other residents or which prevent participation in group or community activities;
3. Are capable of attending appropriate day services or engaging in sheltered or competitive employment; and,
4. Are capable of being maintained in a community-based setting.

Clients certified at this level of care may be provided Class II ICF/MR services or those HCB-DD services as set forth in the sections on HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED in this manual.

B. Specialized Intensive - developmentally disabled individuals whose psychological, behavioral, and/or developmental needs require 24-hour supervision, and who have potential for movement to a less restrictive living arrangement within 24 months (on the average). These individuals must conform to one of the profiles described below:

1. Behavior development profile:

- Function at a severe to moderate overall level of retardation;
- May present a danger to self or others in the absence of supervision and habilitative services;
- Display severe maladaptive and/or anti-social behaviors, and may have exhibited delinquent behaviors;
- May display destructive or physically aggressive behaviors;

- Need specialized behavior management, counseling, and supervision;

2. Social emotional development profile:

- Function at a moderate to mild overall level of retardation.
- Exhibit severe social and emotional problems attributable to a mental disorder.
- May be verbally abusive and/or physically aggressive toward self, others, or property.
- May display run-away, withdrawal, and/or bizarre behavior attributable to a mental disorder;
- Need social, adaptive, and intensive mental health services.

3. Intensive developmental profile:

- Function at a profound to severe level of mental retardation;
- Exhibit severe deficiencies in behaviors such as eating, dressing, hygiene, toileting, and communication;
- May display inappropriate social and/or interpersonal behaviors;
- Need intensive self-management and adaptive behavior training.

Additionally, these individuals are capable of functioning in a communitybased setting.

Clients certified at this level of care may be provided Class II or Class IV ICF/MR services or those HCB-DD services as provided in the sections on HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED in this manual.

C. Intensive Medical/Psychosocial - developmentally disabled individuals who have intensive medical and psychosocial needs that require highly structured, in house, comprehensive, medical, nursing and psychological treatment. These individuals must meet at least one of the following requirements:

1. Exhibits extreme deficiencies in adaptive behaviors in association with profound or severe retardation or in association with medical problems requiring availability of medical life support services on a continuous basis; and/or

Exhibits maladaptive behavior(s) potentially injurious to self or others to the degree that intensive programming in an institutional or closed setting is required; and

Inappropriate for placement in less restrictive settings, such as minimum/moderate or specialized intensive community-based services, due to the nature and/or severity of their handicaps.

2. Appropriate for service in less restrictive community residential programs, but all local and statewide avenues for alternative placement have been investigated and exhausted prior to referral to a Class IV facility. Plans for eventual community placement have been established;

3. Committed by court action to a Regional Center under the Division for Developmental Disabilities, Department of Institutions.

Clients certified at this level of care may be provided Class IV ICF-MR services or HCB-DD services as provided in the sections on HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED in this manual.

8.404 ADMISSION CRITERIA: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

8.404.1 Clients needing ICF/MR and HCB/DD level of care are those who:

- A. Require aggressive and consistent training to develop, enhance or maintain skills for independence (e.g., on-going reliance on supervision, guidance, support and reassurance); or
 - B. Are generally unable to apply skills learned in training situations to other settings and environments; or
 - C. Generally cannot take care of most personal care needs, cannot make basic needs known to others, and cannot understand simple commands, (e.g., requires assistance or prompts in bathing and/or dressing, neglects to wear protective clothing, does not interact appropriately with others, speaks in muffled/unclear manner, fails to take medications correctly, confuses values of coins, spends money inappropriately); or
 - D. Are unable to work at a competitive wage level without support,(e.g., specially trained managers, job coach, or wage supplements) and are unable to engage appropriately in social interactions (e.g., alienates peers by teasing, arguing or being cruel, does not make decisions); or
 - E. Are unable to conduct themselves appropriately when allowed to have time away from the facility's premises (e.g., loses self-control when s/he cannot get what s/he wants, performs destructive acts, unsafe crossing streets or following safety signs) or
 - F. Have behaviors that would put self or others at risk for psychological or physical injury.
- .11 Clients needing placement in an ICF/MR are those who require an active treatment program. An active treatment program is defined as the aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:
- A. The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and
 - B. The prevention or deceleration of regression or loss of current optimal functional status.
- .12 Clients needing placement in the HCB/DD program are those who require an active habilitation program. Active habilitation is determined by assessing that the quantity, quality, and importance of a client's opportunities for independence, social integration, and responsible decision making are being provided consistent with his/her needs and directed toward:
- A. The acquisition of the behaviors necessary for the client to function with as much self-

determination and independence as possible; and

- B. The prevention or deceleration of regression or loss of current optimal functional status.

8.404.2 CONTINUED STAY REVIEW CRITERIA: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

Same as admission criteria unless the individual needs the help of an ICF/MR to continue to function independently because s/he has learned to depend upon the programmatic structure it provides. The fact that s/he is not yet independent, even though s/he can be, makes it appropriate for s/he to receive active treatment services directed at achieving needed and possible independence.

8.404.3 Adherence to the following sections of Colorado Department of Public Health and Environment and/or Division for Developmental Disabilities rules and regulations are critical to the provision of active treatment and active habilitation:

- A. Assessments
- B. Individual habilitation plans
- C. Individual program plans
- D. Community integration
- E. Independence training
- F. Behavior management
- G. Psychotropic medication use

For individuals needing placement in the ICF/MR facility and HCB/DD Program, a list of specific services or interventions needed in order to make progress must be provided.

8.405 ADMISSION PROCEDURES: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

.10 PREADMISSION REVIEW

For admission to ICF/MR facilities or the provision of services through programs of Home and Community Based Services for the Developmentally Disabled (HCB-DD), Developmentally Disabled clients must be evaluated by the Residential Referral/ Placement Committee (RR/PC) serving the Community Centered Board (CCB) in the area where the client resides. If services will be provided through a CCB in another area, the client shall be evaluated by that area's RR/PC.

The client shall be referred by the RR/PC to the Utilization Review Contractor for admission review and to the appropriate County Department of Social/Human Services for determination of Medicaid eligibility. The Utilization Review Contractor shall not determine admission certification under Medicaid for any Developmentally Disabled client in the absence of a referral from the RR/PC except for emergency admissions to the Class I facilities.

- .11 The RR/PC evaluation must contain background information as well as currently valid assessments of functional, developmental, behavioral, social, health, and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

.12 RR/PC ADVERSE RECOMMENDATION

In cases where the RR/PC declines to recommend placement of a developmentally disabled individual into an ICF/MR facility or equivalent HCB-DD services, the RR/PC shall inform the client of the recommendation using the HCB-DD-21 Form. The RR/PC shall also notify the client or the client's designated representative of the client's right to request a formal Utilization Review Contractor level of care review.

The client shall have thirty (30) days from the postmark date of the notice to request a formal Utilization Review Contractor review. If the client requests a formal Utilization Review Contractor level of care review, the RR/PC shall submit the required documentation plus any new documentation submitted by the client to the Utilization Review Contractor. The Utilization Review Contractor shall review and make a level of care determination in accordance with the admission procedures below.

8.405.2 ADMISSION PROCEDURES FOR ICF/MR FACILITIES

- .21 When the client, based on RR/PC review, cannot reasonably be expected to make use of ICF/MR or Home and Community Based Services for the Developmentally Disabled, the RR/PC shall notify the physician and the Utilization Review Contractor. The physician and the Utilization Review Contractor/Community Center Board (URC/CCB) agency then proceed with the SNF or ICF placement under the provisions set forth at §8.402.10 through §8.402.16.
- 22 When the RR/PC determines that a client is not appropriately served through HCB-DD services or, in accordance with provisions permitting the client or the client's designated representative to choose institutional services as an alternative to HCB-DD services, the RR/PC shall recommend placement to an ICF/MR facility. The RR/PC shall seek the approval of the client's physician. The physician shall notify the URC/CCB agency of the proposed placement. Based on information provided by the RR/PC and the client's physician, the URC/SEP agency may certify the client for long term care prior to ICF/MR admission.
- .23 The URC/CCB agency shall advise the County Department of Social/Human Services of the certification to enable the County Department staff to assist with the placement arrangements.
- 24. The ULTC-100.2 and other transfer documents concerning medical information as applicable must accompany the client to the facility.
- .25 Following receipt of the fully completed ULTC 100.2, the URC/CCB shall review the information and make a final certification decision. If certification is approved, the URC/CCB shall assign an initial length of stay according to the guidelines at §8.404.1. If certification is denied, the decision of the URC/CCB may be appealed in accordance with the appeals process at §8.057.

8.405.30 ADMISSION PROCEDURES FOR THE HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD)

- .31 RR/PC's may evaluate clients for HCB-DD services if, in the judgment of the RR/PC, such services represent a viable alternative to SNF, ICF, or ICF/MR services. The evaluation shall be carried out in accordance with the procedures set forth in 2 C.C.R., 503-1.
- .32 If the RR/PC recommends HCB-DD placement, then the URC/CCB will approve certification for services for the developmentally disabled at the level of care recommended by the RR/PC. The client will be placed in alternative service.

Following receipt of the completed ULTC 100.2 and any other supporting information, the URC/CCB will review the information and make a final certification determination.

If certification is approved, the URC/CCB shall assign an initial length of stay for HCB-DD services.

If certification is denied, the decision of the URC/CCB may be appealed in accordance with §8.057.

8.405.4 CONTINUED STAY REVIEW PROCEDURES; SERVICES FOR THE DEVELOPMENTALLY DISABLED

- .41 Continued stay reviews shall be conducted by the Utilization Review Contractor for all developmentally disabled clients in ICF/MR services. The frequency of these reviews will be based on the length of stay assigned by the Utilization Review Contractor consistent with the following guidelines:
 - A. Minimum/Moderate Level of Care: No less than twelve months but no more than twenty-four months.
 - B. Specialized Intensive Level of Care: Twenty-four months.
 - C. Medical/Psychosocial Level of Care: No less than twelve months and no more than twenty-four months.
- .42 Continued stay reviews shall be conducted by the Utilization Review Contractor for all developmentally disabled clients in HCB-DD services at least annually.
- .43 Continued stay reviews may be conducted more frequently at the request of the Community Centered Board case manager.
- .44 As a result of the continued stay review, the Utilization Review Contractor shall renew or deny certification.

8.405.50 GENERAL PROVISIONS

- A. These rules shall not be construed nor interpreted to expand, diminish, or change any statutory provisions or duties of registered professional nurses, licensed practical nurses, or any other person subject to, or under the supervision of registered professional nurses or licensed practical nurses pursuant to the Professional Nurses Act, but are intended to explain the method by which the Department shall reimburse the providers of nursing care services available under the Colorado Medical Assistance Program.
- B. The Department of Health Care Policy and Financing ("Department") is the single state agency responsible for administration of the Medical Assistance Program ("Medicaid") pursuant to Title XIX of the Social Security Act. The Department is responsible for determining eligibility for program benefits; providers of medical care; level of reimbursement for the provision of medical care; and terms and conditions that shall govern the payment of such providers for the medical care services provided.
- C. The Department receives partial reimbursement from federal funds pursuant to Titles I, X, XIV, XVI, and XIX of the Social Security Act.
- D. All participating skilled nursing care facilities and intermediate health care facilities must be administered by a nursing facility administrator licensed pursuant to 91-8-1 et seq., C.R.S. 1973, as amended. For inclusion in the audited cost rate (see§ 8.440 et seq.) the administrator must be employed full-time by the applicant facility, and may not have other conflicting employment obligations. The administrator must be responsible on a 24-hour-a-day basis, with primary duties

being performed during the day shift.

8.406 NURSING FACILITY CARE - LEVELS OF CARE

The Department provides payment for nursing facility care in three (3) categories or levels of care: (1) "skilled nursing care", (2) "intermediate nursing care", and (3) "residential care."

8.406.1 SKILLED NURSING CARE

Skilled nursing care is available for eligible clients when a physician licensed to practice in the State of Colorado certifies care to be medically necessary. Such care must be provided in a facility that holds a valid and current license from the Colorado Department of Public Health and Environment as a Nursing Care Facility pursuant to the Standards for Hospitals and Health Facilities, Colorado Department of Public Health and Environment, Health Facilities Division. The facility must also meet the standards defined in the U.S. Code of Federal Regulations, Title 42 C.F.R., incorporated herein by reference as rules of the Department.

Section 1902(a)(26) of the Social Security Act and 42 C.F.R. require the Department to:

- A. Pursue a regular program of medical review and evaluation of each eligible client's medical need for skilled nursing care; and
- B. Conduct periodic inspections of all skilled nursing care facilities which participate in the Medicaid Program (see 8.420) to ascertain:
 - 1. The actual care being provided;
 - 2. The adequacy of the services available to meet the current health needs and to promote the maximum physical well-being of the eligible client;
 - 3. The necessity and desirability of the continued placement of eligible clients in skilled nursing care facilities; and
 - 4. The feasibility of meeting the client's health care needs through alternative services.

8.406.2 INTERMEDIATE NURSING CARE

[Removed per S.B. 03-088, 26 CR 7]

The Department shall:

- A. Pursue a regular program of medical review and evaluation of each eligible client's medical need for intermediate nursing care; and
- B. Conduct periodic inspections of all intermediate health care facilities which participate in the Medicaid Program (see 8.420) to ascertain:
 - 1. The actual care that is being provided;
 - 2. The adequacy of the services available to meet the current health needs and to promote the maximum physical well-being of the eligible client;
 - 3. The necessity and desirability of the continued placement of eligible clients in intermediate health care facilities; and

4. The feasibility of meeting the client's health care needs through alternative services.

8.406.3 INTERMEDIATE NURSING CARE - MENTAL RETARDATION 15 BEDS OR LESS

- A. Intermediate nursing care is available in facilities of 15 beds or less for eligible clients who are mentally retarded or have related conditions provided:
 1. The facility holds a valid and current license from the Colorado Department of Public Health and Environment as a residential care facility or higher classification.
 2. [Removed per S.B. 03-088, 26 CR 7]
 3. Clients who are mentally retarded or have related conditions are certified by a physician licensed to practice in the State of Colorado to be (a) ambulatory, (b) receiving active treatment, (c) capable of following directions and taking appropriate action for self-preservation under emergency conditions, and (d) not in need of professional nursing services.
- B. All other provisions of these rules shall apply to care and services provided in such facilities, but where these rules conflict with the provisions of 42 C.F.R., Sections 442.300 and 442.400, the federal rules shall control.

8.407 SPECIAL PROVISION CONCERNING CLIENTS ELIGIBLE FOR SOCIAL SECURITY AGE-72 BENEFITS (PROUTY)

8.407.1 SPECIAL AGE-72 BENEFITS (PROUTY)

Federal regulations require that welfare clients cannot receive both the Special Age-72 Benefit and a public assistance payment. Rule A-4232 requires that all available income to a client (or applicant) must be sought by the client or applicant.

SSA must receive assurance from the County Departments of Social/Human Services that as of a certain date no further assistance payments (including \$50 personal needs allowance) will be paid to the client.

8.407.2 REQUEST FOR ADDITIONAL INFORMATION ON FORM SSA-1610

When a county has authorized a nursing facility placement for a person over 72 years of age, who is eligible for a Prouty Benefit, Social Security must be notified.

8.408 LEVELS OF CARE DEFINED - SKILLED NURSING CARE

- A. Skilled nursing services in a licensed nursing care facility are those services performed by licensed nursing personnel, or personnel under their supervision. These services must be performed according to a plan of treatment written by a physician licensed to practice medicine in the State of Colorado. These services apply to clients whose condition(s) require medical services to maintain a degree of stability, which has been achieved. Components of these services include:
 1. The medical need for the attending physician to visit the client on a professional basis at least once every thirty (30) days.
 2. Observation and assessment of the total needs of the client, utilizing skilled nursing judgment.
 3. Planning, organizing, and managing the client care plan which requires specialized training to accomplish delivery of health care, or to attain the desired results or to render direct services to "the patient".

- B. These health care services require regular medical care and 24-hour licensed nursing services for illnesses, injury, or disability. Nursing service shall be organized and maintained to provide 24-hour licensed nursing services under the direction of a registered professional nurse employed full time and at least two (2) hours total nursing staff time for each patient per 24-hour day.
- C. Covered skilled nursing services must adhere to one or more of the following principles:
 - 1. A service which requires a substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical, and social sciences, necessary to perform or supervise effectively the services rendered, or
 - 2. A service that is unskilled but which requires skilled performance, supervision, or observation because of special medical complications. Medical complications and special services must be documented by the physician's order and the nursing notes.
- D. In addition to meeting the definition of skilled nursing services, coverage of such services is warranted only if skilled nursing personnel must be available on a continuous 24-hour basis. In determining whether the continuous availability of such personnel is warranted, the following principles apply:
 - 1. Frequency of Services - The frequency of skilled nursing services required, rather than their regularity, is the controlling factor in determining whether the continuous availability of skilled nursing personnel is warranted.
 - 2. Observation - Where observation is the principle continuous service provided, because symptoms exist that indicate the need for immediate modification of treatment of institution of medical procedures.
- E. The purpose of the above-stated components and principles, and of Rules §8.408.1, et seq., is to provide general direction and guidelines for admission, utilization review, and medical review; with the intent that the individual's overall medical situation (including mental condition) shall be taken into account in evaluation and determination of the level of care to be provided.

8.408.1 SPECIFIC SERVICES WHICH ARE SKILLED

Based upon the principles set forth, skilled nursing services include but are not limited to the following:

- A. Subcutaneous or intramuscular injections and intravenous medications and/or feedings.
- B. Levine tube and gastrostomy feedings.
- C. Naso-pharyngeal aspiration.
- D. Insertion and replacement of catheters.
- E. Aseptic application of dressings involving prescription medications.

8.408.2 SPECIFIC SERVICES WHICH ARE SUPPORTIVE

Supportive services which can be learned and performed by the average non-medical person who has been trained in these procedures, provided to either skilled or intermediate care patients include but are not limited to the following:

- A. Provision of routine maintenance medications.
- B. Prevent decubiti, keep clean, and comfortable.

- C. Safety measures against accident and injury.
- D. General maintenance are of colostomy or ileostomy.
- E. Routine services in connection with in-dwelling bladder catheters.
- F. Changes in dressings in noninfected postoperative or chronic conditions.
- G. Prophylactic and palliative skin care, including bathing and application of creams, and care of minor skin problems.
- H. General methods of caring for incontinent patients, including use of diapers.
- I. General care of patients with a plaster cast.
- J. Routine care in connection with braces and similar devices.
- K. Use of heat for palliative and comfort purposes.
- L. Administration of medical gases after initial phases of institution of therapy.
- M. Assistance in dressing, eating, and going to the toilet.
- N. General supervision of exercises which have been taught to the patient.
- O. Diet supervision and administration for those persons requiring specialized diet.
- P. Skilled paramedical services involving specialized training outside the licensed nursing curriculum.

8.408.3 ORGANIZATION OF SKILLED NURSING SERVICE

The following nursing care services and organization must be established as a minimum in order for a skilled nursing care facility to receive reimbursement.

- A. Administrative and supervisory responsibilities must be in writing.
- B. Duties must be clearly defined in writing and assigned for staff members.
- C. Written policies and procedures for client care must be available to all personnel.
- D. All professional services rendered by the nursing facility staff, physician, or other professional personnel, must be entered in the client's individual record and signed.

8.408.4 PROFESSIONAL PERSONNEL

8.408.41 DIRECTOR OF NURSING

The nursing services must be under the direction of a director of nursing service who:

1. Is a registered professional nurse.
2. Is qualified by education, training, or experience for supervisory duties.
3. Is responsible to the administrator for development of standards, policies, and procedures governing skilled nursing care, and for assuring that such standards, policies, and procedures are observed.

4. Is responsible to the administrator for the selection assignment, and direction of the activities of nursing services personnel.
5. Is employed full time in the facility.
6. Devotes his/her full time to direction and supervision of the nursing services; and,
7. Is on duty during the day shift.

8.408.42 CHARGE NURSE (RN OR LPN)

At all times, there must be on duty and in charge of the facility's nursing activities either:

1. A registered professional nurse; or,
2. A practical (or vocational) nurse who:
 - a. Is licensed by the State as a practical (or vocational) nurse; and
 - b. Has graduated from a State-approved school of practical nursing; or,
 - c. Has other education and formal training that is found by the State authority responsible for licensing of practical nurses to provide a background considered to be equivalent to graduation from a State-approved school of practical nursing.

8.408.43 NURSING PERSONNEL

Nursing personnel means registered nurse (RN), licensed practical nurse (LPN), and those auxiliary workers, other than RN or LPN, in the nursing service.

To assure the provision of adequate nursing services, each nursing care facility must provide sufficient:

1. Numbers and categories of personnel as determined by the number of patients in the facility and their particular nursing care needs. This determination is made in accordance with accepted policies of effective nursing care and with these guidelines will provide at least two (2) hours total nursing staff time for each patient per 24-hour day.
2. Nursing and auxiliary personnel employed and assigned to duties on the basis of their qualifications or experience to perform designated duties.
3. Amounts of nursing time to assure that each patient:
 - a. Receives treatments, medications, and diet as prescribed;
 - b. Is kept comfortable, clean, and well-groomed;
 - c. Receives proper care to prevent decubitus ulcers;
 - d. Is protected from accident and injury by appropriate safety measures;
 - e. Is encouraged to perform out-of-bed activities as permitted; and,
 - f. Receives assistance to maintain optimal physical and mental function.

8.408.44 ANCILLARY PERSONNEL

Authorized subsidiary personnel performing duties in support of professional health care services may or may not be included in arriving at the computation of cost allowances set forth in § 8.400, et seq.

A. Dietary - Professional planning and supervision of meal services.

Special and restricted diet files shall be maintained for thirty (30) days, and any substitutions or variations noted. The patient's reaction and acceptance of food must be observed and recorded.

Menus must be planned and supervised by professional personnel meeting the following qualifications:

1. A dietician who meets the American Dietetic Association's standards for qualification as a dietician; or,
2. A graduate holding at least a Bachelor's Degree from the university program, with major study in food or nutrition; or,
3. A trained food service supervisor, an associate degree dietary technician, or a professional registered nurse, with frequent and regularly scheduled consultation from a dietician or a nutritionist meeting the above-stated qualifications.

Inclusion of dietary consultation costs are an allowable item in computing the rate of payment above-referenced.

B. Pharmacy Consultant - A person licensed to practice pharmacy in the State of Colorado, and whose duties are related to the nursing facility administration of drugs to patients. Such duties relate to:

1. Drug interactions;
2. Proper medication usage pertinent to the diagnosis and length of medication; specific to proper usage in records, stop orders, etc.;
3. Appropriate storage and safeguards of medications;
4. Study of possible brand interchanges;
5. Check on authenticity of medication pursuant to labeling;
6. Contraindications and other professional activities related to drug administration, receipting, storage, etc.

Costs related to pharmacal consultation are allowable in determining the rate to be paid, under the same conditions as for dietary in item 1 above.

C. Housekeeping and Maintenance - Allowed pursuant to above-cited rules on cost computation.

8.408.5 CLINICAL RECORDS

8.408.51 MAINTENANCE

The following records, as a minimum, must be kept current, dated and signed, and must be made available for review if applicable:

1. Identification and summary sheets.

2. Hospital discharge summary sheet.
3. Medical evaluation and treatment plan.
4. Physician's orders.
5. Physician's progress notes.
6. Nurse's progress notes.
7. Medication and treatment record.
8. Laboratory and X-ray reports.
9. Consultation reports.
10. Dental reports.
11. Social Service notes.
12. Pharmacal Consultant records.
13. PASARR documentation to include the Level I and Level II Reviews and the determination letters.

8.408.52 RETENTION OF RECORDS

1. Files shall be retained for at least six years.
2. In the event that a client is transferred to another health facility, certain transfer information should be incorporated in a record to accompany the client. Such transfer information shall include:
 - a. Transfer form with diagnosis;
 - b. Aid to daily living information;
 - c. Transfer orders;
 - d. Nursing care plan;
 - e. Physician's orders for care.

8.408.53 CONFIDENTIALITY OF RECORDS

1. Disclosed only to authorized persons.
2. Form APA-4, "Authorization for Release of Medical Information" shall be executed in duplicate (original to the nursing facility medical record with a copy to the County Department of Social/Human Services) at the time of admission. This form must be signed by the client, the client's designated representative, the client's parent (if a minor), guardian, or other legally responsible person.

8.408.54 RECORDS ADMINISTRATOR

The nursing care facility must have available, and a staff person designated:

- a. A consultant or full-time employee who is a registered records administrator (Medical Records

Librarian), or an accredited records technician, or;

- b. A registered records administrator or other employee who is trained in medical records, and who receives supervision from a registered records administrator; or,
- c. If the facility does not have such employee with such training, an employee of the facility is assigned the responsibility for assuring that records are maintained, completed, and preserved. Such person, however, must be trained by, and receive regular consultation from a registered records administrator or accredited records technician.

8.408.6 MEDICAL BASIS FOR CARE - SKILLED NURSING FACILITY CARE

Eligible clients may be admitted to approved facilities only upon the certification of a physician licensed to practice in Colorado that there is a medical need for such admission (Form ULTC-100). The clients' freedom of choice of physician shall be respected. Health care of the client must continue under the supervision of a physician. The facility must have a physician available for necessary medical care in case of emergency.

8.408.61 PHYSICIANS' INVOLVEMENT

8.408.62 DETERMINATION FOR SKILLED NURSING CARE

The medical need of a client for skilled nursing care shall be delineated in the plan of treatment and substantiating orders written by the physician and by the performance of the necessary skilled nursing services implementing such plans and orders. Upon admission to a skilled nursing care facility, the facility must obtain for the medical record of each such client:

1. A summary of the course of treatment by the attending physician or which was followed in the hospital, the diagnosis(es) and current medical findings, and the rehabilitation potential.
2. An evaluation by the physician. Physical examination must be accomplished within 48 hours of admission and recorded; unless such an examination has been accomplished within five days prior to admission to the skilled nursing care facility.
3. Physician's orders. Orders must be written for the immediate care of the client. These may be written by the attending physician or by the physician who has the responsibility for emergency care in this facility. The current hospital summary of the course of treatment, with orders used, is acceptable as emergency orders.
4. The physician's treatment plan. The plan must be written and must be directed towards maintaining the health status of the client, preventing further deterioration of the physical well-being of the client, and preparing the client for normal non-institutional life. The plan must be reviewed and revised as necessary, and must include medication and treatment orders which will be in effect for the specified number of days indicated by the physician. This period shall be monthly unless reordered in writing by the physician. Telephone orders may be accepted by licensed nurses only and must be written into the clinical record by the receiving nurse. These orders must be countersigned by the ordering physician within 48 hours.

The medical necessity for a physician's visit, at least once every thirty (30) days, must be evidenced in the clinical record by a valid signed entry.

5. Plan for Emergency Care - Each skilled nursing care facility must provide for one, or more, physicians to be available to furnish emergency medical care if the attending physician is not immediately available. A schedule listing the name, telephone number and days on call for a given physician will be posted at each nursing station. The skilled nursing care facility must also establish

procedures which will be followed in the emergency care of the client, the persons to be notified, and the reports to be prepared.

8.408.63 PHYSICIANS' INVOLVEMENT - REDETERMINATION FOR SKILLED NURSING CARE

The medical need of the client for skilled nursing care shall be redetermined monthly at the time of the physician's required monthly visit.

The term "substantial change" does not encompass short-term treatment regimens for temporary illness, adjustments to prescribed medications, or changes to be in effect for less than a thirty (30) day period.

8.408.7 MEDICAL REVIEW AND MEDICAL INSPECTION - SKILLED NURSING CLIENTS

Medical review of the treatment of all clients in skilled nursing care facilities who are entitled to medical assistance will be accomplished prior to May 2, 1972 (to meet requirements of 42 C.F.R. 456.2), and annually thereafter. Medical review procedures herein are in addition to those set forth in §8.449 concerning Utilization Review.

8.408.71 MEDICAL REVIEW TEAM

8.408.72 COMPOSITION AND MEMBERSHIP REQUIREMENTS

The medical review team for skilled nursing care clients will be led by a Colorado Registered Nurse or a Colorado Licensed Physician. The teams will include other appropriate health and social service personnel. Nurse-led teams will report to a physician.

No member of the team may be employed by or have financial interest in any nursing facility. No physician member of a team may inspect the care of clients for whom he is the attending physician.

8.408.73 FUNCTION - MEDICAL REVIEW AND EVALUATION

1. The medical treatment of skilled nursing clients entitled to medical assistance shall be reviewed at least annually.
2. Annual review shall consist of an evaluation of the treatment, utilizing the medical record and personal contact with, and observation of, each client in the nursing facility surroundings. This review, at a minimum, will elicit:
 - a. Medical necessity for visit by attending physician at least once every thirty (30) days.
 - b. Adequacy in quality and quantity as well as the timeliness of treatment to meet health needs.
 - c. Adherence to the written physician's treatment plan.
 - d. Tests, or observations of clients, indicated by their medication regimen have been made at appropriate times and properly recorded.
 - e. Physician, nurse, and other professional staff progress notes are made as required, and appear to be consistent with observed condition of the client.
 - f. Adequate services are being rendered to each client as shown by such observations as cleanliness, absence of decubiti, absence of signs of malnutrition or dehydration, and apparent maintenance of optimal physical, mental, and psychosocial function.
 - g. Client's need for any service not available in, or actually being furnished by the particular

facility, or through arrangements with others.

- h. Each client actually needs continued placement in the facility, or there is an appropriate plan to transfer the client to an alternate method of care.

8.408.74 REPORTS

1. Review reports of care in each facility are submitted to the Department.
 - a. After review copies are forwarded to:
 - 1) Nursing care facility
 - 2) Nursing care facility Utilization Review Committee
 - 3) Colorado Department of Public Health and Environment
2. Reports will cover observations, conclusions and recommendations with respect to adequacy and quality of client services in the facility, and of physician services to clients in the facility. They will also cover specific findings with respect to individual clients and any recommendations resulting therefrom.

8.408.75 STATE DEPARTMENT ACTION

1. Reports submitted as a result of Medical Review may result in decisions to reclassify clients into a different level of care, or recommendations for modification of treatment.

Such decisions or recommendations will be transmitted as appropriate, to the:

- a. Attending physician.
 - b. Administration of the nursing facility.
 - c. County Department of Social/Human Services responsible for the client.
2. Changes in classification recommended will be effected prior to the next billing period.

8.408.76 REVIEW OF STATE DEPARTMENT ACTION

Disagreements with the decisions and recommendations of the Review Team may be adjudicated through the Administrative Review mechanism of the Department; however, the Division of Medical Assistance will retain the right to final decision.

8.409 LEVELS OF CARE DEFINED - INTERMEDIATE NURSING CARE

Intermediate nursing services in a licensed intermediate health care facility are defined as those services furnished in an institution or distinct part thereof to those clients who do not have an illness, disease, injury, or other condition that requires the degree of care and treatment which a hospital, Extended Care Facility, or Skilled Nursing Care Facility is designed to provide. Such services are provided under the supervision of a registered professional nurse or licensed practical nurse during the day shift, seven (7) days per calendar week. Covered intermediate services will be at a level less than those described as skilled nursing services and will include guidance and assistance for each client in carrying out his personal health program to assure that preventive measures, treatment, and medications prescribed by the physician are properly carried out and recorded.

These services are provided for according to a plan of treatment written by a physician licensed to practice medicine in the State of Colorado, and apply to clients whose conditions require medical services to maintain a degree of stability which has been achieved.

There must exist a medical need for the attending physician to visit the client on a professional basis at least once in every calendar quarter.

8.409.1 SEPARATION OF SKILLED NURSING FACILITY PATIENTS FROM THOSE REQUIRING INTERMEDIATE CARE: DISTINCT PART REQUIREMENT

All nursing facilities which provide both skilled nursing facility care and care and services to clients classified as requiring intermediate nursing care, shall set aside a distinct part, or identifiable unit in such facility for the provision of such intermediate care to such clients.

A “distinct part” is one that meets the following conditions:

Identifiable unit - The distinct part of the nursing facility is an entire unit such as an entire ward or contiguous wards, wing, floor, or rooms. With respect to facilities having 2 or more rooms, such must be contiguous. The identifiable unit must consist of all beds and related facilities in the unit and house all patient-clients classified as intermediate care clients for whom payment is being made, except as provided in paragraph (d) below. It is clearly identified and is approved, in writing (licensed), by the Colorado Department of Public Health and Environment.

Staff - Appropriate personnel shall be assigned to the identifiable unit and must work regularly therein. Immediate supervision of staff shall be provided at all times by qualified personnel as required for licensure.

Shared Facilities and Services - The identifiable unit may share such control services and facilities as management services, dietary, building maintenance and laundry, with other units.

Transfers Between Distinct Parts - Nothing herein shall be construed to require transfer of a client within the nursing facility, when, in the opinion of the client's physician, such transfer might be harmful to the physical or mental health of the client. Such opinion of the physician must be recorded on the patient's nursing facility medical chart and stand as a continuing order unless the circumstances requiring such exception change.

8.409.2 ORGANIZATION OF INTERMEDIATE NURSING SERVICE

The following nursing care services and organization must be established as a minimum in order for an intermediate nursing care facility to receive reimbursement:

1. Administrative and supervisory responsibilities must be in writing.
2. Duties must be clearly defined in writing and assigned for the staff members.
3. Written policies and procedures for client care must be available to all personnel.

8.409.21 PROFESSIONAL PERSONNEL - “DIRECTOR OF NURSING”

There must be on duty and in charge of the facility's nursing activities either a registered professional nurse or a licensed practical nurse who:

1. Is qualified by education, training, or experience for supervisory duties;
2. Is responsible to the administrator for development of standards, policies, and procedures governing

intermediate nursing care, and for assuring that such standards, policies and procedures are observed;

3. Is responsible to the administrator for the selection, assignment, and direction of the activities of nursing service personnel;
4. Is employed full time (40 hours per week) in the facility;
5. Is devoted, full-time to direction and supervision of the nursing services; and
6. Is on duty during the day shift.

8.409.22 NURSING PERSONNEL

For the two day shifts (16 hours per calendar week) not covered by the Director of Nursing, there shall be a Registered Professional Nurse or a licensed Practical Nurse, and:

1. There shall be, at all times, a responsible staff member actively on duty in the facility, and immediately accessible to all residents, to whom residents can report injuries, symptoms of illness, or emergencies, and who is immediately responsible for assuring that appropriate action is promptly taken.
2. Assistance as needed to clients with routine activities of daily living including such services as help in bathing, dressing, grooming, and management of personal affairs.
3. Continuous supervision for residents whose mental condition is such that their personal safety requires such supervision.

8.409.23 PROFESSIONAL PLANNING AND SUPERVISION OF MEAL SERVICE

At least three meals a day, constituting a nutritionally adequate diet must be served in one or more dining areas separate from the sleeping quarters. Tray service must be provided for clients temporarily unable to leave their rooms.

If the facility accepts or retains clients in need of medically prescribed special diets, the menus for such diets shall be planned by a professionally qualified dietitian, or must be reviewed and approved by the attending physician. The facility must provide supervision of the preparation and serving of the meals and their acceptance by clients.

8.409.24 ANCILLARY PERSONNEL

Authorized subsidiary personnel performing duties in support of professional health care services include:

1. Nurse aides
2. Dietary
3. Housekeeping and maintenance

To assure the provision of adequate nursing services, each intermediate nursing care facility must provide sufficient:

1. Numbers and categories of personnel, as determined by the number of clients in the facility and their particular nursing care needs. This determination is made in accordance with accepted policies of effective nursing care and with these guidelines.

2. Nursing and auxiliary personnel are employed and assigned to duties on the basis of their qualifications or experience to perform designated duties.
3. Bedside care under direction of the client's physician in the presence of minor illness and for temporary periods to include nursing service provided by, or supervised by, a professional nurse or licensed practical nurse.

An intermediate care facility may, at its option, secure the services of a pharmacy consultant. If such facility takes this option, the provisions of rule item 2., are applicable.

8.409.3 CLINICAL RECORDS

8.409.31 MAINTENANCE

The following records, as a minimum, must be kept current, dated and signed, and must be made available for review if applicable:

1. Identification and summary sheets.
2. Hospital discharge summary sheet.
3. Medical evaluation and treatment plan.
4. Physician's orders.
5. Physician's progress notes.
6. Nurse's progress notes.
7. Medication and treatment record.
8. Laboratory and X-ray reports.
9. Consultation reports.
10. Dental reports.
11. Social Service notes.
12. Pharmacy Consultant's notes.

8.409.32 RETENTION OF RECORDS

1. Files retained at least six (6) years. (Before destruction of records, however, the nursing home's legal counsel should be consulted.)
2. In the event that a patient is transferred to another health facility, certain transfer information should be incorporated in a record to accompany the patient. This information should include:
 - a. A transfer form of diagnosis;
 - b. Aid to daily living information;
 - c. Transfer orders;

- d. Nursing care plan;
- e. Physician's orders for care.

8.409.33 CONFIDENTIALITY OF RECORDS

1. Disclosed only to authorized persons.
2. Form APA 4, "Authorization for Release of Medical Information" shall be executed in duplicate (original to the nursing home medical record with a copy to the county department) at the time of admission. This form must be signed by the client, or the client's designated representative, parent (if a minor), guardian, or other legally responsible person.

8.409.34 RECORDS ADMINISTRATOR

It is recommended that the Intermediate Health Care Facility have available:

1. A consultant who is a registered records administrator, or a person who is accredited as a records technician.
2. An employee who is trained or is receiving training in medical records management for accreditation as a records technician or a registered records administrator.

8.409.4 MEDICAL BASIS FOR CARE - INTERMEDIATE NURSING CARE

Eligible clients may be admitted to approved facilities only upon the certification of a physician licensed to practice in Colorado that there is a functional need for such admission. The client's freedom of choice of physician shall be respected. Health care of the client must continue under the supervision of a physician. The facility must have a physician available for necessary medical care in case of emergency.

8.409.41 PHYSICIANS' INVOLVEMENT

8.409.42 DETERMINATION FOR INTERMEDIATE NURSING CARE

The medical need of a client for Intermediate Nursing Care shall be delineated in the plan of treatment and substantiating orders written by the physician and by the performance of the necessary Intermediate nursing services implementing such plans and orders.

Upon admission to an Intermediate Nursing Care Facility, the facility must obtain for the medical record of each such client:

1. A summary of the course of treatment by the attending physician or which was followed in the hospital, the diagnosis(es) and current medical findings, and the rehabilitation potential.
2. An evaluation by the physician. Physical examination must be accomplished within 48 hours of admission and recorded, unless such an examination has been accomplished within five days prior to admission to the Intermediate Nursing Care Facility.
3. Physician's Orders. Orders must be written for the immediate care of the client. These may be written by the attending physician or by the physician who has the responsibility for emergency care in this facility. The current hospital summary of the course of treatment, with orders used, is acceptable as emergency orders.
4. The physician's treatment plan. The plan must be written and must be directed towards maintaining the health status of the client, preventing further deterioration of the physical well-being of the

client, and preparing the client for normal noninstitutional life. The plan must be reviewed consistent with the continuing professional care by the physician, and revised as necessary, and must include medication and treatment orders which will be in effect for the specified number of days indicated by the physician. This period shall not exceed ninety (90) days unless reordered in writing by the physician. Telephone orders may be accepted by licensed nurses, but must be written into the clinical record by the receiving nurse. These orders must be countersigned by the ordering physician within 48 hours. The medical necessity for a physician's visit, at least once every quarter, must be evidenced in the clinical record by a valid signed entry.

5. Plan for Emergency Care. Each Intermediate Nursing Care Facility must provide for one, or more, physicians to be available to furnish emergency medical care, or surgical procedures, if the attending physician is not immediately available. A schedule listing the name, telephone number, and days on call for a given physician will be posted at each nursing station. An RPN or LPN must be on call (for availability to handle emergencies; to contact the physician, receive orders or medications) for all shifts other than the day shift. The Intermediate Nursing Care Facility must also establish procedures which will be followed in the emergency care of the client, the persons to be notified, and the reports to be prepared.

8.409.43 PHYSICIANS' INVOLVEMENT REDETERMINATION FOR INTERMEDIATE NURSING CARE

The medical need of the client for Intermediate Nursing Care shall be redetermined every six months or at the time of the physician's required quarterly visit if the client's condition has changed.

The term "substantial change" does not encompass short-term treatment regimens for temporary illness, adjustments to prescribed medications when the frequency and dosage is not affected, or changes to be in effect for less than a thirty (30) day period.

8.409.5 MEDICAL REVIEW AND MEDICAL INSPECTION - INTERMEDIATE CARE NURSING CLIENTS

Medical review of the treatment of all clients in intermediate nursing care facilities who are entitled to medical assistance will be accomplished annually.

8.409.51 MEDICAL REVIEW TEAM

8.409.52 COMPOSITION AND MEMBERSHIP REQUIREMENTS

The medical review team for intermediate nursing clients shall be composed of one or more nurses and other appropriate health and social service personnel as indicated and will function under the supervision of a physician.

No member of the team may be employed by or have financial interest in any nursing home. No physician member of a team may inspect the care of patients for whom he is the attending physician.

8.409.53 FUNCTION - MEDICAL REVIEW AND EVALUATION

1. The medical treatment of intermediate nursing facility clients entitled to medical assistance shall be reviewed at least annually.
2. Annual review consists of an evaluation of the treatment, utilizing the medical record and physical contact with, and observation of, each client in the nursing facility surroundings. This review, at a minimum, will elicit:
 - a. Medical necessity for visit by attending physician at least once every calendar quarter.

- b. Adequacy in quality and quantity as well as the timeliness of treatment to meet health needs.
- c. Adherence to the written physician's treatment plan.
- d. Review of prescribed medications by the attending physician at least every ninety (90) days during the necessary client visit.
- e. Tests, or observations of clients, indicated by their medication regimen have been made at appropriate times and properly recorded.
- f. Physician, nurse, and other professional staff progress notes are made as required, and appear to be consistent with observed condition of the client.
- g. Adequate services are being rendered to each client as shown by such observations as cleanliness, absence of decubiti, absence of signs of malnutrition or dehydration, and apparent maintenance of optimal physical, mental, and psychosocial function.
- h. Client's need for any service not available in, or actually being furnished by the particular facility, or through arrangements with others.
- i. Each client actually needs continued placement in the facility, or there is an appropriate plan to transfer the client to an alternate method of care.

8.409.54 REPORTS

1. Review reports of care in each facility are submitted to the Department.
 - a. After review copies are forwarded to:
 - 1) The intermediate care facility.
 - 2) The intermediate care facility Utilization Review Committee.
 - 3) Colorado Department of Public Health and Environment.
2. Reports will cover observations, conclusions, and recommendations with respect to adequacy and quality of client services in the facility, and of physician services to clients in the facility. They will also cover specific findings with respect to individual clients and any recommendations resulting therefrom.

8.409.55 STATE DEPARTMENT ACTION

1. Reports submitted as a result of Medical Review may result in decisions to reclassify clients into a different level of care, or recommendations for modification of treatment.

Such decisions or recommendations will be transmitted as appropriate to the:

- a. Attending physician.
 - b. Administration of the Intermediate Nursing Care Facility.
 - c. County department responsible for the client.
2. Changes in classification recommended will be effected prior to the next billing period.

8.409.56 REVIEW OF STATE DEPARTMENT ACTION

Disagreements with the decisions and recommendations of the Review Team may be adjudicated through the Administrative Review mechanism of the Department; however, the Division of Medical Services will retain the right to final decision.

8.415 ROLE OF COUNTIES AND NURSING FACILITIES

.10 ROLE OF THE COUNTY DEPARTMENT OF SOCIAL/HUMAN SERVICE STAFF IN NURSING FACILITY PLACEMENTS

The County Department of Social/Human Services shall be responsible for the following in all nursing facility placements involving either clients of medical assistance or applicants for assistance:

- A. The determination of existing or potential eligibility for medical assistance.
- B. The referral, whenever possible, of all Medicaid eligible clients/applicants who are eligible for Medicare benefits to facilities certified for participation in the Medicare Program.
- C. In those instances in which an individual residing in a nursing facility under some method of reimbursement other than Medicaid makes application for medical assistance, the county must provide notice of the application referral date to both the nursing facility and the Utilization Review Contractor.
 - 1. Such notice must be provided verbally to both the facility and the Utilization Review Contractor within two (2) working days of the application referral date.
 - 2. Written notice must be mailed to the facility within five (5) working days.
 - 3. Such notice is critical to the timely conduct of admission review by the Utilization Review Contractor.
- D. In those instances where eligibility is determined to be effective three months prior to the date of application pursuant to Department rules and regulations, the County Department of Social/Human Services shall notify the nursing facility of this circumstance in writing.

This should be written in the area reserved for comments in Section VI(5) of the Form AP-5615. Similar verbal or written notice must be given or mailed to the Utilization Review Contractor, utilizing a format as determined by the Department.

- .11 The Form AP-5615 is intended as a method for communicating the status of a resident or applicant, or actions which change that status, between nursing facility, the County Department of Social/Human Services, and the Department. Examples of such actions are admission, discharge, readmission, death or changes in resident income. Failure to complete the AP-5615, or to properly verify information reported thereon in a timely fashion, results in inappropriate reimbursement to nursing facilities, inequitable assistance payments, and the loss of documentation necessary for Department field audit staff. Upon receipt of Form AP-5615, the County Department of Social/Human Services shall be responsible for the following.
 - A. Verify, correct, and complete, when necessary, the client/applicant's name, State ID number, and all other identifying data:
 - B. Verify client/applicant income. Such verification must occur on a regular basis. All income of the client which is in excess of the amount reserved for personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, and less

home maintenance allowance, and less allowable expenses for medical and remedial care (see PETI deductions as defined in Medical Assistance Staff Manual §§8.110.49 and 8.482.33), must be applied by the client/applicant toward his/her care. Changes in income must be reflected in submission of a new eligibility reporting form and a new AP-5615.

- C. Verify client payment. This amount must be calculated by per diem appropriately in all months for which Medicaid reimbursement covers less than a full month's care.
 - 1. Client payment may be waived and zero (-0-) client payment applied only under the conditions as defined in §8.483.34, D., 1.
 - 2. Client payment may not be waived (other than for the exceptions provided for in §8.415.11, C., 1.), in the instances as defined in §8.482.34, D., 2.
 - 3. When client payment is calculated by per diem, the amount shown on the AP-5615 will be that amount to be paid by the resident, rather than the amount to be calculated by per diem calculation.
 - 4. Corrections to income or client payment shall be initialed and dated by the income maintenance technician from the County Department of Social/Human Services.
- D. Review the date of action, such as admission, readmission, discharge, death, or change in client payment being reported and verify as necessary;
- E. Indicate approval or denial of action being reported and effective date of that approval or denial; and
- F. Sign and date all copies, and distribute in accordance with instructions on the reverse side of page three of the AP-5615 form.

8.415.20 RESPONSIBILITY OF THE NURSING FACILITY IN NURSING FACILITY PLACEMENTS

These rules set forth the administrative procedures which must be followed by all facilities participating in the Medical Assistance Nursing Facility Program. Failure of the facility to meet the requirements set forth herein shall cause the facility to be denied reimbursement.

A. Admission

When an admission to the nursing facility is proposed, it is the responsibility of the nursing facility to:

- 1. Determine, prior to an applicant's admission, whether or not the individual is a client of medical assistance or has made application for medical assistance;
- 2. Complete the ULTC 100.2 prior to or on day of admission. Based on this information, the Utilization Review Contractor will determine the level of care and assign an initial length-of-stay.
- 3. For purposes of this regulation, admission is defined as
 - a. any new admission; or
 - b. any change from other sources of reimbursement to the Medical Assistance Program.

B. Changes in Resident Status

Form AP-5615 shall be used by the nursing facility to notify the County Department of the current or changed status of all clients and applicants residing within the nursing facility.

1. The nursing facility shall initiate Form AP-5615 (in accordance with instructions on the reverse side), for all admissions, readmissions, transfers from private pay or Medicare, discharges, deaths, changes in client pay, and leaves of absence; and shall submit three (3) copies to the responsible county.
2. The nursing facility is solely responsible for collecting the correct amount of client payment due from the resident, his family, or representatives. Failure to collect client pay, in whole or in part, shall not allow the nursing facility to bill the Medical Assistance Program for the uncollected client payment.
3. The county department may initiate the AP-5615 when appropriate, which may include, but is not limited to, changes in resident income of which the county becomes aware.

C. Transfer and Discharge

The nursing facility must determine that all requirements for an orderly transfer or discharge are met before relinquishing their responsibility to the resident. This is necessary in order to assure continuity of total care. Therefore, the nursing facility is responsible for following the procedures as outlined at section 25-1-120, C.R.S., entitled "Nursing and intermediate care facilities - rights of patients", including the section on grievance procedures.

8.416 NURSING HOME RESIDENT/CLIENT RELOCATION PLAN

- .10 The overall goal of the relocation plan (RP) is to minimize the identified risks of resident relocation to ensure the optimal placement of all involved residents, and to ensure protection of resident health, welfare and rights.

It may become necessary to relocate residents from one facility into another. A variety of events could necessitate resident relocation such as:

- decertification and/or delicensure of a facility;
- a change in the level of care classification of beds;
- withdrawal from participation in the Medicaid program;
- expiration or non-renewal of the Medicaid provider agreement;
- the facility's inability to provide care and related services because of fire, natural disaster, loss of staff, or other reason beyond its control;
- license or certification decrease in licensed bed capacity.

Should the relocation of a resident become necessary, the following rules shall apply.

- .20 The Department of Health Care Policy and Financing shall serve as lead agency for the implementation of the relocation plan except in the instance where the cause for relocation is solely delicensure. Where delicensure of a facility is the sole reason for resident relocation, the Colorado Department of Public Health and Environment has agreed to serve as the lead agency pursuant to the Memorandum of Understanding of February 10, 1982.

- .30 A comprehensive packet explaining the Nursing Home Resident Relocation Plan (NHRRP) shall be available from the lead agency.
- .31 The packet shall explain the goals and objectives of the NHRRP, the role and responsibilities of each involved agency, forms to be utilized for a client relocation, resident rights, and an explanation of the relocation process. Each agency is expected to perform its respective functions as outlined.

8.416.40 Agency Responsibilities.

41. Role of the Department of Health Care Policy and Financing.

Pursuant to §8.416.10 and §8.416.20 of these Rules and upon determination that there will be a client relocation, the Department of Health Care Policy and Financing shall conduct its relocation responsibilities as follows:

- A. Coordinate with the Department of Public Health and Environment, Department of Institutions, the Attorney General's Office, and other involved agencies.
- B. Within 24 hours from the time of nursing home closure decision, notify by phone and in writing the affected county department(s) so they may initiate planning and arranging for resident relocation.
- C. Provide the County Department of Social/Human Services with a copy of the NHRRP within the same 24-hour period as described in .41(B) (above).
- D. Provide the involved County Department of Social/Human Service with a current list of vacant beds by facility in the immediate geographic area and with written assurance that related resident transportation needs are Medicaid reimbursable.
- E. Facilitate the relocation process by offering technical assistance to the county department(s).
- F. Prepare Medicaid resident letters and hold them for later distribution by the county department. This letter shall briefly explain the reason(s) for decertification and offer assistance in resident relocation through the county department.
- G. Cooperate with the Public Relations Officer, Department of Public Health and Environment with regard to the dissemination of public information.

.42 Role of County Department of Social/Human Services.

The County Department in which the facility is located where the occurrence of an event listed above (§8.416.10) necessitates resident relocation shall be responsible for the actual relocation of the clients to the alternate facilities. The County Department shall:

- A. Work closely with the Department and other local agencies to insure the orderly transfer of clients.
- B. Identify all Medicaid clients for which the county has primary responsibility from the Colorado Department of Public Health and Environment's Master List of Nursing Facility Clients.
- C. Assign staff to carry out the relocation activities. The temporary reassignment of staff may be necessary in order to carry out this responsibility.

- D. Open all identified cases for services in the Adult Protection Program.
- E. Whenever possible, notify relatives of the clients of the impending move and enlist their aid in the relocation.
- F. Through Department of Public Health and Environment staff, ascertain whether or not the resident's physician has expressed a preference as to specific nursing facility placement relocation.
- G. Establish time-frames for the actual physical move of each client.
- H. Distribute the Medicaid Client Letters (see .41)(F)(above) and immediately counsel the residents in an effort to dispel anxiety. Share with both the clients and their relatives, information relative to alternate facilities with vacancies (see .41)(D).
- I. Arrangements for pre-discharge visits to other facilities for client and relatives shall be made upon the decision of the clients, relatives and friends and in accordance with § 8.416.43 (F) and (G) (below).
- J. Arrange for an orderly transfer of clients to the new nursing facilities by:
 - 1. Assuring that any prorated refund due to the client accompanies him/her to the new facility.
 - 2. Helping the client, staff and family to assemble all of the client's personal effects. This includes a check of the laundry facilities and any storage area assigned to the client.
 - 3. Assuring that an inventory of the client's personal belongings is compiled and accompanies the client to the new nursing facility.
 - 4. Assuring that the client's personal needs money is properly accounted for and is transferred to the new nursing facility or to the client within forty-five days.
 - 5. Arranging for appropriate transportation to the new nursing facility.
 - 6. Providing assistance to the client with unpacking and getting settled in the new environment, when appropriate.
 - 7. Monitor the client's adjustment and provide at least one follow-up visit during the first month after transfer to assure that the client needs are being adequately met. In cases where the client is moved to another county, contact that County Department of Social/Human Services and arrange for the follow-up visit.
 - 8. Arranging for all county records pertaining to the client to be changed to reflect the new location. This must be done for all Medicaid clients regardless of who has primary responsibility. This information can be obtained from the Department of Public Health and Environment's Master List.
 - 9. Assuring that a change of address has been submitted to the Social Security Administration and any other agency which has fiscal responsibilities to the client.

10. Referring all media inquiries and public requests for information to the properly designated State Agency Official.
 11. Protecting at all times the client's rights of choice and human dignity.
- K. When choosing with the client and/or relatives a facility for relocation, the County Department of Social/Human Services will consider the following:
1. The least restrictive setting which will meet the client's needs.
 2. The location which will facilitate contact with relatives and friends (preferably in the same county if possible).
 3. The capacity of the nursing facility to meet the client's needs.
- L. When any of the following situations prevail, a facility will usually not be considered for client relocation:
1. The facility is engaged in litigation with the Department over possible closure, or
 2. In the opinion of the county representative in collaboration with the Department and the Department of Public Health and Environment, the alternate facility would be overburdened with too many transfer clients from the closing facility.

.43 Role of State Long Term Care Ombudsman.

- A. The State Long Term Care Ombudsman shall monitor relocation activities to insure that clients' rights are observed. The Ombudsman will assure that private pay clients have appropriate notice, counseling and choice. Additionally, the Ombudsman will assure that the following activities are carried out:
- B. Identify those clients who are private payers from the Department of Public Health and Environment's Master List of clients;
- C. Staff and volunteers are assigned to carry out relocation activities which must be completed;
- D. Coordinate with Department and local agencies to insure the orderly transfer of clients;
- E. Notify the client's physician, relatives or friends of the relocation;
- F. In collaboration with the client's physician, relatives and/or friends, assess which activities and responsibilities shall be delegated to physician, relative and/or friend(s);
- G. When appropriate, pre-discharge visits shall be arranged for giving consideration to the following factors:
 - least restrictive relocation alternative;
 - proximity to family and friends;

- remaining within the same county;
- whenever possible, do not relocate a client into a facility currently in litigation relating to certification and/or licensure;
- capacity of the facility to care for the client without being overloaded;
- give primary importance to desires of both client and family.

H. The orderly transfer of the client to the new facility is arranged considering the following items: medical records, prorated funds, personal effects, inventory of personal belongings, needed medication available at time of transfer, appropriate transportation, assistance with getting settled, follow-up visits, seeing that there are appropriate changes of address, protecting at all times the client rights of choice and human dignity.

8.420 REQUIREMENTS AND PROVISIONS FOR PARTICIPATION BY COLORADO NURSING FACILITIES

In order to receive vendor payments from the State Department for care of assistance recipients, a nursing facility must enter into a provider agreement with the Department, in such form as the Department prescribes. For the purposes of this section, the term "nursing facility" includes an intermediate care facility for the mentally retarded (ICF/MR). The facility's provider agreement with the Department carries with it the responsibility of said nursing facility to subscribe to the terms and conditions for payment of care to recipients promulgated by the Colorado Medical Services Board in its rules and regulations set forth in this staff manual. Such nursing facilities also must adhere to all pertinent requirements of federal and state law, and to the rules, regulations, and requirements as prescribed by the Colorado Department of Public Health and Environment (CDPHE) in its minimum standards for nursing facilities. This means that the nursing facility must be duly and appropriately licensed, provide for the use of qualified staff and the provision of nursing care, and adhere to those regulations with respect to the number and qualifications of nursing personnel required by the CDPHE in giving services to recipient patients.

All nursing facilities are required, as a condition for both initial and continuing participation, to comply with the provisions of Section 601 of Title VI of the Civil Rights Act of 1964. Annual on-site inspections for assurance of compliance will be made by the Colorado Department of Public Health and Environment.

In addition, the nursing facility is required to maintain proper accounting of the personal needs funds of recipients as provided in 8.482.5.

Participation in the Colorado Medicaid program of nursing facilities and/or nursing facility beds is limited to the regulations found in this manual entitled LIMITATIONS ON THE NUMBER OF NURSING FACILITY BEDS ENROLLED IN THE COLORADO MEDICAID PROGRAM.

8.421 RESPONSIBILITY OF COUNTY DEPARTMENT CONCERNING PARTICIPATION

It shall be the responsibility of each county department to inform the State Department whenever it is aware that:

A licensed nursing home has permanently discontinued or decreased the qualified nursing service under which it was licensed.

Any person is operating an unlicensed nursing home or violating terms of license for a nursing home in which there are three or more recipients not related to the owner, and is providing any nursing service in an unlicensed home or one with a limited license to such recipients in addition to board and room services.

Any other condition exists which operates to the detriment of the patients in the home. This would include observation by the county department of such things as uncleanliness, poor or inadequate food, safety hazards, overcrowding, poor or inhumane treatment of patients, etc.

8.422 VISITS TO RECIPIENTS BY SOCIAL SERVICES PERSONNEL, PRIVACY FOR CONFERENCES WITH RECIPIENTS

In order to maintain continuing eligibility to recipients, to provide necessary services to recipients, and to conduct other official business pertaining to nursing home payment, the nursing home is required to admit duly authorized representatives of the State or County Departments of Social Services at any reasonable time. Social Services personnel shall be afforded privacy for conferences with nursing home recipient-patients. All such information is considered in terms of the rules contained in the Income Maintenance Manual.

8.423 VISITS TO RECIPIENTS BY THE COLORADO LONG TERM CARE OMBUDSMAN AND DESIGNATED REPRESENTATIVES

A. Definitions:

Designated Representatives - are persons who have been specifically appointed by the Colorado Ombudsman to be an official part of the statewide ombudsman program.

Such designated representatives shall receive a minimum of twenty (20) hours of training using the manual provided by the Colorado Long Term Care Ombudsman Program as well as other materials. Included in this training shall be material regarding the rights of patients and specifically procedures which protect the confidentiality of information regarding Medicaid patients.

Official Colorado Ombudsman Program - the agency which has received the Ombudsman grant from the Older Americans Act through the Colorado Department of Social Services is for purposes of this regulation considered to be the official State Ombudsman Program.

- B. The Colorado Ombudsman and designated representatives shall have access to the physical premises of nursing home facilities and the Medicaid residents of these facilities. Visits to the nursing home should be during reasonable hours except in instances where the nature of a complaint investigation requires visitation during off hours.

All designated representatives (after they have completed the necessary training) will be provided with identification showing them to be a part of the State Ombudsman Program. Under normal circumstances such identifications will be presented to the nursing home administrator or person in charge during the administrator's absence.

- C. The Colorado Ombudsman or designees shall only disclose information received from a Medicaid patient's records and/or files when:

1. The Ombudsman authorizes the disclosure and
2. In cases of identifying a patient, the patient or the legal representative of the patient must consent in writing to the disclosure and specify to whom the identity may be disclosed or
3. A court orders the disclosure.

- D. Non-compliance with the provisions of this section of the regulation will not be considered sufficient good cause as defined in the section of this manual called STANDARDS FOR DENIAL, TERMINATION, AND NON-RENEWAL OF PROVIDER AGREEMENTS.

8.424 PERIODIC VISITS - NURSING HOME RECORDS TO BE MADE AVAILABLE

Members of the Department of Health and Human Services, the staff of the State Department of Social Services or specialized staff acting as agents of said Department or members of the Medicaid Fraud Control Unit, will make periodic visits to nursing homes for purposes of determining compliance of nursing homes with the rules set forth concerning nursing home care to Medicaid recipients, for purposes concerned with the appropriate rate to be paid for care of recipients under applicable rules, and such other purposes as may be related to administration of the Colorado Medical Assistance Program.

All medical records and documents related to the above purposes of visits by the staff members mentioned shall promptly be made available in Colorado to such persons by the nursing facility administrator or his delegated alternate.

"Closing" audits also are to be made at the point of impending change of ownership of a nursing facility in order to determine whether payment adjustments are necessary with respect to continuing payment to the new owner or such adjustments in payments, recoveries, etc., covering former owners or sellers.

Nursing facilities owned by organizations maintaining financial records outside the territorial boundaries of the State of Colorado may, at their option, elect to pay an annual examination fee of \$300 for auditing financial records at the home office in lieu of making such records available in the Colorado nursing facility. The examination fee is payable to the State Department upon submission of the financial and statistical report for nursing facilities for the six month period coinciding with the close of the nursing facility's fiscal year and is to be accompanied by a letter requesting that the examination be made at a specified address.

8.425 NOTIFICATION TO STATE DEPARTMENT IN THE EVENT OF CHANGE OF OWNERSHIP OR OTHER CHANGES

In the event a nursing facility changes ownership or other changes occur which affect the nursing facility's discharge of its responsibility for its patients, as a participating nursing facility, the State Department must be notified as set forth in section 8.441.5.

8.430 MEDICAID CERTIFICATION OF NEW NURSING FACILITIES OR ADDITIONAL BEDS

8.430.1.A. The Department shall consider requests for the Medicaid certification of new nursing facilities in accordance with the procedures and criteria specified in Section 8.430.3 of this rule. Requests for the Medicaid certification of additional beds in existing Colorado nursing facilities shall be considered in accordance with the procedures and criteria at section 8.430.6.

8.430.1.B. These regulations do not apply when a nursing facility has a change of ownership or is placed in receivership if the ownership change or receivership action involves no increase to its previously approved Medicaid bed total. These restrictions also do not apply to facilities exclusively serving the developmentally disabled (ICF/MR's and HCBS/DD group homes).

8.430.1.C. These regulations shall also not apply to a replacement facility for existing residents in a facility owned/operated by the applicant. Approval for the beds shall only be granted if the applicant clearly documents that the old structure was substantially inadequate to efficiently and effectively promote quality of care for the residents, and if the replacement facility is located no more than five miles from the original facility. An exception under this provision shall be limited to the original number of Medicaid-certified beds being replaced. Residents living in the original facility at the time it is closed shall be given the right of first refusal for beds in the replacement facility.

8.430.2 DEFINITIONS

Nursing Facility - an individual nursing facility which meets the Colorado Department of Public Health and Environment's licensure requirements for nursing facilities.

New Nursing Facility - a) Any nursing facility not licensed as a Colorado nursing facility as of November 1, 2003; or b) Any nursing facility which for a period of 30 or more days subsequent to November 1, 2003, has not been licensed as a Colorado nursing facility.

Existing Colorado Nursing Facility - Any nursing facility continuously licensed in Colorado since no later than November 1, 2003.

Licensed Bed Capacity - The licensed bed capacity of a nursing facility on file with the Colorado Department of Public Health and Environment.

8.430.3 Procedures and Criteria for Medicaid Certification of a New Nursing Facility

8.430.3.A. The burden of demonstrating the need for a new Medicaid facility shall be entirely on the applicant. Applications, which, in the sole discretion and judgment of the Department, do not satisfy the applicable criteria, shall be denied.

8.430.3.B. The applicant for Medicaid certification of a new nursing facility shall:

1. File a letter of intent to apply for certification with the Department in January or July of the year in which the application will be filed. The letter of intent shall specify:
 - a. Person or corporation who will submit the application.
 - b. The proposed service area.
 - c. The number of beds in the new facility for which Medicaid approval will be requested.
2. No later than five months from the date of filing of the letter of intent, the applicant shall submit a complete application to the Department which shall include:
 - a. The name, address and phone number of the person or corporation requesting approval for the new nursing facility.
 - b. The total number of proposed beds and the number of beds requested for Medicaid certification.
 - c. A description of the service area and justification that the service area can be reasonably served by the new nursing facility.
 - d. If construction of the additional beds or new nursing facility has not been completed by the date the application is filed, the following documentation shall also be provided:
 - i) Official written documentation showing ownership of the proposed new nursing facility.
 - ii) Location of the proposed new nursing facility including documentation of ownership, lease or option to buy the land.
 - iii) Documentation from a financial institution regarding financing support for the new nursing facility.

iv) Complete, written documentation that preliminary architectural plans for the proposed new nursing facility have been submitted to the Colorado Department of Public Health and Environment.

v) Expected completion date of the new nursing facility.

e. A statement regarding any previous contracts with or enrollment in any state's Medicaid program. The statement shall assure the Department that the applicant has never been found guilty of fraud or been decertified from participation in the Medicaid program in Colorado or any other state.

8.430.3.C. The Department's approval or denial of an application for Medicaid certification of a new nursing facility shall be based on the following information from the applicant:

1. Planned resident capacity and payer mix.
2. Planned differentiation of the proposed new facility from existing nursing facilities in the same service area (e.g., new models of care, special programs, or targeted populations).
3. The applicant's marketing plan, including planned communications and presentations to discharge personnel and placement agencies.
4. Demographic analysis of the applicant's designated service area, including a market analysis of other available long-term care services, e.g., assisted living, home health, home and community based services, etc., and the extent to which such alternative services are utilized.
5. Projections of net patient revenue and operating costs.
6. Audited financial statements for the most recently closed fiscal year for the entity seeking Medicaid certification.
7. Additional financial, market or programmatic information specified by the Department within two months after the application date;
8. Historical information concerning the quality of care and survey compliance in other nursing facilities owned or managed by the applicant or a related entity or individual.
9. Documentation of whether the proposed new facility provides needed beds to an underserved geographical area, as described in section 8.430.4, or to an underserved special population, as described in section 8.430.5.
10. A statement assuring cooperation with de-institutionalization and community placement efforts.

8.430.3.D. A completed application shall be made available on the Department's website for public review and comment on the electronic internet. In addition, the applicant shall provide newspaper notice at the applicant's expense, in such manner and with such content as specified by the Department, that the application has been submitted. In the Department's discretion, a public hearing on the application may be conducted.

8.430.3.E. As a condition of approval, the Department may require the new provider to execute an appropriate performance agreement.

8.430.4 In order to qualify as an underserved geographical area of the state, the application must demonstrate, with appropriate documentation, that:

8.430.4.A. The new nursing facility is located in the service area defined by the application. The service area shall be no more than two contiguous counties in the state.

8.430.4.B. The service area shall have a nursing facility bed to population ratio of less than 40 beds per 1,000 persons over the age of 75 years.

1. The population projections shall be based upon statistics issued by the State Department of Local Affairs.
2. The applicable statistics for applications involving beds for which construction is complete at the time of application shall be the population statistics for the period including the date on which the application is filed.
3. The applicable statistics for applications involving beds for which construction is not complete at the time of application shall be the population projections for the expected date of completion of the beds set forth in the application.

8.430.4.C. The occupancy of existing nursing facilities in the proposed service area exceeds ninety percent (90%) for the six (6) months preceding the filing date of the application, as demonstrated by the nursing facility quarterly census statistics maintained by the Colorado Department of Public Health and Environment.

8.430.5 An application for a new nursing facility to serve an underserved special population shall contain the following information and documentation:

8.430.5.A. A description of the special populations to be served and why they cannot be served in the community.

8.430.5.B. Justification for the service area to be served.

8.430.5.C. A determination of whether there are existing excess beds in the proposed service area and, if so, why the existing excess beds cannot be used by or converted for use by the special populations.

1. The determination of existing excess beds shall include a population ratio analysis and occupancy analysis as set forth in 8.430.4, and shall be calculated by utilizing the formulas, methods and statistics set forth therein.
2. The justification of why existing excess beds cannot be used for or converted for use by the special populations(s) must be clearly demonstrated and supported by relevant and competent evidence.

8.430.5.D. Applications based on underserved special populations must document that one or more of the following special populations is underserved in the proposed service area:

1. Clients with AIDS.
2. Clients with mental or developmental disabilities, as defined by the Preadmission Screening and Annual Resident Review (PASARR) process described at 10 C.C.R. 2505-10, Section 8.401.18 et seq..
3. Clients with a traumatic head injury.

4. Clients who have been certified for a hospital level of care in accordance with 10 C.C.R. 2505-10, Section 8.470.

8.430.5.E. The following requirements also apply to approval of new nursing facilities for special populations:

1. The Statewide Utilization Review Contractor shall certify long-term care prior authorization requests for Medicaid clients who are verified as meeting the special populations definitions provided in Section 8.430.5.B.
2. In the case of applications for approval of new nursing facilities for mentally disabled populations, all restrictions concerning Medicaid reimbursement as described at 10 C.C.R. 2505-10, Section 8.401.41 et seq., entitled GUIDELINES FOR INSTITUTIONS FOR MENTAL DISEASES (IMD's), shall apply.

8.430.5.F. A bed approved for a specific underserved special population shall not be used for any other population, even if a Medicaid client occupying this type of bed is discharged or experiences a change in physical condition which requires transfer to a general skilled nursing unit bed.

8.430.6 Certification of Additional Medicaid Beds in Existing Colorado Nursing Facilities

8.430.6.A. Beginning November 1, 2003, any existing Colorado nursing facility, as defined in Section 8.430.2, may request approval to convert some or all of its licensed non-Medicaid beds to general skilled Medicaid nursing facility beds. A licensed non-Medicaid bed in an existing Colorado nursing facility shall be eligible for Medicaid certification under this section regardless of when construction of the bed was completed, and regardless of whether the bed was previously licensed for a purpose other than nursing facility care.

8.430.6.B. To be considered for additional Medicaid beds under this section, the applicant shall submit a signed, written request to the Department which contains the following:

1. The number of additional Medicaid beds requested.
2. The nursing facility's total licensed bed capacity on the date of the request, consisting of Medicaid-certified beds and licensed non-Medicaid beds.
3. A certification that the facility has been continuously licensed in Colorado since no later than November 1, 2003.

8.430.6.C. A nursing facility shall be eligible for the approval of additional Medicaid beds if the facility:

1. Has been continuously licensed as a Colorado nursing facility since no later than November 1, 2003.
2. Is in compliance with all applicable federal and state requirements, as indicated by the most recently completed survey by the Colorado Department of Public Health and Environment.
3. Has not been subjected to a remedy listed below as a result of a standard or abbreviated facility survey in the last survey period, unless the remedy was imposed but later rescinded.

- a. state monitoring.

- b. civil money penalty.
 - c. denial of Medicaid payment for new admissions.
4. Has agreed to cooperate with any Department efforts to return individuals to the community from nursing facilities including, but not limited to, Nursing Facilities Transitions Grant and Fast Track program.

8.430.7 Out-of-State, New Facilities or Additional Beds

8.430.7.A. Applications for Medicaid approval of additional beds or new nursing facilities in other states may be granted at the sole discretion of the Executive Director of the Department or his/her designee. Approval of beds shall be limited to meet the conditions described at 10 C.C.R. 2505-10, Section 8.461 et seq., entitled PAYMENT FOR OUT-OF-STATE NURSING FACILITY CARE.

8.430.8 Action on Applications

8.430.8.A. Action means denial or approval of the application or request by the Department for additional information regarding an application.

8.430.8.B. Applicants may appeal the Department's action by filing an appeal in accordance with the regulations at 10 C.C.R. 2505-10, Section 8.057. Appeals must be filed within thirty (30) days of the Department's action. If the Department does not take action on a completed application within ninety (90) days of its receipt, the applicant may commence an appeal within thirty (30) days of the lapse of the ninety (90) day period.

8.430.9 Completion of approved beds for new nursing facilities

8.430.9.A. Construction of approved beds shall adhere strictly to the specifications provided in the application or shall result in forfeiture of the Department's finding of the need for the beds. A new application shall be submitted and shall be subject to the criteria for approval in effect at the time of the new application when any of the following changes apply to new beds for a new facility:

- 1. Person or corporation which has ownership.
- 2. The site upon which the new beds were built or will be constructed.
- 3. Proposed service area.
- 4. Condition under which approval of beds is requested.

8.430.9.B. The applicant shall complete the project within 30 months of the date of the Department's approval of the application or forfeit the Departmental finding that there was a need for the new beds.

8.430.9.C. No extension beyond the 30 month period shall be considered unless completion of the project is delayed for reasons beyond the applicant's control.

- 1. The following shall be considered reasons beyond the applicant's control:
 - a. Natural disasters.
 - b. Hazardous soil or water conditions documented by local authorities.

- c. Fires or explosions at the construction site serious enough to substantially delay the project.
- 2. The following shall not be considered beyond the applicant's control:
 - a. Lack of financing or changes in need for financing.
 - b. Delays due to litigation.
 - c. Construction delays (examples of construction delays which would not be granted an extension: weather, management-labor problems, subcontractor missed deadlines, permit or zoning variance problems).
- 3. A decision to extend the 30 month deadline and the specific length of an approved extension shall be authorized in writing by the Executive Director or his/her designee.

8.430.9.D. Applicants who complete the project within the 30 month period or any extension period shall be eligible for a Medicaid provider agreement provided the facility is inspected on-site and found by the Colorado Department of Public Health and Environment to be in compliance with standards for licensure as a nursing facility and certification for Medicaid participation.

8.430.9.E. In cases where two or more different applications for the same service area or special population are received in the same application period the following conditions apply:

- 1. Upon request by the Department, each applicant shall submit the estimated per diem costs to be incurred by the provider/developer over the first five (5) years of the project. The applicant shall provide assurances that the per diem costs to be incurred shall be sufficient to meet all quality of care standards during this period. The application with the lowest per diem costs shall be chosen for enrollment in the Medicaid program.
- 2. The rate to be paid for the new beds shall be based on the estimated per diem costs for all costs not including registered nurses, licensed practical nurses and nurses' aides for the five year period or the actual audited Medicaid rate during the period, which ever is lower. Should the estimated per diem costs for registered nurses, licensed practical nurses and nurses' aides be higher than the estimate, these costs shall be subject to the actual audited. Medicaid rate-setting procedures. The rate to be paid to an existing provider is the per diem rate approved by the Department for that facility.
- 3. Approval of beds under this regulation in no way exempts applicants from any of the requirements for Medicaid participation.

8.435 ENFORCEMENT REMEDIES FOR VIOLATION OF FEDERAL AND/OR STATE REQUIREMENTS FOR PARTICIPATION

Enforcement Remedies for Violation of Federal requirements for participation in the Medicaid as enumerated in the Federal Omnibus Reconciliation Act of 1987, 1989 and 1990, 42 USC 1396r(h).

A. The Department may impose the following remedies:

- 1. Deny, terminate or not renew the Medicaid provider agreement.

2. Civil monetary penalties.
3. Deny payment for new admissions.

The Department of Social Services does not participate in nor authorize the following additional remedies which the Department of Health may impose:

1. Impose temporary management.
2. Appoint a receiver pursuant to regulations.
3. Suspend, terminate or non-renew the licensing automatic cancellation clause.
4. Require a plan of correction and other related activities associated with the survey and certification process.
5. Other remedies as warranted by Federal or State law and regulations.

B. Termination or non-renewal of the Medicaid provider agreement.

1. The Department shall deny, terminate or non-renew a provider agreement in accordance with the provisions found in Section 8.051, Standards for Denial, Termination and Non-renewal of Provider Agreements.
2. An aggrieved provider may appeal these actions in accordance with Section 8.050, Provider Appeals and Hearings.

C. Civil Monetary Penalties and the Nursing Home Penalty Cash Fund.

1. Assessment, enforcement and collection of a civil money penalty and denial of Medicaid payments shall be the responsibility of the Department of Social Services and shall be made upon the recommendation of the Department of Health pursuant to 26-4-122(1)(a) CRS.
2. The Department of Health may make a written recommendation in a timely manner to the Department of Social Services that a civil money penalty be assessed against a provider for failure to comply with a federal requirement of participation in Medicaid.
3. The Department of Health's recommendation shall be based on the criteria provided for in State statute 25 107.5(2) (b)(II)(A) through (H), CRS and Health Department regulations at Chapter V, Part 29.
 4. a. The Department of Social Services shall accept, enforce and collect the civil money penalty recommended by the Health Department pursuant to 25-1-107(5)(2)(b) (II)A through H, CRS and Health Department regulation at Chapter V, Part 29.
 - b. Should the Department determine that the recommended civil money penalty is not in accordance with the criteria, the Department shall remand such recommendation to the Health Department for reconsideration.
 - c. Any such civil money penalty shall accrue from the date the facility is found by the Department of Social Services to be in violation of any federal requirement of participation pursuant to Section 25-1-107.5(2)(6)(1), CRS. The penalty accrues from the date the facility is determined to actually have been out of compliance with the requirements of participation. The legal rate of interest pursuant to CRS

13-21-101 (1987) shall also be applied to the amount of the civil money penalty for each day the penalty accrues.

5. All appeals received from providers shall be handled in accordance with Section 8.050 to 8.050.03.08, Provider Appeals and Hearings. Any appeal submitted by the provider shall cause the collection to be suspended until the appeal is decided by the Administrative Law Judge.
6. Collection of the civil money penalty shall be enforced by withholding subsequent Medicaid payment to which the provider is entitled. The amount withheld shall not exceed twenty-five percent of the payment to which the provider is entitled. Money shall continue to be withheld until the amount of the civil money penalty assessment is collected. A higher percent of withhold may occur where the provider and the Department mutually agree to the higher withholding amount. Upon notice to the Department of change in ownership or termination of the Medicaid agreement, the Department may withhold all or part of the monies due the owner to satisfy the civil money penalty.
7. The provider shall be informed in writing by certified mail of the imposition of the civil money penalty.
 - a. The letter shall state the civil money penalty shall not be collected until at least 30 days from the mailing date of the certified letter.
 - b. The notice shall further inform the provider should the provider appeal the penalty will not be collected until the appeal is decided by the Administrative law judge. Interest will continue to accrue during the appeal process.
 - c. The letter shall inform the provider of the nature, scope and duration of the violation and the regulatory basis for the civil pay penalty.
8. Any and all civil penalties collected by the Department shall be transmitted to the State Treasurer to be credited to the Nursing Home Penalty Cash Fund. The Nursing Home Penalty Cash Fund is authorized by and will be administered pursuant to State statute 26-4-122, CRS.
9. Payment of penalties is not an allowable cost and should not be reported on the Med-13.

D. Denial of payments for new admissions

1. The Department may deny Medicaid payment for new admissions into a nursing facility under the following criteria.
 - a. The Health Department finds the facility violates direct care related requirements of participation and recommends to the Department Medicaid payment for new admissions not be authorized.

The denial of payment for admissions may be limited to certain types of residents which the Health Department finds may not be adequately treated in the facility.
 - b. The facility's deficiencies do not pose immediate jeopardy to the residents health and safety and the denial of payment for new admissions is in lieu of termination of non-renewal of the provider agreement.
 - c. The facility's deficiencies do pose an immediate jeopardy to the residents' health and safety and thereby terminates or causes non-renewal of the facilities provider

agreement.

- d. Medicare has denied payment for new admissions due to violation of the requirements of Medicare participation. In such cases, the Department's actions shall be limited to the new admissions which are skilled residents meeting the Medicare Level of Care definition.
2. The Department shall deny Medicaid payment for new admissions into a nursing facility under the following criteria:
 - a. The Health Department finds the facility has shown substandard care on three consecutive standard surveys.
 - b. Deficiencies identified in surveys prior to 10/01/90 will not be used for the purpose of repeat deficiencies.
 - c. The Health Department finds that the facility failed to correct a deficiency or deficiencies within three (3) months after the date the facility was found to be out of compliance with a requirement of participation.
 3. The provider shall be informed in writing by certified mail of the denial of payment for new admission. The denial of payment sanction shall be collected thirty (30) calendar days after the certified letter is mailed.
 - a. The letter shall state the regulatory basis for the denial of payment for new admission.
 - b. The letter shall inform the provider of rights to appeal such findings in accordance with Section 8.050 to 8.050.03.08, Provider Appeals and Hearings.
 4. The denial of payment for new admissions shall end on the date the Health Department finds new admissions may be resumed by the facility.

8.440 COST RELATED REIMBURSEMENT

Nursing facilities participating in the Colorado Medicaid Program which provide skilled and or intermediate care shall receive reasonable reimbursement in accordance with these rules as promulgated by the Medical Services Board in the Department of Health Care Policy and Financing and based upon the individual nursing facility's allowable audited costs. The rates established are reasonable and adequate to meet the costs that efficiently and economically operated facilities must incur. A facility is considered to be operated efficiently and economically when it complies with the State and federal licensing and certification requirements, applicable State reporting requirements and at a patient per diem cost equal to or less than the maximum reasonable allowable cost ceiling as described below.

In the determination of reasonable rates for nursing facilities, the Department shall reference federal and the State Medicaid statutes and regulations. Where no specific Medicaid authority exists, the below listed sources and other relevant data will be considered in reaching a rate determination:

Medicare statutes;

Medicare regulations; and

Medicaid and Medicare guidelines.

8.441 FORM MED-13 AND MINIMUM DATA SET (MDS): GENERAL INFORMATION

- A. The determination of the individual nursing facility's allowable costs is based on an individual audit of the per diem costs of operation for each such facility. The basic data for conducting such audits is based on the completion of the "Financial and Statistical Report for Nursing Facilities, MED-13." The Medical Services Board of the Department of Health Care Policy and Financing has authority to require such uniform accounting and reporting procedures as it deems necessary. All financial and statistical records of the nursing facility must be maintained in accordance with generally accepted accounting principles (i.e., those principles approved by the American Institute of Certified Public Accountants).
- B. For purposes of completing MED-13, each nursing facility shall establish a 12-month period which is designated the facility's fiscal year.
- C. MED-13 is then submitted at 12-month intervals within 90 days of the close of the facility's fiscal year. When the Department has received the cost data as submitted by the nursing facility and audited by the Department's contract auditor, such data shall be used to adjust the individual nursing facility cost and rate of payment thereto, subject to the applicable ceiling. (Class IV, State-administered tax supported facilities are not subject to the maximum cost ceilings.) These audits shall be conducted in accordance with generally accepted auditing standards (i.e., those standards approved by the American Institute of Certified Public Accountants) and applicable State and Federal regulations and may be a field audit, desk review, or rate calculation. If there are properly documented reasons for failure to comply, nursing facilities may present a written request to the Executive Director of the Department, or his/her designee, for an extension in submitting the MED-13. Such request must be presented no less than ten working days prior to the final due date for submission of the MED-13.
1. Following completion of a field audit, desk review, or rate calculation, the Department or its contract auditor shall notify the affected nursing facility in writing of any proposed adjustment(s) to the costs reported on the facility's MED-13 form. The notification shall also inform the facility of the basis of the proposed adjustment(s).
 2. The facility shall have 35 calendar days from the date the notification was mailed to submit additional documents or other supporting information to the Department or its contract auditor in response to the proposed adjustment(s). The Department may grant an additional period, not to exceed 30 calendar days, for the facility to submit such documents and information, when necessary and appropriate, given the facility's particular circumstances.
 3. The contract auditor shall complete its review of such additional documents or information, if any, no later than 30 calendar days following its submission, and a rate letter shall be issued promptly thereafter.
- D. All facilities must provide adequate cost data which:
1. Must be based on their financial and statistical records;
 2. Must be verifiable by reference to adequate supporting documentation by qualified auditors during the normal course of their audit.
 3. Must be based on the accrual basis of accounting. (See E below for exceptions.); and
 4. Must include the Medicare cost report which was most recently filed with the Medicare fiscal intermediary. If the facility cannot file a current Medicare cost report for reasons beyond its control, the facility shall submit other, reliable Medicare cost information which the Department has approved.

- E. Where governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.
- F. Under the accrual basis of accounting, the following occurs:
1. Revenue is reported in the period when it is earned, regardless of when it is collected;
 2. Expenses are reported in the period in which they are incurred, regardless of when they are paid.
- G. In order to provide the required cost data and not impair comparability, financial and statistical records shall be maintained in a manner consistent from one reporting period to another.
- H. Nursing facilities shall retain all records required to support information supplied on the MED-13 for a period of at least five years from the date of submission.
- I. The Department shall retain all nursing facility financial and statistical records, cost reports, and reports of all audits and rate calculations for a period of at least five years. Cost reports and financial and statistical records filed after September 1, 1982, shall be public information with the following exceptions:
1. In order to maintain the validity, testing and sampling of the Department's audits of nursing facilities and to protect the integrity of the Medicaid auditing process, the audit program which identifies the testing and sampling specific to each nursing facility, and or those working papers or parts of working papers which reveal the methods or criteria utilized in the testing and sampling performed, shall be maintained by the Department and shall not be made available to the public or to any nursing facility provider.
 2. Any documents or parts of documents which do not reveal specific information on the audit testing or sampling, and are relevant in explaining adjustments made as described above, shall be made available to the nursing facility provider who is the subject of the audit, upon request, but not to the general public.
- J. The fiscal year for all providers shall remain the same as on record with the Department. There are two exceptions to this rule:
1. Providers seeking to coordinate their fiscal year with the fiscal year they have established with the IRS.
 2. Subchapter "S" corporations are required by law to have a fiscal year end of December 31.
- K. Submission to the federal system
- Nursing facilities shall submit all Minimum Data Set (MDS) resident assessments and tracking documents to the Health Care Financing Administration MDS database for Colorado maintained at the Colorado Department of Public Health and Environment.
- L. Editing and Validation according to federal specifications
- Submitted assessment data shall conform to federal and state specifications and meet minimum editing and validation requirements.
- M. Parallel assessment system
- A parallel MDS assessment database shall be maintained at the Department of Health Care

Policy and Financing. This system shall be updated monthly from downloads of the system maintained at the Department of Public Health and Environment. All Resource Utilization Groupings calculations for Medicaid payment shall be performed using the parallel data structure.

8.441.1 TREATMENT OF DELAYS IN THE SUBMITTAL AND AUDITING OF THE MED-13 AND TREATMENT OF DELAYS IN MDS SUBMITTAL AND INCOMPLETE ASSESSMENTS

8.441.11 Failure of a nursing facility to submit its Financial and Statistical Report (MED-13) within the required 90-day period will result in the Department withholding all warrants not yet released to the provider as described below:

A. When a nursing facility fails to submit a complete and auditable MED-13 (i.e., the information represented on the MED-13 can not be verified by reference to adequate documentation as required by generally accepted auditing standards) on time, the MED-13 will be returned to the facility with written notification that it is unacceptable. The facility will be allowed an additional 30 days from the postmark date of this notice in which to submit a corrected MED-13, or until the end of the original 90-day submission period, whichever is later. If the corrected MED-13 is still determined to be incomplete or unauditable, the nursing facility will again be given written notification and shall, at its own expense, submit a MED-13 which has been prepared by a certified public accountant (CPA). The CPA shall certify that the report is in compliance with Departmental rules and regulations, and shall give an opinion of fairness of presentation of operating results or revenues and expenses. Once the original 90-day filing period and 30-day extension have expired, and no acceptable MED-13 has been submitted, the Department shall withhold all warrants not yet released to the provider as described below.

B. When a nursing facility submits a MED-13 which is determined to be incomplete or unauditable at the time of the audit, the nursing facility will be given written notification that a corrected MED-13 will be required. The facility will be allowed 30 days from the postmark date of this notice in which to submit an acceptable MED-13 before the Department begins to withhold payments.

If the resubmitted MED-13 is still incomplete or unauditable, the nursing facility will be notified in writing, and the Department shall withhold all warrants not yet released to the provider as described below. In addition, the nursing facility shall, at its own expense, submit a corrected MED-13 which has been prepared by a CPA. The CPA shall certify that the report is in compliance with Departmental rules and regulations, and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

C. If the audit of the MED-13 is delayed by a lack of cooperation of the nursing facility, then the effective date for the new rate will be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall be considered to exist when the nursing facility has not met its responsibility to submit a timely MED-13, or does not provide documents, personnel, or other resources within its control and necessary for completion of the audit, within a reasonable time.

D. When the rate for the facility during this period of delay is found to have been higher than the new rate, the new rate shall be applied retroactively to this period, and any adjustments and/or recoveries of overpayments shall be made by the Department.

E. Missing, Incomplete, or Incorrect Assessments

As indicated during the time periods below. MDS assessments not containing sufficient in-range data to perform the RUG-III algorithm shall be excluded or assigned the non-classifiable category of BC1. Non-classifiable assessments may be replaced following the

CMS policy for correction of a prior assessment. This replacement assessment shall be completed and transmitted to the CMS MDS database for Colorado nursing facilities maintained by the Department of Public Health and Environment prior to the last day of the second month of the quarter in order to be included in the rate calculation for rates effective the following quarter.

1. Incomplete MDS assessments used in quarterly resident case mix acuity calculations effective on July 1, 1999, and used in calculations effective on or after May 1, 2002.

All incomplete MDS assessments in the database shall be excluded from all average resident case mix index acuity calculations.

- E. 2. Incomplete MDS assessments used in quarterly resident case mix acuity calculations effective between October 1, 1999 and June 30, 2001.

All incomplete assessments in the database shall be assigned, based on the payment source of the resident, either the "Other" average case mix index which is calculated excluding all incomplete assessments and current assessments older than 122 days or the "Medicaid" acuity average case mix index which is calculated excluding all incomplete assessments and current assessments older than 122 days.

- E. 3. Incomplete MDS assessments used in quarterly acuity calculations effective between July 1, 2001 and January 31, 2002.

All incomplete MDS assessments in the database shall be assigned the non-classifiable category of BC1 and given a default case mix acuity index of the lowest index in the state.

4. A nursing facility may request that the Colorado Department of Health Care Policy and Financing accept late, completed, and/or corrected MDS assessments for the purpose of recalculating quarterly resident case mix acuity calculations. The Department shall only consider such a request if it pertains to MDS assessments which could affect the facility's per diem reimbursement for the rate year in which the request is made. For example, if a facility has a fiscal year-end of December 31 and submits such a request on February 15, 2002, the Department shall only consider late, completed, and/or corrected MDS assessments which could affect the facility's reimbursement rate for the rate year between March 1, 2001, and February 28, 2002. In addition, such a request shall only be approved if:

- a. The number of missing, incomplete, and/or inaccurate MDS assessments for one, or more, of the quarters is equal to, or greater than, 25% of the facility's total number of residents for that quarter, and
- b. The facility transmits corrected complete MDS assessments for at least 95% of the total number of missing, incomplete, and or inaccurate MDS assessments for the respective quarter.

The request shall be made in writing and shall include such supporting information as is required by the Colorado Department of Health Care Policy and Financing. If the request is approved, all late, completed, or corrected MDS assessments shall be transmitted to, and accepted by, the MDS database maintained by the Colorado Department of Public Health and Environment.

F. Delays in MDS Submittal

1. Current MDS assessments in the database older than 122 days used in quarterly resident case mix acuity calculations effective on or after 07/01/1999.

All current MDS assessments in the database older than 122 days shall be assigned, based on the payment source of the resident, either the "Other" acuity average case mix index which is calculated excluding all incomplete MDS assessments and current MDS assessments older than 122 days or the "Medicaid acuity average case mix index" which is calculated excluding all incomplete assessments and current assessments older than 122 days.

2. Current MDS assessments in the database older than 122 days used in quarterly resident case mix acuity calculations effective on or after 07/01/2001.

All current MDS assessments in the database older than 122 days shall be assigned the non-classifiable category known as BC1 and given a default case mix acuity index of the lowest index in the state.

8.441.12 Requests by the nursing facility provider to amend or correct the MED-13 after it has been submitted to the Department shall be subject to the following requirements:

- A. Such requests shall be in writing and shall include an explanation of the need for the revision. If the revision will not be submitted to the Department within the original 90-day filing period, the MED-13 will not be considered to have been submitted until such revision has been received. In these cases, the Department may grant a 30-day extension of the filing period. Once the original 90-day filing period and 30-day extension have expired, if the revision still has not been submitted to the Department, the Department shall withhold all warrants not yet released to the provider as described below.

8.441.13 In all of the instances described above where the Department withholds warrants not yet released to the provider, the following shall apply:

- A. The Department shall withhold all warrants not yet released to the provider for services rendered in the prior three calendar months (four months if an extension was granted) and thereafter until an acceptable MED-13 is received. Once the Department determines that the MED-13 submitted is complete and auditable, the provider's withheld payments shall be released. If an acceptable MED-13 has not been submitted within 90 days after the Department began withholding payments, the provider's participation in the Medicaid program shall be terminated and the payments withheld shall be released to the provider.
- B. Interest paid by the provider on loans for working capital while payments are being withheld shall not be allowable costs for purposes of reimbursement under Medicaid.
- C. When the delayed submission of the MED-13 causes the effective date of a new lower rate to be delayed, the new rate shall be applied retroactively to this period, and recoveries of overpayments shall be made by the Department.

8.441.2 COMPUTATION OF INDIVIDUAL REIMBURSEMENT RATE FOR ALL NURSING FACILITIES EXCEPT THE STATE-ADMINISTERED, CLASS IV, INTERMEDIATE NURSING CARE FACILITIES FOR THE MENTALLY RETARDED

- A. On the basis of information supplied by the nursing facility on Form MED-13 and secured by the Department, or its agents retained for the purpose of cost auditing, and Minimum Data Set resident assessment information submitted by Class I and Class V facilities, a payment rate for

each participating nursing facility is determined.

B. With respect to the said rate, the Department shall determine what are audited allowable costs per patient day, in accordance with the report and pertinent other rules and regulations applied to the cost and statistical information submitted by the nursing facility on its MED-13.

1. In computing the audited allowable cost per patient day for all rates for services rendered on or after January 1, 1984, the Department shall utilize the total audited patient days on the MED-13 which establishes the rate, in effect on or after January 1, 1984, unless the Department finds that the audited patient days on the MED-13 constitute an occupancy rate of less than 85 percent of licensed bed day capacity. In such cases the patient days shall be imputed to an 85 percent rate of licensed bed day capacity for the nursing facility and the per diem cost along with the resulting per diem rate shall be adjusted accordingly. For rates effective on or after July 1, 2000, for each such Class I and Class V facility such imputed occupancy shall not be applied in calculating the facility's health care costs. For purposes of the initial implementation of this regulation, the licensed bed capacity on file with the Colorado Department of Public Health and Environment for January 1, 1984 shall be used. This licensed bed capacity shall remain in effect until the Department is advised that the licensed bed capacity has changed through the filing of a subsequent cost report.

The imputed patient day calculation shall remain in effect until a new rate from a subsequent cost report is calculated. Should the subsequent cost report indicate an occupancy rate of less than 85 percent of licensed bed day capacity, the resulting rate shall be imputed in accordance with the provisions of this section.

2. Nursing facilities which are located in rural communities and have a census of less than 85 percent shall not be subjected to the imputed occupancy regulation. A nursing facility in a rural community shall be defined as a nursing facility in:
- a. a county of less than fifteen thousand population; or
 - b. a municipality of less than fifteen thousand population which is located ten miles or more from a municipality of over fifteen thousand population; or
 - c. the unincorporated part of a county ten miles or more from a municipality of fifteen thousand population or more.
3. The Class V rehabilitation nursing facility shall also not be subject to the imputed occupancy regulation.
4. Any nursing facility which has a reduction in census resulting from the relocation of mentally ill or developmentally disabled residents to alternative facilities pursuant to the provisions of the Omnibus Reconciliation Act of 1987 shall be treated as follows whenever such relocation causes the census to be less than 85 percent. The facility will be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department. These provisions shall be in effect for two cost reporting periods. At the end of this period, the weighted average rate provision is removed and the imputed occupancy calculation is applied when required.
5. With respect to all rates effective on or after July 1, 2000 for each Class I and Class V facility, health care services and food costs shall be determined using actual patient days for both urban and rural facilities.
6. Imputed occupancy shall be applied to a new nursing facility, a facility not in the Colorado

Medicaid program within 30 days prior to the start date of the Medicaid provider agreement (Form MED-11A), as follows:

- a. Imputed occupancy shall be applied to the first cost report submitted by a new facility. The facility will be entitled to the higher of the imputed rate or the monthly weighted average rate computed by the Department.
 - b. Imputed occupancy shall be applied to the second cost report submitted by a new facility. However, the rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in the monthly weighted average computation.
 - c. Imputed occupancy shall be applied to the third cost report submitted by the facility without exception.
7. Nursing facilities undergoing a state-ordered change in case mix or patient census which significantly reduces the level of occupancy in the facility shall be treated as follows. The facility will be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department. These provisions shall be in effect for two cost reporting periods. At the end of this period, the imputed occupancy calculation shall be applied when required.
- C. In accordance with allowable costs as reported in the most recent MED-13, the rate of reimbursement shall include a nursing facility's audited cost, or reasonable cost of services, whichever is less. (Section 8.441.3)
- D. 1. In addition to the above payment, an allowance for fluctuating cost will be allowed. This allowance will be applied to all audited costs except the following:
- a. Interest
 - b. Costs covered by the fair rental allowance
2. This allowance shall equal the annual percentage change in the National Bureau of Labor Statistics Consumer Price Index (U.S. city average, all urban consumers), from the preceding year, times actual costs (less interest expense and costs covered by the fair rental allowance) or times reasonable cost for that class facility, whichever is less. This amount shall be allowed for all proprietary, non-profit and tax supported nursing facilities. This annual percentage change in the National Bureau of Labor Statistics Consumer Price Index shall be rounded at least to the fifth decimal point.
3. For rate effective dates on or after 07/01/00 this allowance shall be applied to actual costs (less interest expense and costs covered by the fair rental allowance) or times reasonable cost for the class facility, whichever is less. The inflation shall be based on the Data Resources, Inc. Consumer Price Index (U.S. city average, all urban consumers). The allowance shall be applied from the midpoint of the cost report period to the midpoint of the payment period. This amount shall be allowed for all proprietary, non-profit and tax supported nursing facilities. This percentage change in the Consumer Price Index shall be rounded at least to the fifth decimal point. The DRI Indexes listing in the latest available quarterly publication prior to the July 1 limitation setting shall be used to determine monthly inflation indexes. The monthly inflation indexes shall be revised and published every July 1 to be used for rate effective dates between July 1 and June 30.
- E. If the nursing facility's combined audited administration, property, and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) cost per patient day is less than the

maximum reasonable cost for administration, property, and room and board (excluding raw food, land, buildings, leasehold and fixed equipment) costs for the class, the provider will earn an incentive allowance. Effective January 1, 1995, the incentive allowance shall be calculated at 12.5 percent of the difference between the facility's audited cost and the maximum reasonable cost, not to exceed 12 percent of the maximum reasonable cost for Class I and Class V facilities only. The incentive allowance for Class II and privately owned Class IV facilities will be calculated at 25 percent of such difference. No incentive allowance will be paid on health care services, raw food, fair rental value allowance and leasehold costs.

- E. 1. The allowance described in this subsection E shall not be included in the Medicaid reimbursement paid to every class I and V facility for dates of service between April 1, 2003, and June 30, 2003.
2. The allowance described in this subsection E shall be reinstated and included in the Medicaid reimbursement paid to every class I and V facility for services rendered on or after July 1, 2003.

F. The rate effective date:

1. For cost reports filed by all facilities except the State-administered Class IV facilities, the rate shall be effective on the first day of the calendar month, for the third month following the last day of the cost report.
2. Effective July 1, 2002, the schedule for implementation of reimbursement rates for Class I providers specified in Paragraph F.1. above shall be modified as follows: Rates otherwise scheduled to take effect on and after July 1, 2002 pursuant to Paragraph F.1. above shall instead become effective on the first day of the eleventh month following the end of the provider cost reporting period. The following table provides examples of how this change will be applied by the Department for providers with various cost report end dates.

Provider Cost Report End Date	Effective Date of Rate Under Section F.1 (Superseded by F.2)	Effective Date of Rate, Under Section F.2
April 30, 2002	July 1, 2002	March 1, 2003
May 31, 2002	August 1, 2002	April 1, 2003
June 30, 2002	Sept. 1, 2002	May 1, 2003
Sept. 30, 2002	Dec. 1, 2002	Aug. 1, 2003
Dec. 31, 2002	March 1, 2003	Nov. 1, 2003

3. Effective July 1, 2000, Class I and V nursing facilities shall have a semi-annual Medicaid resident case mix acuity adjustment applied to the rate to be effective on the first day of the calendar month for the ninth month following the last day of the cost report. Effective July 1, 2002, this semiannual adjustment shall be effective on the first day of the seventh month following the effective date of the rate implemented pursuant to Section F.2. If the rate calculated is less than or equal to a \$.25 change from the prior rate, no rate change is warranted or shall be made by the department.
4. For 12-month cost reports filed by the State-administered Class IV facilities, the rate shall be effective on the first day covered by the cost report. Specifically, the cost report for the period of July 1, 1988 through June 30, 1989 shall establish a rate effective July 1, 1988.
5. For all cost reports, the rate shall apply to all eligible residents in eligible residents in the facility who meet the criteria for nursing facility care in that facility's designated class, and

6. For all rates shall be accepted as payment in full by each provider.
- G. The permanent rate shall be established, issued and shall pay Medicaid claims billed on and after the later of the following dates: the beginning of the provider's new rate period, as defined in paragraph F,2 or 100 days after the date the MED-13 is filed by the provider. In the event a permanent rate cannot be established, issued and paid as just stated, the following shall occur:
 1. The Department shall establish and issue a temporary rate which shall be calculated on the provider's as filed cost report.
 2. All temporary rates issued pursuant to the provision above shall, at the time the permanent rate is established, issued and paid, be subject to adjustment and recovery of any over or under payments determined once the permanent rate is established, after completion of the audit of the provider MED-13 by the contract auditor.
 3. Any delay in completion of the contract auditor's audit of the MED-13 that occurs within 90 days from the filing of the MED-13, and which is attributable to the provider, shall operate on a time equivalent basis, to extend the time in which the Department shall establish, issue and pay a temporary rate under the provisions set forth above.
- G. 4. Delay in completion of the audit which is attributable to the provider shall include, but not be limited to, the following:
 - a. Failure of the provider to meet with the contract auditor at reasonable times requested by the auditor;
 - b. Failure of the provider to supply the contract auditor with information reasonably needed to complete the audit, including the Medicare cost report which the provider most recently filed with the Medicare fiscal intermediary or other Medicare information approved by the Department.
 - c. The time period which elapses during completion of the procedures described in section 8.441,C,1 through C,3, i.e., from the date the Department or its contract auditor mails a notice of proposed adjustment(s) until the facility's deadline for filing additional information or the contract auditor's deadline for completing its review of that information, whichever is relevant and later in a particular case.
5. Any adjustment to the temporary rate or any delay and extension of the time under which the Department is required to establish, issue and pay a temporary rate under these provisions is subject to appeal. (See Section 8.050).
- H. When the data discussed above has been processed, the Department will notify each such nursing facility of the rate of payment for care of residents. Such individual rate shall apply to all Medicaid eligible residents in the facility who meet the criteria for nursing facility care. (County departments also will be notified of the rates of payment for each of the participating nursing facilities.) Such rates are open records.
- I. Case Mix Index Calculation for Class I and Class V nursing facilities
 1. The resource utilization group-III (RUG-III) 34 category, index maximizer model, version 5.12b, as published by CMS, shall be used to adjust costs reported in the health care cost center in the determination of limits and in the rate calculation. (The department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.)

2. Resident listings shall be prepared and distributed to facilities by the Department of Health Care Policy and Financing. These listings shall identify current assessments for residents in the nursing facility on the 1st day of the first month of each quarter as reflected in the database maintained by the Department of Health Care Policy and Financing.

These listings shall identify resident social security numbers, names, assessment reference date, the calculated RUG-III category and the payor source as reflected on the prior full assessment and/or current claims data. Resident listings shall be reviewed by the nursing facility for completeness and accuracy. Correction procedures described in this rule shall be followed. Each nursing facility shall sign and return its resident listing to the Department of Health Care Policy and Financing no later than 15 calendar days after it was mailed by the Department.

If data reported on the resident listings is in error or if there is missing data facilities shall have until the last day of the second month of each quarter to correct data submissions, or until a later date if approved by the Department of Health Care Policy and Financing pursuant to 8.441.11.E.4.

- a. Errors or missing data on the resident listings due to untimely submissions to the CMS database maintained by the Department of Public Health and Environment shall be corrected by the nursing facility transmitting the appropriate assessments or tracking documents to DPHE.
 - b. Errors in key field items shall be corrected by following the CMS key field specifications through the Department of Public Health and Environment.
 - c. Errors on the current payor source shall be noted on the resident listings prior to signing and returning to the Department of Health Care Policy and Financing.
3. Each resident shall be assigned a RUG-III group calculated on their most current non-delinquent assessment available on the 1st day of the first month of each quarter as amended during the correction period. This RUG-III group shall be translated to the appropriate case mix index or weight. From the individual case mix weights for the applicable quarter, the DHCPF shall determine two average case mix indices for each Medicaid nursing facility. The facility average case mix index is a simple average, carried to four decimal places, of all resident case mix indices. The Medicaid average case mix index is a simple average, carried to four decimal places, of all residents where Medicaid is the per diem payor source anytime during the 30 days prior to their current assessment. Any incomplete assessments and current assessment in the database older than 122 days shall be included in the calculation of the averages using the case mix index established in these rules.

J. Health Care Reimbursement Rate for Rate Effective Dates on or after 7/1/00

1. Determination of acuity information used in the calculation of the health care reimbursement rate. Facility acuity information is not available for quarters prior to July 01, 1999. The July 1, 1999 acuity data shall be used for all prior quarters.
 - a. A facility's cost report period resident acuity case mix index is the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period. For example a 01/01/2000 - 12/31/2000 cost reporting period would use the facility averages calculated for quarters beginning on 04/01/2000, 07/01/2000, 10/01/2000 and 01/01/2001.

- b. The facility's Medicaid resident acuity case mix index is a two quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. For example, the averages used for a March 1, 2001 rate effective date would be the averages calculated for quarters 07/01/2000 and 10/01/2000. The two quarter average used in the July 1 rate calculation is the same two quarter average used in the rate calculation for the rate effective date prior to July 1.
 - c. The statewide average case mix index is a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1st.
 - d. The normalization ratio is determined by dividing the statewide average case mix index by the facility's cost report period case mix index.
 - e. The facility Medicaid acuity ratio is determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.
 - f. The facility overall resident acuity ratio is determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.
2. Determination of the annual facility specific health care maximum reimbursement rate for rate effective dates on or after 7/1/00

The health care reimbursement rate shall be divided into two rate calculation components. One component contains the case mix adjusted nursing costs defined in 26-4-502.5(1), C.R.S. The second component contains other health care costs reported in the health care cost center which are not adjusted for case mix.

Each nursing facility's allowable per diem case mix adjusted nursing cost and other health care per diem cost shall be established. The allowable per diem case mix adjusted nursing cost is normalized by multiplying each nursing facility's per diem case mix adjusted nursing cost by the facility's normalization ratio as provided within these rules.

- a. Determination of the annual facility specific maximum reimbursement rate for case mix adjusted nursing costs.

The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

The statewide health care maximum allowable reimbursement rate is multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.

The facility specific maximum reimbursement rate for case mix adjusted nursing costs is determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.

- b. Determination of the annual facility specific other health care maximum reimbursement rate

The percentage of the other health care per diem cost to total health care cost shall be determined by dividing the other health care per diem cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

The facility specific other health care maximum reimbursement rate is determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.

3. Determination of the case mix reimbursement rate component

The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio. This ratio is multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation is the case mix reimbursement rate component.

4. Determination of the other health care reimbursement rate

The other health care reimbursement rate shall be established based upon the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

8.441.21 COMPUTATION OF INDIVIDUAL REIMBURSEMENT RATE FOR STATE-ADMINISTERED INTERMEDIATE NURSING CARE FACILITIES FOR THE MENTALLY RETARDED

- A. On the basis of information supplied to the Department by June 1 of each year by each State-administered intermediate nursing care facility for the mentally retarded, an interim rate for each such facility shall be established to be effective on the following July 1 for the ensuing 12-month period. At the close of each 12-month period, each State-administered intermediate nursing care facility for the mentally retarded shall submit a form MED-13 in accordance with the requirements of the previous section. Adjustments in such interim rates shall be authorized by the Department upon the submission of information to the Department which demonstrates a significant change in the estimated actual costs.
- B. On the basis of the audited form MED-13, the interim payment rate for each such facility shall be adjusted to assure that each such facility is reimbursed its actual allowable audited cost. In computing the audited allowable costs per patient day for all rates for services rendered on or after July 1, 1988, the Department shall utilize the total audited Medicaid patient days for the reporting period as reported on the form MED-13.
- C. The effective date for each interim rate shall be the first day of the 12-month reporting period. The effective date of the first such interim rate shall be July 1, 1988, and such rate shall remain in effect until a final rate is established based on the audited MED-13 for the period from July 1, 1988, through June 30, 1989.
- D. All interim rates issued pursuant to the provision above shall be subject to adjustment and recovery of any overpayments determined once the final rate is established, after completion of the audit of the provider's financial and statistical report (MED-13). Any underpayments are also subject to adjustment once the final audit of the MED-13 is completed.
- E. Any adjustment to the interim rate is subject to appeal by the provider according to the provisions of 8.050 of this Staff Manual.
- F. When the data discussed above has been processed, the State Department will notify each such

State-administered intermediate nursing care facility for the mentally retarded of the rate of payment for care of residents. Such individual rate shall apply to all eligible Medicaid residents in such facility who meet the criteria for Class IV nursing facility care. (County Departments also will be notified of the rate of payment for each of the participating intermediate nursing care facilities for the mentally retarded.) Such rates are open records.

G. Under no circumstances may the Medicaid daily rate for a facility exceed that charged to private-pay residents or residents with other sources of payment. The weighted average private pay rate shall be determined by the actual rate, including discounts, charged to private pay residents or private insurance payers for nursing facility services, including ancillaries covered by the Medicaid rate. The weighted average private pay rate determination shall consider the following guidelines:

1. In cases where part of the provider's private pay rates include rates from private insurance payers or Medicare, these rates when included in the weighted average private pay rate calculation shall not exceed one hundred twenty-five percent (125%) of the provider's Medicaid per diem rate.
2. Providers who offer discounts for early payment by residents or for any other reasons, may have their private pay rate charged to those residents reduced by the amount of the discount; however, under no circumstances shall the discount be greater than five percent (5%).
3. Facilities with less than ten percent (10%) private pay residents of the total facility population shall not be held to the private pay rate to assure adequate reimbursement for these residents.

If a provider receives formal notice of a Medicaid rate increase later than the effective date of the increase, the reduction of the Medicaid rate to the private pay rate shall not occur until sixty (60) days from the date the notice was sent to the provider. Should the provider increase their private pay rate during the sixty (60) day period, the new private pay rate shall be used for purposes of rate comparison.

8.441.3 DETERMINATION OF MAXIMUM REIMBURSEMENT RATE

- A. There shall be no reimbursement for nursing facility care unless and until the nursing facility (1) meets the licensing requirement of the Colorado Department of Public Health and Environment, and (2) is a participating provider of nursing care services *8.420) and further, meets the provisions of the rules set forth herein; Section 8.400. et seq.
- B. For purposes of reimbursement, there shall be four (4) classes of nursing facilities in the Colorado Medical Assistance Program. All four shall be reimbursed in accordance with these rules as promulgated by the Colorado Medical Services board, and shall be based upon the individual nursing facility's audited costs.

Each facility shall serve those residents certified for admission to its class as specified at 8.481.1, D.

1. Class I facilities are those licensed and certified to provide general skilled nursing facility care.
2. Class II facilities are those facilities whose program of care is designed to treat developmentally disabled individuals whose medical and psychosocial needs are best served by receiving care in a community setting. Such facilities shall provide care and services designed to maximize each resident's capacity for independent living, and shall seek out and utilize other community programs and resources to the maximum extent possible according to the needs and abilities of each individual resident.

These facilities serve sixteen or more persons whose medical and psychosocial needs require services in an institutional setting and are expected to provide such services in an environment which approximates a home-like living arrangement to the maximum extent possible within the constraints and limitations inherent in an institutional setting.

Each such facility shall be certified in accordance with 42 CFR 442.400 as a Class II nursing facility and shall be licensed by the Colorado Department of Public Health and Environment. Class II facilities shall provide care and a program of services consistent with licensure and certification requirements.

3. Class IV facilities are those facilities whose program of care is of care is designed to treat developmentally disabled individuals who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental, and psychological treatment program. Such facilities must offer full-time, 24-hour interdisciplinary and professional treatment by staff employed at such facility. Staff must be sufficient to implement and carry out a comprehensive program to include, but not necessarily be limited to, care, treatment, training, and education for each individual. Each such facility shall be certified in accordance with 42 CFR 442.400 and shall be licensed under applicable state regulations by the Colorado Department of Public Health and Environment as a Class IV facility. Class IV facilities shall provide care and a program of services consistent with licensure and certification requirements.

For purposes of this regulation, there are two types of Class IV facilities which are reimbursed under two different reimbursement methodologies. The first type are the State-administered, tax-supported facilities which provide care and treatment to the individuals as specified in this section. These facilities are not subject to the maximum reimbursement provisions as set forth below. (Nor do these facilities earn an incentive allowance.)

The other type of Class IV facilities are private, non-profit or proprietary facilities which are not tax-supported or State-administered. These facilities provide care and treatment to the individuals as specified in this section. These facilities are subject to the maximum reimbursement provisions as set forth below. (These facilities may earn an incentive allowance.)

4. Class V facilities shall consist of a single pilot facility whose program of care is designed to meet the rehabilitative needs of adult disabled individuals. Such pilot facility shall meet the basic requirements of skilled nursing facilities. In addition, the pilot facility shall employ on a full-time basis, and shall make available on a twenty-four hour basis, the services of a professional staff trained and experienced in rehabilitative care, in accordance with the Division of Health Facilities. Colorado Department of Public Health and Environment standards.

While the pilot project may appropriately include the long-term care of certain individuals, the project is not basically a custodial program.

No Medicaid-eligible person shall be placed in a pilot project unless:

- a. His attending physician has referred him for such admission;
- b. The Department has completed a pre-admission review of his case; and
- c. The Department has accepted a written care plan; and
- d. Provision is made for a period review of the individual's progress to assure continued

eligibility under the requirements of this section.

C. With rates effective July 1, 1995, the Department shall determine the reasonable cost of services for each class of nursing facility (except the State-administered, tax-supported, Class IV facilities). Reasonable cost shall be defined as the maximum allowable reimbursement. Costs shall be imputed to the 85th percentile for urban facilities with occupancy rates below 85 percent for purposes of calculating the ceilings. With respect to all rates effective on or after July 1, 2000 for each Class I and Class V facility, health care services and food costs shall be determined using actual patient days for both urban and rural facilities for purposes of calculating the ceilings.

C. 1. The maximum allowable reimbursement of providing health care services and food costs shall not exceed:

Class I - One hundred twenty-five percent (125%) of the weighted average actual costs of all Class I facilities. For rates effective on or after July 1, 1997, the ceiling on weighted average actual costs shall be calculated by the method described in 8.441.3.C.3. For rates effective on or after July 1, 2000, the ceiling on weighted average actual costs shall be based upon the normalized case mix adjusted nursing cost for each facility.

Class II - One hundred twenty-five percent (125%) of the weighted actual costs of all Class II facilities;

Class IV - One hundred twenty-five percent (125%) of the weighted average actual costs of all Class IV facilities.

“Health Care Services” means the following categories of reasonable, necessary, and patient-related support services. No service shall be considered a health care service unless it is listed below:

- The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, nurse aides, medical records librarians, social workers, and activity personnel. These personnel must be appropriately licensed and/or certified, as applicable, although nurse aides may work in any facility for up to 4 months before becoming certified;
- Non-prescription drugs ordered by a physician which are included in the per diem rate;
- Consultant fees for nursing, medical records, patient activities, social workers, pharmacies, physicians and therapies. Consultants must be appropriately licensed and/or certified, as applicable, and professionally qualified in the field for which they are consulting;
- Purchases, rental, and repair expenses of health care equipment, and supplies used for health care services such as nursing care, medical records, social services, activity and recreational therapy;
- Depreciation and interest for major health care equipment purchases;
- Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.
- Photocopying expenses related to health care services (e.g., residents medical

records), as documented by appropriate logs;

- Salaries, fees, or other expenses related to work performed by a facility owner or manager who has a medical or nursing credential;
- Malpractice insurance for the health care personnel listed above;
- Medical director fees;

Therapies and services provided by an individual qualified provide these services under Federal Medicare/Medicaid regulations including:

Utilization review;

Dental care, when required by federal law;

Audiology;

Psychology and mental health services;

Physical therapy;

Recreational therapy; and

Occupational therapy.

Food cost is the cost of raw food, and shall not include the costs of real or personal property, staff, preparation, or other items related to the food program.

- C. 2. The maximum allowable reimbursement of administration, property and room and board costs (excluding raw food, land, buildings and fixed equipment) shall not exceed:

Class I - One hundred twenty percent (120%) of the weighted average actual costs of all Class I facilities. For rates effective on or after July 1, 1997, the ceiling on weighted average actual costs shall be calculated by the method described in 8.441.3.C.3;

Class II - One hundred twenty percent (120%) of the weighted average actual costs of all Class II facilities;

Class IV - One hundred twenty percent (120%) of the weighted average actual costs of all Class IV facilities.

“Administration costs” means the following categories of reasonable, necessary, and patient-related costs:

- The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, janitorial and plant staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records in order to properly allocate their salaries between cost centers;
- Any portion of other staff costs directly attributable to administration;

Advertising;

- Recruitment costs and staff want ads for all personnel;
- Public relations;
- Office supplies;
- Telephone costs;
- Purchased services: management and home office fees for administrative services; accounting fees, legal fees; computer services;
- Payroll taxes;
- Licenses, liability insurance, non-medical transportation. training for administrative personnel, dues for professional associations and organizations;

All travel of facility staff, except that required for transporting residents to activities or for medical purposes;

- All insurance except for malpractice insurance for health care personnel. Insurance on vans, whether owned or leased, is an administrative cost;
- Facility membership fees in trade groups or professional organizations;
- Miscellaneous general and administrative costs;
- Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs;
- Purchases, rentals, repairs, betterments and improvements of equipment utilized in administration;
- Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below;
- All other reasonable, necessary, and patient-related costs which are not specifically set forth in the description of "health care services" above, and which are not property, room and board, food, or capital-related assets.

Property costs include:

- Depreciation costs of non-fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care);
- Rental costs of non-fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care);
- Property taxes;
- Property insurance;
- Interest on loans associated with property costs covered in this section;

- Repairs, betterments and improvements to property not covered by the fair rental allowance;
- Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by the regulations at Section 8.448.54, Expensed Items.

Room and board includes:

- Dietary other than raw food;
- Laundry and linen;
- Housekeeping;
- Plant operation and maintenance; and
- Repairs, betterments and improvements to equipment related to room and board services.

C. 3. LIMITATIONS ON GROWTH OF ALLOWABLE COSTS: With respect to all rates effective on or after July 1, 1997 for each class I and class V facility, any increase in allowable (i.e.; reimbursed) administrative costs shall not exceed six percent (6%) per year, and any increase in allowable health care services costs shall not exceed eight percent (8%) per year. This 8% limitation shall not apply to rate effective dates on or after July 1, 2000. These limitations shall apply to the costs which are used in annually calculating the weighted average cost ceilings for all class I nursing facilities, and also to the costs which are allowed when calculating an individual rate change for a class I or V facility.

a. APPLYING THE LIMITATIONS TO THE ANNUAL CALCULATION OF THE WEIGHTED AVERAGE COST CEILINGS FOR ALL CLASS I NURSING FACILITIES: The above limitations shall be applied to the administrative and health care services costs which are used by the Department in calculating the weighted average cost ceilings (hereafter referred to as the "cost ceilings") for class I facilities, as described in regulatory sections 8.441.3,C,1 and 8.441.3,C,2 and statutory section 26-4-410(4)(b), C.R.S. Calculation of the July 1, 1997 cost ceilings shall be as follows:

1. The 6% and 8% limits are applied to the 1996 weighted average cost ceilings.
2. If an individual facility's 1997 cost statistics are lower than the limits described in paragraph 1, the facility's statistics shall be used.

C. 3. b. APPLYING THE LIMITATIONS TO RATE CHANGES FOR INDIVIDUAL CLASS I NURSING FACILITIES: For all class I facility rates effective on or after July 1, 1997, any increase in the allowable (i.e., reimbursed) administrative and health care services costs for any individual facility shall not exceed 6% and 8% per year, respectively, or the applicable weighted average cost ceiling described in the previous paragraph, whichever is less. Except that the 8% limitation for health care costs shall not apply to rate effective dates on or after July 1, 2000. These limitations shall be applied to any cost increases which are allowed by the Department for each facility between July 1 and the following June 30 of each year, beginning with July 1, 1997. The base to which the limitations are applied shall be the individual facility audited costs which were used to set the July 1, 1997 rate for the facility. However, after application of the limitations described in

this paragraph and the preceding paragraph, the allowable costs for the facility may be increased through the payment of a fluctuating cost allowance and/or administrative cost incentive allowance, if in accordance with the regulations stated elsewhere in this staff manual.

- c. APPLYING THE LIMITATIONS TO RATE CHANGES FOR THE CLASS V NURSING FACILITY: For all class V facility rates effective on or after July 1, 1997, any increase in the allowable (i.e., reimbursed) administrative and health care services costs for any individual facility shall not exceed 6% and 8% per year, respectively. Except that the 8% limitation for health care costs shall not apply to rate effective dates on or after July 1, 2000. As of 7/1/97, no weighted average cost ceilings are applicable to the single class V facility. However, in all other respects, the 6% and 8% limitations shall be applied as described in the preceding paragraph.
- C. 4. LIMITATION ON MEDICARE PART A COSTS: For all rates effective on or after July 1, 1997, the Department shall limit the Medicare Part A ancillary costs (hereafter referred to as "Part A costs") which are allowed in calculating the Medicaid per diem rate for each class I and class V nursing facility.
 - a. For all rates effective on 7/1/97, the Department shall include whatever level of Part A costs the Department allowed from the most recent Medicare cost report submitted by the facility to the Department prior to July 1, 1997.
 - b. The Part A costs described in the preceding paragraph shall be used as the base figure in limiting subsequent Part A cost increases. Any subsequent increase in the facility's allowable Part A costs shall not exceed the increase over the corresponding time period in the Consumer Price Index ("medical care" component in the "U.S. City Average") published for all urban consumers (the "CPI-U") by the United States Department of Labor, Bureau of Labor Statistics. For example, if a facility's allowable Part A costs as of 6/30/97 are \$10, and the CPI-U medical care component increases from 235.2 to 238 between June 1997 and February 1998, the facility's allowable Part A costs for February 1998 shall not exceed \$10.12, which is calculated as follows: 238 minus 235.2 equals 2.8; 2.8 divided by 235.2 (the base CPI-U medical care component for June 1997) equals 1.19%; 101.19% times \$10 equals \$10.119, which rounds off to \$10.12.
- C. 5. LIMITATION ON MEDICARE PART B COSTS: For all rates effective on or after July 1, 1997, only those Medicare costs which are reasonable, necessary and patient-related shall be included in calculating the allowable Medicaid reimbursement for class I and V nursing facilities. Part B direct costs for Medicare shall be excluded from the allowable Medicaid reimbursement for class I and V nursing facilities.
- D. 1. The determination of the reasonable cost of services shall be made every 12 months, and is subject to the limitations described in section 8.441.3.C. In determining the rates beginning on July 1 each year, the Department shall utilize the Medicaid population in each class on May 1, as well as the most current cost information submitted in accordance with Department regulation by each facility on or before May 2. The MED-13 cost report shall be deemed submitted if actually received or postmarked by the U.S. Postal Service on or before May 2. The Department has the discretion to exclude part of all of a provider's cost information if, in the judgment of the Department, that information contains errors, whether willful or accidental, which would impair the accurate calculation of reasonable costs for the class. Alternatively, in place of erroneous provider cost information, the Department may substitute the cost information which that provider submitted in its most recent audited cost report. If the Department chooses the second alternative, it shall adjust the provider's most recent, audited cost information in

accordance with the change in the “medical care” component of the CPI-U over the time period from the provider's most recent audited cost report to May 2.

2. Commencing with State fiscal year 1989 the maximum reasonable rates shall be determined as specified above except for the following changes:
 - a. The tax-supported, State-administered Class IV facilities are not subject to the maximum reasonable rate ceiling.
 - b. The non-profit or proprietary Class IV facilities are subject to the maximum reasonable rate calculation. This calculation shall use all the most recent Class IV cost reports submitted on or before May 2, for the establishment of the maximum rates for the following July 1. The tax-supported, State-administered Class IV facilities shall continue to submit their cost reports on the same schedule as now required by these regulations (i.e., within ninety (90) days of the end of the fiscal year end) so the maximum rate calculation for the other Class IV facilities may be calculated.
 3. The data utilized by the Department in its determination of the reasonably practicable after the actual determination is made by the Department. The Department's establishment of the maximum reasonable rate and the data used in that computation shall be subject to administrative appeal on or before the expiration of the thirty (30) day period following the date the information is made available. If no such appeal has been filed within the time period specified above and in accordance with any other applicable rules described in this manual under provider appeals and hearings, the maximum reasonable rate established by the Department shall become final.
- E. The maximum rate for reimbursement (for all nursing facilities except the State-administered Class IV facilities) shall be changed effective July 1 of each year in accordance with the findings made based on this section, and individual facility rates adjusted accordingly.
- F. Class II and Class IV facility beds shall be limited by the Department on the basis of the number of beds necessary to meet the needs of the mentally retarded patients through the use of such devices as the Department of Human Services annual certification of the number of beds necessary to meet the needs of mentally retarded patients.

8.441.4 RATES FOR NEW FACILITIES

A. A new nursing facility means a facility:

1. Which has not previously been certified for participation in Title XIX;
2. Which has not participated in Title XIX for a period in excess of 30 days prior to the effective date of the current Title XIX certification;
3. Which has changed from one class designation to another (see 8.441.3).

Nursing facilities which have undergone a transfer of ownership are not “new facilities” provided the previous owner had participated in Title XIX (Medicaid) in the last 30 days prior to ownership change.

- B. A new facility, as defined above, shall receive a per diem rate equal to the most recent average weighted rate for the appropriate nursing facilities class at the time the new facility begins business as a Medicaid provider. This per diem rate shall remain in effect until a new rate is established based on the first cost report submitted as specified below. The average weighted

rate is calculated by the Department on the 30th of each month and is not revised when new rates are established which would retroactively affect the calculation. The average weighted rate paid a new facility will be adjusted on July 1 each year. The new facility's rate will be adjusted by the average weighted rate in effect on July 1.

- C. New facilities shall submit cost reports during their initial year of operation as follows:
 - 1. Providers shall submit their first cost report for a period covering the first day of operation through the fiscal year end;
 - 2. If the cost report for the period specified above should cover a period of 89 days or less then the provider's first cost report shall not be submitted until the next fiscal year end;
 - 3. The next cost report shall be submitted for the twelve month period following the period of the first cost report.
- D. A new facility shall advise the Department of the date its fiscal year will end, and of the reporting option selected.
- E.
 - 1. Imputed occupancy shall be applied to the first cost report submitted by a new facility. This facility will be entitled to the higher of the imputed rate or the monthly weighted average rate computed by the Department.
 - 2. Imputed occupancy shall be applied to the second cost report submitted by a new facility; however, the rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in the monthly weighted average computation.

8.441.5 NURSING FACILITY CHANGE OF OWNERSHIP OR WITHDRAWAL FROM MEDICAID

- A. A licensed nursing facility owner(s) which intends to change the ownership of a Medicaid nursing facility, or which intends to terminate its participation in the Medicaid program, shall notify the Department in writing at least 45 calendar days in advance of the proposed change or termination.
 - 1. The advance written notice shall include a specific date for the proposed change or termination and shall be delivered to the Department.
 - 2. The exact date of the change of ownership or termination of Medicaid participation shall be subject to approval by the Department, after consultation with the parties to the proposed transaction and the Colorado Department of Public Health and Environment.
- B. In the case of a change of ownership which does not require a new license from the Colorado Department of Public Health and Environment, the existing Medicaid provider agreement shall continue in effect, together with all associated rights and responsibilities.
- C. In the case of a change of ownership which does require a new license from the Colorado Department of Public Health and Environment, the transferring owner's Medicaid provider agreement shall be assigned to the successor owner, unless the successor owner refuses in writing to accept assignment of that provider agreement.
 - 1. The assignment of an existing Medicaid provider agreement shall be accomplished by the successor owner's signature of an appropriate acceptance document, as specified by the Department.

2. The assignment of the Medicaid provider agreement shall not be effective prior to the effective date of the successor owner's nursing facility license from the Colorado Department of Public Health and Environment.
 3. In the event that a successor owner refuses to accept assignment of the transferring owner's Medicaid provider agreement, the successor owner shall indicate such refusal in a written communication to the Department.
 4. Until a successor owner has signed a written acceptance of assignment, the Department shall assume that the successor owner intends to refuse such assignment, and the Department shall act accordingly to protect its interests and those of the facility's residents.
- D. An assigned Medicaid provider agreement shall be subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including but not limited to the following:
1. Any existing plan of correction;
 2. Any expiration date for an ICF/MR's provider agreement;
 3. Compliance with applicable health and safety requirements;
 4. Compliance with the ownership and financial interest disclosure requirements, and any other requirements described elsewhere in this staff manual;
 5. Compliance with the civil rights requirements cited in the provider agreement; and
 6. Where appropriate in connection with a proposed change of ownership, the Department shall have the discretion to notify facility residents and/or their guardians that Medicaid reimbursement for facility care may be temporarily or permanently discontinued. The Department will make reasonable efforts to assist facility residents who choose to relocate to a different facility.
- F. A licensed nursing facility owner which transfers ownership or terminates its Medicaid participation is responsible for submitting a final financial and statistical report (Form MED-13) covering the period from the ending date of the last previous report through the date of the transfer or termination. The initial rate for the successor owner shall be the rate which would have been paid to the previous owner based on the audited final cost report. However, if the previous owner's final cost report is for a period of less than 89 days, that report shall be disregarded and the previous owner's last cost report for a twelve (12) month period shall be used to set a rate for the successor owner.
- G. The successor owner shall submit one (1) cost report during the initial year of operation as follows:
1. Providers shall submit their first cost report for a period covering their first date of operation through the fiscal year end;
 2. If the cost report for the period specified above should cover a period of 89 calendar days or less, then the provider's first cost report shall not be submitted until after the next facility fiscal year;
 3. The next cost report shall be submitted for the twelve (12) month period following the period of the first cost report.

6. In the discretion of the Department, payment of any debts or other obligations (whether known, fixed, definite, liquidated, or not) owed to the Department by the transferring owner. Such liability may also apply, in the discretion of the Department, to any debts or obligations which arose under any earlier, assigned provider agreement(s), but shall not apply to any debt or obligation which was assigned prior to August 1, 2003.
 7. The assignment of liability described in the preceding paragraph 6 shall not prejudice the Department's right to pursue any remedy against a previous facility owner or owners for repayment of the assigned debts or obligations.
- E. In the event that a successor owner refuses to accept assignment of the transferring owner's Medicaid provider agreement, the following shall apply:
1. The transferring owner's Medicaid provider agreement shall terminate on the date approved by the Department for the change of ownership.
 2. Prior to the termination of the transferring owner's Medicaid provider agreement, the Department shall have the discretion to withhold reimbursement to the transferring owner for whatever period of time is necessary to recover overpayments or other debts owed to the Department by the transferring owner.
 3. The successor owner shall file a new application for a Medicaid provider agreement with the Department or its designated agent. The Department shall not approve the new agreement until the successor owner complies with all requirements for such approval. In addition, the Department may delay the effective date of the successor owner's Medicaid provider agreement until the expiration of the withholding period described in the preceding paragraph 2, or until the Department has approved alternative payment arrangements or security for the transferring owner's debts.
 4. Even if a new facility survey is not required by the federal Medicare program (e.g., where the successor owner has accepted assignment of an existing Medicare provider agreement), the Department may require a new facility survey as part of the successor owner's application for a new Medicaid provider agreement.
 5. No Medicaid reimbursement shall be paid to the successor owner until the application for a Medicaid provider agreement has been approved, regardless of the effective date of the successor owner's license from the Colorado Department of Public Health and Environment.

8.441.6 RATES FOR RECEIVERSHIP

When a receiver has been appointed by the Court (pursuant to Section 25-3-108, C.R.S.) at the request of the Colorado Department of Health, the following special rate setting provisions apply. These special provisions do not apply when the receiver is appointed at the request of any other party such as the previous operator, landlord or other interested party.

A. During the Receivership

1. During the term of the receivership, the receiver is to receive the rate payable to the previous operator. The Department may increase the amount of this rate should it find the patient related, necessary and reasonable costs of the facility operation are not covered by the rate payable to the previous operator. In such cases, the Department's analysis of necessary, patient related and reasonable costs incurred by the receiver will not include any previous unpaid expense of the prior owner or the mortgage costs of the facility.

2. The receiver is to submit a cost report for the time the receiver is appointed until the time the receiver is no longer operationally in control of the nursing facility operation.
3. This cost report shall set a rate payable to the receiver for the date the receiver took operational control of the facility. This retrospective rate may set a rate higher or lower than the initial rate established and paid to the receiver in which case the under or over payment shall be either paid to or collected from the receiver. The retrospectively set rate may not exceed the maximum allowable rates as established pursuant to Section 8.441.3 entitled Determination of Maximum Reimbursement Rate.

B. New providers after the receivership period

1. In those cases where a new operator takes control and ownership of a nursing facility from the receiver, the new operator is to receive an initial rate paid to the prior owner. The rate of the prior owner is to remain in effect until the new provider submits a cost report pursuant to Section 8.441.4 unless the new operator utilizes the retrospective option described below.
2. The new operator may elect to have a retrospective rate set for the initial three (3) months of operation. To exercise this option the new operator must file a cost report for the first three (3) months of operation. The first day of operation is defined to mean the first day of licensure of the new operator. The last day of the initial three (3) months of operation will be the last day of the month in which the 90th day occurs. The cost report must be filed within 90 days of the end of the initial three (3) months of operation.
3. The retrospective rate established from this three (3) month cost report shall be in effect from the first date of licensure of the new owner until the last day of the month in which the 90th day occurs. This same rate shall be a prospectively paid rate to the new operator beginning with the first day of the month after the three (3) month cost reporting period.
4. The initial rate paid to the new operator shall be the prior owner's rate. However, the retrospective rate established by the three (3) month cost report shall replace the initial rate paid to the operator. This retrospective rate may be higher or lower than the initial rate established and paid to the new operator in which case the under or over payment shall be either paid to or collected from the new operator. This retrospectively established rate shall not exceed the maximum reasonable cost rates as established pursuant to Section 8.441.3 entitled DETERMINATION OF MAXIMUM REIMBURSEMENT RATE.
5. The three (3) month cost report shall also establish the prospective rate for the period established by the regulations at Section 8.441.2.F entitled COMPUTATION OF INDIVIDUAL REIMBURSEMENT RATE FOR ALL NURSING HOMES.
6. The provider shall file the first cost report after the three (3) month cost report pursuant to regulation at 8.440. Should the first cost report filed for the period immediately following the three (3) month cost report described above demonstrate a reduction in per diem costs more than five (5) percent which is caused by a reduction in per diem costs and not an increase in census, the following special provision shall apply: The provider's prospective per diem rate driven by the three (3) month cost report shall be retroactively reduced to the per diem rate as determined by the actual costs of the provider. The Department shall recover the difference between the provider's actual costs and the prospective rate paid to the provider. This recovery shall not apply to the three (3) month retrospective rate as established by the initial three (3) month cost report.

8.442 SERVICES, ITEMS AND EQUIPMENT TO BE FURNISHED WITHIN THE PER DIEM RATE

- A. Payment to skilled and intermediate nursing facilities is made in an amount intended to cover the cost of necessary services to the resident (including room and board), as well as costs of ordinary supplies and equipment related to the day-to-day care of the resident and the operation of the facility. All such costs shall be reported on the facility's MED-13, from which the audited cost is derived for each nursing facility.
- B. The amount-of-payment formula accounts for all nursing services and supplies, including the supplies listed in this section. The nursing facility is expected to provide supplies and services and to include all costs in the cost of doing business.
 - 1. Any costs expended for meeting certification standards shall be considered allowable in accordance with 42 C.F.R. 447.253, October 1994.
 - 2. Nursing facility services and ICF/MR are to be provided in accordance with the certification standards required by 42 C.F.R. 442.100, October 1994. In addition, nursing facility services and ICF/MR are to be provided in accordance with standards of quality and quantity established by the Colorado Department of Public Health and Environment rules and regulations cited at 6 CCR 1011-1, Standards for Hospitals and Health Facilities, Chapter V, Long Term Care Facilities; or 6 CCR 1011-1, Standards for Community Residential Homes for Persons with Developmental Disabilities, Chapter VIII, and in accordance with Resident Rights 42 C.F.R. 483.10, October 1994. The nursing and related services to be provided are in general areas.

No later amendments to or editions are incorporated. Copies of 42 C.F.R. 447.253, 42 C.F.R. 442.100 and 42 C.F.R. 483.10 are available for public inspection during normal business hours and will be provided at cost upon request to the Director, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any State Publications Depository Library.

- 3. The following is a list of general service areas that shall be provided within the per diem rate:
 - a. Nursing services, therapies, aide services and medically related social services;
 - b. Dietary Services;
 - c. Activities program;
 - d. Room/bed maintenance services;
 - e. Routine personal hygiene items and services; and
 - f. Provision of waived laboratory services which are provided by nursing facilities enrolled in the Medicaid program are subject to the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as set forth in 42 C.F.R. 493, October 1, 1994 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Director, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado, 80203-1714; or may be examined at any State Publications Depository Library. Facilities that collect specimens, including drawing blood specimens, but do not perform testing of specimens, are not subject to CLIA requirements. A facility must obtain a Certificate of Waiver from the Health Care Financing Administration or its designated agency if the facility only performs waived tests as defined by Clinical Laboratory Improvement Amendments of 1988 (CLIA).

4. Each nursing facility shall furnish equipment necessary to the operation of the facility and provide for necessary medical, nursing, respiratory and rehabilitation care. The facility shall report the cost of such equipment on the MED-13 form. Such equipment includes, but is not limited to, the following:
- a. Adaptive equipment for activities of daily living;
 - b. Air mattresses, other special mattresses, sheepskins and other devices for preventing/treating decubitus ulcers;
 - c. Apnea monitors and necessary supplies and equipment;
 - d. Atomizers;
 - e. Autoclaves and sterilizers;
 - f. Bath equipment, i.e., raised and/or padded toilet seats, trapeze benches, tub/shower stools or benches;
 - g. Bedrails, footboards, trapeze bars, traction and fracture frames, bedside stands;
 - h. Bed linens;
 - i. Beds, including hospital beds;
 - j. Blood glucose monitors;
 - k. Commode chairs;
 - l. Deodorizers;
 - m. Emesis basins;
 - n. Flameproof curtains;
 - o. Flashlights;
 - p. Foot pumps;
 - q. Gerry chairs, cushioned chairs;
 - r. Ice bags or equivalent;
 - s. Intermittent positive pressure breathing equipment, including Sodium Chloride or sterile water required for operation;
 - t. Irrigating solutions, i.e., Acetic Acid, Potassium Permanganate, Sodium Chloride, and sterile water;
 - u. Lifts, i.e., hydraulic, tub, slings;
 - v. Lymphedema pumps and compressors;
 - w. Medically necessary manual or power wheelchairs for intermittent and full-time use, including cushions and pads as required for the prevention or treatment of skin

breakdown, if purchased by the nursing facilities. Wheelchairs, if required, must meet the specific needs of the resident and must be ordered by a physician. The Primary Care Physician (PCP) must concur that the wheelchair being prescribed for the resident is medically necessary. All costs associated with the purchase of the wheelchair shall be charged to the health care line of the nursing facility. Wheelchair expenses shall be capitalized and depreciated over a fourteen (14) month period. The wheelchair will be sent with the resident in the event the resident is transferred to another facility or returns home.

The transferring facility will expense the remainder of the chair in the fiscal year during which the transfer occurs.

- x. Medicine cups;
 - y. Oxygen masks, regulators, humidifiers, hoses, nasal catheters, as needed, for the administration of oxygen;
 - z. Percussors and respirators;
 - aa. Positioning pillows;
 - bb. Reading lights;
 - cc. Scissors, forceps, and nail files;
 - dd. Sitz baths;
 - ee. Sphygmomanometers, stethoscopes, and other examination equipment;
 - ff. Splints;
 - gg. Stryker pads;
 - hh. Suction apparatus and gavage tubing;
 - ii. Supplies and equipment necessary for delivery of special dietary needs;
 - jj. Surgical stockings for routine use;
 - kk. Ventilators and related equipment and supplies;
 - ll. Walkers, crutches, canes and medically necessary accessories for ambulatory devices;
 - mm. Weighing scales.
5. As a part of the audited costs, all supplies (including disposables) necessary for effective resident care shall be provided by the nursing facility. Such supplies include, but are not limited to, the following:
- a. Band-aids, gauze pads, dressings and bandages;
 - b. Bedside utensils, bedpans, basins,
 - c. Catheters and related supplies, irrigating trays and accessories;

- d. Charting supplies;
 - e. Colostomy and ileostomy bags, supplies, and dressings, ostomy supplies;
 - f. Disposable sterile nursing supplies, i.e., cotton, face masks, gloves, tape, finger cots, etc.;
 - g. Drinking tubes/straws, water pitchers/glasses;
 - h. Fleece pads;
 - h. Foot soaks;
 - i. Hypodermic syringes and needles, including syringes and needles for insulin administration, intravenous supplies and equipment, and related equipment;
 - j. Minor medical surgical supplies;
 - k. Miscellaneous applicators;
 - l. Nebulizers, recreational/therapeutic equipment and supplies to conduct on-going activities program;
 - m. Safety pins;
 - n. Thermometers;
 - o. Tongue depressors;
 - p. Tracheostomy care kits, cleaning supplies;
 - q. Urinals, urinary bags, and tubes and supplies.
6. Routine personal hygiene items/services including but not limited to, hair hygiene services (i.e., simple trims, such as trimming bangs or cutting of some hair that may need minor cutting in the back) hair hygiene supplies (i.e., shampoo, hair conditioner, comb, brush); bath soap, disinfecting soaps or specialized cleaning agents when indicated to treat special skin problems or to fight infection; razors, shaving cream; toothbrush, toothpaste, mouthwash, denture adhesive, denture cleanser, dental floss; moisturizing lotion; tissues, cotton balls, cotton swabs; deodorant) incontinence care and supplies (i.e., pads, cloth and disposable diapers, pants, liners, sanitary napkins and related supplies) towels, washcloths; and hospital gowns; bathing; shaving; nail hygiene services (i.e., routine trimming, cleaning and filing, not polishing).
7. Various over-the-counter (OTC) drugs and supplies as required to meet the residents' assessed needs are to be furnished by the facility at no charge to the resident.

Facilities must provide drugs/supplies/products that are sufficient to meet the needs of the resident. It is the required assessment of resident's needs, not the resident's preference, that will dictate the variety of products a facility needs to provide.

OTC drugs/supplies including but not necessarily limited to:

- a. Artificial tears;

- b. Aspirin, acetaminophen, ibuprofen, and other non-prescription analgesics available now or in the future;
 - c. cough and cold supplies, i.e., cold tablets, decongestants, cough syrup/tablets;
 - d. Douches;
 - e. Evacuant suppositories, laxatives, stool softeners, enemas;
 - f. First aid supplies, i.e., alcohol, hydrogen peroxide, merthiolate and other antiseptics/germicides, Betadine, PhisoHex, chlorhexidine gluconate, providone/iodine solution and wash, epsom salt;
 - g. Lubricants, rubbing compounds and ointments, i.e., petroleum jelly, bag balm, other body lotions for treatment of dry skin or skin breakdowns, bacitracin ointment and other ointments used in treatment of wounds;
 - h. Vitamins (multi and single) and mineral supplements;
8. The following services and provisions shall also be included in the nursing facility's audited costs:
- a. Food and dietary services (including special diets, supplements, and nutrients ordered by the physician) shall be provided, in accordance with the needs of the residents and appropriate licensing requirements;
 - b. Room for accommodation of the resident shall be provided in accordance with licensing requirements, including storage for personal belongings, bedside equipment, suitable bed, clean and comfortable mattress, pillows, and an adequate supply of clean linen;
 - c. Maintenance of clean, comfortable, and sanitary environment shall be provided through provision of heat, light, ventilation, and sanitation to meet health and aesthetic needs of the resident, in accordance with the physicians' orders and licensing regulations;
 - d. Basic personal laundry (excluding dry cleaning, mending, handwashing, or other specialties).
9. When the facility employs or contracts with persons to provide consultant services in an effort to meet regulations, it may be reimbursed only through the per diem costs within the daily rate.
10. If specialized rehabilitative services (such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation) are required in the resident's comprehensive plan of care, the facility must provide the required services or obtain the required services from a provider of specialized rehabilitative services.
- Medicaid covers therapy services needed for active, restorative treatment and equipment within the nursing facility's per diem rate of reimbursement. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.
11. When a nursing facility, in an effort to meet its mental health programming responsibilities,

contracts with a community mental health center to provide psychiatric services to nursing facility residents, the community mental health center shall bill the Medicaid program directly using the physician claim form. In such instances the community mental health center's charges would not be included in the nursing facility's audited costs.

12. The nursing facility must provide for an ongoing activities program directed by a qualified professional, to meet the interests and the physical, mental, and psychosocial well-being of each resident.

The nursing facility can charge for entertainment and social events that are outside the scope of the required activities program.

8.442.1 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM RATE (Chargeable to Patient Trust Funds)

The following general categories and examples of items and services may be charged to the resident's personal needs funds if requested by a resident. Before a resident's Patient Trust Fund can be charged, the nursing facility must have received a written request from the resident and/or family authorizing the charges.

- A. Cosmetic and grooming items and services in excess of those for which payment is allowed under the per diem rate, i.e., beauty permanents, hair relaxing, hair coloring, hair styling, hair curling, shaving lotion and cosmetics such as lipstick, perfume, eye shadow, rouge/blush, haircuts normally performed by licensed barbers, or beauticians (beyond simple trimming);
- B. Flowers and plants;
- C. Gifts purchased on behalf of a resident;
- D. Non-covered special care services, i.e., a private duty nurse not employed by the nursing facility, prescribed by the resident's physician;
- E. Other items or services requested by the resident and not included as either a benefit of Medicaid, within the per diem rate, or as allowable under the Post Eligibility Treatment of Income (PETI), Section 8.110.49;
- F. Over-the-counter drugs/related items not prescribed by a physician, not included in the nursing care plan, and not ordinarily furnished for effective patient care;
 1. The resident has made an informed decision supported by a statement in the Personal Needs Funds file that he/she/family is willing to use personal funds; and
 2. The balance of current Personal Needs Funds in the resident's ledger is sufficient to cover the charge
- G. Personal clothing and dry cleaning;
- H. Personal comfort items, including smoking materials, notions, novelties and confections/candies;
- I. Personal reading material, subscriptions;
- J. Private room;

- K. Social events and entertainment offered off premises and outside the scope of the regular facility activities program;
 - L. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. If the resident refuses the prepared food the facility must also provide food that meets individual needs and must offer substitutes to residents who refuse food offered. Residents may be charged only for specially prepared food if they are informed that there will be a charge, and the charge may be only the difference in price between the requested item and the covered item, 42 C.F.R. 483.35.
 - M. Telephone, television/radio for personal use.
- .12 There are two special treatments which require approval by the Department before a resident or his/her relatives may be billed for services or equipment not covered by the Medicaid Program.
- A. The physician orders that a full-time R.N. or L.P.N. is needed. She is not employed by the nursing facility and has duties limited to the care of a particular resident, or two such residents in the same room; and
 - B. The physician orders a private room.
- .13 When one of the two situations requiring prior Department approval occurs, the following procedure shall be as follows:
- A. The attending physician shall indicate medical necessity on the resident's chart; and
 - B. The attending physician submits to the Department a completed copy of Form 10013 (Physician's Request for Additional Benefits).
- .14 When the Form 10013 has been approved, payment for such services and equipment may be received from the resident's personal needs fund, from relatives, or others. No such charge may be made without prior approval.

8.443 FORM MED-13: DEPARTMENT RESPONSIBILITIES

The following are the responsibilities of the Department:

- A. To send two copies of the MED-13 to each participating nursing facility in advance of the close of each report period, and additional copies if requested. A letter of notification also is sent informing the facility of submittal procedures.
- B. Following submission and audit, to adjust the individual nursing facility rate, based upon the audit by the Department's contract auditor and, as applicable, subject to the ceiling recognized as reasonable cost (Section 8.441.3).
- C. To determine such adjustment to the individual nursing facility rate to be effective the first day of the third calendar month following the last day of the cost report, and on July 1 of each year, if applicable.
- D. Where per diem rates are based upon a MED-13 and found to contain errors when audited, a settlement of the amount overpaid or underpaid shall be required between the Department and the nursing facility.

8.443.1 OTHER DEPARTMENT RESPONSIBILITIES - DISSEMINATION OF INFORMATION

Public notice of all proposed rule-making will be provided as required by 24-4-103, C.R.S. (1995 Supp.), Administrative Procedure Act.

8.444 FORM MED-13: NURSING FACILITY RESPONSIBILITIES

The following are the responsibilities of the nursing facility:

- A. To forward to the Department's contract auditor two complete copies of the MED-13 which have been signed by an officer of the nursing facility.
- B. Such report must be submitted to the contract auditor no later than 90 days after the close of each facility's established fiscal year. Failure of the nursing facility to submit the MED-13 within the prescribed 90-day period shall result in penalties described in Section 8.441.1.
- C. To address any questions as to completion of the report to the contract agent, and questions or requests regarding policies or procedures to the Department.
- D. Nursing facilities owned by organizations maintaining financial records outside the territorial boundaries of the State of Colorado may, at their option, elect to pay an annual examination fee of \$300 for auditing financial records at the facility office in lieu of making such records available in the Colorado nursing facility. The examination fee is payable to the Department upon submission of the MED-13 for nursing facilities for the 12-month period coinciding with the close of the nursing facility's fiscal year and is to be accompanied by a letter requesting that the examination be made at a specified address.

At no time may patient medical records, nursing care ledgers, or personal needs ledgers be removed from the nursing facility without the specific written permission of the Department.

- E. Staff of the Department, or specialized staff acting as agents of the Department, will make periodic visits to nursing facilities for purposes of determining compliance of nursing facilities with the rules concerning nursing facility care to public assistance residents, for determining compliance with requirements of the Civil Rights Act, for purposes concerned with the appropriate rate to be paid for care of residents under applicable rules, and such other purposes as may be related to administration of medical program components of public assistance.

All medical records and documents related to the above purposes of visits by staff members and agents of the Department shall promptly be made available in Colorado or with regard to financial records, at the home office of organizations located outside the territorial boundaries of Colorado which own nursing facilities in Colorado.

- F. A facility terminating participation in the Medicaid program or a facility changing its licensed operator ("licensee") must submit a cost report for the period ending with the date of change or termination. The Department may withhold reimbursement to the facility until audits have been completed to determine that no monies due the State or the residents remain unpaid. Such reimbursement shall continue to be withheld until all questions and issues raised by the audits are resolved. As an alternative to such withholding, the Department may permit the transferring or terminating licensee to submit a surety bond or other security, in a form and amount acceptable to the Department, which assures the payment of any monies found to be owed as a result of the final audits.
- G. In the event a nursing facility changes ownership or other changes occur which affect the nursing facility's discharge of its responsibility as a participating nursing facility for its residents, the Department must be notified as set forth in Section 8.441.5.

8.445 FORM MED-13: CONTRACT AUDITOR RESPONSIBILITIES

The following are the responsibilities of the Department's contract auditor:

- A. The contractor will make examinations of the MED 13's submitted by all licensed nursing facilities participating in the Medicaid Program in the State of Colorado. Said examinations and reports shall be performed and made in accordance with an orderly schedule and shall be submitted within a reasonable time after the examinations are made.

The examinations will be made in accordance with generally accepted auditing standards and accordingly will include such tests of the accounting records and such other auditing procedures, in relation to financial and statistical summaries, as the contractor shall deem necessary and appropriate for the purpose of obtaining financial data and statistical information relating to costs of services rendered to residents.

- B. Included in the services of the contractor shall be the following:

- 1. Review analytically the MED 13's submitted annually to the State and prove their arithmetical accuracy. Audits will be performed yearly and shall consist of an on-site field audit, desk review, or rate calculation. The Department shall have the discretion to choose among these three alternatives for particular facilities, based on the consideration of appropriate risk-analysis factors. The fact that the auditor did not examine, require documentation or adjust a cost during an earlier desk review or rate calculation will not prevent the auditor from examining, requiring documentation or adjusting a cost in a later field audit. Tests will vary in scope as to the nursing facilities to be visited, depending upon the size of the nursing facility, the extent of utilization reported, and other reported factors, but in general will include the following:

- a. Testing of statistics relating primarily to inpatient days by reference to records pertaining to admissions and discharges, census information, Department reports, etc.;
- b. Tracing operating expenses to books and records with limited tests of the recorded amounts by inspection of vendors' invoices and other supporting evidence; and
- c. Reviewing all expenses regardless of whether they are reimbursable costs.

- C. Following on-site visits, the contractor shall submit to the Department a report of the audit which represents generally accepted auditing standards and shall declare the auditor's opinion as to whether in all material respects the cost report submitted by the nursing facility is in compliance with the rules and regulations of the Department relating to reimbursement.
- D. Refer to the Department all suggestions for improving nursing facility accounting procedures and unusual discrepancies affecting the interest of the Department, including the failure of a nursing facility's records to substantiate the report submitted to the Department.
- E. Refer to the Department any facts determined during the audit regarding irregular activities or practices, including those possibly in conflict with Federal, State, or local laws and with Department rules and regulations.
- F. "Closing" audits also are to be made at the point of a change of ownership or decertification, whether such decertification is voluntary or involuntary on the part of the nursing facility. Such audits are to determine whether payment adjustments are necessary with respect to continuing payment to the new owner or such adjustment in payments, recoveries, etc., covering former owners or sellers. Details concerning ownership changes are set forth in Sections 8.441.5 and 8.444.F.
- G. Cost allocations shall be in accordance with the MED-13 instructions.

8.446 QUALITY OF CARE INCENTIVE PAYMENT (QCIP) PROGRAM

8.446.2 General Definitions:

- A. Advisory Committee: The Advisory Committee is that committee defined at C.R.S., 26-4-410(2)(c.5)(VI)(A).
- B. Class I Facilities: Facilities licensed and certified to provide general skilled and/or intermediate nursing facility care, pursuant to Section 8.441.3.B.1 and are participating providers in the Medicaid program.
- C. Deficiency: Any failure to comply with a requirement of participation as determined by the Colorado Department of Public Health and Environment. Failure to comply is determined during a nursing facility's standard survey, revisit, or a complaint investigation.
- D. Department: The Colorado Department of Health Care Policy and Financing.
- E. ResQUIP: The "Resident-Centered, Quality Improvement Program."
- F. ResQUIP Audit Checklist: The form used by the Department or its designee in reviewing a nursing facility's ResQUIP plan. The checklist is labeled as "ResQUIP Form 1, Revised 7/1/01," and is included in these rules.
- G. ResQUIP portion: The part of the QCIP program that is based on the class I facility submittal and Departmental approval of a ResQUIP plan.
- H. Standard Survey: The standard survey of a class I facility conducted by the Department of Public Health and Environment for compliance with the requirements for participation in the Medicaid Program.
- I. Standard Survey Date for Initial Certification or Recertification: The date the survey team exits the Class I facility after completion of the standard survey and the formal exit conference with the nursing facility.
- J. Survey portion: The part of the QCIP program that is based on the standard survey, revisit, and results of complaint investigations conducted by the Department of Public Health and Environment.

8.446.3 QCIP Payment

- A. The sum of the Quality of Care Incentive Payments (QCIP) program, shall be equal to the aggregate sum of the administrative incentive allowance payments made to all nursing facility providers as set forth at C.R.S., 26-4-410(2)(c)(II) (B). Fifty percent of the sum shall be used for the survey portion as set out in Section 8.446.5 and fifty percent shall be used for the ResQUIP portion of the QCIP program. No payment for the survey portion of the QCIP program shall be made for any time period beyond June 30, 2002. No payment for the ResQUIP portion of the QCIP program shall be made for the time period between July 1, 2002, and June 30, 2003. However, the ResQUIP program shall be reinstated beginning July 1, 2003, subject to available appropriations.
- B. Class II and IV facilities are not eligible to participate in the QCIP program.

8.446.4 General Criteria for Operation of the QCIP Program from July 1, 2001 through June 30, 2002.

- A. Class I facilities which meet the state nursing facility licensing and certification standards and

other requirements in these QCIP regulations, shall have the opportunity to participate in the QCIP Program.

- B. Only Class I facilities are eligible to participate in QCIP.
- C. The payments available to nursing facilities shall consist of two components:
 - 1. A survey portion as set out in 8.446.5 and;
 - 2. A ResQUIP portion as set out in 8.446.6.
- D. A nursing facility shall not be eligible to participate in the QCIP program, if the nursing facility has received any of the following remedies as determined by the Department of Public Health and Environment:
 - 1. Deficiency with a severity J, K, or L;
 - 2. A civil monetary penalty;
 - 3. Imposition of temporary management;
 - 4. A directed plan of correction;
 - 5. Denial of payment for new admissions; or
 - 6. Monitoring sanctions imposed by the Health Facilities Division.
- E. If a nursing facility qualifies for a QCIP payment but has a remedy imposed, as described in Section 8.446.4 D, the nursing facility shall not be paid the survey and ResQUIP plan portion of the payment for the next six-month payment period following the period in which the remedy is imposed.

8.446.5 Survey Portion of the QCIP Program

Effective July 1, 2001, through June 30, 2002, the following factors shall be used to determine the eligibility and payment method for the survey portion of the QCIP program:

- A. A nursing facility shall be-eligible to participate in the survey portion of the QCIP program if it has received no more than two (2) deficiencies at a scope and severity of D or higher resulting from the facility's last full recertification standard survey completed on or before May 31 and November 30 of each year. This includes deficiencies cited during revisits of nursing facilities and/or complaints resulting in deficiencies during the appropriate time periods.
- B. In order to be eligible to receive any QCIP payment, each facility must submit its paid Medicaid patient days incurred for the appropriate periods as stated in 8.446.5, F. The form provided by the Department shall be used to report the facility's total number of paid Medicaid patient days. No post-payment adjustments to increase payments will be made by the Department for facility errors in reporting paid Medicaid patient days.
- C. The paid Medicaid patient days shall be subject to a Department review.
- D. Nursing facilities determined by the Department not to meet the established criteria for the QCIP program shall have the right to appeal the Department's decision regarding their QCIP program payment or non-payment in accordance with the provisions of Section

8.050.03, Appeal by the Aggrieved Provider. A nursing facility may have the option, but shall not be required, to pursue informal reconsideration of the QCIP program decisions as provided in Section 8.050.09. The burden of proof shall be on the nursing facility to prove that it has met the established criteria.

- E. The amount available for the survey portion of the QCIP payment shall be determined by multiplying the total amount allowed for QCIP by the 50% allocated by the Department for the survey portion.

F. Payment Periods

1. A nursing facility's survey portion of QCIP for January 1, 2002, through June 30, 2002, shall be based on:

- a. The deficiencies cited in the nursing facility's last standard survey completed on or before the previous November 30, and
- b. The complaint or revisit deficiencies cited, effective the date of the citation, during the time period from the prior June 1 through November 30.

No later than March 31, 2002, all facilities shall report their total paid Medicaid patient days for the time period between June 1 and November 30 of the previous year. These reports shall be subject to a Department review.

2. A nursing facility's survey portion of QCIP for July 1, 2001, through December 31, 2001, shall be based on:

- a. The deficiencies cited in the nursing facility's last standard survey completed on or before the previous May 31, and
- b. The complaint or revisit deficiencies cited, effective the date of citation, during the time period from the prior December 1 through May.

No later than September 30, 2001, all facilities shall report their total paid Medicaid patient days for the time period between the previous December 1 and May 31. These reports shall be subject to a Department review.

G. Establishing the Base Rate for the Survey Portion of the QCIP payment:

The base rate for a facility shall be established by the following calculation:

- 1. Paid Medicaid patient days for the determined period times a factor of 4 for 0-deficiency facilities; plus
- 2. Paid Medicaid patient days for the determined period times a factor of 2 for 1-deficiency facilities; plus
- 3. Paid Medicaid patient days for the determined period times a factor of 1 for 2-deficiency facilities.
- 4. The sum of the above weighted patient days shall be divided into the amount available for the survey portion of QCIP. The result of this calculation establishes the base rate.

H. Payments to Nursing Facilities

The amount payable to each nursing facility shall be determined for the applicable periods as follows:

1. The 0-deficiency facilities shall receive the base rate amount per deficiency times 4, multiplied by the Medicaid paid patient days of the facility;
2. The 1-deficiency facilities shall receive the base rate amount per deficiency times 2, multiplied by the Medicaid paid patient days of the facility; and
3. The 2-deficiency facilities shall receive the base rate amount per deficiency times 1, multiplied by the Medicaid paid patient days of the facility.

8.446.6 ResQUIP Portion of the QCIP Program

Effective July 1, 2001, through June 30, 2002, the payment pertaining to the ResQUIP Plan portion of the QCIP program shall be determined using the following methodology:

- A. The amount available for the ResQUIP portion of the QCIP payment shall be determined by multiplying the total amount allowed for QCIP by the 50% allocated by the Department for the ResQUIP portion.
- B. No later than March 15, 2002, any Class I nursing facility which wishes to be considered for a QCIP payment must submit a resident-centered, quality improvement plan ("ResQUIP plan"), including a budget based on the projected expenditures for the plan, to the Department for review. The plan shall include the following features:
 1. The plan shall be designed, implemented, and evaluated by the nursing facility's ResQUIP team. At least one-third of the membership of the ResQUIP team shall be residents of the nursing facility, unless the nursing facility demonstrates that it has been unable to meet this requirement, despite documented good faith efforts. In that event, the one-third resident membership requirement may be satisfied by including other individuals who are in a position to represent the views of the facility's residents, including but not limited to family members of nursing facility residents and local ombudsmen. The names and titles of the team members shall be listed in the ResQUIP plan submitted to the Department.
 2. The ResQUIP plan shall have four stages: (a) assessment, (b) planning, (c) implementation, and (d) evaluation.
 3. The plan shall be completed and submitted to the Department, or Department's designee, by March 15, 2002. The plan shall cover the time period from January 1, 2002, through December 31, 2002.
- C. No later than April 15, 2002, the facility shall be notified of the Department's decision regarding the ResQUIP plan.
 1. The notice shall inform the facility whether its plan is approved, disapproved or whether further information is necessary.
 2. If the plan is disapproved or further information is necessary, a facility may, within 30 days from the mailing date of the notice or May 15, 2002, whichever is sooner, submit a revised ResQUIP plan to the Department. The facility shall be notified within 30 days after receipt of the revised plan by the Department whether the plan is approved or disapproved.

3. A facility whose plan is disapproved, may appeal the Department's decision in accordance with Section 8.050. The burden of proof shall be on the nursing facility to prove that it has met the established criteria.
4. The plan shall be in writing and shall follow the format prescribed by the Department. In designing the ResQUIP plan, the facility's ResQUIP team shall include the criteria listed in the "ResQUIP Audit Checklist" as well as the following:
 - a. Relationships. A measure of the increase in new or enhanced relationships between residents, staff and/or community as a result of the plan.
 - b. Resident Centered. The plan must document
 - (1) That all residents or representatives were given the opportunity to provide suggestions for the initial design of the plan and how this was done;
 - (2) The accommodations the facility will make to promote resident participation in plan activities;
 - (3) The number of residents or representatives that voted on the choice of the initial design of the plan;
 - (4) How residents will provide input into the project structure and other changes throughout the year;
 - (5) The number of residents or representatives who assisted in preparing the plan;
 - (6) That a resident survey will be completed to determine how the project improved the quality of life for residents in the facility (attach a copy).
 - c. Participation. Documentation that all residents were provided the opportunity to participate in plan activities.
 - d. Choice.
 - (1) The steps the facility will take to provide multiple options for residents to choose from, based on the individuality of the residents, and how the facility will empower the residents to make the choices.
 - (2) The number of residents who have increased choices as a result of the plan.
 - e. A detailed explanation of how the plan outcomes exceed the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) minimum standards for maintaining the highest practicable level of care and quality of life for the facility's residents.
 - f. An estimated budget for total costs of the ResQUIP plan.
 - g. An estimated time line for all tasks.
5. ResQUIP plans which contain the following in their project shall not qualify for a

ResQUIP payment:

- a. Equipment or renovations in the plan used to meet the minimum requirements of OBRA 87 or access under the Americans With Disabilities Act, including but not limited to fire doors, automatic access doors, grab bars, ramps.
 - b. Durable medical equipment.
 - a. Capital expenditures which address the health, safety and comfort of the residents and are required by Americans with Disabilities Act, Life Safety Standards, Provider Agreement, OBRA 87 and other state and federal regulations cannot be considered part of the ResQUIP plan. In order for capital expenditures to be included in the plan, the plan must include goals to measure how the expenditure directly impacts residents' choices, relationships, participation and quality of life.
 - b. ResQUIP plan expenditures that exceed thirty (30%) percent for indirect costs and forty (40%) for capital costs.
6. All four stages of the plan ("Assessment, Planning, Implementation, and Evaluation") shall be scheduled for completion by December 31 of the year the plan was submitted.
- D. For the time period from January 1, 2002, through June 30, 2002, ResQUIP payments shall be awarded to eligible nursing facilities that have submitted approved ResQUIP plans. The amount of the ResQUIP payment to each qualifying facility shall be based on the number of paid Medicaid patient days reported by eligible facilities for the time period from June 1 through November 30 of the prior year. The facility shall submit the reports listing paid Medicaid patient days to the Department, on the Department's prescribed form, no later than March 31, 2002, and shall be subject to Department review. Payments for approved ResQUIP plans shall be made within ninety (90) days of June 30, 2002.
- E. For the time period from July 1, 2001, through December 31, 2001, ResQUIP payments shall be awarded to eligible nursing facilities that have submitted a final report to the Department or its designee not later than December 31, 2001, and have demonstrated satisfactory progress in completing its ResQUIP plan as verified by the on-site evaluation conducted by the Department. Although no ResQUIP payment will be made for any time period beyond June 30, 2002, nursing facilities with approved ResQUIP plans for calendar year 2002 shall nonetheless submit a final report to the Department or its designee no later than December 31, 2002. The final report shall provide verification that all of the stages described in the ResQUIP Audit Checklist were completed and shall include a statement as to whether the nursing facility intends to continue its current ResQUIP plan during the subsequent calendar year. Such reports shall follow the format prescribed by the Department. The amount of the ResQUIP payment to each qualifying facility for the time period from July 1, 2001, through December 31, 2001, shall be based on the number of paid Medicaid patient days reported by qualifying facilities for the time period from December 1, 2000, through May 31, 2001. The maximum payment shall be limited the amount of the budget within the approved plan. The number of paid Medicaid patient days shall be submitted to the Department on the Department's prescribed form no later than September 30, 2001. These paid Medicaid patient days, as reported, shall be subject to review. Payments for approved ResQUIP plans shall be made within ninety (90) days of December 31, 2001.
- F. Calculation of ResQUIP Base Rate and Payment to Facility

1. The base rate for the ResQUIP portion of the QCIP program shall be calculated by dividing (a) the sum of the most recently reported Medicaid patient days for all nursing facilities eligible for a ResQUIP payment into (b) the amount available for the ResQUIP portion of the QCIP Program during that payment period.
 - a. The nursing facilities shall receive a per diem estimate of the maximum amount available for the July payment by February 28 and a per diem estimate of the maximum amount available for the December, 2001 payment by August 30. The estimated payment amount shall be updated when the actual base rate and payment are calculated.
 - b. The maximum ResQUIP payment to an eligible facility shall be calculated by multiplying the ResQUIP base rate times the most recently reported Medicaid patient days for that facility.

G. Selection and Payment of ResQUIP STARS

1. To recognize facilities whose contribution to promoting the highest quality of life for its residents is outstanding, \$12,000 of the total QCIP moneys paid for calendar year 2001 shall be set aside from the survey and ResQUIP plan portion payments as described in Section 8.446.5. Up to 12 facilities whose ResQUIP projects are recommended by the advisory committee and approved by the Department to be outstanding shall receive a "ResQUIP Star" payment. Payment amounts shall be determined by dividing \$12,000 by the number of facilities which are chosen as "Stars". No payments under this subsection G shall be made for ResQUIP plans approved during calendar year 2002.
2. Following review and evaluation of facility progress report and/or completion of onsite visits by the Department or its designee, ResQUIP "Star" awards shall be recommended by the ResQUIP advisory committee and approved by the Department. The committee shall base its recommendation for "Star" projects on exemplary performance in four criteria categories:
 - a) resident impact and participation;
 - b) improvement in resident choices and relationships;
 - c) creativity, and
 - d) sustainability of the project beyond the year of implementation.

H. A facility's ResQUIP plan shall be considered "completed" when the on-site evaluator has determined that the facility has addressed the criteria in the third and fourth sections ("Implementation" and "Evaluation") of the "ResQUIP Audit Checklist."

I. Recoveries

1. The Department shall recover from the nursing facility the amount of the ResQUIP payment that has not been spent on the ResQUIP plan.
2. Any discrepancy between the reported paid Medicaid patient day census and the audited figures shall cause an adjustment in the QCIP payment, including any recoveries if necessary.
3. Recoveries shall be made in accordance with Subsection 8.040 "RECOVERIES"

FROM PROVIDERS”.

4. Nursing facilities shall have the right to appeal the Department's decision to recover as provided in Section 8.050.

LONG TERM CARE - QUALITY OF CARE INCENTIVE PAYMENT: ResQUIP Form 1, Revised 7/1/01

RESIDENT-CENTERED QUALITY IMPROVEMENT PROGRAM - AUDIT CHECKLIST

Assessment:

- ? Is there authentic resident participation?
- ? Is there a collaborative multi-party approach to participation including such sources as:
 - ? resident/family suggestion?
 - ? resident council?
 - ? resident survey?
 - ? Public Health survey?
 - ? staff observation?
 - ? family groups?
 - ? advocacy agency?
 - ? provider networking?
 - ? facility management (internal quality assurance) reports?
 - ? literature review (of similar projects)?
- ? Is the selected issue related to the enhancement of residents' quality of life in the area of:
 - ? choices?
 - ? relationships?
- ? Is there evidence of the issue being of importance to residents?
- ? Is there a statement articulating the current situation?
- ? Is there a statement of the desired quality improvement - the goals of the ResQUIP?
- ? Can you explain how the needs of cognitively impaired residents are taken into consideration?

Planning:

- ? Is there authentic resident involvement?
- ? Is the process resident focused?

? Is there interdisciplinary staff involvement? What staff is involved?

? Does the plan address key processes?

? Is the plan written?

? Does the plan contain goal statements?

? Are the goal statements:

? specific?

? measurable?

? agreed upon by all parties?

? realistic?

? resource appropriate?

? time defined by month name? Approximate number of months?

? relevant to the identified problem?

? Does the plan describe activities and goals which focus on significantly more than the minimal activities necessary for compliance and as stated in OBRA 87 and the ADA.

? Are activities/steps to be taken to achieve the desired results identified with time frames for completion?

? Are tasks assigned? Are checkpoints identified?

? Does the plan include an adequate budget of projected expenditures?

? Are evaluation criteria identified?

Implementation:

? Was the plan followed?

? Or, if not followed, was the rationale for changes documented?

? Was there monitoring at specified checkpoints?

? Was there documentation and assessment of activity and progress at least on a quarterly basis or more frequently as determined by team?

Evaluation:

? Were any changes in the original plan documented with written explanation of the rationale underlying the changes?

? Was there a multi-party, collaborative approach to the evaluation?

- ? Were the identified goals met?
 - ? Or, if not, is the rationale documented?
- ? Are permanent changes in place as a result of the plan?
 - ? Or, if not, is the rationale documented?
- ? Is there a written evaluation report? Does it include:
 - ? a summary description of the assessment process?
 - ? a summary description of the planning process?
 - ? a summary description of the implementation process?
- ? Does the report include the specific criteria used to determine and measure quality improvements?
- ? Does the report identify the outcomes, including whether the identified goals were met?
- ? If appropriate, as specified in the ResQUIP plan, has a report been generated in relation to the ResQUIP plan? (If not specified in the plan, do not include this question.)
- ? If appropriate, as specified in the ResQUIP plan, has data been generated in relation to the ResQUIP plan? (If not specified in the plan, do not include this question.)
- ? Over the last 12 months, has there been a continuous ResQUIP plan?
 - ? YES
 - ? NO

8.448 INSTRUCTIONS FOR COMPLETING THE MED-13

8.448.1 GENERAL INSTRUCTIONS

- A. The intent of any adjustments which may be required and applied by the contract auditor is to obtain information concerning costs of providing care to patient on a basis that is fair and comparable among nursing facilities, considering the effects of differences in the accounting bases, systems, and procedures, as is possible.
- B. This report consists of the certification page and Schedules A, B, C, D, E, and F. All information called for in the schedules must be furnished unless (1) it is not applicable to the nursing facility operation, or (2) the books and records do not provide the information and it is not available by other reasonable means.
- C. Failure to maintain adequate accounting and/or statistical records is deemed cause for termination or suspension of participation in the program.
- D. The financial information to be included should be based on that appearing in the audited financial statement Adjustments to convert to the accrual basis of accounting are required if the records are maintained on other accounting bases.
- E. Nursing facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing facility care may submit a cost apportionment

schedule prepared in accordance with recognized methods and procedures. In certain instances, such cost apportionment schedules may be required by the Department if deemed necessary for a fair presentation of expense attributable to nursing facility patients.

- F. The instructions do not cover each line on any page but are designed to cover those items which, it is believed, may require additional explanation or to provide an example.
- G. It is not possible to foresee all items which now or in the future may be an expense of a nature which may be considered to be non-patient expenses, and a reservation is made concerning unusual expenses which occur so infrequently that they warrant only specific consideration or agreement.
- H. Cost allocations shall be as set forth in the MED-13 (Financial and Statistical Report).

8.448.2 COMPLETION OF THE CERTIFICATION PAGE

- A. Type of control indicates ownership or auspices under which the nursing facility is conducted.
- B. Accounting basis:
 - 1. Accrual - Recording revenue when earned and expenses when incurred.
 - 2. Modified cash - Recording revenue when received and expenses when incurred.
 - 3. Cash - Recording revenue when received and expenses when paid after giving effect to adjustments for pre-payments, etc., and depreciation.
- C. Nursing facilities not using the accrual basis of accounting are required to adjust recorded amounts to the accrual basis. For example expenses incurred in the following report period which are paid in the first month of the following report period are to be included in the report in which incurred and not in the report period when paid.
- D. Records of cash receipts and disbursements must be adjusted to reflect accruals of income and expenses.
- E. Adjustments to recorded amounts may be made as follows:
 - 1. Subtract cash receipts of the first month of the report which represent collections for services performed in the prior period; add amounts uncollected at the end of the report period;
 - 2. Subtract cash disbursements of the first month of the report period which represent bills for expenses incurred in the prior period; add amounts payable for services and expenses at the end of the report period; and
 - 3. Physical inventories of supplies should be taken and priced, and expense accounts adjusted at the end of each twelve-month period.
- F. Statistical Data:
 - 1. Accuracy in statistical data is essential. Resident days is that period of service rendered a resident between the census taking hours on two (2) successive days, the day of discharge being counted only when the resident was admitted that same day.
 - 2. The total resident days for the period (entered in Item C-4) is the most important statistic in the report. Resident days should include days for residents having special duty nurses. It is essential that this statistic be accurate and not an "estimate" of days of care provided.

- G. The certification statement on the MED-13 must be read and signed by the licensed owner (or corporate officer), and the preparer of the MED-13
- H. In some instances, the Department may notify a nursing facility that an opinion of a certified public accountant will be required. This requirement will be based upon adjustments made to prior reports which indicate disregard of the certification and reporting instructions. The CPA shall certify that the report is in compliance with Departmental rules and regulations, and shall give an opinion of fairness of presentation of operating results or revenues and expenses

8.448.21 REQUIRED METHOD FOR CALCULATION OF RESIDENT DAYS

- A. In order to facilitate accurate and uniform reporting of statistical data discussed in Section 8.448.2 concerning resident statistics, the accumulation method format set forth in Form NH-1 ("Mutiny Census Summary Nursing Home Patients") is required. Such monthly record must be kept concerning all patients (both welfare recipients and non-recipients) by the nursing facility for use by the State Department or its agents in their audits' or other activities in determining cost allowances for nursing facility care to eligible recipients.
- B. Sample copies of the required format may be secured from the State Department. The State Department does not supply this form. Nursing facilities may secure supplies of the form (if they desire to use it as presented) from their own printers.

8.448.22 IMPUTED OCCUPANCY OF PATIENT DAYS

- A. For all rates for services rendered on or after January 1, 1984, the Department shall utilize the total audited patient days on the MED-13, unless the Department finds that the audited patient days on the MED-13 constitute an occupancy rate of less than 85 percent of licensed bed day capacity. In such cases, the patient day calculation shall be imputed to an 85 percent rate of licensed bed day capacity for the nursing home and the per diem cost along with the resulting per diem rate shall be adjusted accordingly. For rates effective on or after July 1, 2000, for each Class I and Class V facility, such imputed occupancy shall not be applied in calculating the facility's health care costs. For purposes of the initial implementation of this regulator, the licensed bed capacity on file with the Colorado Department of Health for January 1, 1984, shall be used. This licensed bed capacity shall remain in effect until the Department is advised that the licensed bed capacity has changed through the filing of a subsequent cost report Effective July 1, 1988, for all rates for services rendered by State-administered Class IV intermediate nursing care facilities for the mentally retarded, rates for services shall be calculated using the total Medicaid patient days as reported on the form MED-13.
- B. The imputed patient day calculation shall remain in effect until a new rate from a subsequent cost report is calculated. Should the subsequent cost report indicate an occupancy rate of less than 85 percent of licensed bed day capacity the resulting rate shall be imputed in accordance with the provisions of this section.
- C.
 - 1. Nursing homes which are located in rural communities and have a census of less than 85 percent shall not be subject to the imputed occupancy regulations. A nursing home located in a rural community shall be defined as a nursing home in:
 - a. A county of less than fifteen thousand population; or
 - b. A municipality of less than fifteen thousand population which is located ten miles or more from a municipality of over fifteen thousand population; or

- c. The unincorporated part of a country ten miles or more from a municipality of fifteen thousand population or more.
 2. Exception: Any nursing home in a rural area which expands to increase its licensed bed capacity through new construction (on or after October 1, 1989) shall be subject to the imputed occupancy provisions in these regulations.
- D. The Class V rehabilitation nursing home shall not be subject to the imputed occupancy regulation.
- E. Any nursing facility which has a reduction in census resulting from the relocation of mentally ill or developmentally disabled patients to alternative facilities pursuant to the provisions of the Omnibus Reconciliation Act of 1987 shall be treated as follows whenever such relocation causes the census to be less than 85%. The facility will be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department. These provisions shall be in effect for two cost reporting periods. At the end of this period, the weighted average rate provision is removed and the imputed occupancy calculation is applied when required.
- F. Imputed occupancy shall be applied to a new nursing facility, a facility not in the Colorado Medicaid program within thirty (30) days prior to the start date of the Medicaid provider agreement (Form MED-11A), as follows:
1. Imputed occupancy shall be applied to the first cost report submitted by the new facility. The facility will be entitled to the higher of the imputed rate or the monthly weighted average rate computed by the Department.
 2. Imputed occupancy shall be applied to the second cost report submitted by a new facility; however, the rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in the monthly weighted average computation.
 3. Imputed occupancy shall be applied to the third cost report submitted by the facility without exception.
 4. Imputed occupancy shall not be applied to new facilities with rates effective October 1, 1991 through September 30, 1992.
- G. Nursing facilities undergoing a state-ordered change in case mix or patient census which significantly reduces the level of occupancy in the facility shall be treated as follows. The facility will be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department. These provisions shall be in effect for two cost reporting periods. At the end of this period, the imputed occupancy calculation shall be applied when required.
- H. Imputed occupancy shall not be applied to the administrative and health care costs of urban facilities with rates effective October 1, 1991 through September 30, 1992.
- I. With respect to all rates effective on or after July 1, 2000 for each Class I and Class V facility, health care services and food costs shall be determined using actual patient days for both urban and rural facilities for purposes of calculating the ceilings

8.448.3 COMPLETION OF SCHEDULE A - REVENUES

8.448.31 GENERAL

- A. Revenues are to be listed as recorded in the general books and records and are, to a great extent,

affected by the accounting basis and procedures used Expense recoveries credited to expense accounts should not be reclassified in order to be reflected as revenues for purposes of this report

- B. Revenue from patients should be classified sufficiently in the accounting records to allow preparation of this schedule. It is essential that "routine daily service" represent only the established charge for daily care, excluding additional charged, if any, for other services.
- C. "Routine services" or "daily services" are those services which include room, board, nursing services, and such services as supervision, feeding incontinency, etc., for which the associated costs are in nursing service.
- D. Revenue from patients, or others, resultant from charges made for room reservations must be used in reduction of related expenses. See 8.448.32, C. following.
- E. Revenue from ancillary services provided to patients - pharmacy, medical supplies, occupational therapy supplies, etc., must be applied in reduction of the related expense. The resulting expense, after adjustment, should not be a negative figure. A revenue classification "Miscellaneous" or "Sundry" ordinarily requires an analysis and determination of the amounts included therein, which represent expense recoveries or income to be applied in reduction of a related expense.
- F. Prescription drugs, with certain specific exemptions, are provided patients under other medical assistance programs, and a nursing home normally does not incur costs for such prescription drugs for welfare patients. See 8.442.B.4.
- G. Medical supplies, with certain specific exceptions (see 8.442.2), are to be provided welfare patients without separate additional charges to the patient or relatives. The costs of these supplies or services are to be included in audited costs.
- H. Those specific medical supplies or services for which a separate additional charge is allowed are to be accounted for on Schedule C as "Items Purchased for Resale" and the cost thereof shown on Schedule A on the appropriate line for elimination of Schedule C.

8.448.32 SPECIFIC INSTRUCTIONS FOR COMPLETION OF SCHEDULE A

- A. Revenues related to services rendered which are not an obligation of the state are to be entered in "Column 9" to the extent of the related expense (i.e., if beauty and barber shop revenue if \$1,000 and the related expense if \$900, enter \$900; however, if expenses cannot be determined, enter \$1,000).
- B. Revenues not related to patient care ("Other Revenue Centers") are to be applied in reduction of the related expense. Enter on Schedule A in "Column 9" the cost, if know, (such as employee meals or telephone expense) or the gross revenue-if cost cannot be determined.
- C. Revenue from patients, or others, resultant from charges made for room reservations, must be classified sufficiently in the accounting records, and such amount shall be entered on Schedule A, in the section on revenues immediately following the line "Personal Purchases, for Patients," and identified as room reservation charges. This revenue then also shall be shown in Column 9, Schedule C, Line 33.
- D. Investment income adjustment is necessary only if interest, expense is incurred, and only to the extent of such interest expense.
- E. Laundry revenue should be applied to laundry expense.

- F. Open lines are provided for entry of sundry sources of revenue not directly related to patients, such as pay-telephone commissions, contributions and grants received, etc. These items need not be applied as a reduction of expense.
- G. Accounts receivable charged off or provision for uncollectible accounts should be reported on Schedule A as a deduction from gross revenue. However, if a nursing home accounts for such revenue deductions as an administrative expense, the amounts should be entered on Schedule B as "Other expenses not related to patient care."
- H. The amounts entered on Schedule A, "Column 9" are to be transferred to Schedule C, Column 9. The totals of these columns on both schedules should agree.

8.448.4 COMPLETION OF SCHEDULE B - NON-REIMBURSABLE EXPENSES AND EXPENSE LIMITATIONS AND ADDITIONS

Certain expenses are to be excluded from operating expenses or limited because they are not normally incurred in providing patient care. Rules concerning these matters are set forth below.

8.448.41 DIRECTORS AND NON-WORKING OFFICERS

Fees paid directors and non-working officers salaries are not allowed as reimbursable costs.

8.448.42 LOAN ACQUISITION AND STANDBY FEES

Loan acquisition fees and standby fees are not considered part of the current expense of patient care but should be amortized over the life of the related loan.

8.448.43 COMPENSATION OF OWNERS AND OWNER-RELATED EMPLOYEES

Compensation of owners and owner-related employees shall be subject to the limitations and requirements of this section.

A. Definitions - For purpose of this section, the following definitions shall apply:

"Necessary Services" are those needed for the efficient operation and sound management of the facility such that had the owners or owner-related individual not rendered the service, the facility would have had to employ another person to perform the services.

"Ownership Interest" means the entitlement to a legal or equitable interest in any property of the facility whether such interest is in the form of capital, stock, or profits of the facility.

"Owner" - An owner shall be considered any individual with a 5% or more ownership interest in the facility.

"Owner-Related Individual" - An owner-related individual shall be considered an individual who is a member of an owner's immediate family which includes: spouse, natural or adoptive parent, natural or adopted child, step-parent, step-child, sibling or step-sibling, in-laws, grandparents and grandchildren.

"Compensation" means the total benefit received by the owner for the services he renders to the institution. Such compensation shall only include:

1. Salary amounts paid for managerial, administration, professional, and other services;
2. Amounts paid by the institution for the personal benefits of the proprietor,

3. The costs of assets and services which the proprietor receives from the institution; and
 4. Deferred compensation.
- B. Owners of provider organizations often render services as managers, administrators, or in other capacities. In such cases, it is equitable that reasonable compensation for the services rendered be an allowable cost. To do otherwise would disadvantage such owners in comparison with corporate providers or providers employing persons to perform some more services.
- C. Ordinarily, compensation paid to proprietors is a distribution of profits. However, where a proprietor renders necessary services for the institution, the institution is, in effect, employing his services and a reasonable compensation for these services is an allowable cost. In corporate providers, the salaries of owners who are employees are subject to the same requirements of reasonableness. Where the services are rendered on less than a full-time basis, the allowable compensation should reflect an amount proportionate to a full-time basis. Reasonableness of compensation will be determined by reference to or in comparison with compensation paid for comparable services and responsibilities in comparable institutions or it may be determined by other appropriate means.
- D. Compensation for services of owners and owner-related employees shall be allowable costs subject to the limitations described in this section provided these services are adequately documented to be necessary, and such employees are adequately documented to be qualified to provide these services. Adequate documentation shall include but not be limited to:
1. Date and time of services;
 2. Position description;
 3. Individual's educational qualifications, professional title, and work experience;
 4. Type and extent of ownership interest;
 5. Relationship to and name of owner (if an owner-related individual).
- E. The following method shall be utilized by the department in determining the allowable costs of salaries paid to owner and owner-related employees provided such employees are qualified to provide these services and their services are necessary. For each method, if an owner or owner related employee is compensated for services to the facility, any compensation paid to another individual in the same position shall be excluded from the allowable costs for that cost reporting period.
1. Owner and Owner - Related Administrators - The maximum allowable cost of salaries paid to such administrators shall be equal to the median of salaries paid to all non-owner and non-owner-related administrators in facilities of comparable size. The median shall be computed by the Department from a survey of all Colorado Medicaid participating facilities conducted each January, and shall be applied to salaries for that calendar year. Categories of facilities, based on licensed bed capacity, for purposes of determining comparability shall be as follows: 1-74; 74-99; 100-149; 150-200; and more than 200.
 2. Owner and Owner-Related/Assistant Administrator - The maximum allowable cost for such services shall be set at 75% of the maximum allowable salary of an owner or owner-related/assistant administrator of a comparable facility. No costs shall be allowable for owner or owner-related assistant administrators in facilities with licensed bed capacities less than 150.
 3. Owner and Owner-Related Physicians Performing Administrative Services - Salaries for owner

and owner-related physicians performing administrative services shall be an allowable cost up to the maximum established for owner and owner-related administrators in a comparable facility.

4. Owner and Owner-Related/Nursing Directors - Salaries for owner and owner-related nursing directors shall be an allowable cost up to a maximum of 65% of the maximum allowable salary of an owner or owner-related administrator of a comparable facility.
- F. Fringe benefits for owner and owner-related employees shall be allowable costs up to a maximum established by the Department each March for that calendar year. This maximum shall be equal to the fringe benefit percentage of private employees in Colorado as determined by the survey conducted by the State Department of Personnel, minus that portion of the computation which includes holidays, vacation and sick leave days. Leave days are excluded from the comparison since the cost of these benefits are included under the salary allowance.
- G. Exceptions to the application of the median as the maximum allowable salary for owner and owner-related employees shall be approved by the Department only where the nursing home can demonstrate that it has unique characteristics or the employee in question has special qualifications and experience which would make application of the median for that size facility unreasonable. Requests for consideration as such an exception must be submitted to the contract auditor in writing no later than 90 days prior to the end of the facility's fiscal year.

8.448.48 LEGAL FEES, EXPENSES AND COSTS

- A. Legal fees, expenses and costs incurred by nursing facilities shall be allowable if said costs are reasonable, necessary and patient-related. Said costs shall be allowable costs in the period incurred and shall be reimbursed only to the extent the costs affect the rates for those periods. The following categories shall not be deemed reasonable, necessary and patient-related:
1. Legal fees, expenses and costs incurred in connection with the appeal of a Medicaid classification or reimbursement rate, rate adjustment, personal needs audit, or payment for any financial claim by or against the State of Colorado, or its agencies by a provider, in the event the State of Colorado or any of its agencies prevails in such a proceeding. In the event that each party prevails on one or more issues in litigation, allowable legal fees, expenses and costs in such cases shall be apportioned by percentage, for reimbursement purposes, by the administrative law judge rendering the final agency decision. In the event of the stipulated settlement of any such appeal, the parties shall, by agreement, determine the amount of allowability for the provider's legal fees, expenses and costs. If a settlement agreement is silent concerning legal fees, expenses or costs, they shall not be allowable.
 2. Legal fees, expenses and costs incurred in connection with a proceeding by the Colorado Departments of Health or Social Services to deny, suspend, revoke or fail to renew or terminate the license or provider contract of a long-term care facility, or to refuse to certify, decertify or refuse to recertify a long-term care facility as a provider under Medicaid and the Departments prevail in such a proceeding. Legal fees, expenses and costs incurred in connection with a proceeding by the United States Department of Health and Human Services to refuse to certify, decertify, or refuse to recertify a long-term care facility and the Department prevails in such a proceeding. For the purposes of this paragraph, the word "prevail" shall mean a result, whether by settlement, administrative final agency action, or judicial judgment, which results in a change of the terms of a previously granted provided license, certification, or contract, including involuntary change of ownership or probation.
 - 3.

- a. Legal fees, expenses and costs incurred in connection with a civil or criminal judicial proceeding against the provider by the State of Colorado and any of its agencies as the result of the provider's participation in the Medicaid program, resulting from-fraud or other misconduct by the provider, and the State or its agencies prevail in such proceeding. For the purposes of this paragraph, the word "prevail" shall mean any result but dismissal or acquittal of a criminal action or dismissal, directed judgment, or judgment for the provider in a civil action.
 - b. Legal fees, expenses and costs incurred in connection with an investigation by federal, state, or local governments and their agencies that might lead to a civil or criminal proceeding against the provider as a result of alleged fraud or other misconduct by the provider in the course of the provider's participation in the Medicaid program shall not be allowable where the provider makes any payment of funds to any federal, state, or local governments and their agencies as a result of the alleged fraud or misconduct which was the subject of the investigation.
- 4. Legal fees, expenses and costs incurred for lobbying Congress, the Legislature of Colorado, or the State Boards of Health or Social Services.
- 5. Legal fees, expenses and costs incurred by the seller in the sale of a nursing home.
- 6. Nonrefundable retainers paid to Counsel.
- 7. Legal fees, expenses and costs incurred for any reason after a change of ownership has occurred shall not be allowable as a part of a Medicaid rate QT in a lump sum amount to the provider or provider's attorney.
- 8. Legal fees, expenses, or costs as a result of an attorney entering an appearance in person or in writing by counsel for the provider during the Informal Reconsideration. However, legal fees expenses and costs that are advisory in nature before and during the Informal Reconsideration process will be allowable.

B. Adjusting rates as a result of litigation of nursing facility provider Dates:

Legal fees, expenses and costs that had been disallowed and are now consider allowable as a result of litigation shall be reported on the MED-13 in the period incurred and included in the prospective rate. Retroactive rate adjustments that are necessary due to the inclusion of legal fees, expenses and costs previously disallowed shall be paid to the provider by retroactive rate adjustment within 60 days of when a provider prevails during the appellate process, commencing with the entry of a final agency decision upon the appeal. If during the appellate process, the resulting judgment changes the prevailing party, rates will be readjusted accordingly bay the Department. During the pendency of proceedings identified in Paragraph A, the provider shall be deemed to have appealed and made a timely claim for its legal fees, expenses and costs incurred in that appeal. All other disallowance of legal fees, expenses and costs must be appealed in accordance with § 8.050.

C. Documentation of Legal Fees

Providers shall report the legal fees, expenses and costs described in Paragraph A on the cost report for the period in which incurred. These legal fees, expenses and costs shall be documented in the provider's files, and shall be clearly identifiable, including identification by case number and title, if possible. Failure to clearly identify these costs shall result in disallowance.

8.448.5 DEPRECIATION

8.448.51 DEFINITIONS

For purposes of this section concerning depreciation, the following definitions shall apply:

“MAI Appraiser” refers to the designation “Member, Appraisal Institute” awarded by the American Institute of Real Estate Appraisers.

“Straight Line Method of Depreciation” - Under this method of depreciation, the amount to be depreciated is first determined by subtracting the estimated salvage value of the asset from its cost (or fair market value in the case of donated assets). The amount to be depreciated is then distributed equally over the estimated useful life of the asset

8.448.52 REQUIREMENTS FOR DEPRECIATION

Except as specified in this manual, Medicare rules and regulations as delineated in the Medicare and Medicaid Guide, 1981, published by Commerce Clearing House, paragraph 4501-4897P, shall be utilized in the treatment of depreciation costs for purposes of reimbursement under Medicaid.

Depreciation on assets used to provide covered services to Medicaid recipients may be included as an allowable patient cost. Only the straight line method of computing depreciation may be utilized for purposes of Medicaid reimbursement. Depreciation costs must be identifiable as such, and must be recorded in the provider's accounting records in accordance with “generally accepted accounting principles.”

8.448.53 DEPRECIABLE ITEMS

Depreciable items must be capitalized and written off over the estimated useful life of the item using the straight line method of depreciation. With respect to expenditures during every facility fiscal year which begins on or after July 1, 1998, the following items must be depreciated:

- A. Assets which, at the time of acquisition, had an estimated useful life of (2) two years or more; and a historical cost of \$5,000 or more.
- B. Betterments or improvements which extend the original estimated useful life of an asset by (2) two years or more, or increase the productivity of an asset significantly; and cost \$5,000 or more.
- C. For the purpose of applying the \$5,000 threshold in paragraphs A and B above, the costs of assets, betterments, and/or improvements shall be combined if the costs
 - 1. are incurred within the same fiscal year of the nursing facility; and
 - 2. are of the same type or relate to the same project. For example, renovations or improvements to a facility's kitchen, done in three phases costing \$3,000 each, must be combined.
- D. Major repairs are repairs which:
 - 1. Occur infrequently, involve significant amounts of money, and increase the economic usefulness of the asset in the future, because of either increased efficiency, greater productivity, or longer life; or
 - 2. Restore the original estimated useful life of an asset where without such repairs, the useful life of the asset would be reduced or immediately ended; these repairs occur infrequently and have a significant cost in relation to the asset being

repaired.

If the composite method of depreciation is used, the time period over which the major repair must be depreciated is not necessarily the remaining life of the composite asset. For example, a major repair to a roof of a facility that has a remaining useful life of thirty (30) years would not have to be depreciated over thirty (30) years if the normal life of the roof is only fifteen (15) to twenty (20) years; the shorter period could be used.

The following are examples of major repairs and are not intended as a complete list: replacement or partial replacement of a roof, flooring, boiler, or electrical wiring.

8.448.54 EXPENSED ITEMS

With respect to expenditures during every-facility fiscal year which begins on or after July 1, 1998, items which are to be entirely expensed in the year of purchase, rather than depreciated, are as follows:

- A. All repair and maintenance costs, except major repairs.
- B. Assets which, at the time of acquisition, had an estimated useful life of less than two (2) years; or cost less than \$5,000.
- C. Betterments or improvements which do not extend the useful life of an asset by two (2) years or more, or do not increase the productivity of an asset significantly; or cost less than \$5,000.
- D. For the purpose of applying the \$5,000 threshold in paragraphs B and C above, assets, betterments, and/or improvements which are purchased separately shall be combined if they meet the criteria described in section 8.448.53, C.

8.448.55 HISTORICAL COSTS

- A. Historical costs shall be established in accordance with the Medicare and Medicaid Guide, 1981, as cited above, except that any appraisals required or recommended shall be performed by an MAI Appraiser rather than an "appraisal expert" as defined in the Guide.
- B. When the Internal Revenue Service requires a facility to change its allocation of costs of land, buildings or equipment for purposes of tax reporting, a copy of the IRA notice must be submitted to the State in order for the changes to be reflected in the cost report.
- C. In regards to a determination of a bona fide sale, an initial presumption that the sale was not bona fide may be offset by a valuation report of an MAI appraiser of the reproduction cost depreciated to date on a straight-line basis. Cost determined in this manner will be accepted for future depreciation purposes.

An initial presumption that a sale was not bona fide will be made when any of the following factors exist:

1. The seller and purchaser are persons for whom a loss from the sale or exchange of property is not allowed under the Internal Revenue Services Code between:

Members of a family;

An individual and a corporation if the individual owns (directly or indirectly) more than 50% in value of the outstanding stock;

Two corporations if more than 50% in value of the outstanding stock in both is owned,

directly or indirectly, by the same individual, but only if either one of the corporations was a personal holding company or a foreign personal holding company for the taxable year preceding the date of the sale or exchange;

A grantor and a fiduciary of any trust;

A fiduciary of one trust and a fiduciary of another trust, if the same person is grantor of both trusts;

A fiduciary of a trust and any beneficiary of such trust;

A fiduciary of a trust and a beneficiary of another trust, if the same person is a grantor of both trusts;

A fiduciary of a trust and a corporation more than 50% in value of the outstanding stock of which is directly or indirectly owned by or for the trust or a grantor of the trust. This would, for example, have the effect of denying a loss in a transaction between a corporation, more than 50% of the stock of which was owned by a father, and a trust established for his children. Under the constructive ownership rules (below), the children are treated as owning the stock owned by the father; and

A person and an exempt charitable or education organization controlled by the person or, if the "person" is an individual, by the individual or his family.

2. The term "family" means a brother or sister (whole or half-blood relationship, spouse, ancestor, or lineal descendant, including in-laws and in-laws of ancestors of lineal descendants).
3. In determining stock ownership;
4. The transaction was effected without significant investment on the part of the purchaser, i.e., cash or property was not transferred from the purchaser to the seller and the sales price was met by assumption of existing debt and promises to pay additional amounts or issuance of life annuities to the seller.
5. The sales price could be considered excessive when compared with other sales or costs of constructing, furnishing, and equipping other facilities of comparable size and quality during the preceding twelve months.

8.448.6 INTEREST

Necessary and proper interest on both current and capital indebtedness is an allowable cost. The following definitions are offered for clarification of this statement

- A. Interest is the cost incurred for the use of borrowed funds.
- B. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expense.
- C. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long term loans.
- D. Necessary requires that the interest:
 1. Be incurred on a loan made to satisfy a financial need of the provider. Loans which

result in excess funds or investments would not be considered necessary,

2. Be incurred on a loan made for a purpose reasonably related to patient care; and
3. Be reduced by investment income except where such income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or provider's qualified pension fund is not used to reduce interest expense.

E. Proper requires that interest:

1. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and
2. Be paid to a lender not related through control or ownership or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor restricted funds, the funded depreciation account or provider's qualified pension funds.

8.448.61 BORROWER/LENDER RELATIONSHIP AND APPLICATION OF RULE 8.448.6

- A. To be allowable, the interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors would affect the bargaining process that usually accompanies the making of a loan and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed and that the interest rate is reasonable.
- B. Interest on loans to providers by partners, stockholders, or related organizations is allowable as costs at a rate not in excess of the prime rate.
- C. Where the general fund of a provider "borrows" from a donor restricted fund and pays interest to the restricted fund, this interest is an allowable cost. The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.
- D. Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.
- E. Allowable interest expense on current indebtedness of a provider will be adjusted to reflect the extent to which working capital needs which are attributable to covered services for beneficiaries have been met by payment to the provider designed to reimburse currently as services are furnished to beneficiaries.

8.448.7 FAIR RENTAL ALLOWANCE FOR CAPITAL RELATED ASSETS

- A. Effective with rates on or after July 1, 1985, the method of reimbursement for capital related assets shall be in accordance with section 26-4-103.1 of the Medical Assistance Act entitled "Concerning Medicaid Reimbursement of a Fair Rental Allowance for Capital Related Assets of Nursing Home

Vendors". This section mandates that the historical method of reimbursement as specified in the section of this manual called DEPRECIATION no longer be used. In place of the historical method of reimbursement shall be a fair rental allowance system. The fair rental allowance system, however, does not supersede the historical method of reimbursement pertaining to repairs, maintenance, betterments or improvement costs to fair rental allowance property which is due to be expensed as required by the depreciation regulation at section 8.448.54.

B. Definitions:

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. "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent, the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the Boeckh Commercial Building Valuation System for Nursing Homes, December 1985 edition. This rule does not contain any later amendments to the December 1985 edition. A copy of this edition is available for inspection at the office of the Manager, Long Term Care Section, Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203. The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing homes. Such new appraisals shall be based upon rules and regulations promulgated by the State Board of Social Services.
3. "Base value" means:
 - a.
 - (1)
 - (a) For the Fiscal Year 1985-86, the acquisition cost of a capital-related asset together with any increase or decrease each year since the date of acquisition as reflected in the index.
 - (b) In determining the base value for the Fiscal Year 1985-86 of a capital-related asset acquired prior to July 1, 1981, the date of acquisition shall be deemed to be July 1, 1981.
 - (2) For Fiscal Year 1986-87 and every fourth year thereafter, the appraised value of a capital-related asset.
 - (3) For each year in which an appraisal is not done pursuant to subparagraph (II) of this paragraph (a), the most recent appraisal together with fifty percent (50%) 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. Any improvement to a capital related asset shall increase the base value by the acquisition cost of the improvement See definition of "Improvement" below.

4. "Capital-related asset" means the land, buildings and fixed equipment of a participating facility.
5. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.
6. "Fiscal year" means the State fiscal year from July 1 through June 30.
7. "Fixed equipment" means building equipment as defined under the Medicare principle of reimbursement as specified in the Medicare provider reimbursement manual, part 1, section 104.3. Specifically, building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:
 - a. Affixed to the building and not subject to transfer; and
 - b. A fairly long life, but shorter than the life of the building to which affixed.
8. "Improvement" means the addition to a capital-related asset of additional land, buildings, or fixed equipment. These improvements are to be added to the appraisal under fair rental value and capitalized. The improvements that may be expensed and added to the administrative cost center are defined in the regulations at section 8.448.54. With respect to expenditures during every facility fiscal year which begins on or after July 1, 1998, improvements that must be capitalized are:
 - a. Assets which have an estimated useful life of two(2) years or more and a cost of \$5,000 or more.
 - b. Betterments or improvements which extend the original estimated useful life of an asset by two (2) years or more, or increase the productivity of an asset significantly and cost \$5,000 or more.
 - c. For the purpose of applying the \$5,000 threshold in paragraphs a and b above, the costs of assets, betterments, and/or improvements which are purchased separately shall be combined if they meet the criteria described in section 8.448.53,C.
 - d. Major repairs which occur infrequently, involve significant amounts of money and increase the economic usefulness of the asset in the future, because of increased efficiency, greater productivity or extended life; or major repairs which restore the original estimated useful life of an asset where lacking such repair, the useful life would be reduced or ended.
9. Prior to July 1, 1989, "index" means the Dodge Construction system cost index which is based upon a survey of prices of Common building materials and wage rates for nursing home construction.

On July 1, 1989, and thereafter, "index" means the index of the R.S. Means Company, Inc., specific to commercial/industrial institutional nursing homes (2.450), herein after referred to as the Means Index and which is based upon a survey of prices of common building materials and wage rates for nursing home construction. For July 1, 1989 this rule does not contain any later amendments to the 1989 Means Index information used. For July 1, 1990 this rule will not contain any later amendments to the 1990 Means Index information. A copy of the Means Index information is available at the office of the Manager, Long Term Care Section, Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203.

C. Implementation of the Fair Rental Allowance for Capital Related Assets in State Fiscal Year 1988-1989 and Fiscal Year 1989-1990.

1. The following definitions shall serve as the basis by which the fair rental allowance payments are calculated and paid to municipalities beginning July 1, 1988.
 - a. Base value: Value of the capital related assets of a nursing home is determined by the appraisal report completed by the Department's appraiser pursuant to RFP-GB-347 (October 21, 1985) and any additional information used by the Department to establish the appraised value. This appraised value shall be increased or decreased by fifty percent (50%) of the change in the Dodge Construction Index. For Fiscal Year 1989-1990 the Means Index is used. Under no circumstances will the base value be greater than \$25,000 per bed plus the percentage rate of change in the Dodge Construction Index dollar cost per square foot for the average nursing home building type since State Fiscal Year 1985-1986 and the Means Index in Fiscal Year 1989-1990.
 - b. Rental Rate: Means the average annualized rate for twenty-year treasury bonds issued by the United States for the preceding year. The 20 year treasury bond rate shall be based on the higher of the issue rate or the yield rate for the 20 year treasury bond.
 - c. Fair rental allowance amount: The base value times the rental rate. This sum shall then be adjusted to reflect the period of days covered by the cost report (MED-13) used to calculate the fair rental allowance per diem rate as described below. Specifically, this figure is divided by number of days in the year and then multiplied by the number of days in the period covered by the cost report (MED-13).
 - d. Fair rental allowance per diem rate: The fair rental allowance rental allowance amount divided by the higher of audited patient days on the MED-13 or ninety percent (90%) of bed capacity on file with the Colorado Department of Health when the onsite portion of the appraisal was completed, except as otherwise provided in subparagraph 3 below:
 - (1) The patient days used in this calculation are from the MED-13 report which established the Medicaid rate for the other cost centers. As the rates change due to new MED-13 cost reports, so shall the fair rental allowance calculation due to the change in patient days.
 - (2) The higher of audited patient days or 90% of bed capacity regulation applies to both rural and urban facilities.
 - (3) Changes in licensed bed capacity, which in turn affects the 90% licensed bed capacity standard specified above will be recognized by the Department as follows:
 - (a) Reductions or increases in licensed bed capacity of a facility shall be recognized due to either physical (structural) and or use modification of the facility. (An example of a change in use is when a portion of the nursing home is converted to an alternative care facility.)
 - (b) Reductions in licensed bed capacity including physical modifications undertaken solely to avoid the financial impact of the 90%

licensed bed capacity shall not be recognized.

- (c) Recognized changes in licensed bed capacity (and its impact on the 90% licensed bed capacity standard) shall go into effect with rates driven by the cost report covering the period of the change in licensed bed day capacity.

2. In cases where the nursing home's per diem rate on or after July 1, 1987 and thereafter, is lower than the per diem rate in effect on June 30, 1985, solely as a result of adjustment to property costs to implement the fair rental allowance method of reimbursement, the following shall occur
 - a. The contract auditor shall determine the difference between both the July 1, 1988 for Fiscal Year 1988-1989, and July 1, 1989 for Fiscal Year 1989-1990, property reimbursement and the June 30, 1985, property reimbursement. Included in the calculation of this difference shall be rates which were lowered due to adverse changes in the incentive allowance of fluctuating costs allowance payments due solely to the fair rental allowance system of reimbursement.
 - b. In cases where the June 30, 1985, property reimbursement is higher than both the July 1, 1988 for Fiscal Year 1988-1989, and July 1, 1989 for Fiscal Year 1989-1990, property reimbursement, the providers fair rental allowance shall be increased by fifty percent (50%) of the difference identified by the contract auditor.
3. On and after July 1, 1988, if a vendor payment under the fair rental allowance system is greater than the vendor payment in effect on June 30, 1985, and such increase is wholly or partly the result of the payment of a fair rental allowance for capital-related assets, then that portion of the increase in the vendor payment attributable to the payment of a fair rental allowance for capital-related assets shall be reduced by fifty percent (50%). This fifty percent (50%) reduction shall not be applied to vendors who's current acquisition costs for the capital related assets of the facility are different (due to the sale of the facility) than the acquisition (historical) costs which determined the rate of reimbursement on June 30, 1985.
4. The fair rental allowance as established by these regulations shall only be adjusted due to the following:
 - a. The base value of a facility can be increased in subsequent cost reports due to improvements as specified in the definitions section of this regulation.
 - b. Changes in MED-13 patient days when calculating the fair rental allowance per diem.
 - c. At the start of a new State Fiscal Year (July 1) by a new rental rate amount or additional Construction Indexes.
5. The fair rental allowance as established by these regulations shall not be changed during State Fiscal Year 1988-1989 and thereafter by the following:
 - a. A fluctuating cost allowance as specified in the section of this manual entitled "Computation of Individual Rates".
 - b. By changes in ownership in cost reporting periods with rate effective dates on or after July 1, 1985.

- c. Changes in the maximum reasonable cost ceilings for administrative, room and board and property and related incentive allowance payment.
- 6. All owned and leased facilities are reimbursed under the fair rental allowance methodology with the exception of the state administered Class IV nursing homes.
- D. Implementation of the Fair Rental Allowance for Capital Related Assets in State Fiscal Year 1990-1991 and each year thereafter.
 - 1. The following definitions shall serve as the basis by which the fair rental allowance payments are calculated and paid to facilities beginning July 1, 1990.
 - a. Base value: Value of the capital related assets of a nursing home is determined by the most current appraisal report completed by the Department's appraiser pursuant to the most recent RFP and any additional information used by the Department to establish the appraised value. This appraised value shall be increased or decreased by fifty percent (50%) of the change in the Means Index. Under no circumstances will the base value be greater than \$25,000 per bed plus the percentage rate of change in the Index dollar cost per square foot for the average nursing home building type since State Fiscal Year 1985-1986.
 - b. Rental Rate: For all rates effective through June 30, 2000, means the average annualized rate for twenty-year treasury bonds, issued by the United States for the preceding year. The 20 year treasury bond rate shall be based on the higher of the issue rate or the yield rate for the 20 year treasury bond. For all rates effective on or after July 1, 2000 rental rate means the annualized composite rate for treasury bonds issued and outstanding by the United States neither due nor callable in less than 10 years, plus 2 percent. Not to total less than 8.25 percent and limited to a maximum of 10.75 percent. The rental rate shall be adjusted each year based on the over 10 year composite rate for the month of April as published by the Federal Reserve.
 - c. Fair rental allowance amount: The base value times the rental rate. This sum shall then be adjusted to reflect the period of days covered by the cost report (MED-13) used to calculate the fair rental allowance per diem rate as described below. Specifically, this figure is divided by number of days in the year and then multiplied by the number of days in the period covered by the cost report (MED-13).
 - d. Fair rental allowance per diem rate: The fair rental allowance amount divided by the higher of audited patient days on the MED-13 or ninety percent (90%) of the licensed bed capacity on file with the Colorado Department of Public Health and Environment during the relevant cost reporting period.
 - (1) The patient days used in this calculation are from the MED-13 report which established the Medicaid rate for the other cost centers. As the rates change due to new MED-13 cost reports, so shall the fair rental allowance calculation due to the change in patient days.
 - (2) The higher of audited patient days or 90% of bed capacity regulation applies to both rural and urban facilities.

NOTE: Section 8.448.7 D.1.d(3) was deleted effective December 2, 2002.

- e. Excess Land: Land shall be deemed excess and excluded from the property appraisal

process under the following conditions:

- (1) Urban setting: Nursing homes in an urban area having any land or land-area in excess of 4,732 square feet per licensed bed shall be deemed excess.
- (2) Rural setting: Nursing homes in a rural area having any land or land-area in excess of 6,500 square feet per licensed bed shall be deemed excess.
- (3) For purposes of this section, "rural setting" will be given the same definition as in 8.448.22(C). All nursing homes that do not meet the definition of rural setting will be considered to be in an urban setting.

f. "Appraised Value". - effective July 1, 1990, the 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 shall be based on the most recent edition of the Boeckh™ Commercial Building Valuation System for Windows™ available on December 31st of the year preceding the year in which the appraisals are to be performed. This applies to all appraisals after 1998. For the 1998 appraisals, the Department will use the Boeckh program available on April 1, 1998, as described in subsection 8.448.7, D, 3, b. Information about obtaining or examining the applicable edition is available at the office of the Manager, Nursing Facilities Section, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203. The incorporated material may also be examined at any state publications depository Library.

2. Adherence to certain physical findings:

- a. In the case of facilities for which an appraisal was completed pursuant to RFP-GB-347 (October 21, 1985) and no major physical plant expansions or additions were completed prior to the State re-appraisal of the property, the following data will remain unchanged through the ensuing appraisal process:

Average storey height

Gross floor area

Total perimeter

Construction classification

Construction quality

Year built

- b. In the case of those facilities that have completed a major physical plant expansion, addition or deletion, the initial appraisal measurements and data indicated in 8.448.7, D.2.a, above (pursuant to RFP-GB-347) shall be modified only to the extent of the relevant appraisal data specific to the new expansion, addition or deletion.
- c. The appraisal shall take into consideration the economic impact the addition, deletion or use modification may have had on the overall value of the entire facility.

3.

a. The variables from the Boeckh program that are to be calculated/determined by the contract appraiser, and which will be incorporated into the Request for Proposal (RFP) which defines the scope of the appraisals, include:

- (1) RECORD INFORMATION - State identification number of the nursing facility as provided by the Department.
- (2) PROPERTY OWNER - Name of nursing facility.
- (3) STREET ADDRESS, CITY.
- (4) ZIP CODE.
- (5) LAND VALUE.
- (6) SECTION NUMBER - Assign lowest to oldest section and have basements immediately follow the section they are beneath.
- (7) OCCUPANCY - Primarily nursing facility or basement.
- (8) CONSTRUCTION CLASSIFICATION.
- (9) NUMBER OF STORIES.
- (10) GROSS FLOOR AREA- Shall be the determination of the exterior dimensions of all interior areas including stairwells of each, floor. In addition, interior square footage measurements must be reported for (a) non-nursing facility areas: (b) shared service area by type of service: and (c) revenue-generating areas so that these non-nursing facility portions of the facility can be omitted from the total square footage or allocated based on their nursing facility related use.
- (11) CONSTRUCTION QUALITY.
- (12) YEAR NURSING FACILITY BUILT.
- (13) BUILDING EFFECTIVE AGE.
- (14) BUILDING CONDITION.
- (15) EXTERIOR WALL MATERIAL.
- (16) TOTAL PERIMETER - Common walls between sections are to be excluded from both sections.
- (17) AVERAGE STOREY HEIGHT.
- (18) ROOF MATERIAL.
- (19) ROOF PITCH.
- (20) HEATING SYSTEM.

- (21) COOLING SYSTEM.
- (22) PLUMBING FIXTURES - (Basements only).
- (23) PASSENGER ELEVATORS - Actual number.
- (24) FREIGHT ELEVATORS - Actual number.
- (25) SPRINKLER SYSTEM - Percent of gross area served.
- (26) MANUAL FIRE ALARM SYSTEM - Percent of gross area served
- (27) AUTOMATIC FIRE DETECTION - Percent of gross area served.
- (28) FLOOR FINISH.
- (29) CEILING FINISH.
- (30) TOTAL PARTITION WALLS - (Basement only).
- (31) PARTITION WALL STRUCTURE.
- (32) PARTITION WALL FINISH.
- (33) MISCELLANEOUS ADDITIONAL ITEMS - All components not included in the preceding list and also not automatically calculated by the Boeckh Program are to be included here. The appraiser shall use professional judgment when valuing such items. Some examples described in the Boeckh Manual are fire escapes, pipe tunnels, canopies, skylights, and balconies. See Building Items and Improvement section of the Boeckh Manual. Items shall be entered at depreciated value.
- (34) SITE IMPROVEMENTS - Items shall be included at depreciated value except landscaping) to be determined by the appraiser based upon professional judgment. It is expected that depreciation for site improvements will, in many instances, be different from the depreciation for the structure. A list of site improvements and corresponding values must be retained with the appraiser's work papers.
- (35) USER ADJUSTMENT FACTOR - Used in those cases where facilities are appraised in total and only partly used as a nursing facility (i.e., hospital and nursing facility combined or a residential and nursing facility combined).

- b. For the 1998 appraisals, the Department will use the most current Microsoft Windows version of the Boeckh program that is available on April 1, 1998. For subsequent appraisals, the Department will use the most current Windows version available on December 31 of the year preceding the year in which the appraisals are to be performed.
- c. The Department's use of the depreciation tables specified in the preceding subsection is based on the understanding that the Boeckh program will publish a depreciation table that establishes depreciation using one-year effective age increments ("a progressive table"). If the Boeckh program ceases publishing a progressive table, the Department shall evaluate any proposed table and engage

in rule-making procedures for a new depreciation table or method to be used for the appraisals.

4. When the first rate letter for the July 1, 1990 rates that incorporates the new appraisal is issued, the provider may appeal the appraisal. Failure to timely appeal this rate letter shall cause all subsequent appeals by the provider of appraisal issues to be untimely and the appeal shall not be heard.

The administrative law judge (ALJ) shall not under any circumstances alter the appraisal methodology which is described in the most recent RFP. This limitation means that the RFP defines how the appraisal is to be conducted and the ALJ may not change the RFP's described method, in particular, where the RFP describes which variables or components from the Boeckh program are to be specifically calculated through Boeckh's built-in data, those requirements from the RFP cannot be altered by the ALJ. This limitation on the ALJ's scope of review also means that where the RFP requires physical depreciation to be calculated through the use of the tables published in the Boeckh manual, the ALJ has no authority to consider appeals from providers requesting the use of alternative tables or any other method of calculating depreciation.

The ALJ may alter the findings of fact, judgments and opinions contained in the appraisal report (e.g., measurements, decisions regarding the depreciation components of effective age and building condition).

Otherwise, the appraisals are subject to the appeal provisions found in Section 8.050 of these regulations.

5. The procedures set forth in 8.448.7. D.4, above shall apply to all subsequent Departmental nursing facility appraisal appeals.
6. On and after July 1 1990, and for all rates effective through June 30. 2000, if a vendor payment under the fair rental allowance system is less than the vendor payment in effect on June 30, 1985, and such decrease is wholly or partly the result of the payment of a fair rental allowance for capital-related assets, the following shall occur
 - a. The contract auditor shall determine the difference between the July 1, 1990. property reimbursement and the June 30. 1985. property reimbursement. Included in the calculation of this difference shall be rates which were lowered due to changes in the incentive allowance or fluctuating costs allowance payments due solely to the fair rental allowance system of reimbursement.
 - b. In cases where the June 30. 1985, property reimbursement is higher than the July 1, 1990, property reimbursement, the providers fair rental allowance shall be increased by fifty percent (50%) of the difference identified by the contract auditor.

However, this increase shall be eliminated if the vendor has constructed and occupied a new physical plant and is no longer using the old structure for providing care to nursing facility residents.

7. On and after July 1, 1990, and for all rates effective through June 30, 2000, if a vendor payment under the fair rental allowance system is greater than the vendor payment in effect on June 30, 1985, and such increase is wholly or partly the result of the payment of a fair rental allowance for capital-related assets, then that portion of the increase in the vendor payment attributable to the payment of a fair rental allowance for capital-related assets shall be reduced by fifty percent (50%). This fifty percent (50%) reduction shall not be applied to vendors who's current' acquisition costs for the capital related assets of the

facility are different (due to the sale of the facility) than the acquisition (historical) costs which determined the rate of reimbursement on June 30, 1985.

The fifty percent (50%) reduction shall not be applied to a vendor that has constructed and occupied a new physical plant and is no longer using the old structure for providing care to nursing facility residents, even though there is an increase over June 30, 1985. caused wholly by the payment of a fair rental allowance for the capital-related asset.

8. The fair rental allowance as established by these regulations shall only be adjusted due to the following:
 - a. The base value of a facility can be increased in subsequent cost reports due to improvements as specified in the definitions section of this regulation.
 - b. Changes in MED-13 patient days when calculating the fair rental allowance per diem.
 - c. At the start of a new State Fiscal Year (July 1) by a new rental rate amount or additional indices.
 - d. The base value of a facility can be decreased by a change in either the physical (structural) and/or use modification of the facility, i.e., the destruction of a portion of the facility would be an example of a physical change. An example of a change in use is when a portion of the nursing home is converted to an alternate care facility.
 - e. The provider has constructed and occupied a new physical plant and is no longer using the old structure for providing care to nursing facility residents. Base value will be a new appraisal conducted by the state's contract appraiser at the time the new physical plant is ready for occupancy.
 - 1) The provider will continue to be reimbursed at the old fair rental allowance rate until the first scheduled MED-13 after the move sets a new rate.
 - 2) A new appraisal will be performed to coincide with the filing of the next scheduled cost report which will set a rate for the facility.
 - 3) The fair rental allowance reimbursement based on the new appraisal will not include a hold harmless or negative share amount
9. The fair rental allowance as established by these regulations shall not be changed during State Fiscal Year 1990-1991 and thereafter by the following:
 - a. a fluctuating cost allowance as specified in the section of this manual entitled "Computation of Individual Rates".
 - b. by changes in ownership in cost reporting periods with rate effective dates on or after My 1,1985.
 - c. changes in the maximum reasonable cost ceilings for administrative, room and board and property and related incentive allowance payment.
10. All owned and leased facilities are reimbursed under the fair rental allowance methodology with the exception of the state administered Class IV nursing facilities.
11. The 90th percentile licensed bed day calculation for all urban and rural facilities will not be

impacted by the regulation at 8.441.8.

9. The fair rental allowance as established by these regulations shall not be changed during State Fiscal Year 1990-1991 and thereafter by the following:
 - a. a fluctuating cost allowance as specified in the section of this manual entitled "Computation of Individual Rates".
 - b. by changes in ownership in cost reporting periods with rate effective dates on or after July 1, 1985.
 - c. changes in the maximum reasonable cost ceilings for administrative, room and board and property and related incentive allowance payment
10. All owned and leased facilities are reimbursed under the fair rental allowance methodology with the exception of the state administered Class IV nursing facilities.
11. The 90th percentile licensed bed day calculation for all urban and rural facilities will not be impacted by the regulation at 8.441.8.

8.448.8 ITEMS FURNISHED BY RELATED ORGANIZATIONS OR COMMON OWNERSHIP

Costs applicable to services, facilities, and supplies furnished by or organizations related to the nursing home by common ownership or control are includable in the allowable costs of the nursing facility at the cost to the related or organization. However, such costs must not exceed the prices of comparable services, facilities, or supplies that could be purchased elsewhere.

The following definitions are applicable for the purposes of this regulation:

A. Related to the nursing facility means:

1. The nursing facility, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the or organization: furnishing the services, facilities or supplies; or
2. An owner-related individual, as defined in 8.448.43,A, is employed by the nursing facility at the time that the nursing facility is obtaining services, facilities or supplies from an organization whose owner is related to the nursing facility employee; or
3. An owner-related individual, as defined in 8.448.43,A, is employed by an organization which is providing services, facilities or supplies to a nursing facility whose owner is related to the supplier's employee.

B. Common ownership exists when an individual or individuals directly or indirectly possess a significant (5% or more) ownership interest, as defined in 8.448.43,A, in the nursing facility and the institution or organization serving the nursing facility.

C. Control exists when an individual or an organization ha; common ownership with or is related to another organization or institution, or has the power, directly or indirectly, to influence significantly or to direct the actions or policies of another organization or an institution.

8.448.81 APPLICATION OF RULE 8.448.8

- A. When a nursing facility obtains items of services, facilities, or supplies from an organization which is

related to, owned or controlled by the owner(s) of the facility, those items in effect are obtained from the facility, even though the supplying organization is a separate legal entity.

For example, a corporation building a nursing facility and subsequently leasing it to another corporation controlled by the owner, would meet the criteria of a related transaction.

- B. In related transactions, reimbursable costs shall include the cost of such services, facilities, or supplies at the costs of the supplying organization, or at the open market price, whichever is less.
- C. Such related providers or organizations must be identified by the nursing facility on Schedule F of the MED-13.

8.448.82 EXCEPTION TO APPLICATION OF RULE 8.448.81

An exception is provided to the foregoing principles. The charge by the supplier for the services, facilities or supplies shall be considered an allowable cost when the nursing facility demonstrates all of the following by clear and convincing evidence:

- A. The supplying organization is a bona fide separate organization; and
- B. A substantial part of the supplier's business activity of the type carried on with a nursing facility is transacted with others than the nursing facility and organizations related to the supplier by common ownership or control; and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; and
- C. The services, facilities, or supplies are those which commonly are obtained by institutions, such as the nursing facility, from other organizations and are not basic elements of patient care ordinarily furnished directly to the patients by such institutions; and
- D. The charge to the nursing facility is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

8.448.83 MANAGEMENT SERVICES

- A. The following requirements apply to all management companies:
 - 1. Records shall be made available at the beginning of the field audit and upon request following the field audit. Failure to provide records will result in disallowances of all unsubstantiated management company costs claimed, and/or delay in auditing and issuing rates pursuant to 8.441.1 and 8.441.2,G.
 - 2. Management company costs shall be considered administrative costs unless all management company personnel charged to health care are professionally qualified in the health care field per 8.441.3,C.
 - 3. Management company costs allocated to facilities must be based on actual services provided to the facility. The allocation must be documented.
 - 4. If the compensation to on-site management staff is separately reported on the cost report, that compensation shall not also be included in the allowable management costs for the facility. This rule shall apply regardless of whether owners or owner related organizations are involved in the administration or management services.
- B. In addition to A above, the following requirements apply to owner-related management companies:

1. "Owner-related management company" means an individual or organization which is related to, owned or controlled by the owner(s) of the nursing facility, as described in 8.448.8.
2. Management services provided to the nursing facility by an owner-related management company are subject to the related party rules at 8.448.8 and 8.448.81.
3. When management services are provided to a nursing facility by an owner-related management company the nursing facility shall compile and present for inspection supporting documentation of actual costs incurred in providing the management company services. This shall include, at a minimum, the following:
 - a. Documentation supporting the reasonableness of salaries paid to owners and owner-related employees of the management company, as specified in 8.448.83,4,a;
 - b. Allocation schedules;
 - c. Medicare Home Office cost reports;
 - d. All tax records and filings of the management company;
 - e. All management company records to support financial statements.
4. Salaries and other compensation paid to owners and employees of an owner-related management company are subject to the following standards:
 - a. Documentation supporting the reasonableness of such salaries must be available for inspection and include, but not be limited to, the following:
 - (1) Salary survey(s) for the geographic location demonstrating that the salaries and other compensation are comparable to market for their respective position and size of entity;
 - (a) If the provider does not provide a salary survey, the auditor will use the latest survey of the Healthcare Financial Management Association (HFMA).
 - (b) Salary surveys are to be of a sufficiently large sample, including non-related nursing facility management companies, to lend support to the salaries. Surveys including a small number of facilities (less than ten), facilities related through common ownership or control, or facilities of incomparable size shall be considered unacceptable.
 - (2) A position description for the person listing the duties performed;
 - (3) Date and time of services provided by each owner-related individual;
 - (4) Job applications, resumes, professional title, educational qualifications, and other documentation of work experience and qualifications; and
 - (5) The type and extent of ownership interest for each owner or owner-related individual employed by or performing services for the management company.
 - b. Limitations will be based on the median salaries included in the survey(s) referenced

in 8.448.823,3,a,(l) above. If the owner or owner-related party receives compensation from two or more entities, the total compensation received from those entities will be evaluated for reasonableness. In the absence of reasonable documentation that the owners and/or owner-related parties are working employees, the compensation claimed for these persons will be disallowed as a cost not related to patient care.

5. Compensation to owners of related party companies, regardless of organizational structure, must be paid within seventy-five (75) days of the end of the fiscal year. Payment of the compensation must be evidenced by documentation submitted to the IRS. Failure to provide adequate documentation at the field audit visit will result in disallowance of unsupported or unpaid amounts. Disallowed compensation will not be allowed in any future period.

8.448.84 ADJUSTMENTS CONCERNING COMPENSATION OF NON-SALARIED STAFF

Some adjustments may be necessary to provide compensation as an expense for non-salaried working proprietors and partners (see 8.448.43).

Members of religious orders serving under an agreement with their administrative offices are allowed comparable salaries paid persons performing comparable services. If maintenance is provided such persons by the nursing facility (room, board, clothing, etc.), consideration must be given to the value of these benefits. This amount should be deducted from the amount otherwise allowed for a person not receiving maintenance.

8.448.85 ENTRIES TRANSFERRED TO SCHEDULE C

The amounts entered on Schedule B are to be transferred to Schedule C, Column 10. The totals of these columns on both schedules should agree.

8.448.9 COMPLETION OF SCHEDULE C - OPERATING EXPENSES

- A. Expense centers are listed on the lines number 1 to 37 and Columns 1 to 7 are provided for distribution of expenses by object or natural classifications within the department or function.
- B. The expenses should be classified sufficiently within the accounting records to allow preparation of this schedule. All adjustments to eliminate expenses or to apply expense recoveries are to be made on Schedule C.

8.448.91 GENERAL INSTRUCTIONS FOR COMPLETION OF SCHEDULE C

- A. Administrative salaries, line 1, column 1, include salaries paid to the administrator, bookkeeper, and clerical help. Other administrative general expenses are:

1. Telephone - line 1, column 3.
2. Legal accounting, administrative fees - line 1, column 4.
3. Payroll taxes, licenses, (not real estate nor income taxes) - Line 1, column 6.

- B. Dietary, line 4; salaries, column 1; supplies, column 2.

- C. Food, line 5, column 2.

- D. Laundry and linen expenses distributed according to columnar headings. Outside laundry service,

column 4.

- E. Repairs, if classified by function or department, should be entered in column 5 on appropriate lines. If not so classified, enter on line 8, column 5.
- F. Utility charges should be entered on line 8, column 3.
- G. Health care: salaries, if classified or available, should be entered on lines 1 to, 12, and 13. If classification is not available, enter on line 10, column 1. Other nursing service expenses should be distributed on line 10 to appropriate columns.
- H. Drugs, medicines, and medical supplies should be entered in column 2 on lines 14 and 15.
- I. Property and related expenses should be entered on appropriate lines and columns.
- J. Expenses relating to an object not specifically shown in columnar headings, should be entered in Column 7, "other."
- K. Totals should be extended on each line to column 9, and, after adjustment by subtracting or adding amounts in column 11, the patient expenses entered in column 12.

All expenses should be reported on Schedule C. Column 8 of Schedule C should agree with the total expenses in the general ledger. Adjustments which may be required are to be effected in columns 9, 10, and 11 of Schedule C.

8.449 INSTRUCTIONS CONCERNING UTILIZATION REVIEW IN LONG-TERM FACILITIES PARTICIPATING IN THE MEDICAL ASSISTANCE PROGRAM

8.449.1 REQUIREMENTS FOR UTILIZATION REVIEW

Utilization review requirements are that all long-term health care facilities participating in the Medical Assistance Program make provision for utilization review and medical care appraisal to assure quality patient care and appropriate use of health care facilities. Each facility shall submit to the Department of Social Services a plan for doing so that agrees in principle with the model plan attached. Individual case reviews are to be so scheduled as to provide for annual review of each patient certified for skilled nursing care and semi-annual review of each patient certified for intermediate care.

The Utilization Review Plan developed by the long-term care facility lists the members of the Utilization Review Committee. Any change in membership of the Committee is to be communicated to the State Department of Social Services and the State Department of Health.

The minutes of Utilization Review Committee meetings are to be kept on file in the facility and available to representatives of the Department of Social Services and the State Department of Health.

8.449.2 USE OF FORMS AND COMMUNICATION CONCERNING RESULTS OF UTILIZATION REVIEW

Recommendations as to individual patients shall be recorded in duplicate on Forms MED-60. The original is filed with the committee minutes, the copy in the patient's administrative file. (Forms are secured by nursing homes from the Caridge Printing Company, 1505 So. Pearl, Denver.)

When the U.R. Committee recommends a change in the level of care to be given the patient, form letter Med-60A is completed in triplicate and sent to the patient's physician by the nursing home. If the attending physician agrees with the recommendations, he should date and sign the Med-60A and return it to the Nursing Home U.R. Committee. The nursing home shall then complete Form NH-8 to be sent, together

with the Med-60A to the State Department of Social Services and to the county department. The original of Form Med-60A shall be kept in the patient's chart.

If the attending physician disagrees with the recommendations, he shall return the Form Med-60A with the reasons entered in the space provided, to the U.R. Committee. The U. R. Committee will review the reasons the physician did not accept the recommendations, and if valid, the classification will remain the same, and the U.S. Committee will notify the State and County Departments. If the Committee does not agree, a copy of the minutes and the form will be sent to the Colorado Medical Society Utilization Review Committee for review and evaluation. The results of that review will be communicated to the physician, the State Department of Social Services, the County Department of Social Services, and to the U.R. Committee.

It shall be the responsibility of the Department to make the final decision, in all such cases, following a review of the recommendations of the Colorado Medical Society Utilization Review Committee, the facility Utilization Review Committee, and the attending physician.

8.461 PAYMENT FOR OUT-OF-STATE NURSING FACILITY CARE

Payments for out-of-state nursing facility care will be made to providers participating in the Medicaid program in their state when:

- A. Nursing facility services are needed because of a medical emergency;
- B. Nursing facility services are needed because the resident's health would be endangered if he/she were required to travel to Colorado, and the attending physician has certified to such in the resident's medical records;
- C. The Department determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are not available in Colorado but are readily available in another state;
 - 1. In those cases where the resident needs rehabilitation services, the resident must meet all of the following criteria. The criteria shall not apply to those residents placed out-of-state prior to February 1, 1992.
 - a. The resident's level of functioning should be evaluated by the PRO to determine the appropriateness of admission and the PRO shall have documentation that the resident will demonstrate significant improvement.
 - b. The resident's medical condition (as documented by the physician) should be stable to the extent that the resident's primary need is no longer for acute medical care but for intensive, multidisciplinary rehabilitation care.
 - c. The resident's disability must be recent (e.g., within 12 months). The admission evaluation should include an individualized program for the resident which includes:
 - 1) problem list and rehabilitation goals;
 - 2) treatment plan relative to each rehabilitation goal;
 - 3) time frame for goal achievement; and
 - 4) statement of expected discharge status (e.g., timing and the

resident's condition on discharge).

2. Those residents without need for rehabilitation services shall be expected to meet Colorado nursing facility admission requirements as described in Sections 8.402.01-8.402.10; or

D. It is general practice for residents in a particular locality to use nursing facility services in another state; or

E. The resident of an out-of-state nursing facility has been determined to be eligible for Colorado Medicaid due to his inability to indicate his/her intended state of residence.

8.461.01 The out-of-state nursing facility will be paid based on the following :

All claims must be submitted to the Department with documentation of the above requirements. All out-of-state nursing facilities submitting claims shall be required to send a copy of their current Medicaid provider agreement with their state, their provider number, and their Medicaid rate at the time services were rendered; and shall be required to enroll in the Colorado Medicaid Program.

The Department shall instruct the Colorado PRO to conduct; an admission certification review when it learns of a planned admission to an out-of-state nursing facility.

If certification is denied, the resident shall be advised of his/her appeal rights. The decision of the PRO may also be appealed (Section 8.059) by the resident.

Payment shall in no case exceed 100 percent of audited Medicaid costs as determined by the Department and/or its agent. These audited costs will be based on Medicaid costs in the state where the facility is located. If the facility is not a Medicaid participant, it shall submit to the Department prior to payment, an audited Medicare cost report. The payment shall in no case exceed 100 percent of audited Medicare costs.

The Department will instruct the fiscal agent to pay the claims or notify the provider of the need for additional information or the denial of the claim.

8.461.02 CONTINUED STAY REVIEW GUIDELINES FOR OUT-OF-STATE REHABILITATION RESIDENTS

The Department shall also instruct the Colorado PRO to conduct a continued stay review once the resident is known to be residing in an out-of-state nursing facility and every 30 days thereafter unless the PRO determines that longer periods of recertification are appropriate and the Department has given authorization for the extended period.

The Continued Stay Review shall include:

- A. A monthly report to the PRO with documentation showing that the resident is progressing toward established goals. The progress report should be made as a result of an interdisciplinary conference and should include the resident's progress towards the goals addressed in the treatment plan. This report should result in a clear statement of the resident's progress relative to each goal.
- B. Prior to the authorization for payment, the PRO will perform both the admission and monthly (or longer if requested by the PRO and approved by the Department) continued stay review, to determine the resident's progress. Payments will be made only for the specific treatments and/or services authorized by the Department and recommended by the PRO. The out-of-state nursing facility will be responsible for providing the PRO (on a monthly or

as requested basis) those medical records necessary for PRO review. Non-compliance with a PRO request for medical records will result in denial of reimbursement.

- C. The Department shall make the determination concerning the relocation of the resident to an in-state facility and discontinuation of out-of-state services, pending appropriate in-state placement, considering recommendations from the PRO, and assessing the need for continuation of services in order to comply with Section 8.401.17 (D.), 2.

Once the attending physician has determined that the individual is able to travel, the county department will be notified of this change in condition.

The county will assist in arranging transportation to Colorado and in placing the individual in an appropriate nursing facility. Colorado will discontinue Medicaid payments for residents in out-of-state nursing facilities if the resident has not moved to Colorado and transportation and appropriate placement in Colorado have been arranged. (Section 8.463.)

The Department shall also notify the county department that the resident is residing in an out-of-state nursing facility. The county department shall prepare an AP-800 immediately upon notice of the resident's need for nursing facility care, in order to revise the resident's assistance grant by deletion of all payments which are not for the purpose of maintaining a residence.

Continuing eligibility of residents in out-of-state nursing facility care is governed by the Colorado Department of Human Services Income Maintenance Staff Manual, Volume 3.

The out-of-state nursing facility shall have a transfer agreement with the discharging hospital where the hospital agrees to re-admit the resident, should care problems develop.

8.461.03 DISCHARGE PLANNING

Upon discharge from the out-of -state facility, the facility will submit to the PRO and the Department a documented physician coordinated multi -disciplinary discharge plan which includes:

- A. Status relative to each of the goals defined on admission;
- B. A plan for continued support toward progress of remaining feasible goals (e.g., living arrangements, therapeutic and support services) ;
- C. Documentation that any rehabilitative care has included:
 - 1. Satisfactory management of complications;
 - 2. Education of resident and/or family relative to resident's continued needs for care; and
 - 3. Contacts with appropriate referral agencies including long term care, if appropriate.

Definitions of Rehabilitation and Treatment Plan

Rehabilitation: The restoration of normal form and function after injury or illness.

Treatment Plan: A written plan describing the management and care of a resident for the purpose of combating disease or disorder.

8.465 OXYGEN FOR PATIENTS IN LONG TERM CARE FACILITIES

When the attending physician has prescribed oxygen for a recipient in a long term care facility, the facility shall provide oxygen as prescribed. Reimbursement for the cost of oxygen shall be paid to the facility in accordance with the following requirements:

I. CERTIFICATION

- A. The physician will certify and update every six (6) months the need for an amount of oxygen in the medical records of the patient under "Physician's Orders". The use of oxygen not so certified shall not be reimbursed by the Medicaid program. Should an audit, investigation or other competent evidence reveal Medicaid payments for oxygen which are not certified in accordance with these provisions, such payments shall be recoverable from a provider as overpayment.
- B. The Department may also limit reimbursement to only those oxygen services and supplies which were medically needed by Medicaid recipients based on an independent utilization or quality assurance review.

II. BILLING AND PAYMENT

- A. Effective with the service month of March 1, 1991, all oxygen supplies except oxygen provided by oxygen concentrator shall no longer be reimbursed by the Medicaid program on the nursing home claim form. Oxygen concentrator expenses shall continue to be reimbursed on the nursing home claim as specified below.
 - 1. Liquid, piped in, and gaseous oxygen, as well as equipment and supplies provided by the medical equipment supplies for administration in a nursing home or group home, shall be billed directly to the Department's Fiscal Agent by medical supply provider.
 - 2. In order to assure accurate and appropriate billing by the medical supplier, the nursing home or group home shall be responsible for providing the following information to the medical supplier within twenty (20) days following the date the supplier delivers the item to be billed. The required information shall be in the form of a certification statement and shall contain the following, as a minimum:
 - a. the name and state ID number for all Medicaid clients provided liquid or gaseous oxygen, or the equipment/supplies necessary for administration, by the medical supplier.
 - b. an indicator of Medicare Part A or B, or other third party resources.
 - c. the name and state identification number for all Medicaid clients utilizing an oxygen concentrator being rented from the oxygen supplier. This applies only to patients in those facilities which choose not to commit to the purchase of concentrators.
 - d. certification guaranteeing that equipment, supplies, and oxygen were used only by the patient for which they were supplied; or in the case of centralized oxygen systems, each client's oxygen usage, expressed in liters.
 - 3. The medical supplier shall bill the Medicaid program based upon the above information provided by the nursing home, using the appropriate HCPCS codes relating to liquid/gaseous oxygen or the equipment/supplies necessary for its administration. Reimbursement shall be made in accordance with the Department's fee schedule or the provider's usual and customary charges, whichever is lower.

B. Oxygen Concentrators Purchased by Nursing Facilities

1. Oxygen concentrators purchased by nursing homes provider on or after March 1, 1991, shall be billed on the nursing home claim form at a fee of \$175.00 per month of service. All supplies, equipment and service, costs associated with the concentrators (purchased after March 1, 1991) are to be covered by the \$175.00 per month fee.
2. Payment of the \$175.00 per month fee shall only continue through service date February 28, 1992. After this date this payment through the nursing home claim form shall no longer be made.
3. Effective with service dates after March 1, 1991, nursing home facilities are permitted to report on their yearly Financial and Statistical (MED-13 Cost Report) the costs associated with the concentrators purchased after March 1, 1991. Such costs include, but are not limited to, all supplies, equipment and servicing expenses.

The nursing homes are to record for verification by the contract auditor the costs incurred with the concentrators purchased after March 1, 1991. These costs are to be segregated by expense; associated with Medicaid residents and non-Medicaid residents.

4. For those cost reporting periods of the various nursing facilities covering the period of March 1, 1991 through February 28, 1992, the following cost settlement process will occur.
 - a. The contract auditor shall make a comparison between the oxygen concentrator Medicaid revenues received by the nursing facility and the oxygen concentrator costs incurred by the nursing home provider for periods consistent with the cost reporting periods of the provider.
 - b. In cases where the audit of this cost report finds oxygen concentrator revenues exceeded oxygen concentrator costs for Medicaid residents the provider shall be found to be overpaid and collection of the overpayment shall occur.
 - c. In cases where the audit of the cost report finds concentrator revenues are less than oxygen concentrator costs for Medicaid residents the provider shall be found to be under paid and shall receive an additional payment from Medicaid to the amount of the underpayment.
 - d. The costs of the oxygen concentrators shall be included in the next rates set by the above mentioned cost reports.
 - e. Allowable costs of oxygen concentrators shall be defined as follows. All concentrators purchased by nursing facilities shall be capitalized over the useful life of the asset. All supplies and service costs are allowable.

C. Oxygen concentrators provided by medical supply companies to Medicaid nursing home residents.

1. These costs shall be billed directly to the Medicaid program by the medical supply company. These costs shall be billed, documented and reimbursed in accordance with the regulation at 8.585.
2. These costs shall not be included on the Financial and Statistical report (MED-13 Cost Report).

8.470 HOSPITAL-LEVEL NURSING FACILITY CLIENTS

This program provides for a payment system for hospitalized Medicaid clients who, due to their need for high-cost hospital care, would not otherwise be admitted and treated in a nursing facility.

8.470.1 Client Eligibility

8.470.1.A. The individual shall meet all Medicaid long-term care requirements.

8.470.1.B. The individual shall be eighteen years of age or older.

8.470.1.C. Third party benefits shall be exhausted before the client shall be approved for the program.

8.470.1.D. The client shall be hospitalized prior to admittance to the program.

8.470.1.E. Clients shall be identified by the Statewide Utilization Review Contractor (SURC) as persons who continue to need hospital level of care but who could also be successfully treated in a nursing facility.

8.470.1.F. The SURC shall certify that a person requesting participation in this program Ms in one of the following groups:

1. Ventilator-dependent clients (3 levels of care),
2. Wound-care clients, or
3. Medically complex clients.

8.470.1.G. The SURC shall have considered all other Medicaid programs and determined them to be unable to meet the client's needs if the client remained at home.

8.470.1.H. The Department shall determine that the cost of treating the client exceeds Class I nursing facilities' reimbursement and that this is the primary reason why the client has not been or will not be discharged to a nursing facility.

8.470.1.I. Prior-authorization by the Department is required for enrollment of clients in Ms program before any payment can be made to a nursing facility.

8.470.2 Facility Requirements

8.470.2.A. Prior to admittance, the facility must submit an application to the Department. The application must demonstrate:

1. Financial stability for corporate and individual facility(ies),
2. Staff stability, and
3. History of survey compliance.

8.470.2.B. The Department may request financial stability and survey compliance be met periodically throughout the facility's participation.

8.470.2.C. The facility shall be Medicaid certified and licensed to provide skilled care.

8.470.2.D. The facility shall be in compliance with the direct client care of participation regulations "Chapter II - General Licensure Standards" and "Chapter V - Long Term Care Facilities" administered by the Colorado Department of Public Health and Environment.

8.470.2.E. The survey reports from the most recently completed standard or abbreviated survey shall show that the facility is not subject to a remedy, unless it has been rescinded, and has not been cited for a quality-of-care deficiency with a severity of E or greater.

8.470.2.F. The Department of Public Health and Environment shall make a recommendation regarding the facility's ability to treat the client.

8.470.2.G. The Department may revoke a facility's authorization to participate in the program if the facility is not in compliance with the regulations or if there is a history of noncompliance.

8.470.2.H. The Department may deny a facility's request for admission into the program if the facility is not in compliance with the regulations or if there is a history of noncompliance.

8.470.2.I. An ineligible facility must wait a period of time determined by the Department, not to exceed six (6) months after achieving substantial compliance, to be eligible to admit new Hospital-level Nursing Facility clients. The period of time shall be based on the type of Technical Assistance Guidelines (TAG) and the scope and severity of the TAG.

8.470.2.J. The facility shall have a transfer agreement with the discharging hospital pursuant to which the hospital agrees to re-admit the client should care problems develop.

8.470.2.K. If the facility has applied to admit ventilator-dependent clients, the facility shall meet the following additional requirements:

1. Staff dedicated to the ventilator unit;
2. A generator that is capable of providing heating, cooling and continuous electricity for needed equipment;
3. Staff that has experience and current training in the care of ventilator dependent clients;
4. A wound care consultant available as needed; and
5. Twenty-four (24) hour on-site coverage by a respiratory therapist.

8.470.2.L. The facility shall use the forms approved by the Department to document the care for Hospital-Level Nursing Facility clients.

8.470.3 Client Screening Procedures

8.470.3.A. When a hospital contacts the facility, the facility shall contact the SURC to obtain needed forms and information. The facility shall complete the following activities:

1. Assess the client on-site (in the hospital) to determine if the facility can provide appropriate care;
2. Notify the client of community based options for which he/she may be eligible;
3. Notify the Department that it is considering admitting the client; and
4. Prepare a care plan on Department approved forms for review by the SURC.

8.470.3.B. The care plan submitted to the SURC shall demonstrate that the facility can adequately meet the needs of the prospective client. The SURC will review care plans to determine whether they meet pre-established standards of care. On the basis of this information and any other medical or demographic

information that the SURC deems necessary to make such a decision, the SURC shall notify the Department in writing as to whether the client can be successfully treated in the nursing facility.

8.470.4 Prior Authorization of Services

8.470.4.A. The SURC shall apply the following criteria in deciding whether to grant an initial prior authorization for Medicaid payments on behalf of applicants for the Hospital-Level Nursing Facility program.

1. Prospective clients shall be pending or approved for Long Term Care and pending or financially eligible for Medicaid.
2. A completed ULTC 100.2, the Department designated assessment forms specifically related to the client's condition, and the PASRR Level I shall be submitted on behalf of the prospective client and must demonstrate that the applicant is medically stable and meets the criteria for one of the following three eligibility groups:
 - a. Ventilator-dependent clients.
 - i) Level III is the highest level of ventilator care. It applies to a client who is actively weaning from the ventilator; requires intermittent ventilator support between two and 24 hours each day; needs skilled nursing or respiratory therapy at least twelve hours each day in order to progress with weaning; requires physical therapy, occupational therapy and/or speech therapy five days per week; and has documented rehabilitation potential.
 - ii) Level II is a moderate level of ventilator care, and requires that the applicant meet the first criterion and at least three of the remaining four criteria: (1) requires continuous ventilator support between eight and 24 hours each day, (2) needs skilled nursing or respiratory therapy at least 6.5 hours each day in order to remain medically stable, (3) requires access to respiratory therapy staff and modality support, (4) has an ADL score of at least 10 on the MDS assessment form and (5) is unable to communicate his/her needs.
 - iii) Level I is the lowest level of ventilator care, and requires that the applicant meet the first criterion and at least three of the remaining four criteria: (1) requires continuous ventilator support between eight and 24 hours each day, (2) needs skilled nursing or respiratory therapy at least 3.5 hours each day in order to remain medically stable, (3) requires access to respiratory therapy staff and modality support, (4) has an ADL score of at least 10 on the MDS assessment form and (5) has difficulty in communicating needs, as evidenced by a score of at least 1 on the speech clarity section of the MDS assessment form.
 - b. Wound care clients must meet the following criteria:
 - i) Have at least one of the following: (1) a complex surgical or traumatic wound, (2) complicated wound graft surgery, (3) at least one stage HI or stage IV pressure ulcer requiring a Medicare-rated group 2 or 3 pressure-relieving surface or (4) a specialized wound-healing device, (e.g., Wound-Vac).
 - ii) Existing nutritional deficiencies are being treated.

- iii) Debridement therapy has been initiated, if indicated.
- iv) The SURC and the designated Departmental staff have individually evaluated whether the applicant is appropriate for placement in a Hospital-Level Nursing Facility.
- v) The applicant has had a consultation with a wound specialist and a resulting treatment plan has been initiated.

c. Medically complex clients must:

- i) Meet all of the following: (1) require at least 5 hours of skilled nursing care each day; (2) be cognitively impaired and/or unable to express their needs; and (3) require close onsite monitoring by a physician at least once per week; and
- ii) Require at least three of the following: (1) gastric tube, nasogastric tube, and/or jejunostomy tube (J-tube), (2) tracheotomy requiring suction at least every two hours, (3) total parenteral nutrition (TPN) with or without lipids, (4) central line in active use for fluids and/or medications, excluding TPN, (5) monitoring which requires skilled intervention at least every 30 minutes in order to avoid a medically life-threatening situation for the client.

3. Initial Length of Stay

- a. The length of stay for the initial prior authorization for every ventilator-dependent client shall be 90 days.
- b. The length of stay for the initial prior authorization for every wound-care client shall be 90 days.
- c. The length of stay for the initial prior authorization for a medically complex client shall be between one and three months.

- 4. When a hospitalized client's care level becomes chronic and the client is approved for the Hospital-Level Nursing Facility Program, the SURC shall notify the client in writing that continued certification for Medicaid payment in the hospital shall be discontinued. The written notice shall notify the client that an alternative placement in a nursing facility has been prior authorized and Medicaid payments will be available to pay for this care.

Should the client disagree with the SURC's and Department's determination as to whether the client can be adequately treated in a nursing facility, the client may appeal such determination in accordance with the appeal procedure described in 10 CCR 2505-10, Section 8.057. Medicaid payment to the hospital shall continue until the appeal is determined by the final agency decision.

- a. When the hospital receives written notice from the Department that it has prior authorized the treatment of the client in a nursing facility, Medicaid payment for hospital care shall be discontinued, and the nursing facility shall be advised of the rate of payment prior authorized to the nursing facility. In cases where the hospital agrees to treat the client at the same payment level as the nursing facility, the client may choose which care provider to use.

8.470.5 Continued Stay Review for Hospital-Level Nursing Facility Clients

8.470.5.A. The SURC shall conduct an onsite continued stay review for each Hospital-Level Nursing Facility client prior to the end of the client's currently approved stay in the program. The purpose of the continued stay review shall be to determine whether (1) the client's care needs are adequately being met, (2) the approved plan of care is being implemented, (3) appropriate services are being provided, (4) the plan of care for the client should be adjusted to more appropriately meet the client's needs, and (5) the client continues to meet the particular eligibility criteria for hospital-level care in a nursing facility. The nursing facility and/or Department may request an unscheduled Continued Stay Review and the SURC shall conduct such review when directed by the Department.

8.470.5.B. If during the Continued Stay Review, the SURC determines that the client's level of care no longer meets the Hospital-Level Nursing Facility criteria, a physician will conduct an additional review. This review will determine whether the client requires the level of care for participation in the program. If this level of care is no longer required, the SURC shall discontinue the client from the program in accordance with the procedures required in the Recipient Appeals Section at 8.057. A copy of the letter shall also be sent to the facility.

8.470.5.C. Length of Stay

1. The length of an approved continued stay for a Level I or Level II ventilator-dependent client shall be one year.
2. The length of the first approved continued stay for a Level III ventilator-dependent client shall be 90 days. Thereafter, the length of an approved continued stay shall be one year.
3. If the client cannot be weaned in six (6) months, a re-evaluation of the level of care shall be completed at the next six (6) month period to determine the level of ventilator care needed.
4. The length of an approved continued stay for a wound-care client shall be 90 days.
5. The length of an approved continued stay for a medically complex client shall be between three (3) months and one (1) year.

8.470.6 Reimbursement of Nursing Facilities Serving Hospital-Level Nursing Facility Clients

8.470.6.A. The Medicaid reimbursement for services provided to a Hospital-Level Nursing Facility client shall be negotiated between the Department and nursing facility in accordance with this subsection.

1. The Medicaid reimbursement for each client shall correspond to the negotiated cost of the services, durable equipment, and supplies approved by the SURC and the Department in the client's plan of care.
2. The Medicaid reimbursement for a Hospital-Level Nursing Facility client shall not be based upon or related to the audited, cost-based reimbursement for a facility's class I nursing facility residents. The appeal rights and procedures applicable to the Department's determination of a facility's class I rate, shall not apply to the reimbursement offered or paid by the Department for a Hospital-Level Nursing Facility client.
3. The Department and nursing facility shall, in good faith, negotiate the Medicaid reimbursement for an approved Hospital-Level Nursing Facility client, both at the time of initial placement in the nursing facility and whenever there is a significant change in the client's approved plan of care or other relevant circumstances.
4. In the event that the Department and nursing facility are unable to reach agreement on an appropriate level of Medicaid reimbursement for a Hospital-Level Nursing Facility client,

arrangements shall be made for the discharge of the client to another appropriate placement. Until that discharge and transfer have been completed, the Department shall continue to reimburse the nursing facility for the client's care at the most recently agreed level of reimbursement.

8.470.6.B. Under no circumstances shall the payment for a Hospital-Level Nursing Facility client exceed ninety percent (90%) of the Medicaid payment to the discharging hospital.

8.470.6.C. Payments for such a client shall not be approved should the Department determine that third party coverage (private insurance or Medicare) of the client will cover the care of the clients in either a hospital or nursing facility.

8.470.6.D. The Medicaid reimbursement for Hospital-Level Nursing Facility clients (hereafter referred to in this paragraph as "hospital-level reimbursement") shall not be allowed to impact the Medicaid per diem cost and rate set for the facility's class I Medicaid clients based on the MED-13 cost reporting process.

8.470.6.E. The hospital-level reimbursement shall be reported on the MED-13 cost report form in the following manner so that it does not impact the class I Medicaid per diem rate established by the cost report:

1. The hospital-level reimbursement shall be included on the appropriate line in columns 1-8 on Schedule C.
2. Offset of the hospital-level reimbursement shall be made on Schedule B with a detailed supplemental schedule attached.
3. Drugs and oxygen shall be billed directly to Medicaid by providers.

8.470.7 Termination of Program

8.470.7.A. This program may be terminated by the Colorado Medical Services Board should they find the program is not cost effective.

8.470.7.B. Should the program be terminated, the Department shall instruct the SURC to authorize the certification for readmission of clients from this program back into hospitals. Upon such certification, the Department shall make Medicaid payments to the readmitting hospital.

8.481 MEDICAL REVIEW/INDEPENDENT PROFESSIONAL REVIEW

The Department has entered into a Memorandum of Understanding with the Colorado Foundation for Medical Care (PRO) for the conduct of medical review in skilled nursing homes and independent professional review in intermediate care facilities.

The PRO, under the terms of its agreement with the Department and with the Department of Health and Human Services, Section 1151 et seq. of the Social Security Act and the rules and regulations of the Department of Health and Human Services shall establish procedures for the review program. Such procedures as established pursuant to the plan of review approved by the Department pursuant to the Memorandum of Understanding between the Department and the Colorado Foundation for Medical Care shall cover the following areas of review:

- A. Medicaid residents' need for admission;
- B. Need for continuing care;
- C. Quality of care;

- D. Facility assessment of care provided in the facility;
- E. Adequacy and quality of services provided; and
- F. Where applicable, plans for care and rehabilitation.

8.481.1 RESPONSIBILITY OF NURSING HOMES IN MEDICAL REVIEW PROCESS

It shall be the responsibility of all nursing homes participating in the Colorado Medical Assistance Program to cooperate with the PRO in its conduct of Medical Review/Independent Professional Review, and to follow those requirements and procedures set forth by the PRO, pursuant to the plan for review as approved by the Department pursuant to the Memorandum of Understanding between the Department and the Colorado Foundation for Medical Care.

8.482 RESIDENT INCOME AND POSSESSIONS

8.482.1 PURPOSE AND LIMITATIONS

Resident income, whether contributed or direct, shall be used for the care of the resident, except for 2 personal needs allowance as set forth in 8.482.5.

No person, institution, partnership, corporation or other entity shall divert resident income from the control and exclusive use of the resident, without proper legal authorization or power.

8.482.2 DEFINITIONS

- A. "Contributed income" is defined as the amount of income of parent or unrepaid spouse, over and above the needs of such spouse or parent which is contributed toward the needs of the resident.
- B. "County Department" is defined as the County Departments of Social Services.
- C. "Department" is defined as the Colorado Department of Health Care Policy and Financing.
- D. "Direct income" is defined as payments made directly to the resident, or to a conservator or guardian for the exclusive use of the resident. Examples of such income are Social Security benefits, supplementary security income, railroad or other retirement benefits.
- E. "Nursing facility" is defined as an intermediate or skilled care facility, the owners, administrators, and staff thereof.
- F. "Personal needs" is amount specified in 8.110.42 to be deducted from resident income, and used for the exclusive benefit of the resident prior to application of income to nursing facility care.
- G. "Resident income" is defined as all income used in the determination of eligibility for Medicaid payments.
- H. "Patient payment" is defined as the payment made by the resident for nursing facility care, after the personal needs allowance is deducted.
- I. "Responsible Party" is defined as any of the persons below, who accepts the responsibility for a resident's funds, mail or personal possessions and is willing to sign a written declaration of such responsibility:
 - 1. a legally appointed guardian, conservator or trustee;

2. relative or friend;
3. the county department.

J. "Post Eligibility Treatment of Income (PETI)" is defined as the reduction of resident payment to a nursing facility, for the costs of care provided to an individual by the amount that remains after certain deductions are applied to reduce the individual's total income. The individual is liable to pay the remaining amount to the institution.

8.482.3 RESIDENT INCOME

The control of resident income is vested in the resident, or in such person as the resident may designate. Such designee may be a conservator, administrator, family member or other representative. The income is to be used by the resident, or on behalf of the resident. No such designee, or any other person or institution, shall convert any of these monies to their own use for any reason.

8.482.31 DETERMINATION OF INCOME

- A. The initial determination of resident income shall be made by the county department. The county department shall then notify the nursing facility of current resident income as detailed in Section 8.482.34, B.
- B. The nursing facility must notify the county immediately of any changes in resident income. And, if the facility is authorized to receive the resident's income, the facility has the duty and obligation to verify the amount of resident income.
- C. If the nursing facility is not authorized to receive the payments for resident income, it is the responsibility of the resident, or the person administering such income on behalf of the resident, to report all changes in such income, as required by the Colorado Department of Human Services Income Maintenance Staff Manual, Volume 3, under the penalties set forth in Section 8.482.45 of this Staff Manual.

8.482.32 COLLECTION OF INCOME

A. Responsibility of Nursing Facility

1. It shall be the responsibility of the nursing facility to collect from the resident, or from the resident's family, conservator or administrator, all income which is to be applied to the cost of resident care. The Department is not responsible for any deficiency in patient payment accounts, due to failure of the nursing facility to collect such income.
2. If, however, the nursing facility is unable to collect such funds, through refusal of the resident or the resident's family, conservator, or administrator to release such income, the nursing facility shall immediately notify the county department.

B. Responsibility of County Department

When notified by the nursing facility of the refusal of the resident or the resident's family, conservator or administrator to release resident income due, the County Department shall immediately contact the refusing party. If, after such contact, the party still refuses to release such income, the action shall be deemed a failure to cooperate. and the county department shall proceed to discontinue Medicaid benefits for the resident.

8.482.33 POST ELIGIBILITY TREATMENT OF INCOME

Effective April 8, 1988, with respect to the post-eligibility treatment of income of individuals who are institutionalized there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by Colorado Medicaid or third party insurance, including health insurance premiums, deductibles or co-insurance, dental care, hearing aids, supplies and care, and corrective lenses, eye care, and supplies, and other incurred expenses for medical or remedial care that are not subject to payment by a third party.

A. All PETI expenses in excess of \$400 per calendar year must be prior authorized by the Department or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supplies, to validate that the requested expense is not a benefit Of the Medicaid program, and to determine if the expenses requested are a duplication of expenses previously prior authorized.

B. Health insurance premiums, deductibles, or co-insurance as defined by state law.

1. Monthly premium payment paid by the resident for health insurance. If payments exceed the patient payment amount for one month, a monthly average is calculated by dividing the total premium by the number of months of coverage. The resulting amount is to be applied as a monthly PETI expense for the months of coverage.
2. Medicare premiums are not an allowable deduction except in "medical only" eligibility cases and only for me first two months not covered by Medicaid.
3. Health insurance premiums will be allowed for the resident only.
4. Health insurance premiums will only be allowed if the health, insurance information is entered into the automated system for purposes of third party recovery.
5. Health insurance premiums, deductibles, and coinsurance must be reviewed by the Department or its designee for final approval. If duplicate coverage has been purchased, only the cost of the least expensive policy will be allowed. Premiums, deductibles and co-insurances which the Department or its designee determine to be too expensive in relation to coverage purchased shall not be allowed.

C. The allowable expenses for special medical services (dental care, hearing corrective lenses) are subject to the following criteria:

1. General Instructions (applies to all special medical services).
 - a. All PETI expenses exceeding \$400 per calendar year for equipment, supplies, or services must be authorized by the Department or its designee to be considered an allowable cost.
 - b. Costs will be allowed only if they are not a benefit of the Medicaid program, or not a benefit of other insurance coverage the resident may have.
 - c. All allowable costs must be documented in the resident's record with date of purchase and receipt of payment, whether or not these costs meet the requirements for prior authorization. Lack of documentation shall cause the patient payment deduction to be disallowed, causing the provider to be overpaid by the Medicaid program.
 - d. All allowable costs must be for hems that are medically necessary as described in 8.011, and medical necessity must be documented by the

attending physician. The physician statement must be current, within one year of the authorization.

- e. The resident or legally-appointed guardian must agree to the purchase of the service/equipment and related charge, with signed authorization in the residents record.
- f. Nursing facilities are not permitted to assess surcharge or handling fee to the residents income.
- g. For special medical services/supplies provided but not yet paid for, the encumbrance agreement and monthly payment schedule must be documented in the resident's record, as well as receipts of payment.
- h. The allowable costs for services and supplies may not exceed the basic Medicaid rate.
- i. In the case of damage or loss of supplies, replacement items may be requested with relevant documentation. If the damage or loss is due to negligence on the part of the nursing facility, the nursing facility is responsible for the cost of replacement.
- j. Costs will not be allowed if the equipment, supplies or services are for cosmetic reasons only.
- k. If the client does not make a patient payment; then no PETI will be allowed.
- l. PETI payments may not exceed the patient payment Payments made over a period of time shall only be allowed if the provider agrees to accept installment payments.

2. Dental Care Instructions

- a. Prescription of dentures (partial or full plate, fixed or removable) must be made by a licensed dentist (Doctor of Dental Surgery, Doctor of Medical Dentistry).
- b. The prescription (as defined in Section 8.482.33.2.a.) must be part of a comprehensive evaluation to determine the medical necessity and suitability for wearing dentures.
- c. Oral and maxillofacial surgery that is required to render soft-tissue and bony structures suitable for wearing dentures must be prior authorized by the Department as defined in Sections 8.200.10 and 8.200.30.

3. Hearing Aid Instructions

- a. All referrals for hearing aids must be certified by the attending physician, and must include an evaluation for suitability and specifications of the appropriate appliance, in accordance with Section 8.287.02.
- b. Purchase of new hearing aids to replace pre-existing hearing aids must include documentation of necessity of replacement of the pre-existing hearing aid. The documentation shall also describe the trade-in value given for the pre-existing aid, if appropriate.

4. Corrective Lenses Instructions

- a. The evaluation of the need for corrective eyeglasses (lenses) must be a part of a comprehensive general visual examination conducted by a licensed ophthalmologist or optometrist.
- b. The medical necessity for prescribed corrective lenses should not be based on the determination of the refractive state of the visual system alone, but should be identified by the current procedural terminology in the Physician Current Procedures Terminology (CPT) Code as established by the American Medical Association. This document is available through the American Medical Association, 515 North State Street, Chicago, Illinois 60610 or <http://www.ama-assn.org/catalog>. The document referred to does not include later amendments to or editions of the CPT4. Copies are available for inspection and available at cost at the following address: Director, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any State Publications Depository Library.

D. Prior Authorization Request Process:

For allowable PETI expenses that exceed \$400 per client in a calendar year, costs must be prior authorized by the Department or its designee. The process is as follows:

1. Prior authorization requests must be submitted to the Department or its designee on the form prescribed by the State. In addition to the information requested on the form, the following attachments must be included:
 - a. A description of the service or supply, and the estimated cost.
 - b. A physician's statement indicating the medical necessity of the service or supply.
2. Prior authorizations will be certified based on the following criteria:
 - a. The request is not a benefit of the Medicaid program.
 - b. The cost of the request does not exceed the basic Medicaid rate for such services or supply.
 - c. The special medical service or supply is medically necessary.
3. The Department or its designee shall review and approve/deny the Prior Authorization Request within ten working days of receipt
4. Upon receipt of the approved Prior Authorization Request (PAP), the nursing facility shall adjust the patient payment by the amount authorized on the following month's Medicaid billing or on the nursing facility's next billing cycle.
5. All documentation of the incurred expenses must be available in the client's financial and medical record for audit purposes. Lack of documentation shall cause the patient payment deduction to be disallowed causing the

provider to be overpaid by the Medicaid program.

8.482.34 THE “STATUS OF NURSING FACILITY CARE” FORM, AP-5615

A. Responsibilities of the Nursing Facility

1. The AP-5615 form is to be completed by the nursing facility, in duplicate, for all admissions, readmissions, transfers from private pay or Medicare, discharges, deaths, changes in income and/or patient payment, and leaves of absence.
2. Each form must carry the date completed and the actual signature of the nursing facility administrator or his/her authorized representative.
3. All copies of the AP-5615 must be mailed to the appropriate county department within five working days of the action which is being reported, or in the case of a change in resident income, within five working days of the time the change becomes known, in order to expedite reimbursement.
4. The nursing facility will be responsible for assuring that the patient payment, as shown on the AP-5615 and approved by the County Department, is identical to that claimed on the monthly nursing facility, billing form. Failure to enter the latest patient payment data on the billing form will render the nursing facility liable for any discrepancies.

B. Responsibilities of the County Department

On receipt of Form AP-5615, the county department will, within five working days:

1. For an admission, a readmission or a transfer from/to private pay or Medicare:
 - a. Verify and correct, if necessary, data entered by the nursing facility.
 - b. List and/or verify the resident's monthly income; and compute patient payment. Distribute completed form as instructed on back of form.
 - c. Correct the automated system to indicate the nursing facility name and provider number and to reflect the current distribution of income. Submit the AP-5615 to the Department.
2. For change in patient payment with respect to changes in resident income:
 - a. Verify changes in resident income, and correct if necessary. All such corrections must be initialed,
 - b. Correct eligibility reporting form and submit to state department
3. For change in patient payment with respect to the post-eligibility treatment of income, the county department shall:
 - a. Review the AP 5615 for Medicare premium deduction allowances for the first two months of admission or readmission.
 - b. If client is already on the Medicare Buy-In program, do not adjust patient payment on Form 5615 for the Medicare premium deduction. If client is not on the Buy-In program, adjust Form 5615 for the Medicare premium deduction for the first two months of nursing facility eligibility.

4. For resident leave of absence:

- a. Non-Medical/Programmatic Leave. Verify adherence to the restrictions and conditions of Section 8.482.44.
- b. Medical Leave. Verify that the charges made to the resident or the resident's family are correct and that no Medicaid payment is requested for the period. See also Section 8.482.43.

5. For discharge or death of resident:

- a. Verify the date of death or discharge, and verify the correct patient payment (or resident's monthly income) for the discharged month, and the amount calculated by per diem. All corrections must be initialed.
- b. Note if the resident entered another nursing facility and, if so, provide the name of the new nursing facility. This information is needed to assure that duplicate payment will not be made.
- c. In the event the resident may return to the same facility, the AP-5615 may be completed at the end of the month for discharges due to hospitalization.
- d. Make necessary changes on the automated system to reflect the appropriate circumstances. Submit the AP-5615 to the Department

6. Failure to submit the correct form may result in the refusal of the Department to reimburse such nursing facility care.

7. General Instructions:

- a. The AP-5615 form must be verified and the original returned to the nursing facility.
- b. The AP-5615 form must be signed and dated by the director of the County Department, or by his/her designee.
- c. AP-5615 forms may be initiated by either the nursing facility or County Department. If the County Department is aware of information requiring a change in financial arrangements of a resident, and a new AP-5615 form is not forthcoming from the nursing facility, the County Department may initiate the revision to the AP-5615. In such case, one copy of the AP-5615 showing the changes, will be sent to the nursing facility.

8. The Department may deduct excess payments from the county administrative reimbursement as stated in the Colorado Department of Human Services Finance Staff Manual, Volume 5 if the County Department fails to:

- a. Perform the duties as detailed in section B; or
- b. Adhere to the limitations on \$0.00 patient payment; as detailed in Section 8.482.34, D.; or
- c. Notify the nursing facility immediately of any changes in resident income, provided the nursing facility is not authorized to receive the resident's income; and excessive Medicaid funds are paid to the nursing facility as a result of this negligence.

C. Calculating Partial Month Payments

1. Whenever a resident is in the nursing facility on the first day of the month, remains a resident for each day of the month, and is still a resident on the first day of the next month, the total resident income, in excess of the amount reserved for personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, less home maintenance allowance, and less allowable expenses for medical and remedial care (see PETI deductions as defined in Sections 8.110.49 and 8.482.33) will be used as the patient payment, regardless of the actual number of days in that month. If the resident is in the facility less than this period, the rate is computed using the calculation below.
2. In figuring the number of days for payment, the day of admission is included, but not the day of discharge (i.e., the resident dies or leaves the facility).
3. In order to calculate the patient payment:
 - a. determine the amount of available resident income for the month (see subsection 1. above).
 - b. subtract the cost of the care provided to the resident during that month (computed by multiplying the number of days in the facility times the per diem cost of care).
4. If the cost of care exceeds the available resident income, Medicaid will pay the difference. If the available resident income exceeds the cost of care, the excess income is the property of the resident (8.482.3) and must be refunded to the resident or the legal guardian/designated responsible party.
5. When patient payment is calculated by per diem, the final amount shown will be that amount to be paid by the resident, not the amount to be returned to the resident
6. If, at the time the resident is discharged or dies, the patient payment for that month is greater than the properly computed per diem patient payment, the following rules apply:
 - a. If the resident is discharged to another nursing facility, or to the resident's own home, the excess patient payment and personal needs monies must be forwarded to the resident in his/her own home or in the transferred nursing facility, within 45 working days of the date of discharge.
 - b. If the resident is discharged to a hospital, other medical institution, or if the resident dies, the excess patient payment must be immediately transferred from the nursing care account to the resident's personal needs account. These funds then are to be disposed of as detailed in Section 8.482.52, F. If the nursing facility does not handle the resident's personal needs funds, the excess patient payment must be immediately returned to the responsible party.
 - 1) However, if the resident is discharged from the nursing facility to a hospital or other medical institution and is admitted with Medicaid as the primary source of funding, the patient payment in excess of the amount due to the discharging nursing facility may be due to the hospital or medical institution. Any excess patient payment should be sent to the hospital at the end of the month (see 8.358.1). If the resident discharged to a hospital or other medical institution is not readmitted to the nursing facility, the resident's funds, either excess patient payment or personal needs, must be lawfully disposed of as indicated in 8.482.52, F.

- 2) If the resident dies in the nursing facility or is discharged to a hospital or other medical institution where he/she subsequently dies, the resident's funds entrusted to the nursing facility must be transferred as indicated in 8.482.52, F.

7. Changes of financial status within the facility:

- a. Residents transferring from private pay to Medicaid may have a patient payment liability for the Medicaid-funded portion of the month depending on the amount of income applicable to care, as determined on the AP-5615 form.

If the resident's income exceeds the cost of care paid for the private resident portion of the month, the excess income is applicable to the remaining Medicaid portion of the month.

- b. The same patient payment calculation applies for residents transferring from Medicaid to private pay status. The patient payment is first applied to the Medicaid portion of the month and any excess is then applied to the remaining private pay days.

D. Zero Patient Payment

1. Patient payment may be waived and zero \$0.00 patient payment applied only under the following conditions:

- a. A resident's income is equal to or less than the personal needs allowance (see 8.110.42); or
- b. A resident's income is equal to or less than the personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, or less home maintenance allowance, or less allowable expenses for Medicare premiums (see PETI deductions as defined in Sections 8.110.49, and 8.482.33); or
- c. A resident is admitted to the nursing facility from his/her home and the resident's funds are committed elsewhere for that month; or
- d. The resident is admitted from his/her home, where his/her funds were previously committed, to the hospital, and subsequently to the nursing facility, in the same calendar month; or
- e. The resident is discharged to his/her home, and the county department determines that the income is necessary for living expenses; or
- f. The resident is admitted from another nursing facility or from private pay within the facility and has committed the entire patient payment for the month in payment of care already provided in the month of admission.

2. Patient payment may not be waived (other than for the exceptions provided for in 8.482.34,D.1.) in the following instances:

- a. A resident with income in excess of the personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, or less home maintenance allowance, or less allowable expenses for Medicare premiums (see PETI deductions as defined in Sections 8.110.49 and 8.482.33), except as provided in the Colorado Department of Human Services Income

Maintenance Staff Manual Volume 3, concerning increased personal needs allowance; or

- b. Transfers between nursing facilities; or
 - c. Discharges from nursing facility to a hospital or other medical institution; or
 - d. Changes from private pay within the facility and patient payment not already committed for care provided; or
 - e. The death of the resident
3. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment

8.482.4 NO DUPLICATE OR ADDITIONAL PAYMENTS

8.482.41 DUPLICATE PAYMENTS

A. "Duplicate payment" is defined as:

- 1. Payment to two or more facilities, hospitals or other institutions for per diem or room and board care for the same resident for the same time period;
- 2. Payment from two sources, including but not limited to, Medicare and Medicaid, for the same service to the same resident. Supplementary payments in which each source pays a portion (not overlapping) of the total due, is not considered duplicate payment.

B. Duplicate payment shall not be made:

- 1. To a hospital and a nursing facility for the same period of time for care of any one resident;
- 2. To two or more nursing facilities for the same period of time for the care of any one resident;
- 3. For any other instance, whether billed by the provider in good faith or in error.

C. Any provider billing for such duplicate services for any period of time during which the resident was not actually in the facility or the resident did not actually receive any facility billing for services will be subject to the penalties as set forth in 8.482.45.

D. In any instance in which duplicate billings result in Medicaid reimbursement to both providers, a recovery shall be made by the Department against one or both providers.

8.482.42 ADDITIONAL PAYMENTS

A. "Additional payments" are defined as payments made by the resident, or by a resident's family, conservator or administrator for items which are not a benefit of the Medicaid program, such as:

- 1. Items covered in Section 8.442.1, Services and items not included in the Per Diem Rate (chargeable to Patient Trust Funds).
- 2. Room reservations for medical leave in accordance with Section 8.482.43.
- 3. Room reservations for non-medical and/or programmatic leave days in excess of 42 days per calendar year in accordance with Section 8.482.44.

4. Limitations covered in Section 8.462.
- B. Additional payment for resident care and services which are to be furnished within the nursing facility per diem rate are specifically prohibited (Section 8.442). The nursing facility can neither solicit additional funds for such care and services nor accept voluntary monetary contributions for them, from residents or responsible parties. Any such monies collected or accepted by the nursing facility shall render such facility liable for the penalties set forth in 8.482.48.
- C. Additional payments may be charged for:
1. Services and items not included in the per diem rate, as specified in Section 8.442.1. These items may be billed to the resident, to the resident's estate or other responsible party, subject to the restrictions set forth in Section 8.442.1.
 2. Room reservations. "Room reservation" is hereby defined as that charge made to a resident or to a resident's family, conservator or administrator, or other responsible party, to retain the resident's room and provide space for clothing and other personal items during the time which the resident is absent from the facility. Room reservation charges may be made under the circumstances outlined at Sections 8.482.43 and 8.482.44.
 - a. Medical leave. See Section 8.482.43 for conditions and restrictions.
 - b. Non-medical and/or programmatic leave. See Section 8.482.44.
- D. Failure to comply with the following restrictions on additional payment will render the nursing facility liable for repayment of any such funds, or to prosecution as set forth in 8.482.45, or both:
1. Exact physician's orders on the nursing facility charts, for such additional care or services;
 2. Fully itemized billings to the resident or responsible party;
- E. Additional payments by persons other than the resident shall not be regarded as income to the resident, and shall not affect the eligibility of the resident for the Medicaid program.
- F. Additional payments may not be deducted from the resident's personal needs funds, nor may they be applied to a PETI deduction as described in 8.482.33, unless authorized by such resident or the party responsible for such resident. Such authorization must be a separate written authorization for each billing from the nursing facility.

8.482.43 MEDICAL LEAVE FROM NURSING FACILITY

- A. Definition. "Medical leave" is defined as absence of the resident from the nursing facility due to admittance to a hospital or other institution.
- B. Medical leave, as addressed in this section, is subject to the following restrictions:
1. Such absence of the resident must be on the specific orders of a physician, as noted in the resident's chart;
 2. There must be a presumption by the doctor and by the resident that the resident will return to the nursing facility;
 3. The nursing facility must prepare an AP-5615 showing the dates such medical leave commenced and ended. See Section 8.482.34.

4. The resident, or the responsible party if the resident is unable to respond, must be advised, in writing, that payment for holding the nursing facility room cannot be made by Medicaid. In addition, he/she must give written consent to the additional charge, both the daily rate thereof and the anticipated number of days. If the resident is absent from the facility longer than the anticipated number of days shown on the consent form, the nursing facility must obtain agreement on another consent form before continuing to charge for medical leave. The consent form(s) must be retained with other resident records and be subject to audit.

C. Room reservation charges for Medical leave:

1. The per diem charge for room reservations for medical leave cannot exceed the per diem rate currently authorized for the nursing facility, less total food and linen service costs. In no case shall the charge be greater than the current per diem rate less \$2.
2. The specific bed which the resident had occupied prior to leave must be reserved. No other resident may occupy a bed so reserved.
3. If no source of payment, other than the resident's funds, are available, and the nursing facility's current occupancy is less than 90 percent of capacity, the room must be reserved at no charge to the resident.
4. Revenues to the nursing facility from room reservations must be used in reduction of related expenses, on the MED-13 form.
5. If no other funds are available, the room reservation charges may be deducted from the resident's personal needs funds, subject to the restrictions in Section 8.482.42. However, the resident's personal needs must retain at least \$10 at all times, if used for room reservations payment. In case of death of the resident, the entire personal needs account may be used, if necessary.

8.482.44 Room Reservations for Non-Medical and/or Programmatic Leave

Medicaid will pay a nursing facility to hold a bed for non-medical and/or programmatic leave days up to a combined total of 42 days per resident per calendar year.

Non-medical leave days are defined as days of leave from the nursing facility for non-medical reasons. Programmatic leave days are days of leave prescribed by a physician for therapeutic and/or rehabilitative reasons. Programmatic leave may entail visits to family, friends or guardians, or leave to participate in approved therapeutic and/or rehabilitative programs. A leave day is considered to have been incurred for any day during which the resident is absent from the nursing facility for therapeutic and/or rehabilitative purposes and does not return by midnight of that day.

Before Medicaid payment is made for room reservation costs for non-medical and/or programmatic leave, the attending physician must approve each leave and affirm that such leave is not contrary to the resident's written plan of care. In the case of programmatic leave, this approval must be in writing and noted on the resident's chart and/or Individual Habilitation Plan (IHP). In addition, the physician must affirm that the resident's programmatic leave is of therapeutic and rehabilitative value and consistent with the overall plan of care and/or Individual Habilitation Plan developed for the resident.

If the resident has the approval of the attending physician in writing, and such approval is noted on the resident's chart, room reservations for non-medical and/or programmatic leave may be paid for by the resident, after the allowable 42 days per calendar year has been paid from Medicaid funds. Charges to residents for this leave are subject to the following restrictions:

- A. Such charges must not commence until after 42 days of non-medical and/or programmatic leave in any one calendar year.
- B. The Medicaid Program has not been billed for such leave. Billing both Medicaid and the resident for the same leave period will subject the nursing facility to the penalties as set forth in 8.482.45.
- C. The resident or the resident's family must be advised that payment for the nursing facility room cannot be paid from Medical Assistance funds after the resident's allowable leave has been consumed. In addition, the resident and/or legal guardian must give written consent to the room reservation charges, both the daily rate and the anticipated number of days. The consent form must be retained with other resident records and subject to audit.
- D. The maximum allowable charge for non-medical and/or programmatic leave is the same as stated for medical leave in paragraph C of Section 8.482.43.
- E. The specific bed which the resident occupied prior to leave must be reserved. No other resident may occupy a bed so reserved.
- F. Revenues to the nursing facility from room reservations must be used in reduction of related expenses, on the MED-13 form.
- G. In no case shall the nursing facility deduct non-medical and/or programmatic leave charges from the resident's personal needs account, unless specific authorization has been received, in writing, from the resident and/or legal guardian.

8.482.45 PENALTIES

- A. Obtaining vendor payments fraudulently, as outlined in 26-1-127, C.R.S (1995 Supp).
- B. Obtaining additional payments from residents, or resident's families, as outlined in 26-4-112, C.R.S 1989.
- C. License may be revoked according to the provisions of 25-3-103, C.R.S.
- D. Falsification of reports as outlined in 26-1-127, C.R.S, (1995 Supp.)
- E. Incorrect payments due to omission, error or fraud may be recovered as outlined in 26-4-112(2), C.R.S 1989.
- F. Duty of resident to report changes in income and penalties for non compliance, as outlined in 26-2-128, C.R.S (1995 Supp.).
- G. In addition to all penalties imposed above, the Department may also require the reimbursement of the entire amount of any benefits unlawfully obtained.

8.482.46 UTILIZATION OF MEDICARE BENEFITS

- A. Services and equipment which are a benefit of Medicare, as described in 42 CFR 405.230-252, must be billed to Medicare before billing Medicaid. The CFR 405.230-252 refers to the Code of Federal Regulations, Part 400 to end, Published by Office of the Federal Register, National Archives and Records Service, General Services Administration, as a Special Edition of the Federal Register. This document is for sale by the Superintendent of Documents, U.S Government Printing Office, Washington, D.C., 20402. The document may also be examined at any State Publications

Depository Library.

- B. Part "B" deductible and co-insurance amounts for Medicare-eligible Medicaid recipients will be reimbursed by Medicaid. Reimbursement will be made for any service covered by Part "B" of the Medicare program, as described in 42 CFR 405.230-.252, even though that service is not ordinarily covered under the medical assistance program. The services paid for by Medicare cannot be included in costs for calculation of the nursing home provider's daily reimbursement rate. If Medicare Part "B" type services are provided by the facility and the facility has a provider number which it used to bill Medicare, then the following entries must be made to the cost report (MED-13) :
1. The cost of the care reimbursed by Medicare and/or Medicaid crossover for residents who are Medicaid recipients may be deducted from Schedule "C" of the MED-13 Schedule "B" if the costs for providing that care are determinable and auditable; or
 2. The Medicare and/or Medicaid crossover revenue for residents who are Medicare eligible will be deducted from Schedule "C" on Schedule "A".
- C. When the facility provides Medicare Part "B" type services to non-residents of the facility, the following entries must be made to the cost report (MED-13) :
1. Cost of the care reimbursed by Medicare and/or Medicaid crossover for non-residents of the facility must be deducted from Schedule "C" of the MED-13 on Schedule "B" if the costs for providing that care are determinable and auditable; or
 2. The Medicare and/or Medicaid crossover revenue for non-residents of the facility must be deducted from Schedule "C" on Schedule "A".
- D. Co-insurance and deductible costs for the following services (which are covered by Medicare Part "B") may be billed to the Medicaid program without prior authorization:
1. Laboratory Services
 2. Medical Supplies
 3. Durable Medical Equipment
 4. Speech Therapy
 5. Occupational and Physical Therapy
 6. Practitioner Services
- E. Facilities or their suppliers when billing the Medicaid program for those services reimbursed by Medicare, are to use the Medicare/Medicaid crossover system of billing. The facility, in order to bill through the Medicare/Medicaid crossover system, needs only to Complete a Medicare billing form and indicate on that form that they wish to "accept assignment." A Medicare claim form for a Medicare/Medicaid patient, indicating acceptance of assignment, will cross over to Medicare, and co-insurance and/or deductibles will be paid on a Medicaid remittance advice.

8.482.5 RESIDENT'S PERSONAL NEEDS FUNDS

8.482.51 STATEMENT OF POLICY

- A. All residents receiving nursing facility care are allowed to retain the amount of income specified in

Section 8.110.42 as personal needs funds, to purchase necessary clothing or incidentals. These funds may not be used to supplement the Medicaid nursing facility payment, and such funds cannot be used for any other purpose whatsoever by the nursing facility.

- B. Personal needs money is for the exclusive use of the resident as he/she desires. The resident or relatives may not be charged for such items as Chux, tripads, toilet paper, or other nursing facility maintenance items since these items are included in the audited cost described in Section 8.442. Other charges which could be disallowed are as follows:

1. Nursing facility maintenance items and nursing care supplies and services.
2. Charges without the following documentation:
 - a. vendor receipts;
 - b. signed cash receipts; or
 - c. statement signed by the resident for any specifically requested over-the-counter drug.
3. Charges which constitute a duplicate payment as defined in 8.482.41.
4. Charges which constitute an additional payment as defined in 8.482.42.
5. Handling charges, such as personal needs trust account bank service fees.

- C. Items not covered by Medicaid, such as personal items, clothing, private room, etc., may be charged to the personal needs account of the resident. However, all of the restrictions of Section 8.442.1 apply. In addition, only those items actually requested by the resident may be charged to his/her personal needs funds, and there must be a signed, dated receipt for each such item or service signed by the resident, the resident's conservator, guardian or relative, or by a responsible party, retained in the resident's accounts.

8.482.52 RESPONSIBILITIES OF NURSING FACILITIES

A. General Accounting Practices

1. Nursing facilities must administer a resident personal needs fund for those residents who are unable to or have no desire to handle their own personal needs monies. The nursing facility is obligated to exercise due care in the handling of resident funds per federal regulations.
2. If a resident elects to have the nursing facility handle his/her personal needs monies, a personal needs trust agreement must be entered into and signed by the resident or the resident's legal personal representative. This agreement creates a fiduciary relationship between the nursing facility and the resident which includes the legal rights and responsibilities provided for in 15-1-101, C.R.S. 1987. As a condition of the trust agreement, the nursing home is allowed to return the personal needs allowance portion of the resident's income. (See Section 8.110.42).
3. If the resident or responsible party does not elect to have the facility handle the personal needs monies, the resident or responsible party must enter into and sign a personal needs exclusion agreement with the facility.
4. If the total personal needs trust fund balance is less than \$50.00, the resident's personal needs trust fund monies may be held in either an interest or non-interest-bearing

account with a depository institution or in cash at the facility.

5. If the total personal needs trust fund balance is \$50.00 or more, the resident's personal needs funds must be kept in an interest-bearing account. The account can be a checking account, a savings account, or a certificate of deposit.
6. The bank account must be designated as "resident trust funds account."
7. The funds in the depository institution (most often a bank) must be insured.
8. The personal needs trust monies must not be commingled with either the operating funds of the facility or with any other individual's fund who is not a resident of the facility.
9. The personal needs monies of more than one resident can be commingled in the same bank account as long as separate accounting records (i.e., subsidiary ledgers) are maintained.
10. No charge for handling such trust accounts may be made to the recipient or to the estate of the recipient at any time. Such expenses should be included as a part of the audited costs as determined in 8.440.
11. A subsidiary ledger, as specified by the Department, must be kept for each resident for recording personal needs transactions.
12. A reconciliation of the sum of the ledger balances to the bank balance (plus petty cash, if applicable) must be performed on a monthly basis.
13. Deposits and disbursements from the personal needs trust account must be recorded in an accurate amount and in accordance with 8.482.51.B for purchases and 8.482.52.F for refunds.
14. Any interest income must be recorded on the ledgers. If the resident trust funds are pooled in one interest-bearing account, the interest earned on the account must be allocated to each resident's account proportionately (i.e., by dividing the individual resident's account balance by the total personal needs trust fund balance then multiplying that quotient times the amount of interest income).
15. The resident shall be notified when his/her personal needs trust fund balance reaches \$200 less than the SSI resource limit as provided in 8.110.53.A
16. This accounting system must be adequate for audit by the representative of the Department, and in accordance with generally accepted accounting principles.
17. All such accounts, original bank statements, and supporting documentation must be available for audit by any authorized employee of the county department, State Department, or agent of the State Department at any time.
18. Personal needs money is the property of the residents and all accounting records, bank accounts and other documents must remain with the nursing facility when ownership is transferred.

B. Bonding Requirements

1. An additional condition of nursing facility participation in the Medicaid program is the purchase of a surety bond as required by Section 26-4-504(3)(c), C.R.S. The sum of the surety bond must not be less than the personal needs trust fund liability as computed quarterly

during interest proration, or the licensed operator ("licensee") shall otherwise demonstrate to the satisfaction of the Department that the security of the residents' personal needs funds is assured. State owned/operated facilities are bonded separately under the risk management program up to \$100,000 and are exempt from this requirement.

2. The effective dates of the surety bond shall be from January of each calendar year through December 31 of the following calendar year. The nursing facility licensee's Medicaid participation shall be terminated immediately upon lapse of such bond.
3. A copy of the Surety Bond Patient Needs Trust Fund (Form MED-181), or the Certificate of Insurance (Surety Bond), fully executed, signed and sealed, shall be filed with the Department within 15 days prior to the effective date thereof.
4. Upon the termination of Medicaid participation of a nursing facility provider for any reason, either voluntarily or through Departmental action, the bond must be kept in effect until the final audits of resident personal needs funds and resident nursing care accounts can be completed by the Department, and until any adjustments required by such audits have been made.

C. Change of Licensed Operator -Requirements

1. When the licensed operator ("licensee") of a nursing facility is changed, as described in Section 8.441.5, it shall be the duty of the new Medicaid provider :
 - a. To execute a new personal needs account agreement on behalf of Medicaid residents, as required by this section. The new provider shall furnish proof to the Department that it has properly established resident's personal needs accounts and carried forward the proper balance remaining in each resident's ledger.
 - b. To post a surety bond as required by Section 26-4-504(3)(c), C.R.S., and Section 8.482.52, B. above, or to otherwise demonstrate to the satisfaction of the Department that the security of residents' personal needs funds is assured.
 - c. Upon notice to the Department that a nursing facility's licensed operator will change or Medicaid participation will be terminated as required in Section 8.441.5, the Department may withhold all or part of any monies due the prior nursing facility licensee until the personal needs accounts of the residents have been determined to be correct. If such accounts are found to be deficient, the amount of the bond established by the prior licensee shall be forfeited to the Department, and any additional deficit shall be deducted from such monies due to the prior licensee of fee nursing facility. (See also Section 8.444.) The Department will, in such cases, assume the responsibility for proper distribution of such monies to the deficient resident accounts.
2. It shall be the duty of the prior licensee to provide the new licensee written verification, by a public accountant, of the amount of personal needs money being transferred for each resident's personal needs fund. This verification shall include a statement that this amount corresponds to the total of the balances shown on the resident's individual ledger.

D. New Admission When a patient is admitted to a nursing facility for the first time, or transferred from Medicare or private pay, the nursing facility shall set up a new account for personal needs funds, which lists a beneficiary or beneficiaries (with percentages), as specified in A. of this subsection.

E. Readmissions, Transfers from Another Nursing Facility.

1. Upon readmission or transfer of a resident, the nursing facility shall determine the amount of personal needs funds currently in the resident's account in the previous facility, make every effort to obtain such funds, and show this amount as a balance forward in the current ledger. Reconfirmation of the listed beneficiary or beneficiaries shall also be done at this time.
2. Failure to make such effort shall be considered a breach of trust agreement, and may be cause for cancellation of the participation agreement.
3. If, upon making every effort, the current nursing facility is unable to obtain the balance of funds from the resident's previous facility, the current nursing facility should notify the Department immediately. Failure to do so may be construed as a failure to make every effort.

F. Discharge from a Nursing Facility

1. Upon discharge of a resident to the resident's home, to another nursing facility or to the care of a responsible party, the nursing facility shall determine the amount remaining in the personal needs account within 45 days, and make payment of this amount to the resident, responsible party, or transfer these funds to the current nursing facility, if appropriate. Failure to so dispose of the resident's personal needs funds shall render the nursing facility liable for cancellation of the participation agreement or to the penalties as set forth in 8.482.45, or both. All patient's personal possessions shall also be relinquished, as required by 8.482.6.
2. At the end of the month in which a resident is discharged to a hospital, the nursing facility shall:
 - a) set aside the personal needs allowance of \$50 for the resident;
 - b) apply the balance of any monies to the established Medicaid rate for the number of days the resident lived in the facility; and
 - c) if there is still a balance, transfer the funds to the receiving hospital, if Medicaid is the primary funding source.

If the resident returns to the same nursing facility, no additional accounting is necessary. If the resident does not return to the same facility, however, disposition of the personal needs funds shall be made as specified in this section.

3. Death of a resident.
 - a. The nursing facility is required to determine if:
 - 1) The nursing facility resident dies intestate (i.e., without a will) with known relatives, or a listed beneficiary, for whom current addresses are known; or
 - 2) The nursing facility is unsure of the existence of a will or whether there are known relatives and there is no listed beneficiary; or
 - 3) There is a public administrator in the county in which the death occurred. If not, the nursing facility shall, within ten days from the date of death, contact the Department. It shall then be the responsibility of the Department to turn the funds over to the Colorado State Treasurer for

inclusion in the next Great Colorado Payback listing.

Within 60 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 15 days after receiving the funds, the executor, administrator, or other appropriate representative of the resident's estate shall provide written notice to the Department regarding the receipt of the funds. Upon receipt of the notice, the Department may initiate action to recover the funds pursuant to the provisions of this article.

- b. When a nursing facility resident dies intestate (i.e., without a will) and is known to be without relatives or a listed beneficiary, the nursing facility is required to pay any funds remaining in the personal needs account to the Public Administrator of the county in which the nursing facility resident died. 15-12-621(2.), C.R.S. (1995 Supp.) specifically requires that whenever a person without known heirs dies intestate on the premises of another, the personnel in possession of such premises must give immediate notice thereof to the public administrator or incur liability for any damages that may be sustained through neglect. The Clerk of the District Court should be contacted to obtain the name of the current Public Administrator appointed for the county.
- c. In those instances in which the nursing facility resident dies testate (i.e., with a will) the funds in his personal needs account must be transferred to the executor of the estate, unless another person or persons are listed as beneficiaries, in which case the funds can be passed outside the will. Other personal property of the deceased should be given to the executor. 15-12-711, C.R.S. 1987 provides that a personal representative or executor has the same power over the title of the property of the estate as an absent owner.
- d. If the proper disposition of the deceased resident's personal needs funds and/or personal property cannot be made, the nursing facility may elect to use the following provisions of the Colorado Small Estate Act to be discharged from further liability.
 - 1) In accordance with 15-12-1201, et seq., C.R.S., after ten or more days following the death of a nursing facility resident, a person claiming to be the successor or acting on behalf of all successors of the deceased resident may present an affidavit (Form CPC-40, Rev. 6/81) stating that:
 - a) The fair market value of the property owned by the decedent and subject to disposition by will or intestate succession, less liens and encumbrances, does not exceed \$27,000;
 - b) At least ten days have elapsed since the death of the decedent;
 - c) No application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction; and
 - d) The claiming affiant(s) and successor (s) are entitled to payment of all monies due and to delivery of all tangible personal property.
 - 2) In accordance with 15-12-1202, C.R.S. 1987, the nursing facility administrator is discharged and released from further responsibility once funds or

personal property have been released to an individual presenting an affidavit as referenced above. The nursing facility need not inquire as to the truth of the affidavit or of any successor's right to succeed to the deceased resident.

- e. The nursing facility shall also require a signed and dated receipt listing all the resident's personal property items released to a successor, as required by 8.482.6(C).
- 4. Any failure of the nursing facility to properly dispose of the resident's personal needs funds within 90 days of death or discharge will be considered a breach of trust, and may be cause for cancellation of the participation agreement, forfeiture of the required surety bond, and prosecution under the penalties provided in 8.482.45.

8.482.53 RESPONSIBILITIES OF COUNTY DEPARTMENT

- A. It shall be the responsibility of the county department, to explain to the resident the various options for handling the personal needs monies, as well as the resident's rights to such funds. If the resident chooses to allow the nursing facility to hold such funds in trust, the county department is responsible for assuring that the resident assigns all income to the nursing facility. See Section 8.482.52(A)(2).
- B. It shall be the responsibility of the county department, to assure that the nursing facility properly transfers or disposes of the resident's personal needs funds within 45 days of discharge from the nursing facility, or transfer to another nursing facility.
- C. The county department shall notify the State Department if they become aware that a nursing facility has retained personal needs funds more than 90 days after the death of a resident.

8.482.54 RESPONSIBILITIES OF THE STATE DEPARTMENT

- A. It shall be the responsibility of the State Department to accept and to properly dispose of residual personal needs funds, upon the death of the resident, in any of the following conditions:
 - 1. The resident dies intestate (i.e., without a will), but with known relatives or a listed beneficiary for whom current addresses are unknown;
 - 2. There is no Public Administrator in the county and there are no listed relatives or beneficiaries;
 - 3. The nursing facility is unsure of the existence of a will, or whether there are known relatives.
- B. The facility shall be obligated to provide explanation for withholding personal needs funds beyond 90 days after the death of a resident. The Department may apply any or all of the following remedies:
 - 1. Demand immediate return of such funds,-
 - 2. Order an audit of all personal needs accounts;
 - 3. Cancel the participation agreement of such nursing facility.
- C. Perform periodic audits of nursing facility accounts. Audits may be performed at such intervals as determined necessary by the Department. Audits will always be performed when a nursing facility is discontinued from the Medicaid program for any reason and when a change of ownership or management occurs.

- D. If an audit of personal needs accounts reveals discrepancies, the Department, on behalf of the resident, may take administrative action as outlined in Volume 8, Recoveries from Providers; or the Executive Director may refer the case to the appropriate legal authorities. See Section 8.482.45 of this Staff Manual.
- E. If the nursing facility cannot offer proof that any apparent discrepancies in personal needs accounts have been corrected, the Department may withhold payment of nursing care costs in the amount shown due and payable by the audit.

8.482.55 MANAGEMENT OF PERSONAL NEEDS FUNDS BY OTHER THAN RESIDENT

- A. For residents unable to manage their own funds due to a physical or mental condition, a conservator, guardian-trustee, or other responsible person may carry out these acts for the resident.
- B. Personal needs funds shall not be turned over to persons other than a duly accredited agent or guardian of the resident. With the written consent of the resident (is the resident is able and willing to give such consent) the administrator may turn over personal funds belonging to said resident to a close relative or friend to purchase a particular item. However, a signed, itemized, dated receipt will be required.

8.482.6 PATIENT'S PERSONAL POSSESSIONS

- A. The Department rules and regulations are designed to insure that clothing and other property of each resident shall be properly safeguarded and reserved for personal use, and to comply with standards established by the Colorado Department of Public Health and Environment.
- B. The nursing facility shall be responsible for safeguarding personal possessions (including money) and to:
 - 1. Provide a method of identification of the resident's suitcases, clothing, and other personal effects, listing the items on an appropriate form attached to the resident's nursing facility record at the time of admission. Such listings are to be kept current. Any personal effects released to a relative or designated representative of a resident must be delineated in a signed receipt.
 - 2. Provide adequate storage facilities for the resident's personal effects.
 - 3. Exercise careful judgment in the release of resident's personal property to other than the actual owner, and to secure an itemized statement of release, the signature of the resident, duly authorized agent, or responsible party.
 - 4. Insure that all mail is delivered unopened to the resident to whom it is addressed, except for those residents who have a legal guardian or conservator, other legal arrangement, or have voluntarily given written consent to allow opening such mail, in which case the mail is held, unopened, until delivered to the resident.
- C. In the event of death of a resident in the nursing facility, or in a medical institution or on medical leave from a nursing facility, the following rules apply:
 - 1. The nursing facility shall provide the deceased resident's executor, administrator or successor claiming under the Small Estates Act (See 8.482.F,3,d,) with a copy of the resident's personal needs ledger.
 - 2. The nursing facility shall turn over to such responsible party all of the deceased resident's personal property in its possession. All items shown by the personal needs ledger as

purchased by or in behalf of the resident must be returned to the responsible party.

3. The responsible party claiming the possessions must sign a dated, itemized receipt for all such items before removal of the items from the nursing facility.
- D. In the event of discharge of a resident, all personal possessions and a copy of the personal needs ledger signed and dated by the administrator shall be turned over to the patient, or to the responsible party, as is required for a deceased patient in C above.

8.482.7 NURSING FACILITY RESPONSIBILITY FOR ESTABLISHING PERSONAL NEEDS ACCOUNT

Many nursing facility residents are either unable or unwilling to manage their personal funds and the residents or their families or guardians wish this responsibility to be assumed by the nursing facility. Also, since nursing facility residents who are recipients of Medicaid benefits often have income from Social Security, Supplemental Security Income, Railroad Retirement, or other sources, it is necessary for participating nursing facilities to maintain a system of accounting for Medicaid funds, resident income, and resident's personal needs funds. Such system shall be maintained in accordance with standards required by the Department, and adequate for audit by representatives thereof. The following sections outline a standard system of accounting to be used by participating nursing facilities for these purposes. Any deviation from this system must have written approval of the Department.

8.482.71 REQUIRED ITEMS

- A. Book of money receipts in triplicate.
- B. Cash receipts journal including columns for nursing facility operating and resident trust cash accounts.
- C. Checking accounts for nursing facility operating and resident trust accounts.
- D. Cash Disbursements Journal including columns for nursing facility operating and resident trust cash accounts.
- E. General Ledger accounts as follows:
 1. Cash-General or Operating account
 2. Cash-Patient Trust Fund
 3. Cash-Patient Trust Imprest Fund
 4. Accounts Receivable - Nursing Care (Control Account.)
 5. Accounts Payable - Personal Needs Liability (Control Account)

(Note: This is not a complete listing of every account which would normally appear in a General Ledger, but includes the accounts necessary for purposes of this system of accounting.)
- F. Subsidiary Ledger for Accounts Receivable-Nursing Care sub-classified by resident name.
- G. Subsidiary Ledger for Personal Needs sub-classified by resident name.
- H. Personal Needs Cash Paid Out and Personal Needs Cash Request Slips for use with Personal Needs Imprest Fund.
- I. Forms for Certificate of no responsibility for resident's personal needs funds and Appointment of Agent

and authorization to handle resident 's personal needs funds.

J. Cash box or other secure place for petty cash used in Personal Needs Imprest Fund.

8.482.72 GLOSSARY

A. Basic Bookkeeping Terms

1. ACCOUNT -- Basic classification device used in bookkeeping. In a double-entry bookkeeping system, an account consists of a Debit side and a Credit side. Individual accounts within a ledger serve as the basis for financial statements.
2. ACCRUAL OR ACCRUED CHARGE -- A charge arising from an individual or business entity providing goods or services to another individual or entity. An accrual or charge is entered on the Debit side of an individual account. A charge may be accrued in advance of the goods or services provided, or may be accrued afterward, depending upon the basis of accounting used (See ACCRUAL BASIS and/or CASH BASIS)
3. ACCRUAL BASIS -- A basis of accounting wherein revenues are recognized at the time they are "earned" (i.e., at the time goods or services are provided) and expenses are recognized when they are incurred as liabilities. (Opposite of CASH BASIS accounting- See CASH BASIS.)
4. BOOK OF ORIGINAL ENTRY -- An accounting book or record which serves as the point of original entry of accounting transactions recorded. The book of original entry serves as the basis for classification of items to individual accounts. Examples of Books of Original Entry include Cash Receipts Journal, Cash Disbursements Journal, General Journal, etc.
5. CASH BASIS -- A basis of accounting wherein revenues are recognized for accounting purposes at the time they are collected in cash and expenses are recognized at the time that they are paid in cash (Opposite of ACCRUAL BASIS accounting - See ACCRUAL BASIS.)
6. CASH DISBURSEMENTS JOURNAL -- A book of original entry in which transactions involving payments of cash are recorded and summarized for later classification to individual accounts. A Cash Disbursements Journal usually consists of one column for entries to a cash account and another column (or columns) for entries to other accounts affected by the transactions recorded.
7. CASH RECEIPTS JOURNAL -- A book of original entry used to facilitate accounting for receipts of cash by an enterprise. A Cash Receipts Journal usually consists of one column for entries to a cash account and another column (or columns) for entries to other accounts affected by the transactions recorded.
8. CONTROL ACCOUNT -- A general ledger account which summarizes items which are classified in SUBSIDIARY ACCOUNTS or SUBSIDIARY LEDGERS (See SUBSIDIARY ACCOUNT.) The total of the balances in the subsidiary accounts should equal the balance of the control account in the general ledger.
9. CREDIT (Abbreviated CR.) -- In a double-entry bookkeeping system, an entry made on the right-hand side of an account is called a "Credit" entry.
10. DEBIT (Abbreviated DR.) -- In a double-entry bookkeeping system an entry made to the left-hand side of an account is called a "Debit" entry.

11. **DOCUMENTATION** - Supporting data or proof explaining an entry in the accounting records; e.g., a payment on account may be “documented” by an invoice, cancelled check, etc.
12. **DOUBLE ENTRY BOOKKEEPING SYSTEM** -- A system of bookkeeping wherein at least two entries are made for every transaction recorded; for each entry made to the “debit” side, a corresponding entry (or entries) must be made to the “credit” side. A double-entry system is used for purposes of proof of accuracy of transactions recorded; total of “debits” must be equal to the total of “credits” for the system to be “in balance.” (See ACCOUNT, DEBIT, and CREDIT.)
13. **GAAP** -- Generally Accepted Accounting Principles.
14. **IMPREST FUND** (Also called PETTY CASH FUND) -- A fund set up for the purpose of control over cash transactions; most often used when a large number of small transactions must be made. The balance of an imprest fund is constant, and must consist of either cash or receipts or other documentation showing the use of the cash. An imprest fund is “replenished” periodically when the cash in the fund reaches a low point by removing the receipts, totalling them, and replacing them with the amount of cash spent. An imprest fund is sometimes called a “revolving fund”.
15. **LIABILITY** -- An “obligation” or “debit” of an individual or business enterprise to pay a sum of money at some future time. Examples of liabilities are accounts payable, notes payable, bonds payable, monies held in a fiduciary or trust capacity, such as the personal trust funds.
16. **LEDGER** -- A grouping of accounts in a bookkeeping or accounting system. For example, a “general ledger” may contain all the accounts of a business enterprise, while a “subsidiary ledger” may consist of sub-classifications of one particular account in a “general ledger.” (See SUBSIDIARY ACCOUNT or SUBSIDIARY LEDGER.)
17. **POSTING** -- A basic bookkeeping operation wherein information for accounting records is transferred from one place to another; as in “posting” to the general ledger from the cash receipts journal, etc. Posting is usually a preliminary operation to summarization of data for preparation of financial statements, etc.
18. **RECONCILIATION** -- An explanation of differences in accounting records for the purpose of ensuring accuracy of the records. An example is the “Reconciliation” of a bank statement balance to the balance in the check book or cash book.
19. **SUBSIDIARY ACCOUNT or SUBSIDIARY LEDGER** -- An account or group of accounts sub-classifying a particular account in a general ledger which is used with a CONTROL ACCOUNT. An example is Accounts Receivable. The Accounts Receivable would be represented in the general ledger by a control account and sub-classified by name of debtor in a subsidiary ledger. Each account in the subsidiary ledger has an individual balance, and the total of all the balances in the subsidiary ledger should equal to the balance of the control account in the general ledger. (See CONTROL ACCOUNT.)
20. **TRIAL BALANCE** -- A bookkeeping operation in which balances of all accounts in a ledger are taken and summarized to ascertain that postings of debts equal postings of credits. A “Trial Balance” may also be taken of a subsidiary ledger to be certain that the postings to the subsidiary ledger agree with those to the control account in the general ledger.
21. **FIDUCIARY OR TRUST** -- A party who is entrusted to conduct the financial affairs of another person is act

B. Terms Related to Nursing Facility Bookkeeping

1. **BENEFICIARY** -- The listed person/persons/charitable institution or other agency a resident has elected to receive the balance of his/her personal needs trust monies in the event of death.
2. **CENSUS** -- A nursing facility record of admissions and/or discharges of residents within a given time period (examples are 24-hour or "midnight" census, monthly census, etc.) The census is used to determine the number of patient days of care provided by the nursing facility.
3. **FISCAL AGENT** -- Agency under contract to the State Department of Health Care Policy and Financing for the purpose of disbursing funds to providers of services under the Medicaid Program. The fiscal agent collects eligibility and payment information from the county and state Departments and processes this information for payment to providers (nursing care facilities).
4. **FORM AP-5615** -- For purposes of reporting change in patient status, admissions discharges, changes in resident payments, etc. to the county department(s). Commonly referred to as "5615"s.
5. **GENERAL (OR OPERATING) ACCOUNT** -- May describe either an account in the general ledger (as Cash-General or Operating) or a bank account. Used to record monies due to the nursing facility for care or services provided to the resident, are recorded in this account (as distinguished from a Personal Needs or Resident Trust account, which is used to account for personal funds belonging to residents of a facility).
6. **INTESTATE** -- A person who dies without leaving a will is said to have died "intestate."
7. **MEDICAID (TITLE XIX) PROGRAM** -- Program funded by federal and state governments which provides for nursing facility care for the categorically eligible. It is administered in Colorado through the Department of Health Care Policy and Financing.
8. **NURSING CARE (ACCOUNTS RECEIVABLE) ACCOUNT** -- Account in a subsidiary patient ledger which is used to record accrued nursing care charges, patient payments, and Medicaid payments for a Medicaid eligible resident.
9. **PERSONAL NEEDS ACCOUNT** - An account in a subsidiary resident ledger used to record personal needs fund transactions of a resident. Same as "Patient Trust Fund".
10. **PERSONAL NEEDS ALLOWANCE** - A nursing facility resident's monthly allowance for spending money and personal items.
11. **PERSONAL NEEDS LIABILITY** - The liability of a nursing facility or its representatives for funds which the facility is managing on behalf of its residents. If the resident elects to have the facility manage these funds, a fiduciary (trust) capacity is established for the resident, and the facility is responsible to the resident for due care of the funds and sufficient accounting of transactions made by the facility on behalf of the resident.
12. **PROVIDER (OR VENDOR)** - A nursing facility which provides services to residents under the Medicaid Program. A provider facility must be licensed and certified by various government agencies to become eligible to participate in this program.
13. **PUBLIC ADMINISTRATOR** -- An appointed government official with various fiduciary responsibilities, including that of disposition of funds of deceased residents with no

known heirs. (Nursing facility residents often die without leaving a will and with no known heirs, and their remaining funds are paid to the Public Administrator.)

14. RESIDENT TRUST FUND - Same as "Patients' or Resident's Personal Needs Account". Most often used as a title for a bank account for residents' personal needs funds.
15. RESIDENT OR PATIENT PAYMENT - The portion of a nursing facility resident's income which is applied toward his/her care at the facility (according to state department regulations, all income received by a resident, with the exception of the monthly personal needs allowance, or the allowable cost with respect to the post-eligibility treatment of income as defined in 8.110.49, shall be applied toward the resident's care, with the balance paid by Medicaid). A resident's income may be from Social Security, Veterans' Administration, Railroad Retirement, government pensions, an estate or trust, or other sources. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.
16. RESPONSIBLE PARTY -- A party who is responsible for a nursing facility resident's financial affairs. A nursing facility, a friend or designated representative, or a county department may be a responsible party, or a resident may act as his/her own responsible party, if he/she is managing his/her own affairs.
17. TESTATE -- A person who dies leaving a will is said to have died "testate."
18. UB92 CLAIM FORM -- Form utilized by providers to bill nursing facility services.

8.483 ADULT FOSTER CARE

8.483.10 ADULT FOSTER CARE

(AFC) means care provided on a 24-hour basis for no more than sixteen (16) residents in a non-medical facility certified by the agency designated by the State for frail elderly, physically or emotionally disabled adults, 18 years of age and over, who do not require 24-hour medical care.

8.483.20 DEFINITIONS/SERVICES REQUIREMENTS

.21 ADULT FOSTER CARE FACILITY means a licensed Assisted Living Residence (ALR) that meets all applicable federal, state, and local laws and regulations, and that has been additionally certified by the State Department of Health Care Policy and Financing or its designee as a provider of Adult Foster Care Services. AFCs shall provide the following:

- A. Twenty-four hour residential care for no more than 16 residents;
- B. An environment which is sanitary and safe from physical harm;
- C. Adequate sleeping and living areas; and
- D. Adequate recreational areas.

.22 ADULT FOSTER CARE SERVICES means those services which shall be provided by an AFC to each resident. These services shall include but are not limited to:

- A. Availability of three balanced meals per day with provision for special diets when those diets have been prescribed as part of a medical plan;
- B. Assistance with transportation;

- C. Protective, oversight;
- D. Assistance. with basic personal tasks, such as bathing, hair care, and dressing;
- E. Supervision of self-administration of medications;
- F. Housekeeping services such as changing of bed linen, cleaning of living areas, and rearrangement of furniture as needed to promote freer mobility;
- G. Laundering of residents' clothing and bedding; and
- H. Opportunities for structured recreational activities and socializing.

.23 OPERATOR means any person who owns an AFC facility, or an individual with authority delegated by the owner who manages, controls or performs the day-to-day tasks for operating an AFC facility.

.24 PROTECTIVE OVERSIGHT means guidance, of a resident, as required by the needs of the resident or as reasonably requested by the. resident, including the following: Being aware of a resident's general whereabouts, although the resident may travel independently in the community, monitoring the activities of the resident while on the. premises to ensure the health, safety, and well-being of the resident, including monitoring of prescribed medications; reminding the resident to carry out activities, of daily living; and reminding the resident of any important activities, including appointments.

.25 RESIDENT means an individual who has met all the eligibility requirements for Adult Foster Care, has met the appropriate placement criteria for the AFC Program, and has been approved for placement or currently resides in a certified Adult Foster Care facility.

.26 RESTRAINT means any physical or chemical device, application of force, or medication which is designed or used for the purpose of modifying, altering, or controlling behavior for the convenience of the facility and excludes medication prescribed by a physician as part of an on-going treatment plan or pursuant to a diagnosis. Restraints as defined herein are prohibited.

.27 STAFF means a paid employee of the facility.

.28 SUBSTANCE ABUSE means the use of any mind or mood altering material in a manner which deviates from standard medical practice in the community, which acts to the detriment of the individual residents, or the public, and which includes but is not limited to, alcohol, dangerous drugs, or narcotic drugs.

- A. Alcohol refers to beverage alcohol, ethylene alcohol, or ethanol.
- B. Dangerous Drugs refers to cannibus or any depressing drug, hallucinogenic drug, stimulant drug, or tranquilizer. or any such mixture or compound with any other substances.
- C. Narcotic Drugs refers to any drug to which the Federal Controlled Substance Act of 1970 may apply and any drug found by the State Board of Health to be addiction forming or to have an addiction sustaining character similar to morphine or cocaine.

.29 UNIVERSAL PRECAUTIONS refers to a system of infection control which assumes that every direct contact with body fluids is potentially infectious. This includes any reasonably anticipated skin, eye, mucous membrane or parenteral contact with blood, blood-tinged body fluids, or other potentially infectious materials.

8.483.30 ELIGIBILITY

Eligibility for the Adult Foster Care program shall be based on financial need. the client's need for 24 hour supervision and assistance with activities of daily living, appropriateness for the AFC Program and available appropriations. A legal immigrant as defined in 26-2-103(5.7). C.R.S., who meets the eligibility requirements for Adult Foster Care shall be eligible for the program.

.31 FINANCIAL ELIGIBILITY FOR AFC PLACEMENT Financial eligibility for Adult Foster Care shall be determined by County Income Maintenance staff in the client's county of residence. In determining financial need, the client's total countable income is subtracted from the AFC grant amount to derive the net payment to the client.

A. In addition to the needs of the individual, an Adult Foster Care allowance shall be included in the grant of an AND/AB/SSI-CS or OAP recipient when:

1. The need for such care has been determined by the single entry point agency;
2. The care is authorized by the single entry point agency; and
3. The individual is or will be residing in a currently certified Adult Foster Care facility.

B. The maximum amount which can be allowed as Adult Foster Care is the difference between the AND/AB/SSI-CS or OAP standard and the negotiated Adult Foster Care rate of \$680 plus \$50 personal needs allowance. This increase for Adult Foster Care is applicable January 1, 1999. If, for example, the rate for Adult Foster Care negotiated with the provider is \$680 (which is the maximum), computation of the amount to be added to the AND/AB/SSI/-CS or OAP grant is:

1. AND/AB/SSI-CS AFC Standard Calculation

\$680	Maximum AFC provider payment
+50	Reserve for recipient's personal needs

\$730	Total AFC and personal needs
500	AND income (basic grant and/or income)
\$230	Maximum allowance for AND-AFC add-on

2. OAP AFC Standard Calculation

\$680	Maximum AFC provider payment
+ 50	Reserve for recipient's personal needs

\$730	Total AFC and personal needs
\$536	OAP income (basic grant and/or income)
\$ 194	Maximum allowance for

OAP-AFC add-on

- C. The AFC provider rate is \$680 per month. Effective January 1 of subsequent years, this payment shall be permitted to rise in a dollar-for-dollar relationship to any increase in the SSI grant standard. In addition, the AFC payment to providers may be adjusted by the State, as funding becomes available.
- D. Assets in a disability trust, as described in 15-14-409.8., C.R.S., or a pooled trust as described in 15-14-409.9., C.R.S., are counted as available resources in determining eligibility for Adult Foster Care.

8.483.32 FUNCTIONAL ASSESSMENT

- A. Single entry point agencies shall utilize the Uniform Long Term Care Assessment Instrument (ULTC-100) developed by the State to determine functional capacity and need for paid care. Along with the ULTC-100, the functional eligibility of the client for AFC placement shall be determined using the Appropriateness of Placement Form.
- B. The ULTC-100 and the Appropriateness of Placement Criteria shall be completed on an annual basis or more frequently if there are changes in the client's circumstances.

.33 Persons who are developmentally disabled or who are receiving, or are eligible to receive services administered by the Department of Human Services, Developmental Disabilities Services, are not eligible for AFC.

.34 Residents with a primary diagnosis of mental illness must be willing to comply with medications prescribed by the physician and must be receiving on-going services from the local mental health center or other mental health professional.

.35 Adult Foster Care clients shall not receive other public or private funded services which duplicate those services which are mandated to be provided in the Adult Foster Care Program in 8.483.21 and 22.

8.483.40 ADMISSION PROCEDURES

.41 CLIENT INTAKE Refer to 8.393.21, A, 1 for SEP intake procedures.

.42 ASSESSMENT Refer to 8.393.21 and 22 for SEP assessment procedures.

- A. After the ULTC 100 and the Appropriateness of Placement Forms have been completed by the case manager, the information from these forms shall be used in determining if the client is functionally eligible for Adult Foster Care.
- B. If determined functionally eligible, the client cannot be placed and the AFC payment cannot begin until an appropriate AFC facility is found.

.43 APPROPRIATE FACILITY REVIEW The case manager shall review, available Adult Foster Care facilities to determine if the client's needs can be met by a current facility. This review may include contact with other counties which have AFC facilities.

8.483.44 AGREEMENT TO PLACEMENT SERVICES A client shall not be placed in an Adult Foster Care Facility unless one or more of the following conditions are met:

- A. The competent client gives informed consent for placement; or

- B. The court-appointed guardian of the client requests placement; and
- C. The client or his legal representative understands and agrees to. adhere to facility rules.

8.483.45 CARE PLANNINGWhen the. decision is made that the applicant is appropriate for Adult Foster Care and that an appropriate AFC facility exists, the case manager shall:

- A. Discuss the needs of the client with the Adult Foster Care provider to determine if the provider is capable of meeting the client's needs;
- B. Discuss the facility and the provider with the client;
- C. Arrange for an initial visit by the client to the facility;
- D. Have a care plan negotiated with and signed by the client and case manager prior to. admission. The care plan shall be developed in conjunction with the. ALR Board and Care Plan required in Section 8.483.63, R. of this staff manual, and must be renewed at least every twelve months or sooner if there is a change in the client's condition;
- E. Have a current provider agreement signed by the manager of the Adult Foster Care facility prior to. placement. This agreement shall be renewed at least annually, contingent upon the facility meeting all requirements for certification as an AFC facility.
- F. After supervisory review and sign-off, the case manager shall send a signed copy of the Uniform Long Term Care Assessment Instrument (ULTC-100) to the Income Maintenance staff authorizing the Adult Foster Care payment; and within thirty (30) days, shall also send a copy to the State.
- G. In all cases, Adult Foster Care payments shall be made directly to the client or the client's designated representative. The client or representative is responsible for paying the. AFC provider the agreed amount on a regular monthly basis.
- H. The case manager shall explain that the client or client's designated representative is responsible to. pay the AFC provider on a monthly basis.
- I. When the client has been determined to be financially and functionally eligible for AFC, the Adult Foster. Care payment effective date shall be the date that the applicant was. assessed for appropriateness for the AFC program using the Appropriateness of Placement Form. The date, on the Appropriateness of Placement Form shall not exceed a period longer than forty-five (45) calendar days prior to the client's placement in an AFC Facility. If the date is past the forty-five day period, the case manager must reassess the client, make needed changes on the form, enter the date of the new assessment and re-sign the form.

8.483.46 ON-GOING SERVICES TO CLIENTS. IN ADULT FOSTER CARE

- A. Single entry point agency staff shall monitor client records to ensure that a client with a primary diagnosis of mental illness is receiving on -going services from the community mental health center or other mental health professional;
- B. Reassessment
 - 1. Single, entry point agency staff shall conduct the reassessment in accordance with 8.393.25.

2. An Appropriateness of Placement Form must also be completed at the time of the reassessment. If a client is determined to be inappropriate for the Adult Foster Care Program, that client must be discontinued from the AFC program. (See 8.393.28 D.2.b.(2)).
3. The case manager must also determine if the facility continues to meet the client's needs. If the facility no longer meets the client's needs, the case manager must review other AFC facilities to determine the possibility that one will meet the client's needs.
4. If there is no other AFC facility which meets the client's needs, the client will be discontinued from the Adult Foster Care Program and discharged from the facility. (See 8.393.28, D. 5.)

8.483.47 DISCONTINUATION OF ADULT FOSTER CARE Denial or termination of Adult Foster Care shall be in accordance with Long Term Care Single Entry Point System regulations at 8.393.28 APPLICANT/CLIENT NOTICE AND APPEAL PROCESS.

8.483.48 CLIENT NOTIFICATION AND APPEAL RIGHTS Applicants and clients for the Adult Foster Care Program shall be notified of their eligibility status, authorized Adult Foster Care amount, and appeal rights in accordance with Staff Manual Volume 8, Section 8.393.28 APPLICANT/CLIENT NOTICE AND APPEAL PROCESS.

8.483.49 COMPLAINTS, SERIOUS INJURY OR DEATH

A. Complaints When the staff of the single entry point agency receives a complaint regarding an Adult Foster Care facility, the single entry point agency shall:

1. Investigate the complaint within three (3) working days;
2. Provide same day investigation if the situation appears life threatening or in emergency situations;
3. Notify local law enforcement within twenty-four (24) hours if the complaint involves possible criminal activity.
4. Notify the Adult Protective Services Unit of the county department of social services within twenty-four (24) hours if abuse, neglect or exploitation is suspected;
5. Notify the local long term care ombudsman if the complaint involves violation of resident's rights.
6. Notify the Health Facilities Division of the State Department of Public Health and Environment if the complaint is unresolved and is in violation of Health Facilities regulations for Assisted Living Residences;
7. Notify the mental health case manager, if the complaint involves a client of a community mental health center; and
8. Develop a corrective action plan, if needed, and monitor for compliance.
9. Notify the State Department of Health Care Policy and Financing in writing, within ten working days concerning the nature of the complaint, the findings, of the investigation and what corrective action, if any, is being initiated.

- B. Serious Injury or Death When the staff of the single entry point agency receives notice of the serious injury or death of any individual living in an Adult Foster Care facility with an ALR Board and Care Plan, the single entry point agency shall:
1. Investigate the circumstance of the serious injury or death within 24 hours of receiving the report; and
 2. Within 24 hours of the investigation, refer the case to the Adult Protective Services Unit and notify the following if the cause of serious injury or death is unexplained or there are suspicions of abuse and/or neglect:
 - a. Local law enforcement if the circumstances indicate possible criminal violations;
 - b. The Health Facilities Division of the State Department of Public Health and Environment;
 - c. The local long term care ombudsman;
 - d. The mental health case manager, if resident was a client of a community mental health center; and
 - e. The State Department of Health Care Policy and Financing.
 - f. A written report concerning the findings of the investigation and what further steps are being taken shall be submitted to the State Department of Health Care Policy and Financing within ten (10) working days. A format prescribed by the State shall be used for this purpose.

8.483.50 FACILITY CERTIFICATION PROCEDURES

.51 NEW ADULT FOSTER CARE FACILITIES

- A. Facilities that are not currently certified as Adult Foster Care providers must make application to the agency designated by the State to become certified.
- B. After the applicant(s) has completed and returned the State-prescribed Adult Foster Care application, the following actions shall occur:
1. The agency designated by the State shall accept and process all applications for AFC certification and notify the applicants of the certification decision within 30 days of the receipt of the completed application by the agency designated by the State.
 2. The agency designated by the State shall conduct an on-site inspection of the facility using State-prescribed certification forms and procedures to determine if the facility meets all the AFC regulations as contained in this staff manual.
- C. Prior to approving the application for certification, agencies designated by designated by the State shall have on file:
1. Signed and dated local city and single entry point agency approval forms documenting that the facility is in full compliance with local zoning, housing, fire, sanitation and other codes and ordinances;

2. A signed and dated copy of the Assurance of Compliance with the Department of Health and Human Services Regulation under Title VI of the Civil Rights Act of 1964.
 3. A copy of the current general liability and, if applicable, auto insurance policy or policies, issued by a company authorized to do business in Colorado. These liability insurance policies must be in at least the minimum amounts set annually by the Department of Health Care Policy and Financing.
 4. Current physician's statement(s) that all required staff have current TB test and are free of infectious and communicable disease.
- D. As a result of the on-site inspection the agency designated by the State shall take one of the following actions:
1. A full certificate shall be issued when it is determined that the applicant has met all the requirements for Adult Foster Care certification as specified in this staff manual and has signed the provider agreement. Such certificate shall expire after a period not to exceed one year from the date issued, unless revoked.
 2. The certification and the provider agreement must be signed by the Director of the single entry point agency.
 3. A one time provisional certificate may be issued for up to ninety (90) days when the applicant needs additional time to meet all the requirements for Adult Foster Care certification and clients' health and safety is not at risk; or
 4. Certification may be denied for good cause as stated in Section 8.483.55 of this staff manual.
- E. A copy of the Certification Form and Certificate of Approval for the Adult Foster Care Facility shall be submitted to the state within fifteen (15) days of certification decision.

8.483.52 CURRENT ADULT FOSTER CARE FACILITIES

- A. Facilities that are currently certified as AFC providers must apply for renewal of certification not less than thirty (30) days prior to the expiration of the certificate.
- B. The case manager shall follow the requirements in the Section on New AFC Facilities in this staff manual with the addition of the following:
 1. If the application for renewal of certification is not received thirty (30) days prior to the date of expiration of the current certificate, the facility shall be treated as a new applicant.
 2. If the application for renewal is received thirty (30) days prior to the date of expiration of the current certificate, the existing certificate shall not expire until the application for certification has been acted upon by the county, provided that the application for certification is complete.

8.483.53 CHANGE IN OWNERSHIP, MANAGEMENT, NAME OR LOCATION OF A CERTIFIED AFC FACILITY

- A. The Adult Foster Care certificate shall be valid only in the hands of the person(s), association, partnership, corporation or government unit to whom it is issued and shall not be subject

to sale, assignment, or other transfer, voluntary or involuntary, nor shall the certificate be valid for any premises other than for which originally issued

- B. The agency designated by the State shall be notified and an application for certification shall be submitted thirty (30) days in advance of a change in ownership, management, name or location of the facility.
- C. A change in ownership, management or location of a facility shall be treated as a new application. The agency designated by the State shall follow the requirements in the Section on Adult Foster Care Facilities in this staff manual.

.54 CERTIFICATION OF ALTERNATIVE CARE FACILITIES (ACF'S) AS ADULT FOSTER CARE FACILITIES

- A. Facilities which have current certifications as Alternative Care Facilities may be deemed to have met the requirements for certification as AFC Facilities.
- B. ACF's requesting certification as AFC's shall apply to the agency designated by the State in which the facility is located and shall satisfactorily complete the introductory training on AFC rules and regulations required in the Section on Training in this staff manual prior to AFC certification by the agency designated by the State.
- C. AFC certification of deemed facilities shall be for a period not to exceed the period of ACF certification or one year from the date the AFC certification is issued, whichever is less.
- D. On an ongoing basis, deemed facilities shall meet all AFC requirements in this staff manual and shall apply for recertification as AFC's in accordance with the Section on Current Adult Foster Care Facilities in this staff manual.
- E. Failure to meet all requirements of the AFC Program may result in denial or revocation of certification for AFC in accordance with the Section on Denial or Revocation of Certification for Adult Foster Care in this staff manual.
- F. Denial or revocation of certification for ACF shall result in immediate denial or revocation of certification for AFC.

8.483.55 DENIAL OR REVOCATION OF CERTIFICATION FOR ADULT FOSTER CARE

A. Denial of Certification for New AFC

- 1. The agency designated by the State shall deny the certification for for Adult Foster Care of a facility not currently certified as an AFC for any good cause, based on adequate and documented evidence. Good cause is defined as follows:
 - a. The owner/operator (applicant):
 - 1) has demonstrated a high probability of inability to perform his/her obligations under a provider agreement by his/her prior conduct;
 - 2) has failed to conform to and abide by the applicable laws and/or regulations of the State of Colorado and the United States;
 - 3) has failed to conform to and abide by the applicable rules and regulations of the Colorado Department of Health Policy and Financing and/or the Colorado Department of Public Health and

Environment;

- 4) has, either by omission or commission, endangered or is endangering the health, safety, or well-being of AFC recipients;
- 5) has previously been found ineligible to participate in federal or state assisted residential programs by this or other federal or state agency; or
- 6) refuses to accept the payment rate established by the Colorado State Department of Health Care Policy and Financing for the Adult Foster Care Program.
- 7) has failed to remove a resident who does not meet the Appropriateness for Placement Criteria within the required timelines as specified in 8.483.55, D.2.
- 8) has failed to remove a resident whose needs cannot be met by the facility within the required time frames as specified in 8.483.55, D, 2 and E.

b. The owner/operator, staff or volunteers who are in a position of trust in an AFC facility have violated that trust by sexually, financially or otherwise exploiting a resident

2. The agency designated by the State shall notify any applicant by regular mail of the denial within thirty (30) calendar days of the completed application. Good cause shall be documented and the cause shall be specified. See Section 8.483.55, A, 1 for definition of good cause.
3. The denied applicant shall have fifteen (15) calendar days from the mailing date of the denial in which to request a hearing to the Colorado State Department of Administration, Division of Administrative Hearings. The denied applicant shall have the burden of proof to show by a preponderance of evidence that the denial is arbitrary and capricious.
4. For applicant denials, the decision of the administrative law judge shall constitute the initial agency action subject to review and final agency action by the State Department of Health Care Policy and Financing.

B. Denial of Previously Certified Facility Provided timely and sufficient application has been made for renewal, denial at time of recertification shall be treated in all respects as a revocation and the requirements in Section 8.483.55, C, shall be followed.

C. Revocation of Current Certification

1. The agency designated by the State may revoke certification for any good cause, as defined in 8.483.55, A, 1, based on adequate and documented evidence.
2. The agency designated by the State shall notify the AFC owner/operator by certified mail of its intent to revoke certification, stating the findings and conclusions which necessitate revocation.
3. Within thirty (30) calendar days of the date of mailing of the notice of intent to revoke the certification, the owner may submit to the agency designated by the State

written data, views and arguments with respect to the facts or conduct specified in the notice.

4. Except in the case of deliberate and willful violation of local, state, or federal ordinances, laws or agency rules and regulations applicable to, or concerning Adult Foster Care, or deliberate or willful breach of the Adult Foster Care agreement, the owner shall have thirty (30) calendar days from the date of the mailing of the notice of intent to revoke the certification to comply with all requirements concerning Adult Foster Care and/or the Adult Foster Care provider agreement.
 5. The effective date of the revocation shall be stated in the notification. Revocation (other than emergency) shall not be effective sooner than thirty (30) calendar days from the mailing date, except as provided herein. In the case of deliberate and willful violation, the effective date shall be contingent upon the safe relocation of the residents.
 6. The agency designated by the State shall notify all residents affected by the action as soon as is reasonably possible, in a manner calculated to apprise the residents of the contemplated action. Residents shall be advised of the plan developed by the agency designated by State for safeguarding their persons or property during any disruption of service.
 7. Except as otherwise provided herein, the operator shall have thirty (30) calendar days from the mailing date in which to request a hearing from the Colorado State Department of Administration, Division of Administrative Hearings. If an appeal is timely lodged, the effective date of revocation shall be stayed until a final decision is reached.
 8. For revocation of an existing Adult Foster Care facility certification, the decision of the administrative law judge shall constitute the final agency action.
- D. Revocation of AFC Certification Due to Failure to Remove A Resident Who Does Not Meet The Appropriateness For Placement Criteria
1. All residents in an Adult Foster Care Facility shall meet the Appropriateness of Placement criteria in 8.483.63. of this Staff Manual.
 2. If a resident through mental and/or physical deterioration or because of inappropriate placement is unable to meet the Appropriateness of Placement criteria, that resident shall:
 - a. If determined to be an imminent danger to him/herself or others be removed from the facility within 24. hours of the determination;
 - b. If determined to be a danger but the danger is not imminent, be removed within ten (10) calendar days.
 - c. If determined to be inappropriate but not a danger to him/herself or others, be removed within thirty (30) calendar days:
 3. Failure to remove a resident who does not meet the Appropriate of Placement criteria by above time frames shall be cause for revocation of Adult Foster Care Certification.

E. Revocation of AFC Certification Due to Inability to Appropriately Meet a Resident's Needs.

If the AFC facility does not or cannot meet a resident's needs within thirty (30). calendar days of notification, and refuses to remove the resident, the facility's certification shall be revoked.

F. Untimely Application for Renewal of Certification

When a timely and sufficient application has not been made for renewal of certification, the agency designated by the State shall notify the operator of the facility by regular mail of the loss of certification within thirty (30) calendar days after the missed renewal date

.56 CONFIDENTIALITY OF RECORDS

A. The records concerning the certification of facilities are open by the right of the Open Records Law (24-72-202 through 24-72-206, C.R.S.).

B. Anyone wishing to read a certification record must make a written request to the agency designated by the State. Parts of the record not available are:

1. Names of residents and their families shall be deleted from the record upon such inspection. All facts learned about residents and their families shall be deemed confidential both by the facility and the agency designated by the State.

2. References received by the agency designated by the State for the purposes of certification.

3. Client-specific reports received from other agencies.

8.483.60 CIVIL RIGHTS/CERTIFICATION REQUIREMENTS

A. Any person providing any service under these regulations shall strictly comply with all federal, state and local laws, regulations and ordinances. A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

B. All facilities shall operate in full compliance with the requirements of the zoning, housing, fire, sanitation and other codes and ordinances imposed by any city, city and county, county, town, or other political subdivision in which they are located to the extent that such codes are consistent with the Federal Fair Housing Amendment Act of 1988, as amended, 42 U.S.C., Sec. 3601 et seq., and shall be currently licensed as an Assisted Living Residence.

8.483.61 OPERATOR/STAFF QUALIFICATIONSQualifications for operator(s), staff and volunteers shall be as follows:

A. Any person providing any service under these regulations shall strictly comply with all federal, state and local laws, regulations and ordinances.

B. All operators and staff shall read, be familiar with, and follow the rules and regulations for the operation of AFCs. Ignorance of these rules and regulations is not an acceptable defense for their violation.

C. All operators and staff must be trained as defined in 8.483.62.

- D. The operator or staff person responsible for protective oversight of the residents must be able to recognize and respond to emergencies, including contacting emergency services such as 911, ambulance, fire and police departments.
- E. At all times there must be at least one staff person on duty who is 18 years of age or older and who is trained to provide protective oversight.
 - 1. If a facility can document to the State or its designee, the provision for one staff person on duty at all times may be waived in writing by the State.
 - 2. The criteria which must be met and documented in order for the State to waive the requirement that one person shall be on duty at all times shall include, but not be limited, to:
 - a. All residents must be in a day treatment program, in a job training program or on the job. This must be written in each resident's treatment or care plan. A staff person must be at the facility at the time the first resident returns.
 - b. If a resident becomes ill, leaves the day treatment program, job training or work early, the facility must have a telephone number which is manned at all times for the resident to call. A staff person who can meet the resident at the facility and stay with him/her until permanent staff arrives must be available at all times;
 - c. If a resident cannot be depended upon to follow his/her treatment plan and either stay at day placement or call the designated telephone number, then s/he is not appropriate for that facility and must be moved into a licensed facility that is staffed 24 hours per day or a waiver cannot be granted to that facility;
 - d. If a resident is ill or refuses to go to day placement or work, a staff member must stay with him/her or s/he must be taken to a licensed/certified residential facility that is staffed 24 hours per day; and
 - e. At no time may a resident be present in an Adult Foster Care facility without a staff member also being present in the facility who is trained to provide protective oversight
- F. Operator and staff must, prior to beginning duties, have a doctor's statement that they are free of communicable and infectious diseases.
- G. All operators, staff and volunteers providing direct client care or food preparation must have TB testing prior to beginning duties and annually thereafter.
- H. Facilities must maintain a 1:10 staff-to-resident ratio unless the operator can document to the State Department of Health Care, Policy and Financing or its designee that a ratio of less than 1:10 does not jeopardize the health and safety of the residents. Based on adequate documentation, a written staffing waiver may be issued by the state.
- I. A written request for a staff-to-resident waiver must be submitted to the state. The state may request further information which will be reviewed along with the most current Assisted Living Residence deficiency report and fire safety survey. Information which must be submitted to the state for review includes, but is not limited to:
 - a. the types of physical/mental limitations of residents in the facility such as confusion,

Organic Brain Syndrome or Alzheimer;

- b. a diagram of the layout of the facility;
 - c. the number and type of staff and their location during day and night;
 - d. the number of back up staff who will respond to the emergency and the distance they must travel;
 - e. types of training regular staff and back up staff has had in fire safety and other emergency procedures and how often this is done;
 - f. the facility's procedure for evacuation in case of fire or other emergency;
 - g. the number of fire drills held each year,
 - h. time scores in evacuating residents during a fire drill;
 - i. the distance of the nearest fire department that will respond to the call;
 - j. a description of the facility's sprinkler system, smoke alarms, special items for fire safety which have been installed in the facility (dedicated alarm line directly to fire station, 2 hour fire wall, alarms in each room hooked to a central alarm, etc.);
 - k. assurance that staff carry two-way radios or pagers for use in an emergency; and
 - l. staff-to-resident ratio requested.
- I. Any person who is involved in substance abuse, uses alcohol excessively, uses narcotic drugs or dangerous drugs shall not be approved as an operator; nor be employed, act as a volunteer, or reside in a certified facility.

8.483.62 TRAINING

- A. Facility operators must satisfactorily complete an introductory training on AFC rules and regulations prior to certification of the facility. This introductory training shall be conducted by the State Department of Health Care Policy and Financing.
- B. Certified facilities having operators who have not yet had this introductory training will be required to have their operator attend the next available training offered, or document to the State Department of Health Care Policy and Financing or its designee, that they have had previous training equivalent to the required training.
- C. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid and in emergency procedures prior to assuming responsibilities. Facilities certified prior to the effective date of this rule shall have sixty (60) days to satisfy this training requirement.
- D. The operator and staff must have training specific to the needs of the populations served, (e.g. chronically mentally ill, frail elderly, acquired immune deficiency syndrome, Alzheimer's disease).
- E. Thereafter, periodic training may be required of facility operators and/or staff, addressing needs identified by operators and/or by the agency designated by the State and/or State Department of Health Care Policy and Financing.

- F. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty (60) days to satisfy this training requirement.

8.483.63 APPROPRIATENESS OF PLACEMENT Only residents whose needs can be met by the facility shall be admitted to that facility. A facility shall not admit or keep any resident requiring a level of care of type of service which the facility does not provide or is unable to provide. In no event shall a facility admit or keep a resident who:

- A. Needs skilled services on more than an intermittent basis. If skilled services are provided on an intermittent basis they must be provided by a skilled provider;
- B. Is unable or unwilling to meet his/her own personal hygiene needs under supervision;
- C. Has an acute physical illness which cannot be managed through medications or prescribed therapy;
- D. Has a substance abuse problem, unless the substance abuse is no longer acute and physician determines it to be manageable;
- E. Has ambulation limitation, unless compensated for by an assistive device with minimal assistance from staff;
- F. Has a reportable communicable or infectious disease, unless the transmittal of the disease can be managed through the use of universal precautions and appropriate medical and/or drug treatment;
- G. Is consistently disoriented to time, person and place to such a degree that he/she poses a danger to self or others;
- H. Has seizure disorders, which are not adequately controlled by medications;
- I. Requires tray food services on a continuous basis;
- J. Exhibits behavior which poses a physical threat to self or others. Such behavior includes, but is not limited to, violent and disruptive behavior and/or any behavior which involves physical, sexual or psychological force or intimidation;
- K. Requires intravenous or tube, feeding;
- L. Is consistently unwilling to take medications prescribed by a physician;
- M. Is incapable of self-administration of medications unless the facility has a staff member trained in medication administration, in accordance with CRS. 25-1-107, et seq., or who possesses all necessary licenses to do so;
- N. Is a person whose physical safety cannot be assured in an AFC;
- O. Is consistently, uncontrollably incontinent of bowel or bladder that cannot be managed by resident with assistance from staff;
- P. Needs restraints, as defined herein, of any kind; or
- Q. Has a primary diagnosis of mental illness and is unwilling to comply with medications

prescribed by the physician and is not receiving services from the local community mental health center or other mental health professional.

- R. A copy of the ALR Board and Care Plan, jointly developed by the resident, family, caseworker and operator, must be provided to all parties prior to admission to the facility.
- S. Any client admitted for respite care in an AFC must meet the requirements for appropriate placement described above.

8.483.64 RESIDENT RIGHTS/HOUSE RULES All facilities must ensure the following residents rights are not violated:

- A. Residents may voluntarily participate in performing housekeeping duties and other tasks but cannot be required to perform duties of staff.
- B. If a resident is reimbursed by the facility for services performed, there must be a written agreement regarding duties and reimbursement between the resident and the operator. The amount of compensation must be reported to the income maintenance staff of the county department of social services and the single entry point agency case manager.
- C. All house policies regarding smoking and the use of alcohol shall apply equally to operator, staff, volunteers, residents and others residing in the facility.
- D. The withholding of food and water is prohibited unless indicated by written physician's orders or a pharmacist's medication instructions.
- E. The facility must provide an environment free from physical restraint, involuntary confinement, financial, sexual or any other exploitation or threat of intimidation.
- F. The facility must provide an accessible telephone with toll free local calls; and
- G. The facility shall provide residents with written information about the individual's rights under state law to accept or refuse medical treatment; the right to formulate, advance directives; and the providers' policies respecting the implementation of such rights. Documentation shall be kept in the individual's record as to whether the individual has executed an advance directive.
- H. The operator must have, the resident or designated guardian sign that the house rules and resident rights have been read, were explained, and are understood.

8.483.65 SERVICES PROVIDED Facilities, shall provide those, services indicated in Section 8.483.21 and 8.483.22 of this staff manual.

8.483.66 PROVIDER AGREEMENT

- A. Providers who meet all the AFC certification requirements in this staff manual may enter into a provider agreement with the State Department of Health Care Policy and Financing or its designee.
- B. Facilities shall not accept Adult Foster Care payments from AFC clients unless the facility is currently licensed as an Assisted Living Residence, certified as an AFC and has signed a provider agreement with the State Department of Health Care Policy and Financing or its designee.

8.483.67 RECORDS AND REPORTING REQUIREMENTS

- A. The facility shall maintain records, sufficient to document compliance with the State Department of Health Care Policy and Financing rules and contract requirements, including proof of insurance, licenses, permits, and surety bonds, for a period of at least six (6) years.
- B. The facility shall notify the State Department of Health Care Policy and Financing or its designee within five (5) working days, of any suspension, revocation or termination of any required license, permit, insurance, or surety bond.
- C. Facilities which accept responsibility for residents' personal funds shall post a surety bond in a minimum amount of \$10,000.
- D. Personnel records for each employee or volunteer must include name, age, sex, home address and phone number, documentation of training and/or work experience, and results of TB testing for any employee or volunteer providing direct care to residents or involved in meal preparation or food handling.
- E. Residents' records shall include, as appropriate, the name and address of a spouse, the date of termination or transfer from the facility, and the new forwarding address of the resident.
- F. The facility shall notify the case manager within five (5) days of the need for changes to the Board and Care Plan.
- G. The facility shall, within twenty-four (24) hours, notify the case manager of the death or serious injury of any individual living in an AFC facility with an ALR Board and Care Plan, and any severe deterioration in a resident's medical condition or behavior.

8.483.80 REIMBURSEMENT METHOD FOR ADULT FOSTER CARE

- A. AFC facilities shall negotiate a standard rate of payment per resident, per month with the agency designated by the State. For maximum allowable rate refer to this staff manual, section 8.483.31, B.
- B. AFC facilities shall not submit bills or otherwise attempt to collect payments from recipients or recipients' estates for any services provided to recipient which are benefits reimbursable under the program in accordance with the rules of the State Department of Health Care Policy and Financing.
- C. AFC facilities shall charge private pay residents an amount at least equal to that charged to AFC residents.
- D. Adult Foster Care payments shall not be made to residents in non-certified facilities.
- E. AFC operators must immediately notify the single entry point agency of any planned or unplanned absence of a resident for more than 24-hours. The single entry point agency may continue to fund an Adult Foster Care placement while a resident is on medical, programmatic or non-medical leave; however, the combined leave may not exceed a total of forty-two (42) days in a 12 month period beginning with the date the client was admitted into the program. The three types of leave are defined as follows:
 - 1. Medical leave is the absence of the resident from the Adult FOSTER Care facility due to admittance to a hospital or other institution. This must be on the order of a physician, and there must be a presumption on the part of the physician that the resident will be returning to the AFC facility.

2. Non-medical leave days are defined generally as days of leave from the AFC for non-medical reasons and are not part of a client's care plan.
3. Programmatic leave days are days of leave prescribed by a physician in for participation in therapeutic and/or rehabilitative programs and may entail visits to family, friends, or guardians. Any therapeutic and/or rehabilitative programs and visits to family, friends, or guardians must be prescribed by a physician and documented as part of the client's care plan to qualify as programmatic leave.

8.484 HOME CARE ALLOWANCE

8.484.10 Definition

- A. The Home Care Allowance (HCA) is a special allowance for the purpose of securing services to an individual in his/her home, based on the case manager's assessment. The Home Care Allowance is a non-entitlement program designed to serve those clients with the lowest functional abilities and the greatest need for paid care. Eligibility for and authorized amounts of the Home Care Allowance are subject to available appropriations.
- B. Medicine management, is the supervision of self-administration of medications. This means inquiring if a person has taken his/her medications, and/or reminding him/her to take his/her medications and assisting him/her by opening the medication container and handing the container to the person. This includes prescription medications, the container must have legibly written or printed directions of the attending physician or other authorized practitioner on the prescription label. Supervision of self-administration of medications does not include the monitoring of self-administration or the administration of medications: assisting a person in the injections, application, or inhalation of medications; injecting of medications or any intravenous procedure; or the repackaging of medications for ingestion at a later date.

8.484.20 Eligibility

Eligibility for the Home Care Allowance program shall be based on financial need, the client's functional capacity score, the client's need for paid care score and available appropriations. A legal immigrant, as defined in 26-2-103(5.7), C.R.S., who meets the eligibility requirements for Home Care Allowance shall be eligible for the program. Effective July 1, 2002, no client shall be found eligible for Home Care Allowance.

- A. Financial eligibility is determined in accordance with the CDHS Income Maintenance Staff Manual (9 CCR 2503-1) for aged, blind and disabled persons. In determining financial need, the client's Home Care Allowance authorized amount is added to the appropriate categorical grant standard (OAP, AND/SSI-CS, or State only AB or AND). Total countable income is deducted from the total of the Home Care Allowance authorized amount and the categorical grant standard to derive the net payment to the client. Assets in a disability trust, as described in 15-14-409.8., C.R.S., or a pooled trust as described in 15-14-409.9., C.R.S., are counted as available resources in determining eligibility for Home Care Allowance.
- B. The difference in the amount of Home Care Allowance (HCA) payments made to a client while he/she was on State-AND/AB and the amount of HCA payments made to the client when he/she becomes eligible for SSI and the total State AND/AB received by State AND or AB clients will be recoverable as an interim assistance payment upon SSI approval and SSI retroactive payment for the same period, in accordance with the regulations set forth in CDHS Income Maintenance Staff Manual (9 CCR 2503-1) under AND/AB Payment Policies. At the time of application, the SSI payment recovery procedure shall be explained to the applicant and his/her representative.

- C. Single entry point (SEP) agencies shall utilize the state prescribed form to determine Home Care Allowance (HCA) eligibility and authorized amounts for all applicants and clients.
- D. In order to be eligible for the Home Care Allowance Program, each applicant or client must meet the minimum client functional capacity score of 21 points in the following areas and shall score a minimum of one (1) point on the total need for paid care score:
1. Activities of daily living--includes transfers, bladder care, bowel care, mobility, dressing, bathing, hygiene, eating;
 2. Basic instrumental activities of daily living - includes meal preparation, housework, laundry, shopping;
 3. Supportive services - includes medicine management, appointment management, money management, accessing resources, and telephoning.
 4. The need for skilled personal care shall not be included in the case manager's scoring of the need for paid care score. Skilled personal care is not a paid service of the Home Care Allowance Program. See Section 8.489.21 and 8.489.31 for the definition of skilled personal care.
- E. The need for paid care score shall be based on the frequency of the client's or applicant's need for paid care as follows:

Frequency of Need for Paid Care	Need for Paid Care Score
No need for paid care	0
Up to and including once a week	1
More than once a week and up to seven days a week	2
At least two times per day five days per week	3

- F. Each applicant or client meeting the minimum requirements for the HCA program shall be assigned an authorized amount of Home Care Allowance by the case manager. The case manager shall determine the authorized HCA amount up to the maximum amount allowable based upon the need for paid care score as identified below. The case manager shall not approve the maximum authorized HCA amount, if the client's needs can be fully or partially met from other paid or unpaid sources, if the HCA provider is able to provide the authorized services for less than the maximum authorized amount, or if the client is unwilling or unable to use the maximum authorized amount. In determining the authorized HCA amount, the case manager shall ensure nonduplication of services in accordance with Section 8.393.23, C. 4., Care Planning.

Need for Paid Care Score	Authorized Home Care Allowance Amount per Month
1-23	\$1.00 up to -\$126
24-37	\$1.00 up to -\$265
38 and over	\$1.00 up to -\$396

- G. There shall be no retroactive Home Care Allowance payments for hardship provisions.
- H. The Home Care Allowance financial standard calculations are found in CDHS Income Maintenance Staff Manual (9 CCR 2503-1), Section 3.360.4 in the Old Age Pension Standards and in Section 3.460.45 in the AND/AB Standards.
- I. HCA payments shall be adjusted by the Department based on available funding.

8.484.30 DUTIES OF SINGLE ENTRY POINT AGENCY FOR HOME CARE ALLOWANCE CASES

- A. IntakeRefer to 8.393.21, A. 1 for SEP intake procedures.
- B. AssessmentRefer to 8.393.21 & 22 for SFP assessment procedures.
- C. Care PlanningIf the Client is found eligible fagme Home Care Allowance program, the case manager shall work with the client or the client's representative to develop a care plan.
 - 1. The client may select any persons), age 18 or over, to provide services to be paid for by the Home Care Allowance, The case manager snail assess (face-to-face) each care provider's ability and Willingness to provide the services, using the guidelines included in the Uniform Long Term Care Assessment Instrument instructions.
 - 2. The case manager shall negotiate with the client and care provider{s) to arrive at the" total number of paid hours to be provided weekly. State prescribed provider agreement and each shall receive a copy of the agreement.
 - 3. In all cases, Home Care Allowance payments shall be made directly the agreed amount on a regular monthly basis. No portion of the Home Care Allowance may be withheld for the client's personal use. The full HCA authorization, including the client's contribution, of applicable, must be spent for HCA services.
 - 4. The case manager shall explain that the client is responsible to pay each care provider on a monthly basis for the services provided.
 - 5. With the client's agreement per the release of information form, a copy of the provider agreement shall be sent to each care provider specifying the services to be provided, total hours per month, and agreed upon monthly provider reimbursement
 - 6. After supervisory review and sign-off, the case manager shall send a signed copy of the Uniform Long Term Care Assessment Instrument to the Income Maintenance staff authorizing payment of the Home Care Allowance and to the state.
 - 7. Payment of the Home Care Allowance will begin on the first day of the month following the month in which the HCA is authorized.
 - 8. There shall be no retroactive Home Care Allowance payments.
 - 9. Effective July 1, 1995, the maximum Home Care Allowance shall not exceed the maximum amount established in Section 8.484.20, F.
 - 10. The Home Care Allowance may be used for clients residing in congregate settings. A congregate setting is defined as three or more unrelated individuals living in a commonly shared facility which provides room, board and protective oversight All congregate settings shall be in compliance with all state and local licensing requirements. The maximum HCA authorized amount shall not cause the amount paid by the client to the

facility to exceed the maximum rate paid for Adult Foster Care.

11. Authorized HCA amounts for individuals who have been receiving a Home Care Allowance and who have been residing in the same congregate setting since prior to November 1, 1985, may exceed the AFC rate if the client is eligible to receive a higher authorized HCA amount

12. Services for HCA include;

- a. the seventeen (17) areas on page 3 of the ULTC 100. See Section 8.48420, C;
- b. electronic monitoring; and
- c. one-time deep cleaning if referral is initiated by Adult Protective Services and determined necessary by the single entry point case manager

D. Monitoring Services shall be monitored in accordance with 8.393.24 E.

E. Reassessment Single entry point agency staff shall complete the reassessment in accordance with 8.393.25.

F. Discontinuation of Home Care Allowance Denial or termination of Home Care Allowance shall be in accordance with Long Term Care Single Entry Point System regulations at 8.393.28
APPLICANT/CLIENT NOTICE AND APPEAL PROCESS.

G. Notification and Appeal Rights Applicants and clients for the Home Care Allowance program shall be notified of their eligibility status and changes in the authorized Home Care Allowance amount, in accordance with the procedures in Section 8.393.28, APPLICANT/CLIENT NOTICE AND APPEAL PROCESS.

8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED (HCBS-EBD) GENERAL PROVISIONS

8.485.10 LEGAL BASIS

The Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-EBD program is also authorized under state law at 26-4-601 et seq., C.R.S. (1991 Supplement), as amended.

8.485.20 KEYS AMENDMENT COMPLIANCE

All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the Social Security Act of 1935 and 45 CFR Part 1397 (October 1, 1991), by possession of a valid Personal Care Boarding Home license issued under C.R.S. 25-27-105, and regulations of the Colorado Department of Public Health and Environment, at 6 CCR 1011-1, Chapters 2 and Chapters 7. No amendments or later editions are incorporated. The program assistant of the Community Based Long Term Care Section of the Colorado Department of Health Care Policy and Financing may be contacted at 1575 Sherman, Denver, CO 80203, for a copy of 45 CFR Part 1397; or the material may be examined at any State Publications Depository Library.

8.485.30 SERVICES PROVIDED

.31 HCBS-EBD services provided as an alternative to nursing facility placement include:

- A. Adult day services; and
- B. Alternative care facility services, including homemaker and personal care services in a residential setting; and
- C. Electronic monitoring; and
- D. Home modification; and
- E. Homemaker services; and
- F. Non-medical transportation; and
- G. Personal care; and
- H. Respite care.
- I. In-Home Support Services,

.32 Case management is not a service of the HCBS-EBD waiver program, but shall be provided as an administrative activity through Single Entry Point Agencies.

.33 HCBS-EBD clients are eligible for all other Medicaid state plan benefits, including the Home Health program.

8.485.40 DEFINITIONS OF SERVICES

- A. Adult day services shall be as defined at Section 8.491.
- B. Alternative care facility services shall be as defined at Section 8.495.
- C. Electronic monitoring shall be as defined at Section 8.488.
- D. Home modification shall be as defined at Section 8.493.
- E. Homemaker services shall be as defined at Section 8.490.
- F. Non-medical transportation shall be as defined at Section 8.494.
- G. Personal care shall be as defined at Section 8.489.
- H. Respite shall be as defined at Section 8.492.
- I. In-Home Support Services shall be as defined at Section 8.552.

8.485.50 GENERAL DEFINITIONS

- A. Agency shall be defined as any public or private entity operating in a for-profit or nonprofit capacity, with a defined administrative and organizational structure. Any sub-unit of the agency that is not geographically close enough to share administration and supervision on a frequent and adequate basis shall be considered a separate agency for purposes of certification and contracts.

- B. Assessment shall be as defined at 8.390.1(B).
- C. Case management shall be as defined at 8.390.1(D), including the calculation of client payment and the determination of individual cost-effectiveness.
- D. Case plan shall be as defined 8.390.1 C, including the funding source, frequency, amount and provider of each service. This case plan shall be written on a State-prescribed Long Term Care Plan form.
- E. Categorically eligible shall be defined in the HCBS-EBD program as any client eligible for medical assistance (Medicaid), or for a combination of financial and medical assistance; and who retains eligibility for medical assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, but not for medical assistance, or persons who are eligible for HCBS-EBD as three hundred percent eligible persons, as defined at 8.485.50(U).
- F. Congregate facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.
- G. Uncertified Congregate Facility shall be a facility as defined at 8.485.50(F) that is not certified as an Alternative Care Facility. See 8.495.11.
- H. Continued stay review shall be a re-assessment as defined at section 8.402.60 through 8.402.65 and 8.390.1">8.390.1(C).
- I. Corrective action plan shall be as defined at 8.390.1 (E).
- J. Cost containment shall be defined as the determination that, on an individual client basis, the cost of providing care in the community is less than the cost of providing care in an institutional setting. The cost of providing care in the community shall include the cost of providing HCBS-EBD services, long term home health services and care provided under the Home Care Allowance Program.
- K. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-EBD. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected HCBS-EBD.
- L. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized, as defined at 8.485.50(K).
- M. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing faculty care without the provision of HCBS-EBD, and for whom HCBS-EBD services can be provided at no more than the cost containment amount.
- N. Intake/screening/referral shall be as defined at 8.390.1(H).
- O. Level of care screen shall be as defined at 8.401.

- P. Non-diversion shall be defined as a client who was certified by the Utilization Review Contractor as meeting the level of care screen and target group for the HCBS-EBD program, but who did not receive HCBS-EBD services for some other reason.
- Q. Provider agency shall be defined as an agency, certified by the Department and which has a contract with the Department to provide one of the services listed at 8.485.40. A single entry point agency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria at 8.393.61 are met.
- R. Reassessment shall be as defined at 8.390.1 (L).
- S. Single entry point agency shall be defined as an organization as described at 8.390.(1)(P).
- T. Department shall be defined as the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.
- U. Three hundred percent (300%) eligible shall be defined as persons:
 - 1) Whose income does not exceed 300% of the SSI benefit level; and
 - 2) Who, except for the level of their income, would be eligible for an SSI payment; and
 - 3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty consecutive days.

8.485.60 ELIGIBLE PERSONS

.61 HCBS-EBD services shall be offered to persons who meet all of the eligibility requirements below provided the individual can be served within the capacity limits in the federal waiver:

- A. Financial Eligibility Clients shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual, at 8.100.
- B. Level of Care and Target Group Clients who have been determined to meet the level of care and target group criteria shall be certified by the Utilization Review Contractor as eligible for HCBS-EBD. The Utilization Review Contractor shall only certify HCBS-EBD eligibility for those clients:
 - 1. Determined by the Utilization Review Contractor to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult as defined at Section 8.400.16; and
 - 2. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11 through 8.401.15; and
 - 3. A length of stay shall be assigned by the Utilization Review Contractor for approved admissions, according to guidelines at Section 8.402.60.
- C. Receiving HCBS-EBD Services
 - 1. Only clients who receive HCBS-EBD services, or who have agreed to accept HCBS-EBD services as soon as all other eligibility criteria have been met, are eligible for the HCBS-EBD program.

2. Case management is not a service and shall not be used to satisfy this requirement
3. Desire or need for home health services or other Medicaid services that are not HCBS-EBD services, as listed at Section 8.485.30, shall not satisfy this eligibility requirement
4. HCBS-EBD clients who have received no HCBS-EBD services for one month must be discontinued from the program.

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD services while residing in such institutions.
2. A client who is already an HCBS-EBD recipient and who enters a hospital for treatment may not receive HCBS-EBD services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the client from the HCBS-EBD program.
3. A client who is already an HCBS-EBD recipient and who enters a nursing facility may not receive HCBS-EBD services while in the nursing facility.
 - (a) The case manager must terminate the client from the HCBS-EBD program if Medicaid pays for all or part of the nursing facility care, or if there is a Utilization Review Contractor-certified ULTC-100 for the nursing facility placement, as verified by telephoning the Utilization Review Contractor.
 - (b) A client receiving HCBS-EBD services who enters a nursing facility for respite care as a service under the HCBS-EBD program shall not be required to obtain a nursing facility ULTC-100, and shall be continued as an HCBS-EBD client in order to receive the HCBS-EBD service of respite care in a nursing facility.

E. Cost-effectiveness Only clients who can be safely served within cost containment, as defined at section 8.485.50, are eligible for the HCBS-EBD program.

F. Waiting List Persons who are determined eligible for services under the HCBS-EBD waiver, who can not be served within the capacity limits of the federal waiver, shall be eligible for placement on a waiting list

1. The waiting list shall be maintained by the Department
2. the date used to establish the person's placement on the waiting list shall be the date on which eligibility for services under the HCBS-EBD waiver was initially determined.
3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the following priorities:
 - a. Clients being deinstitutionalized from nursing facilities.
 - b. Clients being discharged from a hospital who, absent waiver services, would be discharged to a nursing facility at a greater cost to Medicaid.
 - c. Clients who receive long term home health benefits who could be served at a

lesser cost to Medicaid.

- d. Clients with high ULTC 100.2 scores who are at risk of imminent nursing facility placement

8.485.70 START DATE

.71 The start date of eligibility for HCBS-EBD services shall not precede the date that all of the requirements at Section 8.485.60, have been met. The first date for which HCBS-EBD services can be reimbursed shall be the later of any of the following:

- B. Financial: The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.
- C. Level of Care: This date is determined by the official Utilization Review Contractor's stamp and the Utilization Review Contractor -assigned start date on the ULTC 100.2 form.
- D. Receiving Services: This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept services.
- E. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the hospital or nursing facility.

8.485.80 CLIENT PAYMENT OBLIGATION-POST ELIGIBILITY TREATMENT OF INCOME (PETI)

.81 When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, the Department may reduce Medicaid payment for Alternative Care Facility services according to the procedures at Section 8.486.60.

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

.91 The Department or its agent shall develop the Prior Authorization Request (PAR) in compliance with all applicable regulations, and determine whether services requested are (a) consistent with the client's documented medical condition, and functional capacity, (b) reasonable in amount, frequency and duration, (c) not duplicative, (d) not services for which the client is receiving funds to purchase, and, (e) do not total more than twenty four (24) hours per day of care.

- A. The case manager shall submit prior authorization approvals for all HCBS-EBD and HCBS-PLWA services to the fiscal agent within one (1) calendar month after the utilization review contractor's assigned start date and approval of financial eligibility.
- B. The Department or its fiscal agent will approve, deny or return for additional information home modification PARs over \$1,000 within 10 working days of receipt.

.92 When home modifications are denied, in whole or in part, the single entry point agency shall notify the client or the client's designated representative of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et. seq.

.93 Revisions requested by providers six months or more after the end date shall always be disapproved.

.94 Approval of the PAR by the Department or its agent shall authorize providers of services under the care plan to submit claims to the fiscal agent and to receive payment for authorized services provided

during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for long term care medical assistance (Medicaid) on the dates of service; and upon providers use of correct billing procedures.

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

.95 Every PAR shall be supported by information on the Long Term Care Plan form, the ULTC-100 and written documentation from the income maintenance technician of the client's current monthly income. All units of service requested on the PAR shall be listed on the Long Term Care Plan form. If a range of units is estimated on the care plan, the number of units at the higher end of the range may be requested on the PAR. As needed or PRN services must be given a numerical estimate on the care plan.

.96 If a PAR includes a request for home modification services above the Department prescribed amount, the PAR shall also include all documentation listed at Section 8.493.

.97 If a PAR is for an Alternative Care Facility client who is 300% eligible, all medical and remedial care requested as deductions shall be listed on the Client Payment form.

.98 The start date on the Prior Authorization Request form shall never precede the start date of eligibility for HCBS-EBD services, according to Section 8.485.70.

.99 The PAR shall not cover a period of time longer than the length of stay assigned by the Utilization Review Contractor.

Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.

8.485.200 LIMITATIONS ON PAYMENT TO FAMILY

.201 In no case shall any person be reimbursed to provide HCBS-EBD services to his or her spouse.

.202 Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-EBD program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

.203 The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.

.204 The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

- A. The total number of Medicaid personal care units for members of the client's family shall not exceed the equivalent of 444 personal care units per annual certification for HCBS-EBD and HCBS-PLWA.
 1. The maximum number of Medicaid personal care units per annual certification for HCBS-EBD and HCBS-PLWA shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision, and all other administrative costs.
 2. The maximum number of personal care units per annual certification for HCBS-EBD and HCBS-PLWA shall be 444. Family members must average at least 1.2164 hours of care per day (as indicated on the client's care plan) in order to receive the maximum reimbursement.

- a. If the certification period for HCBS-EBD and HCBS-PLWA is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the client is receiving care by the average units per day for a full year ($444/365=1.2164$).
- B. If more than one family member provides personal care to the same client, the maximum reimbursement number of 444 personal care units per annual certification for HCBS-EBD and HCBS-PLWA shall be divided among all family members providing care. Each family member providing care and sharing in the reimbursement shall be employed by the personal care agency.
- C. If two or more HCBS-EBD clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.
- D. When HCBS-EBD funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance cannot be used to reimburse the family.
- E. Restrictions on allowable personal care units shall not apply to parents who provide Attendant services to their eligible children under In-Home Support Services (§8.552).
- F. Services other than personal care shall not be reimbursed with HCBS-EBD funds when provided by the client's family, with the exception of Attendant services provided under In-Home Support Services (§8.552).

8.485.300 CLIENT RIGHTS

.301 The case manager shall inform persons eligible for HCBS-EBD, in writing, of their right to choose between HCBS-EBD services and nursing facility care. In addition, the case manager shall discuss the option and potential benefits of in-home support services with all eligible HCBS-EBD clients.

8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

8.486.10 HCBS-EBD PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

Single entry point agencies shall comply with single entry point rules at Section 8.390, et. seq., governing case management functions, and shall comply with all HCBS-specific requirements in the rest of this section on HCBS-EBD case management functions.

8.486.20 INTAKE

.21 Refer to 8.393.21 for single entry point intake procedures. The Intake form shall be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the applicant, for purposes of establishing a start date.

.22 Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long term care client assessment (ULTC-100), and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request an assessment if the client disagrees with the case manager's decision.

8.486.30 ASSESSMENT

.31 If the client is being discharged from a hospital or other institutional setting, the discharge planner shall contact the URC/SEP agency for assessment by emailing or faxing the Initial Intake and Screening form as required at Section 8.393.21.

.32 The URC/SEP case manager shall view and document the current Personal Care Boarding Home license, if the client lives, or plans to live, in a congregate facility as defined at Section 8.485.50, in order to ensure compliance with Section 8.485.20.

.35 ASSESSMENT-DEINSTITUTIONALIZATION To deinstitutionalize a client who is in a nursing facility under payment by Medicaid, and with a current ULTC 100.2 already certified by the URC/SEP agency for the nursing facility level of care, the nursing facility staff shall notify the URC/SEP agency of the planned date of discharge. The URC/SEP shall complete the assessment within five (5) working days of notification by the nursing facility. If the ULTC 100 completion date is older than six (6) months, the URC/SEP case manager shall complete a new ULTC 100.2 and determine if the client continues to meet the nursing facility level of care.

8.486.40 HCBS-EBD DENIALS

.41 If a client is determined, at any point in the assessment process, to be ineligible for HCBS-EBD according to any of the requirements at Section 8.485.60, the client or the client's designated representative shall be notified of the denial and the client's appeal rights in accordance with Long Term Care Single Entry Point System regulations at 8.393.28.

8.486.50 CASE PLANNING

Case planning shall include the following tasks:

- A. Documentation of the client's choice of HCBS-EBD services, nursing home placement, or other services, including a signed statement of choice from the client;
- B. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;

8.486.60 CALCULATION OF CLIENT PAYMENT (PETI)

The case manager shall calculate the client payment (PETI) for 300% eligible HCBS-EBD clients according to the following procedures:

- A. For 300% eligible HCBS-EBD clients who are not Alternative Care Facility clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.
- B. For 300% eligible clients who are Alternative Care Facility clients, the case manager shall complete a State-prescribed form, which calculates the client payment according to the following procedures:
 - 1. An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid; and
 - 2. For an individual with financial responsibility for only a spouse, an amount equal to the state Aid to the Needy and Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income; or
 - 3. For an individual with financial responsibility for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any

income of the spouse and/or dependents (excluding part-time employment earnings of dependent children as defined at Section 8.112.3(F) of Staff Manual Volume 8), shall be deducted from the client's gross income; and

4. Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the client's gross income as follows:
 - a. Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS; deductible or co-insurance charges; and
 - b. Necessary dental care not to exceed amounts equal to actual expenses incurred; and
 - c. Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred; and
 - d. Medications, with the following limitations:
 - 1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the Utilization Review Contractor certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.
 - 2) Medications which may be purchased with the Medical Identification Card shall not be allowed as deductions.
 - 3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.
 - 4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.
 - 5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.
 - e. Other necessary medical or remedial care shall be deducted from the client's gross income, with the following limitations:
 - 1) The need for such care must be documented in writing by the attending physician. For this purpose documentation on the Utilization Review Contractor certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.
 - 2) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

- f. Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.
 - g. When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.
 - 5. Any remaining income shall be applied to the cost of the Alternative Care Facility services, as defined at Section 8.495, and shall be paid by the client directly to the facility; and
 - 6. If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the client's income, the remaining income shall be kept by the client and may be used as additional personal needs or for any other use that the client desires, except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services.
- C. Case managers shall inform HCBS-EBD Alternative Care Facility clients of their client payment obligation on a form prescribed by the state at the time of the first assessment visit; by the end of each plan period; or within ten (10) working days whenever there is a significant change in the diem payment amount.
- 1. Significant change is defined as fifty dollars (\$50) or more.
 - 2. Copies of client payment forms shall be kept in the client files at the single entry point agency, and shall not be mailed to the State of its agent except as required for a prior authorization request, according to Section 8.509.31(G) of Staff Manual Volume 8, or if requested by the state for monitoring purposes.

8.486.70 PRUDENT PURCHASE AND SERVICE FUNDING PRIORITIES

.71 The single entry point agency shall be financially responsible for any services which it authorized to be provided to the client which did not meet regulatory requirements, or which continued to be rendered by a provider due to the single entry point agency's failure to timely notify the provider that the client was no longer eligible for services.

8.486.80 COST CONTAINMENT

.81 The case manager shall determine whether the individual meets the cost containment criteria of 8.485.50. J by using a State-prescribed PAR form to:

- A. Determine the maximum authorized costs for all HCBS-EBD services and long term home health services for the period of time covered by the care plan and compute the average cost per day by dividing by the number of days in the care plan period; and
- B. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:
 - 1. Enter (in the designated space on the PAR form) the monthly cost of institutional care

for the individual; and

2. Subtract from that amount the individual's gross monthly income; and
3. Subtract from that amount the individual's monthly Home Care Allowance authorized amount, if any, and
4. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount.

C. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.

Sections 8.486.90 - 8.486.98 deleted by the Medical Services Board February 9,2001.

8.486.100 REVISIONS

.101 SERVICES ADDED TO THE CARE PLAN

- A. Whenever a change in the care plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the fiscal agent.
 1. The revised care plan form shall list the services being revised and shall state the reason for the revision. Services on the revised care plan form, plus all services on the original care plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement
 2. The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.
- B. If a revised PAR includes a new request for home modification service above the Department prescribed amount, the revised PAR shall also include all documentation listed at Section 8.493.

.102 DECREASE OF SERVICES ON THE CARE PLAN

- A. A revised PAR does not need to be submitted if services on the care plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.
- B. If services are decreased without the client's agreement, the case manager shall notify the client of the adverse action and of appeal rights, according to Long Term Care Single Entry Point System regulations at 8.393.28.

8.486.200 REASSESSMENT

.201 The case manager shall complete a reassessment of each HCBS-EBD client before the end of the length of stay assigned by the Utilization Review Contractor at the last level of care determination. The case manager shall initiate a reassessment more frequently if required by single entry point regulations at 8.393.25, or when warranted by significant changes that may affect HCBS-EBD eligibility.

.202 The case manager shall submit a continued stay review PAR, in accordance with requirements at Section 8.485.90. For clients who have been denied by the Utilization Review Contractor at continued

stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ULTC 100.2. Acceptable documentation of an appeal includes: (a) a copy of the request for reconsideration or the request for appeal, signed by the client and sent to the Utilization Review Contractor or to the Division of Administrative Hearings; (b) a copy of the notice of a scheduled hearing, sent by the Utilization Review Contractor or the Division of Administrative Hearings to the client; or (c) a copy of the notice of a scheduled court date. Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be accepted as a substitute for the approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.486.300 TERMINATION

.301 In accordance with Long Term Care Single Entry Point System regulations at 8.393.28, clients shall be terminated from the HCBS-EBD program whenever they no longer meet one or more of the eligibility requirements at Section 8.485.60. Clients shall also be terminated from the program if they die, move out of state or voluntarily withdraw from the program.

8.486.400 COMMUNICATION

.401 In addition to any communication requirement specified elsewhere in these rules, the case manager shall be responsible for the following communications:

- A. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.
- B. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent, the case manager shall provide copies to all the HCBS-EBD providers in the care plan.
- C. Within five (5) working days of receipt from the Utilization Review Contractor of the certified ULTC 100.2 form, the case manager shall send a copy of the ULTC 100.2 form to all personal care,, and adult day services provider agencies on the care plan and to alternative care facilities listed on the care plan.
- D. The case manager shall notify the Utilization Review Contractor, on a form prescribed by the Department, within thirty (30) calendar days, of the outcome of all non-diversions, as defined at section 8.485.50.

8.486.500 CASE RECORDING/DOCUMENTATION

.501 Case management documentation shall meet all of the standards found at 8.393.16, and at 8.393.26.

8.487 HCBS-EBD PROVIDER AGENCIES

8.487.10 GENERAL CERTIFICATION STANDARDS

. 11 Provider agencies shall:

- A. Conform to all State established standards for the specific services they provide under this program; and
- B. Abide by all the terms of their provider agreement with the Department; and

- C. Comply with all federal and state statutory requirements. A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.
- .12 Provider agencies shall have written policies and procedures for recruiting, selecting, retaining and terminating employees.
- .13 Provider agencies shall have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on CONFIDENTIALITY OF INFORMATION at 26-1-114, C.R.S., as amended. Provider agencies shall have written policies and procedures for providing employees with client information needed to provide the services assigned, within the agency policies for protection of confidentiality.
- .14 Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department of Health Care Policy and Financing, and shall have written policies and procedures regarding emergency procedures.
- .15 Provider agencies shall have written policies and procedures regarding the handling and reporting of critical incidents, including accidents, suspicion of abuse, neglect or exploitation, and criminal activity. Provider agencies shall maintain a log of all complaints and critical incidents, which shall include documentation of the resolution of the problem.
- .16 Provider agencies shall maintain records on each client. The specific record for each client shall include at least the following information:
- A. Name, address, phone number and other identifying information about the client; and
 - B. Name, address and phone number of the case manager and single entry point agency; and
 - C. Name, address and phone number of the client's physician; and
 - D. Special health needs or conditions of the recipient; and
 - E. Documentation of the services provided, including where, when, to -whom and by whom the service was provided, and the exact nature of the specific tasks performed, as well as the amount or units of service. Records shall include date, month and year of service, and when applicable, the beginning and the ending time of day; and
 - F. Documentation of any changes in the client's condition or needs, as well as documentation of appropriate reporting and action taken as a result; and
 - G. For personal care agencies, documentation concerning advance directives shall be present in the client record; and
 - H. Documentation of supervision of care; and
 - I. All information regarding a client shall be kept together for easy access and review by supervisors, program monitors and auditors.
- .17 Provider agencies shall maintain a personnel record for each employee. The employee record shall contain at least the following:
- A. Documentation of employee qualifications.
 - B. Documentation of training.

- C. Documentation of supervision and performance evaluation.
- D. Documentation that the employee was informed of all policies and procedures required by these rules.
- E. A copy of the employee's job description.

.18 A provider agency may become separately certified to provide more than one type of HCBS-EBD service if all requirements are met for certification. Administration of the different services provided shall be clearly separate for auditing purposes. The provider agency shall also understand and be able to articulate its different functions and roles as a provider of each service, as well as all the rules that separately govern each of the types of services, in order to avoid confusion on the part of clients and others.

.19 Provider agencies shall send billing and other staff to the provider billing training offered by the fiscal agent, at least once each year.

8.487.20 GENERAL CERTIFICATION PROCESS

.21 An agency, as defined at Section 8.485.50, seeking certification as an HCBS-EBD provider agency, shall submit a written request to the Department or its agent

.22 Upon receipt of the written request, the Department or its agent shall forward certification information and relevant state application forms to the requesting agency.

.23 Upon receipt of the completed application from the requesting agency, the Department or its agent shall review the information and complete an on-site review of the agency, based on the state regulations for the service for which certification has been requested.

.24 Following completion of the on-site review the Department or its agent shall notify the provider agency applicant of its recommendation by forwarding the following information:

- A. Results of the on-site survey;
- B. Recommendation of approval, denial or provisional approval of certification;
- A. If appropriate, a corrective action plan to satisfy the requirements of a provisional approval.

.25 Determination of certification approval, provisional approval or denial shall be made by the Department within sixty (60) days of receipt of the completed application from the agency.

8.487.30 APPROVAL OF CERTIFICATION

If certification is approved, the Department shall enter into a provider agreement with the certified agency in accordance with Section 8.130.

8.487.40 PROVISIONAL APPROVAL OF CERTIFICATION

.41 If agencies do not meet all state established certification standards, but the deficiencies do not constitute a threat to clients' health and safety such agencies may be provisionally certified for a period not to exceed sixty (60) days at the discretion of the state.

.42 If provisional approval has been granted, the Department or its agent shall assure that corrective action has been taken according to the approved plan, and shall conduct an on-site review, if necessary, within the designated time period.

8.487.50 DENIAL OF CERTIFICATION

If the agency is unable to complete an adequate corrective action plan within the prescribed time, certification shall be denied, in accordance with Section 8.130.

8.487.60 RECERTIFICATION PROCESS

The Department or its agent shall follow the same procedures as those followed for certification, as described at Section 8.487.20.

8.487.70 TERMINATION OF PROVIDER AGREEMENTS

The Department shall initiate termination of a provider agreement if an agency is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The state shall follow procedures at Section 8.130.

8.487.80 EMERGENCY TERMINATION OF PROVIDER AGREEMENTS

Emergency termination of any provider agreement shall be in accordance with procedures at Section 8.050.

8.487.90 TRANSFER OF OWNERSHIP

.91 The provider shall notify the Department or its agent within five (5) working days of any change of ownership.'

.92 Upon transfer of ownership of the provider agency or facility, the provider certification may be assigned to the new owner only upon the prior written consent of the Department or its agent. Such assignment of the duties and obligations of the existing certification to the new owner shall be for a period of time determined at the discretion of the Department, but not to extend beyond the current end date of the original certification period.

.93 Upon transfer of ownership, the previous owner's existing provider agreement with the Department is immediately terminated, and the new owner must enter into a new provider agreement.

8.487.100 PROVIDER RIGHTS

The Department shall notify provider agencies in writing of any adverse action taken by the Department against the agency, and shall inform the agency of its appeal rights in accordance with the procedures described in Section 8.050.

8.487.200 PROVIDER REIMBURSEMENT

.201 Payment to certified HCBS-EBD providers for services provided to eligible clients shall be made when claims are submitted in accordance with the following procedures:

- A. Claims shall be submitted to the fiscal agent on State-prescribed forms provided by the fiscal agent according to Section 8.040 and Section 8.043: and
- B. Claim forms shall be filled out completely and correctly; and
- C. Payment shall not exceed Department established limits as described under the reimbursement sections for each HCBS-EBD service; and

- D. Payment shall be made only for the service or services for which the agency is certified; and
- E. Payment shall be made only for the types and amounts of services that are prior authorized by the Department or its agent; and
- F. Payment shall be made only for services provided by persons employed by the agency at the time the services were provided.

.202 Provider agencies shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.02, Section 8.130, and Section 8.487.10.

8.488 ELECTRONIC MONITORING

8.488.10 DEFINITIONS

.11 Electronic monitoring services means the installation purchase or rental of electronic monitoring devices which:

- A. enable the individual to secure help in the event of an emergency;
- B. may be used to provide reminders to the individual of medical appointments, treatments, or medication schedules;
- C. are required because of the individual's illness, impairment or disability, as documented on the ULTC-100 form and the care plan form; and
- D. are essential to prevent institutionalization of the individual.

.12 Electronic monitoring provider means a provider agency as defined at Section 8.484.50,Q, GENERAL DEFINITIONS, which has met all the certification standards for electronic monitoring services specified below.

8.488.20 INCLUSIONS

.21 Electronic monitoring services shall include personal emergency response systems, medication reminders, or other devices which comply with the definition above and are not included in the non-benefit items below at 8.488.31.

8.488.30 EXCLUSIONS, RESTRICTIONS AND NON-BENEFIT ITEMS

.31 Electronic monitoring services shall be authorized only for individuals who live alone, or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision.

.32 Electronic monitoring services shall be authorized only for individuals who have the physical and mental capacity to utilize the particular system requested for that individual.

.33 Electronic monitoring services shall not be authorized under HCBS if the service or device is available as a regular Medicaid benefit

.34 The following are not benefits of electronic monitoring services:

- A. Augmentative communication devices and communication boards;
- B. Hearing aids and accessories;

- C. Phonic ears;
- D. Environmental control units, unless required for the medical safety of a client living alone unattended;
- E. Computers and computer software;
- F. Wheelchair lifts for automobiles or vans;
- G. Exercise equipment, such as exercise cycles;
- H. Hot tubs, Jacuzzis, or similar items.

8.488.40 CERTIFICATION STANDARDS FOR ELECTRONIC MONITORING SERVICES

.41 Electronic monitoring providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES.

.42 In addition, electronic monitoring providers shall conform to the following standards for electronic monitoring services:

- A. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be FCC registered
- B. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer shall train the client in the use of the device.
- C. All equipment, materials or appliances shall be tested for proper functioning at the time of installation and at periodic intervals thereafter. Any malfunction shall be promptly repaired and equipment shall be replaced when necessary, including buttons and batteries.
- D. All telephone calls generated by electronic monitoring equipment shall be toll-free and all clients shall be allowed to run unrestricted tests on their equipment
- E. Electronic monitoring providers shall send written information to each client's case manager about the system, how it works, and how it will be maintained

8.488.50 REIMBURSEMENT METHOD FOR ELECTRONIC MONITORING

.51 Payment for electronic monitoring services shall be the lower of the billed charges or the prior authorized amount. The unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly.

.52 Effective 2/1/99, there shall be no reimbursement under this section for electronic monitoring services provided in uncertified congregate facilities.

8.489 PERSONAL CARE

8.489.10 DEFINITIONS

.11 Personal care services means services which are furnished to an eligible client in the client's home to meet the client's physical, maintenance and supportive needs. When those services are not skilled personal care as described in the EXCLUSIONS section below, do not require the supervision of a nurse, and do not require physician's orders.

.12 Personal care provider means a provider agency as defined at Section 8.484.50. P. GENERAL DEFINITIONS, which has met all the certification standards for personal care providers listed below.

.13 Personal care staff means those employees of the personal care provider agency who perform the personal care tasks.

.14 Skilled personal care means skilled care which may only be provided by a certified home health aide, as further defined at Section 8.526, HOME HEALTH AIDE SERVICES, and in the EXCLUSIONS section below.

.15 Unskilled personal care means personal care which is not skilled personal care, as defined above.

8.489.20 GENERAL PERSONAL CARE RULES

.21 Personal care services shall include unskilled personal care as defined under INCLUSIONS for each personal care task listed in Section 8.489.30.

.22 EXCLUSIONS AND RESTRICTIONS

- A. Personal care services shall not include any skilled personal care, which must be provided as home health aide services or as nursing services under non-HCBS programs. These services as defined under EXCLUSIONS for each personal care task listed in Section 8.489.30, shall not be provided as personal care services under HCBS, regardless of the level of the training, certification, or supervision of the personal care employee.
- B. Personal care staff shall not perform tasks that are not included under INCLUSIONS for each personal care task listed in Section 8.489.30, or tasks that are not listed. For example, personal care staff shall not provide transportation services and shall not provide financial management services. Clients, family, or others may choose to make private pay arrangements with the provider agency for services that are not Medicaid benefits, such as companionship.
- C. The amount of personal care that is prior authorized is only an estimate, including estimated travel time. The prior authorization of a certain number of hours does not create an entitlement on the part of the client or the provider for that exact number of hours. All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the client's needs.
- D. Personal care provider agencies may decline to perform any specific task, if the supervisor or the personal care staff feels uncomfortable about the safety of the client or the personal care staff, regardless of whether the task may be included in the INCLUSIONS section for the task.
- E. Family members shall not be reimbursed to provide only homemaker services. Family members must provide relative personal care in accordance with SECTION 8.485.200, LIMITATIONS ON PAYMENT TO FAMILY. Documentation of services provided must indicate that the provider is a relative.

3.489.30 SPECIFIC PERSONAL CARE TASKS

.31 The specific personal care tasks shall be authorized and provided according to the following rules.

A. BATHING

1. INCLUSIONS: Bathing is considered unskilled only when skilled skin care, skilled

transfer, or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the bathing.

2. EXCLUSIONS: Bathing is considered skilled when skilled skin care, skilled transfer or skilled dressing is required, as described under EXCLUSIONS for skin care at 8.489.31,B,2, EXCLUSIONS for transfers at 8.489.31,K,2, or EXCLUSIONS for dressing at 8.489.31,G,2.

B. SKIN CARE:

1. INCLUSIONS: Skin care is considered unskilled-only when skin is unbroken, and when any chronic skin problems are not active. Unskilled skin care must be of a preventive rather than a therapeutic nature, and may include application of non-medicated lotions and solutions, or of lotions and solutions not requiring a physician's prescription; rubbing of reddened areas; reporting of changes to supervisor, and application of preventive spray on unbroken skin areas that may be susceptible to development of decubiti. Unskilled skin care does not include any of the care described under skilled skin care in the EXCLUSIONS section below.
2. EXCLUSIONS: Skin care is considered skilled when there is broken skin, or potential for infection due to a chronic skin condition in an active stage. Skilled skin care includes wound care, dressing changes, application of prescription medications, skilled observation and reporting, but does not include use of sterile technique.

C. HAIR CARE

1. INCLUSIONS: Hair care is considered unskilled only when skilled skin care, transfer, or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the hair care. Hair care under these limitations may include shampooing with non-medicated shampoo or shampoo that does not require a physician's prescription, drying, combing and styling of hair.
2. EXCLUSIONS: Hair care is considered skilled when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS for skin care at 8.489.313,2, EXCLUSIONS for transfers at 8.489.31,K,2, or EXCLUSIONS for dressing at 8.489.31,G,2, is required in conjunction with the hair care.

D. NAIL CARE

1. INCLUSIONS: Nail care is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the nail care; and only in the absence of any medical conditions that might involve peripheral circulatory problems or loss of sensation. Nail care under these limitations may include soaking of the nails, pushing back cuticles, and trimming and filing of nails.
2. EXCLUSIONS: Nail care is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31,B,2 is required in conjunction with the nail care; and in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation.

E. MOUTH CARE

1. INCLUSIONS: Mouth care is considered unskilled only when skilled skin care, as

described under EXCLUSIONS, is not required in conjunction with the mouth care. Mouth care under these limitations may include denture care and basic oral hygiene.

2. EXCLUSIONS: Mouth care is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31,B,2, is required in conjunction with the mouth care; or when there is injury or disease of the face, mouth, head or neck; or in the presence of communicable disease; or when the client is unconscious; or when oral suctioning is required.

F. SHAVING

1. INCLUSIONS: Shaving is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with shaving; and only an electric razor may be used.
2. EXCLUSIONS: Shaving is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31,B,2, is required in conjunction with shaving.

G. DRESSING

1. INCLUSIONS: Dressing is considered unskilled only when skilled skin care or skilled transfer, as described under EXCLUSIONS, is not required in conjunction with the dressing. Unskilled dressing may include assistance with ordinary clothing; application of support stockings of the type that can be purchased without a physician's prescription; application of orthopedic devices such as splints and braces, or of artificial limbs, if considerable manipulation of the device or limb is not necessary, and if the client is fully trained in the use of the device or limb and is able to instruct the personal care staff.
2. EXCLUSIONS: Dressing is considered skilled when skilled skin care or skilled transfer, as described under EXCLUSIONS for skin care at 8.489.313,2 or EXCLUSIONS for transfers at 8.489.31,0, is required in conjunction with the dressing. Skilled dressing may include application of anti-embolic or other pressure stockings that can be purchased only with a physician's prescription; application of orthopedic devices such as splints and braces, or of artificial limbs, if considerable manipulation of the device or limb is necessary, or if the client is still learning to use the device or limb.

H. FEEDING

1. INCLUSIONS: Feeding is considered unskilled only when skilled skin care or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the feeding, and when oral suctioning is not needed on a stand-by or other basis. Unskilled feeding includes assistance with eating by mouth, using common eating utensils, such as forks, knives and straws.
2. EXCLUSIONS: Feeding is considered skilled when skilled skin care or skilled dressing, as described under EXCLUSIONS for skin care at 8.489.313,2 or EXCLUSIONS for dressing at 8.489.31,0,2, is required in conjunction with the feeding, and when oral suctioning is needed on a stand-by or other basis. Syringe feeding is also considered skilled. Feeding is skilled if there is a high risk of choking that could result in the need for emergency measures such as CPR or Heimlich maneuver.

I. AMBULATION

1. INCLUSIONS: Assistance with ambulation is considered unskilled only when skilled transfers, as described under EXCLUSIONS, are not required in conjunction with the ambulation. In addition, when assisting a client with adaptive equipment, the client must be fully trained in the use of such equipment; and when assisting someone in a cast, there must be no need for observation and reporting to a nurse, and no need for skilled skin care, as described under EXCLUSIONS. Adaptive equipment may include, but is not limited to, gait belts, walkers, canes and wheelchairs.
2. EXCLUSIONS: Assistance with ambulation is considered skilled when skilled transfers, as described under EXCLUSIONS for transfers at 8.489.31,K,2, are required in conjunction with the ambulation. In addition, when assisting a client with adaptive equipment, it is considered skilled if the client is still being trained in the use of such equipment; and assisting someone in a cast is considered skilled there is a need for observation and reporting to a nurse, or if there is a need for skilled skin care, as described under EXCLUSIONS for skin care at 8.489.31,B,2.

J. EXERCISES

1. INCLUSIONS: Assistance with exercises is considered unskilled only when the exercises are not prescribed by a nurse or other licensed medical professional. Unskilled assistance with exercise is limited to the encouragement of normal bodily movement, as tolerated, on the part of the client. Personal care staff shall not prescribe nor direct any type of exercise program for the client.
2. EXCLUSIONS: Assistance with exercises is considered skilled when the exercises are prescribed by a nurse or other licensed medical professional. This may include passive range of motion.

K. TRANSFERS

1. INCLUSIONS: Assistance with transfers is considered unskilled only when the client has sufficient balance and strength to assist with the transfer to some extent. Except for Hoyer lifts, adaptive equipment may be used in transfers, provided that the client is fully trained in the use of the equipment and can direct the transfer step by step. Adaptive equipment may include, but is not limited to, gait belts, wheel chairs, tub seats, grab bars.
2. EXCLUSIONS: Assistance with transfers is considered skilled when the client is unable to assist with the transfer. Use of Hoyer lifts is considered skilled, and use of other adaptive equipment is considered skilled if the client is still being trained in the use of the equipment

L. POSITIONING

1. INCLUSIONS: Positioning is considered unskilled only when the client is able to identify to the personal care staff, verbally, non-verbally or through others, when the position needs to be changed; and only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the positioning. Positioning may include simple alignment in a bed, wheelchair, or other furniture.
2. EXCLUSIONS: Positioning is considered skilled when the client is not able to identify to the caregiver when the position needs to be changed, and when skilled skin

care, as described under EXCLUSIONS for skin care at 8.489.31,B,2, is required in conjunction with the positioning.

M. BLADDER CARE

1. INCLUSIONS:Bladder care is considered unskilled only when skilled transfer or skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the bladder care. Unskilled bladder care may include assisting the client to and from the bathroom; assistance with bed pans, urinals, and commodes; and changing of clothing and pads of any kind used for the care of incontinence. Emptying of foley catheter bags or suprapubic catheter bags is considered unskilled only if there is no disruption of the closed system; the personal care staff must be trained to understand what constitutes disruption of the closed system.
2. EXCLUSIONS:Bladder care is considered skilled whenever it involves disruption of the closed system for a foley or suprapubic catheter, such as changing from a leg bag to a night bag. Care of external catheters is also considered skilled.

N. BOWEL CARE

1. INCLUSIONS:Bowel care is considered unskilled only when skilled transfer or skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the bowel care. Unskilled bowel care may include assisting the client to and from the bathroom; assistance with bed pans and commodes; and changing of clothing and pads of any kind used for the care of incontinence. Emptying of ostomy bags and assistance with other client-directed ostomy care is unskilled only when there is no need for skilled skin care or for observation and reporting to a nurse.
2. EXCLUSIONS:Bowel care is considered skilled when skilled transfer or skilled skin care, as described under EXCLUSIONS for transfers at 8.489.31,K,2, or EXCLUSIONS for skin care at 8.489.3 LB-2. is required in conjunction with the bowel care. Skilled bowel care includes digital stimulation and enemas. Skilled bowel care may include care of ostomies that are new, and care of ostomies when the client is unable to self-direct the care, provided that sterile technique is not required.

O. MEDICATION REMINDING

1. INCLUSIONS:Medication reminding is allowed as unskilled personal care only when medications have been preselected, by the client, a family member, a nurse, or a pharmacist, and are stored in containers other than the prescription bottles, such as medication minders. Medication minder containers must be clearly marked as to day and time of dosage, and must be kept in such a way as to prevent tampering. Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client, and opening the appropriately marked medication minder container for the client if the client is physically unable to open the container. Medication reminding does not include taking the medication out of the container. These limitations apply to all prescription and all over the counter medications, including pm medications. Any irregularities noted in the preselected medications, such as medications taken too often or not often enough, or not at the correct time as marked on the medication minder container, shall be immediately reported by the personal care staff to a supervisor.

2. EXCLUSIONS: Medication assistance is considered skilled care and consists of putting the medication in the client's hand when the client can self-direct in the taking of medications.

P. RESPIRATORY CARE

1. INCLUSIONS: Respiratory care is not considered unskilled. However, personal care staff may clean or change the tubing for oxygen equipment, may fill the distilled water reservoir, and may temporarily remove and replace the cannula or mask from the client's face for purposes of shaving or washing the client's face. Adjustments of the oxygen flow are not allowed.
2. EXCLUSIONS: Respiratory care is skilled care, and includes postural drainage, cupping, adjusting oxygen flow within established parameters, and suctioning of mouth and nose.

Q. ACCOMPANYING

1. INCLUSIONS: Accompanying the client to medical appointments, banking errands, basic household errands, clothes shopping, and grocery shopping to the extent necessary and as specified on the care plan is considered unskilled, when all the care that is provided by the personal care staff in relation to the trip is unskilled personal care, as described in these regulations. Accompanying the client to other services is also permissible as specified on the care plan, to the extent of time that the client would otherwise receive personal care services in the home. Personal care for the purpose of accompanying the client shall only be authorized when a personal care provider is needed during the trip to provide one or more other unskilled personal care services listed in this Section. Accompanying the client primarily to provide companionship is not a covered benefit.
2. EXCLUSIONS: Accompanying is considered skilled when any of the tasks performed in conjunction with the accompanying are skilled tasks. Accompanying does not include transporting the client.

- R. **HOMEMAKING** Homemaking, as described at Section 8.490, **HOMEMAKER SERVICES**, may be provided by personal care staff, if provided during the same visit as unskilled personal care, as described in these regulations.

S. PROTECTIVE OVERSIGHT

1. INCLUSIONS: Protective oversight is considered unskilled when the client requires stand-by assistance with any of the unskilled personal care described in these regulations, or when the client must be supervised at all times to prevent wandering.
2. EXCLUSIONS: Protective oversight for standby assistance with personal care tasks is considered skilled if any of the tasks performed are skilled tasks. Protective oversight to prevent wandering is considered skilled if any skilled personal care tasks are performed while providing oversight.

.32 Personal care services as described above may be used to provide respite care for primary care givers, provided that the respite care does not duplicate any care which the primary caregiver may be receiving payment to provide.

8.489.40 CERTIFICATION STANDARDS FOR PERSONAL CARE SERVICES

.41 Personal care provider agencies shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES, and shall meet all the additional personal care certification requirements in this section.

.42 Personal care provider agencies shall assure and document that all personal care staff have received at least twenty hours of training, or have passed a skills validation test, in the provision of unskilled personal care as described above. Training, or skills validation, shall include the areas of bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care, medication reminding, homemaking, and protective oversight. Training shall also include instruction in basic first aid, and training in infection control techniques, including universal precautions. Training or skills validation shall be completed prior to service delivery, except for components of training that may be provided in the client's home, in the presence of the supervisor.

.43 All employees providing personal care shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of personal care staff, as specified above. Supervision shall include, but not be limited to, the following activities:

- A. Orientation of staff to agency policies and procedures.
- B. Arrangement and documentation of training.
- C. Informing staff of policies concerning advance directives and emergency procedures.
- D. Oversight of scheduling, and notification to clients of changes; or close communication with scheduling staff.
- E. Written assignment of duties on a client-specific basis.
- F. Meetings and conferences with staff as necessary.
- G. Supervisory visits to client's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, client-specific or procedure-specific training of staff, observation of client's condition and care, and assessment of client's satisfaction with services. At least one of the assigned personal care staff must be present at supervisory visits at least once every three months.
- H. Investigation of complaints and critical incidents.
- I. Counseling with staff on difficult cases, and potentially dangerous situations.
- J. Communication with the case managers, the physician, and other providers on the care plan, as necessary to assure appropriate and effective care.
- K. Oversight of record-keeping by staff.

.44 A personal care agency may be denied or terminated from participation in Colorado Medicaid, according to procedures found at Section 8.050 through 8.051.44. based on good cause, as defined at 8.051.01. Good cause for denial or termination of a personal care agency shall include, but not be limited to, the following:

- A. Improper Billing Practices: Any personal care/homemaker agency that is found to have engaged in the following practices may be denied or terminated from participation in

Colorado Medicaid:

1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home, as well as time of departure and time of arrival for all travel time billed. Providers shall submit or produce requested documentation in accordance with rules at 8.079.62.
2. Billing for excessive hours that are not justified by the documentation of services provided, or by the client's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as such time as that authorized.
3. Billing for time spent by the personal care provider performing any tasks that are not allowed according to regulations in this SECTION 8.489. This includes but is not limited to. companionship, financial management, transporting of clients. skilled personal care, or delegated nursing tasks.
4. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:
 - a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.
 - b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 2 1/2 hours plus the number of hours billed for personal care and homemaker.
 - c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 1/2 hours.
 - d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related, to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.
 - e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

- f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.
- 5. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 4 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.
- B. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services Without Also Receiving Payment For Home Health Services. A personal care/homemaker agency that is also certified as a Medicaid Home Health Agency may be terminated from Medicaid participation if the agency refuses to provide necessary and allowed HCBS personal care or homemaker services to clients who do not need Home Health services or who receive their Home Health services from a Home Health Agency not affiliated with the personal care/homemaker agency.
- C. Prior Termination From Medicaid Participation. A personal care/homemaker agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a personal care/homemaker agency or any other type of service provider.
- D. Abrupt Prior Closure. A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

.45 Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. 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 State, the Medical Services Board, or the State's fiscal agent.

.46 When a personal care agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.489.50 REIMBURSEMENT

.51 Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of one hour. The maximum unit rate shall be adjusted by the State as funding becomes available.

.52 Payment may include travel time to and from the client's residence, to be billed at the same unit rate as personal care services. The time billed for travel shall be listed separately from, but documented on the same form as, the time for service provision on each visit. Travel time must be summed over a period of at least a week and then rounded to the nearest hour for billing purposes. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period.

.53 When personal care services are used to provide respite for unpaid primary care givers, the exact services rendered must be specified in the documentation.

.54 when an employee of a personal care agency provides services to a client who is a relative, the

personal care agency shall bill under a special procedure code, in hourly units, using rates and hours which shall not exceed a total cost to Medicaid of more than \$13.00 per day. when averaged out over the number of days in the plan period.

.55 If a visit by a personal care staff includes some homemaker services, as defined at Section 8.490. HOME MAKER SERVICES, the entire visit shall be billed as personal care services. If the visit includes only homemaker services, and no personal care is provided, the entire visit shall be billed as homemaker services.

.56 If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.

.57 Effective 21/99, there shall be no reimbursement under this section for personal care services provided in uncertified congregate facilities. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving these services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued.

.58 Cost Reporting

- A. All personal care agencies shall report and submit to the Department cost report information on a Department prescribed form.
- B. By dates set forth by the Department, personal care providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or the State fiscal year.
- C. Providers that do not comply with Section 8.489.58 shall have their Medicaid provider agreement terminated.

8.490 HOME MAKER SERVICES

8.490.10 DEFINITIONS

.11 Homemaker services means general household activities provided in the home of an eligible client, when the individual ordinarily responsible for these activities is temporarily absent or unable to manage the household activities.

.12 Homemaker provider means a provider agency as defined at Section 8.484.50, P GENERAL DEFINITIONS, which has met all the certification standards for homemaker providers listed below.

8.490.20 INCLUSIONS

.21 Homemaker services include the following activities:

- A. Routine light housecleaning, such as dusting, vacuuming, mopping, and cleaning of bathroom and kitchen areas.
- B. Meal preparation.
- C. Dishwashing.
- D. Bedmaking.
- E. Laundry.
- F. Shopping.

- G. Teaching of all the above skills to eligible clients who are capable of doing such chores for themselves, except for lack of training or previous experience. The goal of such teaching is to decrease client dependence, resulting within ninety (90) days in a decrease in the weekly number of units of service on the care plan. If such a savings in service units is not realized, teaching shall be deleted from the care plan.

8.490.30 EXCLUSIONS AND RESTRICTIONS

.31 Homemaker services shall not include any personal care services.

.32 Homemaker services shall be for the explicit benefit of the eligible client, and not for the benefit of other persons living in the home. Whenever there are other household members eighteen years of age or older who are not physically or mentally disabled, the homemaker shall clean only the client's bedroom and one bathroom used by the client; and shall wash only dishes that were used by the client. The homemaker shall also not perform homemaking services for guests of the client, such as, but not limited to, cleaning up after a party or a family dinner. Clients, family, or others may choose to make private pay arrangements with the provider agency for homemaker services not covered under Medicaid.

.33 The amount of homemaking that is prior authorized is only an estimate, including estimated travel time. The prior authorization of a certain number of hours does not create an entitlement on the part of the client or the provider for that exact number of hours. All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the client's needs.

.34 Family members shall not be reimbursed to provide only homemaker services. Family members must provide relative personal care in accordance with SECTION 8.485.200 LIMITATIONS ON PAYMENT TO FAMILY. Documentation of services provided must indicate that the provider is a relative.

8.490.40 CERTIFICATION STANDARDS FOR HOME MAKER SERVICES

.41 Homemaker provider agencies shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES.

.42 Homemaker provider agencies shall assure and document that all homemakers have received at least eight hours of training, or have passed a skills validation test, prior to service delivery, in the provision of homemaker services as described above. Training, or skills validation, shall include the areas of routine light housecleaning, meal preparation, dishwashing, bed making, laundry, and shopping. Training shall also include proper food handling and storage techniques, and basic infection control techniques including universal precautions.

.43 All employees providing homemaker services shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of homemakers, as specified above. Supervision shall include, but not be limited to, the following activities:

- A. Arrangement and documentation of training.
- B. Informing staff of policies concerning advance directives and emergency procedures.
- C. Oversight of scheduling, and notification to clients of changes.
- D. Meetings and conferences with staff as necessary.
- E. Supervisory visits to client's homes at least every three months, or more often as necessary for problem resolution, skills validation of staff, observation of the home's condition, and assessment of client's satisfaction with services.

- F. Investigation of complaints.
- G. Counseling with staff on difficult cases, and potentially dangerous situations.
- H. Communication with the case managers as necessary.
- I. Oversight of record-keeping by staff.

.44 A homemaker agency may be denied or terminated from participation in Colorado Medicaid, according to procedures found at Section 8.050 through 8.051.44, based on good cause, as defined at 8.051.01. Good cause for denial or termination of a homemaker agency shall include, but not be limited to, the following:

- A. Improper Billing Practices: Any personal care/homemaker agency that is found to have engaged in the following practices may be denied or terminated from participation in Colorado Medicaid:
 - 1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home, as well as time of departure and time of arrival for all travel time billed. Providers shall submit or produce requested documentation in accordance with rules at 8.079.62.
 - 2. Billing for excessive hours that are not justified by the documentation of services provided, or by the client's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as much time as that authorized.
 - 3. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:
 - a . One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.
 - b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 2 1/2 hours plus the number of hours billed for personal care and homemaker.
 - c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 % hours.
 - d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times

of the day.

- e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week,
- f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

4. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 3 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

B. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services Without Also Receiving Payment For Home Health Services. A personal care/homemaker agency that is also certified as a Medicaid Home Health Agency may be terminated from Medicaid participation if the agency refuses to provide necessary and allowed HCBS personal care or homemaker services to clients who do not need Home Health services or who receive their Home Health services from a Home Health Agency not affiliated with the personal care/homemaker agency.

C. Prior Termination From Medicaid Participation. A personal care/homemaker agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a personal care/homemaker agency or any other type of service provider.

D. Abrupt Prior Closure. A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

.45 Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement or who acts in deliberate ignorance or with reckless disregard for truth. 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 State, the Medical Services Board, or the State's fiscal agent.

.46 When a personal care/homemaker agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.490.50 REIMBURSEMENT

.51 Payment for homemaker services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of one hour. The maximum unit rate shall be adjusted by the State as funding becomes available.

.52 Payment may include travel time to and from the client's residence, to be billed at the same unit rate as homemaker services. The time billed for travel shall be listed separately from, but documented on the same form as, the time for service provision on each visit. Travel time must be summed over a period of at least a week and then rounded to the nearest hour for billing purposes. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period.

.53 If a visit by a Home Health Aide from a Home Health Agency includes homemaker services, as defined in this section, only the Home Health Aide visit shall be billed.

.54 If a visit by personal care staff, as defined in Section 8.489, PERSONAL CARE, includes homemaker services, the entire visit shall be billed as personal care only.

.55 THERE SHALL BE NO REIMBURSEMENT FOR HOME MAKER SERVICES PROVIDED IN UNCERTIFIED CONGREGATE FACILITIES UNDER THIS SECTION. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued.

.56 Cost Reporting

- A. All homemaking agencies shall report and submit to the Department cost report information on a Department prescribed form.
- B. By dates set forth by the Department, homemaker providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or the State fiscal year.
- C. Providers that do not comply with Section 8.490.56 shall have their Medicaid provider agreement terminated.

8.491 ADULT DAY SERVICES

.10 Adult Day Services (ADS) means health and social services, individual therapeutic and psychological activities furnished on a regularly scheduled basis in an adult day services center, as an alternative to long-term nursing facility care.

.12 Basic Adult Day Services (ADS) Center means a community-based entity that conforms to all state established requirements as described in Section 8.130 and Section 8.491.14.

.13 Specialized Adult Day Services (SADS) Center means a community-based entity determined by the State to be providing intensive health supportive services for participants with a primary diagnosis of Alzheimer's and related disorders, Multiple Sclerosis, Brain Injury, Chronic Mental Illness, Developmental Disability or post-stroke participants who require extensive rehabilitative therapies. To be determined specialized, two-thirds of an ADS center's population must be participants whose physician has verified one of the above diagnoses and recommended the appropriate specialized services. In addition, verification and documentation of the participant's diagnosis and the recommended specialized services must be included in each participant's case record and must include the following:

- A. For Medicaid participants, the case manager must forward the most recent copy of page 1 of the participant's ULTC-100 to the ADS center as documentation of one of the above diagnoses. Documentation must be verified at the time of admission, reassessment or whenever then; is a significant change in the participant's condition.
- B. For participants from other payment sources, diagnosis and recommended specialized services must be documented in an individual care plan, or other admission form, and

verified by the participant's physician. This documentation must be verified at the time of admission, or whenever there is a significant change in the participant's condition.

- C. The Department or its designee will review an adult day services center's designation as a specialized facility (SADS) on an annual basis.

.14 Only participants whose needs can be met by the Adult Day Services Center within its certification category and populations served shall be admitted to the Center. Adult day services shall include, but are not limited to, the following:

- A. Daily monitoring to assure that participants are maintaining activities prescribed; and assisting with activities of daily living (e.g., eating, dressing, bathing).
- B. Emergency services including written procedures to meet medical crises.
- C. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.
- D. Nutrition services including therapeutic diets and snacks appropriate to the participant's care plan and hours in which the participant is served
- E. Daily services provided to monitor the participant's health status, supervise medications, and carry out physicians' orders in participant's care plan as needed.
- F. Social and recreational services as prescribed to meet the participant's needs and as documented in the participant's care plan. Participants have the right to choose not to participate in social and recreational activities.
- G. Adult day services centers certified on or after July 1, 1996, or upon change of ownership, shall provide basic personal care services including bathing in emergency situations.
- H. Any additional services such as physical therapy, occupational therapy and speech therapy, if such services are prescribed by the participant's physician, documented in the participant's care plan and if such services are not being provided in the participant's home. Such services must be included in the budget submitted to the State in accordance with the section on REIMBURSEMENT METHOD FOR ADULT DAY SERVICES, and determined by the State to be necessary for adult day services.

8.491.15 DEFINITIONS

- A. Director means any person who owns and operates an ADS center, or is a managing employee with delegated authority by ownership to manage, control, or perform the day-to-day tasks of operating the facility as described in section 8.495.C.22.
- B. Participant means any individual found to be eligible for adult day services regardless of payment source.
- C. Restraint means any physical or chemical device, application of force, or medication which is designed or used for the purpose of modifying, altering, or controlling behavior for the convenience of the facility, excluding medication prescribed by a physician as part of an ongoing treatment plan or pursuant to a diagnosis.
- D. Staff means a paid or voluntary employee of the facility.
- E. Universal Precautions refers to a system of infection control which assumes that every direct

contact with body fluids is potentially infectious. This includes any reasonably anticipated skin, eye, mucous membrane or contact with blood-tinged body fluids, or other potentially infectious material

8.491.20 CERTIFICATION STANDARDS

All ADS centers shall conform to all of the following State established standards:

A. General

1. Conforms to all established State standards in the section on general provider participation requirements, as defined in Section 8.130, has in effect all necessary licenses and insurance, and is in compliance with ADS regulations as determined by an annual on-site survey conducted by the Department of Health Care Policy and Financing or its designee.
2. A completed Provider Agreement between the provider and the Department of Health Care Policy and Financing shall serve as proof of Medicaid certification.
3. Denial, termination, or non-renewal of the Provider Agreement shall be for "Good Cause" as provided in Section 8.050 of this staff manual.

B. Environment

1. All providers of ADS shall operate in full compliance with all applicable federal, State and local fire, health, safety, sanitation and other standards prescribed in law or regulations.
2. The agency shall provide a clean environment, free of obstacles that could pose a hazard to participant health and safety.
3. Agencies shall provide lockers or a safe place for participants' personal items.
4. ADS centers shall provide recreational areas and activities appropriate to the number and needs of the participants.
5. Drinking facilities shall be located within easy access to participants.
6. ADS centers shall provide eating and resting areas consistent with the number and needs of the participants being served. Centers certified on or after July 1, 1996, shall provide a minimum of 40 sq. feet per participant.
7. ADS centers shall provide easily accessible toilet facilities, hand-washing facilities and paper towel dispensers. Centers certified on or after May 1, 1996 must provide a facility for bathing in emergency situations.
8. The center shall be accessible to participants with supportive devices for ambulation or in wheelchairs.
9. There shall be adequate means by which food shall be maintained at the following temperatures: Hot 140° F, Cold: 45° F.
10. All medications shall be stored in a secured area.
11. Centers shall be heated to at least seventy (70) degrees during hours of operation.

and no more than 76 degrees in the summer months.

12. ADS centers must provide an environment free from restraints as defined at Section 8.491.15 C. of these rules.

13. ADS Centers, in accordance with 8.491.14 above, must provide a safe environment for all participants, including participants exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

C. Records and Information ADS providers shall keep such records and information necessary to document the services provided to participants receiving adult day services. Records shall include but not be limited to:

1. a. Name, address, sex, and age of each participant

b. Name, address and telephone number of responsible party,

c. Name, address and telephone number of primary physician

d. Documentation of the supervision and monitoring of the services provided,

e. Documentation that all participants were oriented to the center, the policies, and procedures relevant to the facility and the services provided.

f. A services agreement signed by the participant and/or his or her designated representative and appropriate center staff.

g. A plan of care. Plans of care for participants from other payment sources, receiving supportive services in a specialized ADS center must include a primary diagnosis and a physician's signature.

2. Medical Information included in the plan of care:

a. Medications the client participant is taking and whether they are being self-administered.

b. Special dietary needs, if any.

c. Any restrictions on social and/or recreational activities identified by physician in the care plan.

d. Documentation of any nursing or medical interventions; physical, speech, and/or occupational therapy administered to participants whose physician has prescribed such services to be included in the participant's individual plan of care.

e. Any other special health or behavioral management needs.

3. Documentation that the participant and/or other responsible party was provided with written information about his/her rights under state law regarding advance directives in accordance with regulations at 8.130.65. Documentation as to whether the participant has executed an advance directive shall be kept in his/her case record.

4. All entries into the record shall be legible, written in ink, dated, and signed with name

and title designation.

5. Records shall be maintained in such a manner as to ensure safety and confidentiality

D. Staffing Requirements

1. All ADS centers must maintain a staff to participant ratio of 1:8 or lower to provide for the needs of the population served, as described above at 8.491.12 and .13, and shall provide the following:
 - a. Supervision of participants at all times during the operating hours of the program;
 - b. Immediate response to emergency situations to assure the welfare of participants;
 - c. Prescribed recreational and social activities;
 - d. Nursing services for regular monitoring of the on-going medical needs of participants and the supervision of medications. These services must be available a minimum of two hours daily and must be provided by an RN or LPN. CNAs may provide these services under the direction of a RN or an LPN. Supervision of CNAs must include consultation and oversight on a weekly basis or more according to the participant's needs.
 - e. Administrative, recreational, social and supportive functions of the ADS center.
2. In addition to the above services, specialized adult day care services (SADS) centers providing a restorative model of care shall have sufficient staff to provide the following:
 - a. Nursing services during all hours of operation. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 8.491.20 D.1.d, above.
 - b. Therapies, if included in the center's budget and as prescribed by the participants physician, to meet the restorative needs of the client participant

E. Training Requirements

1. ADS centers providing medication administration as a service must have qualified persons on their staff who have been trained in accordance with State Law, Chapter XXIV, Section 25-1-107(1) (ee) (I) (A) Qualified Medication Administration Staff Members.
2. All staff must be trained in the use of universal precautions as defined at Section 8.491.15 E. Facilities certified prior to the effective date of these rules shall have sixty (60) days to satisfy this training requirement
3. The operator and staff must have training specific to the needs of the populations served, e.g., elderly, blind and disabled, and as defined in Section 8.491.13 of these rules.
4. All staff and volunteers must be trained in the handling of emergencies including

written procedures to meet medical crises.

5. All required training must be documented in employees' personnel files.

F. Written Policies The ADS center shall have a written policy relevant to its operation. Such policy shall include, but not be limited to, statements describing:

1. Admission criteria that qualify participants to be appropriately served at the center;
2. Interview procedure conducted for qualified participants and/or family member prior to admission to the center;
3. The meals and nourishments including special diets that will be provided;
4. The hours that the participants will be served in the center and days of the week services will be available;
5. Medication administration;
6. The personal items that the participants may bring with them to the center, and
7. A written, signed agreement drawn up between the participant or responsible party and the center outlining rules and responsibilities of the center and of the participant. Each party to the agreement shall be provided a copy.

8.491.30 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

.31 Reimbursement for ADS services shall be based upon a single all-inclusive payment rate per unit of service for each participating provider which shall be prospectively determined. A unit is defined as:

one (1) unit = a partial day = three (3) to five (5) hours of service

two (2) units = a full day = more than five (5) hours of service

8.491.32 The ADS center's rate of reimbursement shall be the lower of:

A. The maximum allowable applicable Medicaid rate for either

1. Basic ADS Centers-the maximum rate shall not exceed \$18.00 per unit of service, as defined above, except that the Department may adjust the maximum rate based upon future appropriations; or
2. Specialized ADS Centers-the maximum rate shall not exceed \$23.00 per unit, as defined above, except that the Department may adjust the maximum rate based upon future appropriations.

B. The ADS center's private-pay charges to the general public for similar services.

C. The projected cost of ADS, as determined by the Department of Health Care Policy and Financing, after review of a cost report/budget to be submitted by the ADS center annually by such date and in a format as prescribed by the Department, with copies of any and all audit reports prepared within the previous twelve-month period. Failure to timely submit the required cost report to the Department shall result in the Department

assigning the center's costs have not changed and assigning a cost figure at 100% of the prior year's reported cost per unit Failure to submit the cost report a second consecutive year shall result in the Department assigning a cost figure at 00% of the most recently reported met information. Cost reports submitted late shall not be considered until the next year's review. Cost reports shall be reviewed by the Department for appropriateness, with consideration given to: changes in type and intensity of services being provided, the previous year's reported costs adjusted forward by increases in the annual Consumer Price Index (CPI-W as of the beginning of the State fiscal year), and costs of comparable ADS centers in the State. The Department shall notify the provider by September 1 of each year of any costs determined to be inappropriate. The provider must submit any additional documentation supporting the costs in question within thirty (30) days of notification. Supporting documentation received after that thirty-day period will not be considered until the next rate-setting period.

D. The amount billed.

8.491.33 Upon completion of its review, the Department of Health Care Policy and Financing shall notify each ADS center provider of its approved cost per unit and its rate to be effective October 1. Adjustments in the approved cost per unit shall not be made until the next year's cost reporting and rate-setting period.

8.491.34 For new ADS centers the Department shall determine a rate per unit, taking into consideration the following criteria: anticipated costs reported by the provider, costs and rates of comparable ADS centers, any prior owner's reported costs, and proposed private pay charges to the general public for similar services. The determined rate per unit shall remain in effect until the next year's cost reporting and rate-setting period.

8.491.35 EXCLUSIONS:

- A. Transportation to and from adult day services centers shall be reimbursed as non-medical transportation, and these costs shall not be included as part of the adult day services rate. Nothing in this rule shall be construed to prohibit an ADS center from being certified as a transportation provider as specified in the section on NON-MEDICAL TRANSPORTATION below, and receiving reimbursement for transportation of ADS participants.
- B. There shall be no reimbursement for ADS provided to any participant who is a resident of any residential care facility, except for services as defined at Section 8.491.14.H.
- C. There shall be no reimbursement for overnight services in an ADS.

8.492 RESPITE CARE

8.492.10 DEFINITIONS

.11 Respite care means services provided to an eligible client on a short-term basis because of the absence or need for relief of those persons normally providing the care.

.12 Respite care provider means a Class I nursing facility or an alternative care facility which meets the certification standards for respite care specified below.

8.492.20 INCLUSIONS

.21 A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite client, as ordered by the physician.

.22 An alternative care facility shall provide all the alternative care facility services as listed at Section 8.495, ALTERNATIVE CARE FACILITIES, which are required by the individual respite client

8.492.30 RESTRICTIONS

.31 An individual client shall be authorized for no more than thirty (30) days of respite care in each calendar year.

.32 Alternative care facilities shall not admit individuals for respite care who are not appropriate for alternative care facility placement, as specified at Section 8.495, ALTERNATIVE CARE FACILITIES.

.33 Only those portions of the facility that are Medicaid certified for nursing facility or alternative care facility services may be utilized for respite clients.

8.492.40 CERTIFICATION STANDARDS AND PROCEDURES

.41 Respite care standards and procedures for nursing facilities are as follows:

- A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for HCBS-EBD respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.
- B. The nursing facility does not have to maintain or hold open separately designated beds for respite clients, but may accept respite clients on a bed-available basis.
- C. For each HCBS-EBD respite client, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the client. The chart must identify the client as a respite client. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.
- D. An admission to a nursing facility under HCBS-EBD respite does not require a new ULTC-100, a PASARR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment or labwork as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.
- E. The nursing facility shall have written policies and procedures available to the staff regarding respite care clients. Such policies could include copies of these respite rules, the facility's policy regarding self administration of medications, and any other policies and procedures which may be useful to the staff in handling respite care clients.
- F. The nursing facility should obtain a copy of the ULTC-100 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite client's entry into the facility.

.42 Respite care standards and procedures for alternative care facilities are as follows:

- A. The alternative care facility must have a valid contract with the State as a Medicaid certified HCBS-EBD alternative care facility provider. Such contract shall constitute automatic certification for HCBS-EBD respite care.
- B. For each respite care client, the alternative care facility shall follow normal procedures for care planning and documentation of services rendered.

8.492.50 REIMBURSEMENT

.51 Respite care reimbursement to nursing facilities shall be as follows:

- A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-EBD claim form according to fiscal agent instructions.
- B. The unit, of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided. that there was at least one full twenty-four hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.
- C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

.52 Respite care reimbursement to alternative care facilities shall be as follows:

- A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-EBD claim form according to fiscal agent instructions.
- B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.
- C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

.53 The respite care provider shall provide all the respite care that is needed, and other HCBS-EBD services shall not be reimbursed during the respite stay.

.54 Effective 2/1/99, there shall be no reimbursement provided under this section for respite care in uncertified congregate facilities.

8.493 HOME MODIFICATION

8.493.10 DEFINITIONS

.11 Home Modification (referred to herein after as "Home Modification") means specific adaptations, modifications or improvements in an eligible client's existing home setting which based on medical condition:

- A. are necessary to ensure the health, welfare and safety of the individual, and
- B. enable the individual to function with greater independence in the home; and
- C. are required because of the individual's illness, impairment or disability, as documented on the ULTC-100 form and the care plan form; and
- D. prevent institutionalization of the individual.

.12 Home Modification Provider means a provider agency as defined at Section 8.485.50, P, GENERAL DEFINITIONS, which has met all the certification standards for home modification services listed below.

8.493.20 INCLUSIONS

.21 Inclusions shall be eligible for reimbursement only if they meet requirements as listed in Section 8.493. Such adaptations, modifications or improvements may include but are not limited to the following:

- A. the installation of ramps.
- B. installation of grab-bars and other durable medical equipment if approved by Medicaid as medically necessary.
- C. widening of doorways.
- D. modification of bathroom facilities.
- E. installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient

8.493.30 EXCLUSIONS AND RESTRICTIONS

.31 Adaptations, modifications or improvements shall be made based on the following conditions:

- A. Adaptations, modifications or improvements to the existing home which are not a direct medical or remedial benefit to the client shall not be approved. Such non-beneficial adaptations, modifications or improvements include, but are not limited to, carpeting, roof repair, central air conditioning, furnace replacement, or remodeling bare rooms, etc.
- B. No duplicate adaptations, modifications or improvements shall be approved regardless of the payment source. For example, if the client has a safe and useable ramp, a second ramp shall not be approved.
- C. Home modifications, adaptations, or improvements cannot be part of new construction costs.

.32 If the Home Modification is estimated to cost \$1,000 or more, the following procedures shall be followed:

- A. An occupational therapist shall assess the client's needs and the effectiveness of the requested Home Modification and submit a written recommendation consistent with the requirements of Section 8.493. In geographical areas where an occupational therapist is not available, the services of a physical therapist or other qualified individual approved by the State may be substituted. A complete report specifying how the Home Modifications would contribute to a person's ability to remain in or to return to his/her home, and how the modification, adaptations or improvements would increase the individual's independence and decrease the need for other services, such as personal care, must be completed on a State prescribed form. The report must be completed and submitted to the contractors before the bid is obtained. This evaluation must be submitted with the Prior Authorization Request (PAR);
- B. The occupational therapist visit may be provided by a home health agency and billed to Medicaid Home Health provided that the home health agency follows all Home Health rules including physician orders and plan of care rules, Refer to Rules Sections 8.520 through 8.530.10.
- C. The case manager and the occupational therapist shall first consider less costly alternative methods of addressing the client's needs which include prudent purchase of services as

defined in 8.393.23,C. The case manager shall record written documentation of this effort in the case record and send documentation of this activity on the state prescribed form with the PAR; and

.33 The case manager shall first consider alternative funding sources, such as, but not limited to, Worker's Compensation Insurance, private automobile liability insurance, Medicare, vocational rehabilitation funds and volunteer organizations; and shall record in the case record and send written documentation of this activity with the PAR;

.34 The case manager shall follow a bid process as specified below:

- A. After obtaining the evaluation, the case manager must solicit and receive bids from at least two licensed and state certified home modification providers for the work to be done.
- B. The bids shall include a complete breakdown of the costs on the state prescribed form and a letter that includes the enumerated items as listed below:
 - 1. Description of the work to be completed;
 - 2. Estimate of the material and labor needed to complete the job;
 - 3. Estimate for building permit, if needed;
 - 4. Estimated timeline for completing the job;
 - 5. Name, address and telephone number of the provider, and
 - 6. Signature of the contractor.
- C. The case manager shall submit the bids to the State or its agent with the PAR before any work is started for projects \$1,000 or more. The Department or its agent shall authorize payment of the lowest bid received provided the bid is reasonable given current market prices, ensures the health, welfare and safety of the individual based on medical condition, meets Uniform Building Codes as adopted by the State of Colorado, and meets local building codes.

8.493.34 EXCLUSIONS AND RESTRICTIONS

- D. In a situation where the case manager wants to use a bid which is not the lowest bid or where two bids cannot be obtained, the case manager must submit a written justification or explanation to the Department or its agent with the PAR (Refer to Rule 8.493.34).
- E. After the case management agency has made several attempts to obtain a bid from the contractor in writing or by phone, and the contractor has not responded within four (4) weeks, the case management agency may submit the PAR with less than two bids. Documentation of the contacts and an explanation of these attempts must be attached to the PAR.
- F. A revised PAR and bid request shall be submitted according to the procedures as outlined in this Section for any changes from the original approved PAR and/or additions to a Home Modification in progress.

.35 The State or its agent may conduct on-site visits or any other investigations deemed necessary prior to approving, or denying the request for Home Modification.

.36 The State reserves the right to deny requests for Home Modifications that are not within usual and customary charges or industry standards.

.37 The Home Modification shall not reimburse for equipment already available as a regular Medicaid benefit; for example, purchase of grab bars and other durable medical equipment

.38 Home Modifications shall not be approved in any type of congregate facility, certified or uncertified, as defined in 8.485.50, F, G.

.39 There shall be a lifetime cap of \$10,000 per Home Modification client on HCBS-EBD funds approved for home modification services. A family member, client or other source may choose to pay for portions of the Home Modification or amounts over the \$10,000 maximum cap. This work must not be included in the bid submitted to the state. Volunteer work on a Home Modification approved by the state must be completed under the supervision of the state-approved provider as stated on the bid.

.40 The contractor must provide a one (1) year written warranty on materials and labor from date of final inspection on all his/her work.

8.493.40 CERTIFICATION STANDARDS FOR HOME MODIFICATION SERVICES

.41 Home modification providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES.

.42 Home modification providers shall be licensed in the city or county in which they propose to provide home modification services.

.43 All Home Modifications shall be provided in accordance with the Uniform Building Code as adopted by the State of Colorado and all local building codes.

.44 All Home Modifications shall be started within 60 days of signed approval from the State or fiscal agent.

.45 All contractors have a maximum of four (4) weeks to submit a bid for a Home Modification once they have been contacted by the single entry point agency.

.46 All Home Modifications shall be inspected, and approved by a qualified individual, as follows:

- A. Local/county building inspector, or
- B. A licensed engineer, architect, contractor or any other person as agreed upon by the State, and
- C. Copies of building permits and inspection reports shall be submitted to the single entry point agency, and all problems noted on inspections shall be corrected before the provider submits a claim for the Home Modification payment. In the event that a permit is not required, the contractor shall submit to the single entry point agency, a signed and stamped statement from the local building department stating that a permit is not needed.

8.493.50 REIMBURSEMENT METHOD FOR HOME MODIFICATION SERVICES

.51 Payment of home modification services shall be the lower of the billed charges or the prior authorized amount. The unit of reimbursement shall be one unit per service rendered.

.52 If the Home Modification is not completed per specifications as listed on the original bid and/or approved by the local building inspector, the State will only reimburse for materials and labor for work that has been completed satisfactorily. The case manager shall submit a PAR revision including a bid for the

work that was completed. The state will review the revised PAR and bid to assure compliance with usual and customary charges or industry standards as stated in Section 8.493.34. If another contractor is needed to complete the work, the state will pay the difference between the amount reimbursed to the original contractor and the amount needed to complete the Home Modification up to the \$10,000 maximum cap.

.53 Payment shall not be made until the Home Modification has been completed and the single entry point agency has in the client's file copies of all required lien waivers for labor and materials, permits and final inspection. The case manager shall verify that the Home Modification has been completed through contact with the building inspector (Refer to Section 8.493.40-.46), the client, at the face-to-face meeting with the client (Refer to Section 8.393.24.A-E), the family member, responsible party, and/or by making an on-site visit. The single entry point agency shall use a state prescribed form for those modifications over \$1,000 authorizing provider (contractor) to bill for completed work.

8.494 NON-MEDICAL TRANSPORTATION

8.494.10 DEFINITIONS

.11 Non-medical transportation services means transportation which enable eligible clients to gain personal physical access to non-medical community services and resources, as required by the care plan to prevent institutionalization.

.12 Non-medical transportation provider means a provider agency as defined at Section 8.484.50, P, GENERAL DEFINITIONS, which has met all the certification standards for transportation providers listed below.

8.494.20 INCLUSIONS

.21 Non-medical transportation services shall include, but not be limited to, transportation between the client's home and non-medical services or resource such such as adult day services, shopping, therapeutic swimming, dentist appointments, counseling sessions, and other services as required by the care plan to prevent institutionalization.

8.494.30 EXCLUSIONS

.31 Non-medical transportation services shall not be used to substitute for medical transportation, which is subject to reimbursement under Section 8.680 through 8.691, OTHER HEALTH SERVICES - TRANSPORTATION.

.32 Non-medical transportation services shall only be used after the case manager has determined that free transportation is not available to the client

8.494.40 CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES

.41 Transportation providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES.

.42 Transportation providers shall assure that:

A. All drivers shall possess a valid Colorado drivers license, shall be free of physical or mental impairment that would adversely affect driving performance, and have not had two or more convictions or chargeable accidents within the past two years.

B. All vehicles and related auxiliary equipment shall meet all applicable federal, state and local safety inspection and maintenance requirements, and shall be in compliance with state

automobile insurance requirements.

8.494.50 REIMBURSEMENT

.51 Reimbursement for non-medical transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services.

.52 A provider's submitted charges shall not exceed those normally charged to 'the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities.

.53 No payment shall be made for charges when the recipient is not actually in the vehicle.

.54 Effective 2/1/99, there shall be no reimbursement under this section for non-medical transportation services provided to clients residing in uncertified congregate facilities. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued.

8.495 ALTERNATIVE CARE FACILITIES

8.495.10 DEFINITIONS

- A. Alternative Care Facility (ACF) means a provider agency as defined at 8.485.50. GENERAL DEFINITIONS, which has met all the additional standards for alternative care facility providers listed below.
- B. ACF SECURED ENVIRONMENT means, any grounds, building, or part thereof, method or device that prohibits free egress of residents. An environment is secured when the right of any resident thereof to move outside the environment during any hours is limited (see. also Section .210 ACF Secured Environments).
- C. Alternative Care services means personal care, as defined at Section 8.48?. PERSONAL CARE, and homemaker services, as defined at Section 8.490, HOMEMAKER SERVICES.
- D. Operator means any person who owns an ACF, or a managing employee delegated authority by the ownership to manage, control, or perform the day-to-day tasks of operating the facility.
- E. Protective oversight means guidance of a resident as required by the needs of the resident, or as reasonably requested by the resident, including the following: being aware of a resident's general whereabouts, although the resident may travel independently in the community, monitoring the activities of the resident while on the premises to ensure the health, safety, and well-being of the resident, including monitoring of prescribed medications; reminding the resident to carrying out activities of daily living; and reminding the resident of any important activities, including appointments.
- F. Resident means a Medicaid client found to be eligible for HCBS-EBD and HCBS-MI services, and who is appropriate for placement in an Assisted Living Residence (ALR) setting.
- G. Restraint means any physical or chemical device, application of force, or medication which is designed or used for the purpose, of modifying, altering, or controlling behavior for the convenience of the facility and excludes medication prescribed by a physician as part of an on-going treatment plan or pursuant to a diagnosis.

- H. Staff means a paid employee of the facility.
- I. Substance Abuse means the use of any mind or mood altering materials in a manner which deviates from standard medical practice, which acts to the detriment of the individual residents or the public, and which includes, but is not limited to, alcohol, dangerous drugs, or narcotic drugs.
1. Alcohol refers to beverage alcohol, ethylene alcohol, or ethanol.
 2. Dangerous drugs refers to cannabis or any depressant drug, hallucinogenic drug, stimulant drug, or tranquilizer, or any such mixture or compound with any other substances.
 3. Narcotic drugs refers to any drug to which the federal Controlled Substance Act of 1970 may apply, and any drug found by the State Board of Health to be addictive or to have an addiction sustaining character similar to morphine or cocaine.
- J. Universal Precautions refers to a system of infection control which assumes that every direct contact with body fluids is potentially infectious. This includes any reasonably anticipated skin, eye, mucous membrane or parental contact with blood, blood-tinged body fluids, or other potentially infectious materials.

8.495.20 INCLUSIONS

Alternative care facilities shall provide safe, cost-effective services including but not limited to the following:

- A. Twenty-four hour residential care support services;
- B. Adequate sleeping and living areas;
- C. Adequate, recreational areas, and opportunities;
- D. Three nourishing meals per day, with provision for special diets when those diets have been prescribed as part of a medical plan;
- E. Assistance with the arrangement of transportation when needed;
- F. Protective oversight; and
- G. Social and recreational services as prescribed to meet the participant's needs and as documented in the participant's care plan. Participants have the right to choose not to participate in social and recreational activities; and
- H. Alternative care services, as defined above, sufficient to meet the resident's needs.

8.495.30 PROVIDER CERTIFICATION

.31 Alternative care facility providers shall conform to all general certification standards and procedures at Section 8.487, HCBS-EBD PROVIDER AGENCIES.

.32 In addition the alternative care facility provider must have a valid and current Assisted Living Residence license.

.33 The alternative care facility must also comply with the standards at Section 8.489, PERSONAL CARE, and the standards at Section 8.490, HOMEMAKER SERVICES.

8.495.34 The alternative care facility must also comply with all the following regulations in this ALTERNATIVE CARE FACILITY section.

8.495.40 ACFs with Secured Environments shall comply with Department of Public Health and Environment Regulations, Chapter VII, Assisted Living Residence, Section 20, Secured Environment (and with Section 8.495.210, ACF Secured Environments).

8.495.50 OPERATOR/STAFF QUALIFICATIONS

Qualifications for operator(s), employees, and volunteers shall be as follows:

.51 Any person providing any service under these regulations shall strictly comply with all federal, state and local laws, regulations and ordinances.

.52 All operators and staff shall read, be familiar with, and follow the rules, and regulations for the operation of ACFs. Ignorance of these rules and regulations is not an acceptable defense for their violation.

.53 All operators and staff must be trained as defined in 8.495.60.

.54 The Operator or staff person responsible for protective oversight of the residents must be able, to recognize and respond to emergencies, including contacting emergency services such as 911, ambulance, fire and police departments.

.55 At all times there must be at least one staff person on duty who is eighteen (18) years of age or older, and who is trained to provide protective oversight

.56 All operators, staff, and volunteers providing direct client care or food preparation must have TB skin testing or chest x-ray, as appropriate, prior to beginning duties, and annually thereafter.

.57 Effective 2/1/99, Alternative Care Facilities must maintain a minimum 1:10 staff-to-resident ratio from the hours, of 6:00 a.m. to 7:00 p.m. Facilities must maintain a minimum 1:15 staff-to-resident ratio from the hours of 7:00 p.m. through 6:00 a.m. unless the operator can document to the Department or its agent that a ratio of less than 1:15 does not jeopardize the health and safety of the residents. Based on adequate documentation a written staffing waiver, for the nighttime hours only, may be issued by the Department. Upon change of ownership, the existing staffing waiver shall be null and void. The new manager/owner may apply for a new staffing waiver.

.58 Secured Alternative Care Facilities shall maintain a 1:6 staff-to-resident ratio (see also Section 8.495.210, ACF Secured Environments).

.59 Any person who is involved in substance abuse, uses alcohol excessively, uses narcotic drugs or dangerous drugs shall not be approved as an operator, nor be employed act as a volunteer, or reside in a certified facility.

8.495.60 TRAINING

.61 Facility operators must satisfactorily complete an introductory training on ACF rules and regulations prior to certification of the facility. This introductory training shall be conducted by the State or its agent

.62 Certified facilities having operators who have not yet had this introductory training will be required to have their operator attend the next available training offered

.63 The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid and emergency procedures prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty (60) days to satisfy this training requirement

.64 The operator and staff must have training specific to the needs of the populations served e.g. chronically mentally ill, frail elderly, acquired immune deficiency syndrome, Alzheimer's disease.

.65 Thereafter, periodic training may be required of facility operators and/or staff, addressing needs identified by operators and/or by the state.

.66 Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty (60) days to satisfy this training requirement

.67 All required training must be documented in employees' personnel files.

8.495.70 APPROPRIATENESS OF PLACEMENT

.71 Only residents whose needs can be met by the facility within its licensure category shall be admitted.

.72 A facility may not admit, and must discharge within thirty (30) days, any reside: it. under any payment source, who:

- A. needs skilled services on more than an intermittent basis. If skilled services are provided on an intermittent basis, they must be provided by a skilled provider,
- B. is unable or unwilling to meet their own personal hygiene needs under supervision or with assistance;
- C. has an acute physical illness which cannot be managed through medical ions or prescribed therapy;
- D. has a substance abuse problem, unless the substance abuse is no longer a cute and a physician determines it to be manageable;
- E. has ambulation limitation, unless compensated for by assistive device with assistance from staff;
- F. has a reportable communicable or infectious disease, unless the transmit non of the disease can be managed through the use of universal precautions and appropriate medical and/or drug treatment;
- G. is consistently disoriented to time, person and place to such a degree he/she poses a danger to self or others;
- H. has a seizure disorder which is not adequately controlled by medications;
- I. requires tray food services on a continuous basis;
- J. exhibits behavior which poses a physical threat to self or others, including but not limited to, violent and disruptive behavior and/or any behavior which involves physical, sexual, or psychological force or intimidation and tails to respond to interventions, as outlined in the individual's Board and Care Plan or Revised Board and Care Plan;
- K. is consistently unwilling to take medication prescribed by a physician;

- L. is incapable of self-administration of medication, unless the facility has staff appropriately trained in medication administration per 25-1-107, C.R.S., et seq.;
- M. is a person whose physical safety cannot be assured in an ACF;
- N. is consistently, uncontrollably incontinent of bowel or bladder, and incontinence cannot be managed by resident with assistance from staff;
- O. needs restraints, as defined herein; or
- P. is totally bedfast with limited potential for improvement.

8.495.80 RESIDENT RIGHTS/HOUSE RULES

All facilities must ensure the following residents rights:

.81 Residents may voluntarily participate in performing housekeeping duties and other tasks, but cannot be required to perform duties of staff.

.82 If a resident receives compensation from the facility there must be a written agreement regarding duties and reimbursement between the resident and the operator. The amount of compensation must be reported to the income maintenance staff of the County Department of Social Services and the case manager.

.83 All house policies regarding smoking and the use of alcohol shall apply equally to operator, staff, volunteers, residents and others residing in the facility.

.84 The withholding of food and water is prohibited unless indicated by written physician's orders or a pharmacist's medication instructions.

.85 The facility must provide an accessible telephone with toll free local calls.

.86 The facility must provide an environment free from intimidation, physical restraint, involuntary confinement, and financial exploitation.

.87 The facility shall, per regulations at 8.130.65, provide residents with written information about the individual's rights under state law to accept or refuse medical treatment; the right to formulate advance directives; and the provider's policies respecting the implementation of such rights. Documentation shall be kept in the individual's record as to whether the individual has executed an advance directive.

.88 The operator must have the resident or designated representative sign that the house rules and resident rights have been read, were explained, and are understood.

8.495.90 SERVICES PROVIDED

.91 Facilities shall provide those services indicated in Section 8.495.20 above.

.92 Facilities which accept responsibility for a resident's personal funds shall post a surety bond in a minimum amount of \$10,000.00.

8.495.93 Clients admitted for respite care in an ACF must meet the requirements for appropriate placement described at Section 8.495.70, APPROPRIATENESS OF PLACEMENT.

8.495.100 PROVIDER AGREEMENT

.101 Provider agreements shall be executed in accordance with Section 8.130, PROVIDER AGREEMENTS.

.102 In addition, the facility shall notify the State or its agent within five (5) working days of any change of operator.

8.495.110 RECORDS AND REPORTING REQUIREMENTS

.111 The facility shall maintain records sufficient to document compliance with State rules and contract requirements, including proof of insurance, licenses, permits, and surety bonds, for a period of at least six (6) years.

.112 The facility shall notify the State or its agent within five (5) working days of any suspension, revocation or termination of any required license, permit, insurance, or surety bond.

.113 Personnel records for each employee or volunteer must include name, age, sex, home address and phone number, documentation of training and work experience, and results of TB testing for any employee or volunteer providing direct care to residents or involved in meal preparation or food handling.

.114 Residents' records shall include as appropriate the name and address of a spouse, the date of termination or transfer from the facility, and the new forwarding address of the resident.

.115 A copy of the ALR Board and Care Plan, jointly developed by the resident, family, case manager, and operator, must be provided to all parties.

.116 The facility's schedule of structured recreational activities and social activities must be posted in a conspicuous place at all times.

.117 The facility shall, within twenty-four (24) hours, notify the HCBS Case Manager in the event of any death, serious incident or injury of anyone residing in the facility under an ALR Board and Care Plan, and of any severe deterioration in a resident's medical condition or behavior.

8.495.120 MEDICATIONS

.121 Residents shall have the right to possess and self-administer medications.

8.495.130 DIETARY

.131 Any facility having residents on a special or therapeutic diet prescribed by a physician must obtain regular, quarterly dietary consultation from a registered or certified dietician or nutritionist.

.132 There shall be no more than fourteen (14) hours between the evening and breakfast meals, and the withholding of food or water is prohibited unless indicated by written physician's orders or a pharmacist's medication instructions.

.133 Recipes corresponding to planned menus must be available for use in meal preparation, and kept on file at the facility.

8.495.140 LAUNDRY

.141 The frequency of laundry services shall be determined based upon individual resident needs.

.142 The facility shall provide bed and bath linens if requested by the resident.

8.495.150 COMMON AREAS

.151 Access to common areas shall not be through another resident's bedroom.

.152 If allowed by house rules, smoking must be in a designated area.

8.495.160 BEDROOMS/BEDROOM FURNISHINGS

.161 Facilities may not assign more than two persons per bedroom.

.162 Residents are allowed to use personal furnishings in their bedrooms; but if requested by the resident, the facility shall provide such furnishings, including a bedlamp or reading lamp, and a locked closet or locker for storage of personal articles.

8.495.170 BATHROOMS

Facilities shall have grab bars properly installed at each tub and shower, and adjacent to each toilet

8.495.180 ENVIRONMENT

.181 Facilities shall be heated to at least seventy (70) degrees during the day, and sixty-five (65) degrees at night. During the summer months the facility must provide at least one common area where the temperature is no more than seventy-six (76) degrees.

.182 Facilities shall have a battery or generator-powered alternative lighting system available in the event of power failure.

.183 Care, cleaning, laundering, and food preparation shall be performed in a manner so as to minimize the spread of pathogenic organisms.

8.495.190 FIRESAFETY

.191 Facilities must meet all applicable fire safety regulations. Facilities which are not in compliance with fire safety regulations, including requirements for fire drills, shall not be granted a waiver of the 1:10 staff-to-resident staffing requirement and any existing waiver shall be subject to revocation.

.192 Facilities shall not permit cooking in resident bedrooms. Those residents housed in apartments rather than resident bedrooms are not only prohibited from cooking in the bedroom itself, but are also prohibited from cooking in any other room of the apartment.

8.495.200 REIMBURSEMENT METHOD FOR ALTERNATIVE CARE FACILITIES

.201 Room and Board payment:

- A. Residents of ACFs must make payment for room and board from their own funds. Under no circumstances shall room and board be financed using Medicaid funds.
- B. A uniform room and board payment for all ACFs shall be established by the State Department of Health Care Policy and Financing. Effective January 1, 1996, the standard payment for room and board in ACFs is \$424 per month. Effective January 1 of subsequent years, this standard room and board payment shall be permitted to rise in a dollar-for-dollar relationship to any increase in the SSI grant standard.

.202 Alternative Care Services payment:

- A. The reimbursement ceiling for ACF care services shall be \$28.82, and may be adjusted by the State as funding becomes available. Reimbursement shall be per unit, with one unit

equaling one day of care.

- B. Reimbursement shall be the lower of: the maximum Medicaid unit rate, the rate the ACF charges its private-pay residents for similar services, or the amount billed.
- C. When a facility is dually certified as both an ACF and as an Adult Foster Care (AFC) facility per Section 8.483 et seq., its AFC clients shall not be considered private-pay residents for Medicaid ACF reimbursement purposes.
- D. Appeals relating to Medicaid reimbursement for services shall be in accordance with the section titled Rules Governing Submission of Claims, 8.040 to 8.049.

.203 Non-Medical/Programmatic Leave ACF providers must immediately notify the single entry point agency of any planned or unplanned non-medical and/or programmatic leave of a resident for more than 24-hours. The single entry point case manager may continue to authorize ACF placement while a resident is on non-medical and/or programmatic leave at the ACF per diem rate, excluding room and board; however, this leave shall not exceed a total of 42 calendar days in a 12 month period.

- A. Non-medical leave days are defined generally as days of leave from the ACF for non-medical reasons.
- B. Programmatic leave days are days of leave prescribed by a physician for therapeutic and/or rehabilitative reasons. Programmatic leave may entail visits to family, Mends, or guardians, or leave to participate in approved therapeutic and/or rehabilitative programs. A programmatic leave day is considered to have been incurred for any day during which the client is absent from the ACF for therapeutic or rehabilitative purposes. The therapeutic and/or rehabilitative purpose must be documented as part of the client's care plan.

.204 Cost Reporting

- A. All ACFs shall report and submit to the Department cost report information on a Department prescribed form.
- B. By dates set forth by the Department, alternative care facility providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or the State fiscal year.
- C. The rates of providers that do not comply with the Section 8.495.204 shall revert to FY99-00 levels for twelve months.

8.495.210 ACF SECURED ENVIRONMENTS

.211 DEFINITION: ACF Secured Environment means, any grounds, building, or part thereof), method or device that prohibits free egress, of residents. An environment is secured when the right of any resident to move outside the environment during any hours, is limited.

.212 COMPLIANCE: Facilities providing secured environments shall comply with Department of Public Health and Environment (DPHE) regulations, Chapter VII, Assisted Living Residence, Section 20, Secured Environment, as well as with all rules for Alternative Care Facilities. Both these regulations, are available for public inspection during normal business hours and will be provided at cost upon request to the Long Term Benefits Division, Colorado Department of Health Care Policy & Financing, 1575 Sherman Street, Denver, Colorado, 80203-1714.

.213 NUMBER OF BEDS: Facilities, providing a secured environment may be licensed for a maximum of

30 beds. A waiver may be granted, with adequate documentation of the need for additional beds, when this does, not jeopardize the health, safety, and quality of care, for the residents.

.214 STAFF-TO-RESIDENT RATIO: Facilities providing secured environments shall maintain a 1:6 staff-to-resident ratio, unless the operator can document to the state or its agent, and receives an approved waiver from the State, that a ratio of less than 1:6 does not jeopardize the health, safety, or quality of life of the residents. There shall be a minimum of one awake person (or more than one, if appropriate for the number of residents) during all hours of operation...

.215 TRAINING: In addition to the training required in Section 8.495.64, for operators and staff of secured environments, training shall include assessment skills as defined in DPH&E regulations Chapter VII, Assisted Living Residence, Section 20, Secured Environments, providing activities, and handling behaviors specific to the client population served in the secured environment. Training is required for all staff providing direct care to residents.

8.495.216 APPROPRIATENESS OF PLACEMENT

- A. IN conformance with DPH&E regulations Chapter VII, Assisted Living Residence, Section 20.2, Admission or Transfer, a resident shall not be admitted or transferred to a secure environment unless legal authority for admitting the resident has been established by guardianship, court order, medical durable power of attorney, health care proxy, or other means allowed by Colorado, law. However, a resident may voluntarily be admitted or remain in a secured environment if his or her egress is not restricted.
- B. Mentally ill and developmentally disabled residents shall not be admitted into a secured environment unless the facility is in compliance with the appropriate laws as defined in DPH&E regulations Chapter VII, Section 2.

8.495.217 RESIDENTS RIGHTS

- A. A resident who believes that he or she has been inappropriately admitted into a Secured Environment may request the assistance of the facility, and the facility shall provide assistance to the resident, in contacting the case manager, local ombudsman, or the resident's legal representative.
- B. Residents of Secured Facilities shall not be locked into or out of their rooms.

8.495.218 RECORDS AND REPORTING REQUIREMENTS

- A. For residents, residing in secured environments, records shall include documentation as defined in Chapter VII, ALR regulations, Section 20.4.
- B. For Secured Environments, the recreational and social activities referred to in Section 8.495.116 above shall be provided by a trained facility staff member, and the activities shall be appropriate to the population served.

8.495.219 ENVIRONMENTAL REQUIREMENTS

- A. The facility shall identify its method for securing the facility or section of the facility and shall establish and implement policies and procedures for monitoring the effectiveness of the security system. All locks, wander guards, locked gates and other security systems shall meet fire and safety regulations.
- B. The facility shall either designate a section of the facility as a common area or provide common areas within the facility sufficient to accommodate the needs of the residents.

- C. The facility shall provide a safe and secure outdoor area that is accessible to the residents. The grounds in the outdoor area shall be level, well maintained, and equipped with walking paths, handrails, benches and/or other furniture as needed to accommodate the needs of the residents.
- D. The facility shall establish an environment that promotes independence and minimizes agitation through the use of visual cues and signs appropriate to the needs of the residents. Visual cues shall include consideration of items such as high visual contrasts between floors, walls, and doorways in resident areas; high visual contrast between the plate, food, and the table; and lighting which minimizes glare.
- E. All chemicals, cleaning supplies, and other hazardous material shall be secured and locked so that they shall not be accessible to residents.

8.496 HOME AND COMMUNITY BASED SERVICES FOR PERSONS LIVING WITH AIDS (HCBS-PLWA) GENERAL PROVISIONS

8.496.10 LEGAL BASIS

The Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-PLWA program is also authorized under state law at 26-4-641 et. seq., C.R.S. (1991 Supplement), as amended.

8.496.20 KEYS AMENDMENT COMPLIANCE

All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the Social Security Act of 1935 and 45 CFR Part 1397. (October 1, 1991), by possession of a valid Assisted Living Residence license issued under C.R.S. 25-27-105, and regulations of the Colorado Department of Public Health and Environment at 6.CCR 1011-1, Chapters 2 and Chapters 7. No amendments or later editions are incorporated. The program assistant of the Community Based Long Term Care Section of the Colorado Department of Health Care Policy and Financing may be contacted at 1575 Sherman, Denver, CO 80203, for a copy of 45 CFR Part 1397; or the material may be examined any State. Publications Depository Library.

8.496.30 SERVICES PROVIDED

.31 HCBS-PLWA services provided as an alternative to nursing facility or hospital care include:

- A. Adult day services; and
- B. Homemaker services; and
- C. Electronic, monitoring; and
- D. Personal care; and
- E. Private duty nursing and
- F. Non-medical transportation

.32 Case management shall not be a service of the HCBS-PLWA waiver program, but shall be provided as administrative activity through single entry point agencies.

.33 HCBS-PLWA clients are eligible for including the Home Health program. all other Medicaid state plan benefits,

8.496.40 DEFINITIONS OF SERVICES

- A. Adult Day Services shall be services as defined at §8.491.
- B. Homemaker Services shall be services as defined at §8.490.
- C. Electronic Monitoring Services shall be services as defined at §8.488.
- D. Personal Care shall be services as defined at §8.489.
- E. Private Duty Nursing shall be services as defined at §8.496.950.
- F. Non-Medical Transportation Services shall be services as defined at §8.494.

8.496.50 GENERAL DEFINITIONS

- A. Agency shall be as defined at §8.485.50(A).
- B. Assessment shall be an assessment as defined at §8.485.50(B).
- C. Case Management shall be case management as defined at 58.
- D. Case Plan shall be a case Plan as defined at §8.485.50(D)
- E. Categorically Eligible, as the term is used in relation to the program, shall be as defined at §8.485.50(E).
- F. Congregate Facility shall be as defined at §8.485.50(F)
- G. Continued Stay Review shall be a reassessment as define through §8.402.65.
- H. Corrective Action Plan shall be a corrective action plan §8.390.1(E).
- I. Cost Containment shall be defined as the determination individual client basis, the average daily cost of providing HCBS-PLWA services, plus care provided under the Home Care Allowance program, does not exceed the equivalent daily cost of nursing facility care, or of hospital care, according to the assigned level of care.
- J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type services reimbursed by Medicaid, within fourteen calendar days of admission to HCBS-PLWA at the nursing facility level of care; or who were hospitalized on the day of admission to HCBS-PLWA at the hospital level of care.
- K. Diverted shall be defined as HCBS-PLWA waiver clients who were not deinstitutionalized, as defined at §8.496.50(J).
- L. Home and Community Based Services for Persons Living with AIDS shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing facility care or hospital care without the provision of HCBS-PLWA; and for whom HCBS-PLWA service's can be provided at no more than the cost of nursing facility care for persons needing nursing facility level of care, or no more than the cost of hospital care for persons needing

hospital level of care.

M. Intake/Screening/Referral shall be intake/screening/referral as defined at §8.485.50(N).

N. Level Of Care Screen shall be level of care screen as defined at §8.401.

O. Non-Diversion shall be defined as a client who was certified by the Utilization Review Contractor as meeting the level of care screen and target group for the HCBS-PLWA program, but who did not receive HCBS-PLWA services for some other reason.

P. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department to provide one of the services listed at §8.496.40. A single entry point agency is not a provider agency. Case management is not a service, but is administrative activity.

Q. Reassessment shall be reassessment as defined at §8.390.1 (L).

R. Single Entry Point Agency shall be an organization as described at §8.390(1)(P).

S. Department shall be defined at §8.485.50(T).

T. Three Hundred Percent (300%) Eligible shall be three hundred percent (300%) eligible as defined at §8.485.50(U).

8.496.60 ELIGIBLE PERSONS

.61 HCBS-PLWA services shall be offered to persons who meet all of the eligibility requirements below:

A. Financial Eligibility Clients shall meet the eligibility criteria as specified in Staff Manual Volume 3, and §8.100.

B. Level of Care and Target Group Clients who have been determined to meet the level of care and target group criteria shall be certified by the Utilization Review Contractor as medically eligible for HCBS-PLWA. The Utilization Review Contractor shall only certify HCBS-PLWA eligibility for those clients:

1. Determined by a Utilization Review Contractor to meet the target group definition for persons living with AIDS, as defined at §8.400.16; and
2. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to §8.401.11 through §8.401.17; or
3. Determined by a formal level of care assessment to require the level of care available in a hospital, utilizing the Adult and Pediatric Severity of Illness/Intensity of Service Criteria (APSI/ISC).
4. The Utilization Review Contractor shall not assign a length of stay longer than one (1) year, for persons at the nursing facility level of care; or for longer than one (1) month, for persons at the hospital level of care.

C. Receiving HCBS-PLWA Services Only clients who receive, or who have agreed to accept HCBS-PLWA services as soon as all other eligibility criteria have been met, are eligible for the HCBS-PLWA program. Case management shall not be a service and cannot be used to satisfy this requirement. Desire or need for home health services or other Medicaid services that are not HCBS-PLWA services, as listed at §8.496.30, shall not

satisfy this eligibility requirement. HCBS-PLWA clients who have received no HCBS-PLWA services for one month shall be discontinued from the program.

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals shall not be eligible for HCBS-PLWA services while residing in such institutions.
2. A client who is already an HCBS-PLWA recipient and who enters a hospital for treatment may not receive HCBS-PLWA services while in the hospital. If the hospitalization continues for thirty (30) days or longer, the case manager shall terminate the client from the HCBS-PLWA program.
3. A client who is already an HCBS-PLWA recipient and who enters a nursing facility may not receive HCBS-PLWA services while in the nursing facility. The case manager must terminate the client from the HCBS-PLWA program if Medicaid pays for all or part of the nursing facility care, or if there is a Utilization Review Contractor-certified ULTC-100 for the nursing facility placement, as verified by telephoning the Utilization Review Contractor.

- E. Cost-effectiveness Only persons who can be safely served within cost containment, as defined at §8.496.50, shall be eligible for the HCBS-PLWA program. The equivalent cost of nursing facility care or hospital care is calculated by the State according to §8.496.100.

8.496.70 START DATE

.71 The start date of eligibility for HCBS-PLWA services shall not precede the date that all of the requirements at §8.496.60, have been met The first date for which HCBS-PLWA services can be reimbursed shall be the LATER of any of the following:

- A. Financial eligibility start date, as defined at §8.485.71 (A).
- B. Level of Care start date as defined at §8.485.71 (B).
- C. Receiving Services start date as defined at §8.485.71(C).
- D. Institutional Status start date as defined at §8.485.71(D).

8.496.80 CLIENT PAYMENT OBLIGATION - POST ELIGIBILITY TREATMENT OF INCOME (PETI)

(PETI) The client payment obligation shall be in accordance with Section §8.485.80, CLIENT PAYMENT OBLIGATION - POST ELIGIBILITY TREATMENT OF INCOME (PETI).

8.496.90 STATE PRIOR AUTHORIZATION OF SERVICES shall be in accordance with §8.485.90.

8.496.100 STATE CALCULATION OF COST-CONTAINMENT AMOUNTS

.101 The State shall compute the equivalent daily cost of nursing facility care according to §8.485.100.

.102 The State shall calculate the equivalent daily cost of hospital care by determining the total annual costs of hospital care for all Medicaid clients with HIV/AIDS who received hospital care, and dividing by the total number of hospital days for this client group.

8.496.200 LIMITATIONS ON PAYMENT TO FAMILY shall be in accordance with §8.485.200.

8.496.300 CLIENT RIGHTS provisions shall be in accordance with §8.485.300.

8.496.400 SINGLE ENTRY POINT AGENCIES PERFORMING HCBS - PLWA CASE MANAGEMENT ACTIVITIES must comply with single entry point rules 2/01/96 at §8.390 through §8.394 and shall comply with all HCBS PLWA-specific case management requirements below.

8.496.500 HCBS-PLWA CASE MANAGEMENT FUNCTIONS shall be performed in accordance with §8.486. with the following additional requirements:

8.496.600 ASSESSMENT OF PERSONS IN NEED OF HOSPITAL LEVEL OF CARE Case managers shall complete the assessment and submit the ULTC-100 to the Utilization Review Contractor, within twenty-four (24) hours after the original referral, whenever a hospital level of care screen is required.

8.496.610 REASSESSMENT OF PERSONS IN NEED OF HOSPITAL LEVEL OF CARE

- A. For any client being served in HCBS-PLWA at the hospital level of care, the case manager shall complete the reassessment and submit the ULTC-100 to the Utilization Review Contractor for continued stay review, one (1) calendar week prior to the end of the length of stay.
- B. For any client being served in HCBS-PLWA at the nursing facility level of care, whose needs change to require hospital level of care, the case manager shall complete an assessment and submit the ULTC-100 to the Utilization Review Contractor within twenty-four (24) hours.
- C. For any client being served in HCBS-PLWA at the hospital level of care, whose needs change to nursing facility level of care, the case manager shall notify the Utilization Review Contractor by telephone, electronic transmission or fax within one (1) working day; the Utilization Review Contractor shall then assign a new length of stay to the existing ULTC-100 assessment form, provided that all other requirements are met.

8.496.620 COST CONTAINMENT AT HOSPITAL LEVEL OF CARE

.621 To determine cost containment for clients at the hospital level of care, the case manager shall:

- A. Determine the maximum authorized costs for all HCBS-PLWA services needed for the period of time covered by the care plan and compute the average cost per day by dividing by the number of days in the care plan period; and
- B. Determine that this average cost per day is less than or equivalent to the equivalent daily cost of hospital care, as calculated by the Department according to §8.496.100.

8.496.700 DOCUMENTATION OF CLIENT CHOICE

The case manager shall document the client's choice of HCBS-PLWA services or hospital placement, for persons at the hospital level of care.

8.496.800 HCBS-PLWA PROVIDER AGENCIES shall be subject to all the procedures at §8.487.

8.496.900 HCBS-PLWA SERVICES

8.496.910 ADULT DAY SERVICES shall be provided according to §8.491.

8.496.920 HOME MAKER SERVICES shall be provided according to §8.490.

8.496.930 ELECTRONIC MONITORING shall be provided in accordance with §8.488.

8.496.940 PERSONAL CARE shall be provided in accordance with §8.489

8.496.950 PRIVATE DUTY NURSING SERVICES (HCBS-PLWA) are hourly, skilled nursing services provided for up to twenty-four hours per day in a home setting to an eligible HCBS-PLWA program client as a cost-effective alternative to hospitalization or nursing facility placement when care cannot be safely managed within the scope and standards of intermittent nursing care.

.951 DEFINITIONS Private Duty Nursing, for the purposes of this waiver, shall be defined as intensive and continuous, hourly nursing care as different from part-time or intermittent care for persons living with HIV/AIDS. Eligible HCBS-PLWA Program Recipient shall be defined as a client who requires intensive and prolonged, hourly skilled nursing care on more than an intermittent basis. Criteria which would qualify for skilled nursing services on a continuous basis are:

- A. Intravenous, intramuscular, or subcutaneous injections; or
- B. Requiring prolonged intravenous administration of nutritional substances, hydration or drugs;
or
- C. Dependence daily on other respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support, or tube feeding; or
- D. Insertion, irrigation and replacement of catheters; or
- E. Application of dressings involving prescription medications and aseptic techniques; or
- F. Treatment of extensive decubitus ulcers or other widespread skin disorder

These criteria are useful as a guide in evaluating whether a client's needs fall within the designation of skilled level of care. Hourly private duty nursing care can only be provided when care is required continuously and when a combination of the above criteria is indicated. Periodic, episodic, or infrequent need for skilled nursing services does not indicate the need for the level of care designation of private duty nursing.

Skilled Nursing shall be defined as services provided under the licensure, scope and standards of the Colorado Nurse Practice Act, by a registered nurse under the direction of a physician, or a licensed practical nurse under the supervision of a registered nurse and the direction of a physician.

Hospital shall be defined as an institution primarily engaged in providing to inpatients by or under the supervision of physicians, diagnostic and therapeutic services for the purpose of medical diagnosis, treatment and care of an injured, disabled or sick person.

.952 GENERAL ELIGIBILITY REQUIREMENTS An HCBS-PLWA program client shall be determined to be eligible for private duty nursing services when the following requirements are met:

- A. The client shall be an eligible HCBS-PLWA program client as defined above; and
- B. The client shall be medically stable and appropriate for home care, as documented by the physician; and
- C. The client's physician shall certify on a Department prescribed form, at least every sixty (60) days, that without these services, the person would require care in a hospital; and

- D. The client shall require intensive and prolonged, hourly skilled nursing care on more than an intermittent basis; and
- E. All costs to Medicaid in the home shall be less than all costs to Medicaid in the hospital as calculated on a Department-prescribed form; and
- F. All other available, appropriate, and less expensive non-hospital settings shall first be explored and utilized.

Ineligibility for private duty nursing services shall not affect eligibility for other HCBS-PLWA or Medicaid services.

.953 FAMILY/IN-HOME CAREGIVER REQUIREMENTS There shall be documented evidence of:

- A. A family/in-home caregiver who is reliable, willing, capable, and available to assume care for the recipient; and
- B. Designated alternative caregiver(s) who are reliable, willing, capable, and available to provide relief to the family/in-home caregiver, and
- C. Demonstration of the specific skills necessary to care for the recipient; and
- D. Ability to maintain a home environment that allows for safe home care.

8.496.954 HOME ENVIRONMENTAL REQUIREMENTS

Living arrangements that will allow safe home care must be demonstrated including:

- A. Adequate electrical power including back-up power system for life-sustaining equipment; and
- B. Adequate room for equipment and supplies; and
- C. A clean environment; and
- D. A communication system (i.e. telephone, citizen's band radio (CB), radiotelephone, etc.) available 24 hours a day; and
- E. Financial stability of family/in-home caregiver, which is adequate to continue environmental support.

.955 PRIVATE DUTY NURSING REQUIREMENTS Private Duty Nursing Services shall be provided by a Medicaid-reimbursable home health agency using registered nurses or licensed practical nurses who hold a current Colorado Board of Nursing license. Medicaid-reimbursable home health agency is defined in the §8.520 of this manual.

.956 HOME HEALTH AGENCY PROVIDER REQUIREMENTS A Medicaid-reimbursable home health agency may be authorized by the single entry point agency to provide private duty nursing services if the agency:

- A. Has previous experience in providing hourly private duty nursing services; and
- B. Has available nursing personnel with appropriate documented skills for the client's care; and
- C. Is willing to contract with a supplemental home health agency, if necessary, to meet the staffing needs of the client, with assurance that this relationship is adequately supervised,

and meets the conditions of Medicare/Medicaid participation; and

- D. Is willing to have the primary nurse and other personnel, as appropriate, spend time in the hospital prior to discharge, to refine skills and become familiar with individualized care requirements of the HCBS-PLWA client.

8.496.957 DURABLE MEDICAL EQUIPMENT/SUPPLY PROVIDER REQUIREMENTS

A Medicaid certified company supplying life-sustaining and other equipment in the home shall be selected based upon the ability to provide:

- A. Twenty-four hour availability of professionals, for equipment repair or phone assistance, as necessary; and
- B. Pediatric expertise for recipients under 15 years of age; and
- C. Preventative maintenance of equipment; and
- D. Written instructions in the home for the operation and maintenance of equipment, including emergency procedures.

.958 ROLES AND RESPONSIBILITIES

- A. Role and Responsibilities of the Attending Physician. The attending physician shall:

- 1. Determine that the client is medically stable and appropriate for home care; and
- 2. Determine that the client needs intensive and prolonged skilled nursing on more than an intermittent basis; and
- 3. Certify, on a State-prescribed form, at least every sixty (60) days, that without private duty nursing services the client would require care in a hospital; and
- 4. Prescribe a plan of care at least every sixty (60) days, which is appropriate to assure the safety of the client in the home setting. The physician's plan of care must include:
 - a. The client's diagnosis(es) and prognosis; and
 - b. A statement of each discipline involved in home care; and
 - c. The frequency, duration, and purpose of each discipline involved; and
 - d. A brief clinical summary, including pertinent medical and/or psychological/social issues; and
 - e. Short and long-term goals.; and
 - f. Referrals being explored; and
 - g. Involvement of informal resources (i.e., community organizations).

- B. Role and Responsibilities of the Single Entry Point Agency. The single entry point agency shall:

1. Identify eligible HCBS-PLWA clients who are appropriate for home care; and
 2. Coordinate, in conjunction with the health care team (physician, hospital discharge planner, home health agency), a home care plan that is safe, appropriate, and meets state requirements; and
 3. Determine the number of units of Private Duty Nursing (PDN), in conjunction with the home health agency, based on clients' specific needs and cost containment criteria; and
 4. Gather, in conjunction with the health care team, all medical, social, safety, and cost information on state-prescribed forms; and
 5. Verify that all eligibility requirements for private duty nursing services under the HCBS-PLWA program are met; and
 6. If Department (or its designee) approval for private duty nursing services is received, plan for hospital discharge.
- C. The role of the Single Entry Point (SEP) Agency in the management of private duty nursing services cases includes:
1. Providing overall coordination of home services and service providers; and
 2. Monitoring cost effectiveness; and
 3. Reviewing the home care plan submitted by the Home Health Agency for appropriate utilization of services; and
 4. Monitoring and evaluating quality of care. The single entry point agency shall, as appropriate:
 - a. Attend discharge planning conferences to determine that home care is appropriate, to offer guidance, and to offer preliminary approval for home care; and
 - b. Assess the home prior to hospital discharge for a safe and appropriate environment; and
 - c. Conduct on-site visit to each client quarterly, to include an evaluation of:
 - 1) Client/family/in-home caregiver status and satisfaction with services; and
 - 2) Home care plan, to include utilization of alternative resources and striving toward maximum independence; and
 - d. Initiate corrective action.
- If concerns are raised during quality assurance monitoring, the single entry point agency shall inform involved party(ies), in writing, of concerns. Written concern(s) shall be responded to within fifteen (15) days by the involved party and shall include a plan to address or correct any problem. This written plan shall be agreed upon by all involved, to include an anticipated date of correction, and signed by all involved in the concern.

D. Role and Responsibilities of the Home Health Agency. The home health agency shall:

1. Develop and implement each home care plan under the direction of the client's physician and in conjunction with the client and case manager in a manner that will fulfill the client's specific needs; and
2. Assist with the hospital discharge planning process by providing input and information regarding the home care plan, costs, and other state requirements to the single entry point agency; and
3. Assess the home prior to hospital discharge for a safe and appropriate environment; and
4. Communicate the case status with the single entry point agency on timely basis, including changes in physical conditions and/or psychological/social situations which may affect safety and home care needs and
5. Provide private duty nursing services by personnel who have:
 - a. Appropriate licensure to practice nursing in Colorado: a ad
 - b. Appropriate documented skills for the specific care required by the client; and
 - c. Appropriate orientation and on-going in-service education to meet the client's specific needs.

E. Roles and Responsibilities of the Family/In-home Caregiver: The role of the family/in-home caregiver in the management of private duty nursing home care will be to:

1. Meet all requirements specified in the Section on FAMILY/IN-HOME CAREGIVER REQUIREMENTS in this manual; and
2. Participate in the planning, coordination, and provision of home care services, including a routine for emergency situations; and
3. Communicate changes in care and care needs to service providers as appropriate; and
4. Work toward maximum independence, including, finding and using alternative resources as appropriate; and

F. Role and Responsibilities of the Client: The role of the client in the management of private duty home care shall be to participate in home care planning, implementation and evaluation, as the client's ability allows.

8.496.959 REIMBURSEMENT

A. All private duty nursing (PDN) services must be prior authorized by the single entry point agency.

1. Verbal prior authorization must be obtained by the hospital d scharge planner and/or the home health agency providing PDN services before hospital discharge.
2. Written prior authorization requests must be received by the Department or its designee from the single entry point agency within ten (10) days of start of

private duty nursing services and must include all documentation as requested by the Department's guidelines and procedures.

B. Skilled nursing services for the Private Duty Nursing program shall be reimbursed under the Special Program Code for HCBS-PLWA, in units of one hour, at the following rates:

1. The maximum hourly rate for skilled nursing by a registered nurse shall be \$27.39 and shall be subject to adjustment by the Department.
2. The maximum hourly rate for skilled nursing by a licensed practical nurse shall be \$19.72 and shall be subject to adjustment by the Department

8.496.960 NON-MEDICAL TRANSPORTATION shall be provided in accordance with §8.494.

8.500 HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD) WAIVER

8.500.1 DEFINITION

Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver services shall be provided in a home or community based setting to persons with developmental disabilities who meet the level of care criteria for long term care programs for the developmentally disabled and who are eligible under the Medicaid waiver for programs for the developmentally disabled as a cost effective alternative to institutional placement.

8.500.2 PROGRAM ADMINISTRATION

Home and Community Based Services for the Developmentally Disabled (HCB-DD) shall be provided in accordance with the federally approved waiver document and these rules and the rules and regulations of the Colorado Department of Human Services entitled RULES AND REGULATIONS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES and promulgated in accordance with the provisions of section 26-4-624, C.R.S. In the event a direct conflict arises between the rules and regulations of the Department of Health Care Policy and Financing and the Department of Human Services, the provisions of section 26-4-624(5), C.R.S., shall apply and the regulations of the Department of Health Care Policy and Financing shall control.

The Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver program is administered by the Department of Human Services, Developmental Disabilities Services, under the oversight of the Department of Health Care Policy and Financing.

8.500.3 PROGRAM PROVISIONS

The following provisions shall apply in regards to the Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver.

- A. Home and Community Based Services for the Developmentally Disabled (HCB-DD) shall be provided as an alternative to institutional placement for individuals with developmental disabilities and include personal care habilitation residential programs, non-medical transportation, assistive technology, home modification, and habilitation day programs. Individuals eligible for these services shall be eligible for all other Medicaid services for which they qualify.
- B. HCB-DD waiver services shall be waived from the requirements in Section 1902(a)(10)(B) of the Social Security Act concerning comparability of services. The availability of some services may not be consistent throughout the State of Colorado.

- C. HCB-DD waiver services shall be structured to make various services available to individuals based on the level of care certification.
- D. Case management agencies shall provide case management services including assessing the individual's needs to determine if HCB-DD waiver services are appropriate; completing the individual's Individualized Plan (IP); and submitting the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for HCB-DD waiver services. These Individualized Plans shall be subject to review and approval of HCB-DD waiver services by the Department of Health Care Policy and Financing.
- E. The client receiving services is responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources; cooperating with the case manager and service providers as agreed to in the Individualized Plan; choosing between HCB-DD waiver services and institutional care; and where assessed, remitting patient payments by the due date.

8.500.4 ELIGIBLE PERSONS

.41 Home and Community Based Services for the Developmentally Disabled (HCB-DD), under the HCB-DD waiver #007.91, shall be offered to individuals with developmental disabilities:

- A. who meet the medical assistance eligibility criteria as specified at §8.110.8 in this manual; and,
- B. who have been determined to meet the level of care criteria for long term care programs for the developmentally disabled; and,
- C. who have been assessed as potentially appropriately served through the HCB-DD program through application of the Institutional Profile; and,
- D. for whom a Plan of Care (POC) has been developed which conforms to the purchase of services limitations as provided herein; and,
- E. provided the individual can be served within the federally approved capacity limits of the waiver; and,
- F. who receive at least one waiver service each month.

.42 Persons determined eligible to receive services and supports under the HCB-DD waiver which are not immediately available within the federally approved capacity limits in the waiver, shall be eligible for placement on a waiting list for services and supports.

- A. Waiting lists for persons eligible for the HCB-DD waiver program shall be maintained by the Community Centered Boards, uniformly administered throughout the state and in accordance with these and DHS/DDD rules and guidelines.
- B. Persons determined eligible shall be placed on the waiting list for services and supports in the service area of residency.
- C. Persons who indicate a serious intent to move to another service area should services and supports become available shall be placed on the waiting list in that service area. Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in DHS/DDD guidelines for placement on waiting lists in a service area other than area of residency.

D. The date used to establish a person's placement on a waiting list shall be:

1. The date on which eligibility for developmental disabilities services in Colorado was originally determined; or,
2. The fourteenth (14) birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

E. As openings become available in the HCB-DD waiver program in a designated service area, persons shall be considered for services and supports in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:

1. Emergency situations where the health, safety and welfare of the person or others is greatly endangered and the emergency can not be resolved in another way. Emergencies are defined as follows:
 - a. Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode.
 - b. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.
 - c. Danger to Others: the person's behavior and/or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision can not be provided by the current caretaker to ensure safety of persons in the community.
 - d. Danger to Self: a person's medical, psychiatric and/or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.
2. The Legislature has appropriated funds specific to individuals and/or to a specific class of persons.

F. If an eligible individual is placed on a waiting list for HCB-DD waiver services, a written notice, including information regarding client appeals, shall be sent to the individual and/or their legal guardian in accordance with the provisions of 10 CCR 2505-10 Section 8.057 et seq.

.43 Individuals with developmental disabilities who are residents of Nursing Facilities (NF's), Intermediate Care Facilities for the Mentally Retarded (ICF/MR's), or hospitals shall not be eligible for Home and Community Based Services for the Developmental Disabled (HCB-DD).

8.500.5 PROVIDERS

.51 Home and Community Based services for the Developmentally Disabled (HCB-DD) programs shall be provided by agencies that meet the following criteria: Have received and/or maintained program approval from the Department of Human Services, Developmental Disabilities Services for the provision of HCB- DD waiver services; and Have a Medicaid Provider Agreement; and

- A. have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S., and all rules and regulations promulgated thereunder; and

- B. have, if applicable, the current required licenses from the Colorado Department of Public Health and Environment.

8.500.52 Home and Community Based services for the Developmentally Disabled (HCB-DD) waiver providers shall cooperate in the following:

- A. all state authorized on-site program reviews, whether for the purpose of program approval, on-going program monitoring, or state initiated financial and program audits; and
- B. all state efforts to collect and maintain information on the HCB-DD waiver programs, whether required for federal or state program review and evaluation efforts, including information collection; and
- C. any federal program reviews and financial audits of the HCB-DD waiver programs; and
- D. providing access, by the County Departments of Social/Human Services, to records of persons receiving services held by case management agencies as required to determine and redetermine Medicaid eligibility; and
- E. all efforts by the case management agency to review the provider's programs, whether generally or specifically for particular persons receiving services; and
- F. all long term care determinations and continued stay reviews conducted by the Department of Human Services, Developmental Disabilities Services
- G. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.500.6 INDIVIDUAL RIGHTS

The rights of a person receiving Home and Community Based Services are established in Title 27, Article 10.5, Sections 112 through 131, C.R.S., as amended. The rules and regulations regarding these rights are promulgated in Colorado Department of Health Care Policy and Financing, Section 8.484.20 of these rules, and the Department of Human Services, Division for Developmental Disabilities, Rules and Regulations, Chapter 6.

8.500.7 QUALITY ASSURANCE

The monitoring of Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver services and the health and well being of service recipients shall be the responsibility of the Department of Human Services, Developmental Disabilities Services, under the oversight of the Department of Health Care Policy and Financing.

The Department of Human Services, Developmental Disabilities Services, shall conduct on-site surveys of each agency providing HCB-DD waiver services. The survey will include a review of applicable rules and standards developed for programs serving individuals with developmental disabilities.

The Department of Human Services, Developmental Disabilities Services, shall ensure that the case management agency/community centered board fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with the assurances required of these programs.

The Department of Human Services, Developmental Disabilities Service;, shall maintain for three years a complete file of all records, documents, communications, and other materials which pertain to the

operation of the HCB-DD waiver programs or the delivery of services under these programs. The Department of Health Care Policy and Financing shall have access to these records at any reasonable time.

Developmental Disabilities Services shall recommend to the Department of Health Care Policy and Financing the denial and/or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately develop a corrective action plan to Developmental Disabilities Services within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

After having received the denial and/or termination recommendation and reviewing the supporting documentation, the Department of Health Care Policy and Financing shall take the appropriate action.

8.500.8 PATIENT PAYMENT - POST ELIGIBILITY TREATMENT OF INCOME

Individuals who are determined to be Medicaid eligible through the application of the 300% income standard at §8.110.8, are required to pay a portion of their income towards the cost of their HCB-DD services.

.82 This PETI (Post Eligibility Treatment of Income) payment :

- A. shall be calculated by the case management agency during the individual's initial assessment for HCB-DD services;
- B. shall not exceed the cost of HCB-DD services for the month for which payment is being made;
- C. shall be recomputed monthly;
- D. shall be collected and receipted by the case management agency as instructed by the State.

.83 In calculating PETI payment, the case management agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining Medicaid eligibility):

- A. A maintenance allowance equal to the AND/SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of \$245 per month; and
- B. For an individual with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and
- C. For an individual with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate AFDC grant level; and
- D. Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:
 - 1. health insurance premiums (other than Medicare), deductibles, or coinsurance charges (including Medicaid copayments); and
 - 2. necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan.

.84 Case management agencies are responsible for informing individuals of their PETI obligation on a

form prescribed by the Developmental Disabilities Services, Department of Human Services.

.85 PETI payments are due during the month following the month for which they are assessed.

.86 Case management agencies must submit all PETI assessments to the state on the form specified by the division, within 35 calendar days of the end of the month for which they were assessed.

8.500.90 DEFINITION

Supported Living Services (SLS) are services and supports which are available to assist persons with developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an SLS setting. Supported Living Services are subject to the availability of appropriate services and supports within existing resources.

8.500.91 PROGRAM ADMINISTRATION

The Supported Living Services program for persons with developmental disabilities is administered by the Department of Human Services, Developmental Disabilities Services under the oversight of the Department of Health Care Policy and Financing.

Supported Living Services for persons with developmental disabilities shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Developmental Disabilities Services (DDS), 2 CCR 503-1. In the event a direct conflict arises between the rules and regulations of the Department of Health Care Policy and Financing and the Department of Human Services, the rules and regulations of the Department of Health Care Policy and Financing shall control.

Supported Living Services shall not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services. Supported Living Services shall be subject to annual appropriations by the Colorado General Assembly. The Department of Human Services, Developmental Disabilities Services shall limit the utilization of the Supported Living Services waiver based on the federally approved capacity and cost effectiveness of the waiver and the total appropriations, and shall limit the enrollment when utilization of the Supported Living Services waiver program is projected to exceed the spending authority.

Designated Community Centered Boards shall be responsible for performing all functions related to the provision of Supported Living Services, pursuant to 27-10.5-105, C.R.S., et seq. (1995 Supp.).

8.500.92 PROGRAM PROVISIONS

The State of Colorado requested and was granted authority to provide the following services under the Supported Living Services waiver.

- A. Supported Living Services are provided as an alternative to institutional placement for individuals with developmental disabilities and include personal assistant services, habilitation services, environmental engineering, professional services, and dental services.
- B. The Supported Living Services program is waived from the requirements of Section 1902(a)(10)(B) (comparability of services) and Section 1902(a)(1) (statewide) of the Social Security Act. Therefore, the availability and comparability of services may not be consistent throughout the State of Colorado.
- C. Individuals eligible for services under the SLS program are eligible for all other Medicaid services for which they qualify and must first access all benefits available under the

regular Medicaid State Plan prior to accessing funding for those same services under the SLS program.

- D. Case management agencies shall provide case management services under administrative activity including: assessment of the individual's needs to determine if SLS waiver services are appropriate; completion of the Individualized Plan (IP); and submission of the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for SLS waiver services. These Individualized Plans are also subject to review by the Department of Health Care Policy and Financing.
- E. The provision of Supported Living Services may be subcontracted by the SLS agency to other qualified agencies, professionals, individuals, or family members living in the same household as the person with a developmental disability, or vendors in order to provide additional opportunities for individual choice and the use of general services,
- F. The individual receiving services and/or his/her family or guardian are responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources; cooperating with the case management agency and service providers as agreed to in the Individualized Plan; and choosing between SLS waiver services and institutional care.

8.500.93 ELIGIBLE INDIVIDUALS

Supported Living Services may be offered to an individual who meets the following criteria:

- A. Has been determined to have a developmental disability as defined in Section 27-10.5-102, C.R.S., (1995 Supp.), by a designated Community Centered Board; and
- B. Is an adult, eighteen (18) years of age or older; and
- C. Has been certified by the Department of Human Services/Developmental Disabilities Services through the ULTC-100 and LTC-102 assessment forms that he/she meets the established minimum criteria used in the designated screening instrument for the Level of Care for placement into an Intermediate Care Facility for the Mentally Retarded (ICF/MR); and
- D. For whom an Individualized Plan (IP) has been developed which conforms to the purchase of service limitations as provided herein; and
- E. Meets the medical assistance eligibility criteria as specified in the section on PERSONS RECEIVING HOME AND COMMUNITY-BASED SERVICES at §8.110.8; and
- F. Does not require twenty-four (24) hour supervision on an ongoing basis which is paid for with SLS funding; and
- G. Resides in an eligible SLS setting. SLS settings are the individual's "own home" which is defined as the following:
 - 1. A living arrangement (e.g., home, apartment, or condominium) which the individual owns or rents or leases in his/her own name; or
 - 2. The home where the individual lives with his/her family or legal guardian; and
 - 3. No more than three (3) persons receiving Supported Living Services may reside in one household, unless they are all members of the same family; and

- H. The individual receiving Supported Living Services is not simultaneously enrolled in the Home and Community-Based Services for the Developmentally Disabled (HCB-DD) program, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program or any other waiver program; and
- I. The individual is not residing in a hospital, nursing facility or ICF/MR; and
- J. Provided the individual can be served within the federally approved capacity and cost effectiveness limits of the waiver; and,
- K. The individual receives at least one waiver service each month.

8.500.94 WAITING LIST PROTOCOL

Persons determined eligible to receive services under the SLS federally approved capacity and cost effectiveness limits of the waiver, shall be eligible for placement on a waiting list for services.

- A. Waiting lists for persons eligible for the SLS waiver program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the Department of Human Services, Developmental Disabilities Services (DHS/DDS) guidelines.
- B. Persons determined eligible shall be placed on the waiting list for services in the service area of residency.
- C. Persons who indicate a serious intent to move to another service area should services become available shall be placed on the waiting list in that service area. Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in the DHS/DDS guidelines for placement on a waiting list in a service area other than the area of residency.
- D. The date used to establish a person's placement on a waiting list shall be:
 - 1. the date on which eligibility for developmental disabilities services in Colorado was originally determined; or
 - 2. the fourteenth (14th) birthday if a child is determined eligible prior to the age of fourteen and is waiting for adult services.
- E. As openings become available in the SLS waiver program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:
 - 1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered and the emergency cannot be resolved in another way. Emergencies are defined as follows:
 - a. Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode.
 - b. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

c. Danger to Others: the person's behavior and/or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

d. Danger to Self: a person's medical, psychiatric and/or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

2. The Legislature has appropriated funds specific to individuals and/or to a specific class of persons.

F. If an eligible individual is placed on a waiting list for SLS waiver services, a written notice, including information regarding the client appeals process, shall be sent to the individual and/or his/her legal guardian in accordance with the provisions of Section S.057, et seq., of this Staff Manual.

8.500.95 ENROLLMENT

Community Centered Boards shall submit to the State the following document; enroll a person into the SLS program:

A. A copy of the Individual Choice Statement; and

B. A Copy of the Individualized Plan (IP); and

C. A Prior Authorization Request; and

D. A completed ULTC 100.2 and form.

An individual shall only be considered enrolled after prior authorization completed by the State and only for the time period approved.

8.500.97 SERVICE DESCRIPTIONS (Continued)

A. Personal Assistant Services (Continued)

3. Mentorship activities such as planning, decision-making, assistance with his/her participation on private and public boards, advisory groups and commissions, person specific training costs associated with providing unique supported living services to an individual, and child and infant care assistance for parent(s) who themselves have a developmental disability; and

4. Community accessibility services support the abilities and skills necessary to enable the individual to access the community and/or provide the basis for building skills which will assist the individual to access the community. These types of services include socialization, adaptive skills, personnel to accompany and support the individual in all types of community settings, supplies, travel including arranging and providing transportation, and providing necessary resources for participation in activities and functions in the community.

B. Professional Services

Professional services are those services, including evaluation and assessment, provided for a person with a developmental disability which require the service provider to be licensed or certified in a particular

occupational skill area such as an occupational therapist, registered nurse, speech/language pathologist, psychologist, etc.

The following types of professional services can be included under this waiver when they are not available under the regular Medicaid State Plan or third party payment:

1. Communication services to maintain or improve communication skills such as speech/language therapy, or interpreter services;
2. Counseling services including individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations;
3. Therapeutic services such as occupational or physical therapy including diagnostic evaluations or consultations needed to sustain the overall functioning of an individual; and
4. Personal care functions requiring professional care by an RN, LPN, Physician's Assistant or other such licensed or certified medical personnel. This may also include operating medical equipment.

C. Dental Services

Dental costs when dental problems are sufficient to lead to more generalized disease due to infection or improper care or nutrition. (Note: The intent of this service is to provide, at a minimum, routine preventative dental care).

D. Habilitation Services

Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

1. Specialized habilitation services focus on enabling the individual to attain his or her maximum functional level, and are coordinated with any physical, occupational, or speech therapies listed in the Individualized Plan. These services include such training as self-feeding, toileting, and self-care, self-sufficiency and maintenance skills. These services are highly therapeutic in nature, highly individualized with sensory stimulation and integration as major components. In addition, specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.
2. Pre-vocational services not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Pre-vocational services are available only to individuals who have previously been discharged from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Nursing Facility (NF) or ICF/MR. Pre-vocational services are designed to assist individuals with developmental disabilities in acquiring and maintaining work habits and work-related skills. Pre-vocational services are intended to have a more generalized result as opposed to vocational training for a specific job. Individuals must have a demonstrated earning capacity of less than 50 percent of the federal minimum wage, as determined in accordance with certification standards promulgated by the U.S. Department of Labor. Pre-vocational services encompass the following types of work-related activities:
 - a. teaching an individual such concepts as following directions, attending to task, task completion, communication, decision-making, and problem -solving; and

- b. training in the areas of safety, self-advocacy, and mobility; and
 - c. intervention and training needed to benefit from prevocational services which would allow common barriers to participation to be avoided; and
 - d. travel training services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to pre-vocational services and supports identified in the Individualized Plan. When compensated, individuals are paid at less than 50 percent of the minimum wage.
- 3. Supported Employment/Community Integrated Employment (CIE) services and supports are paid employment in an integrated work setting for individuals with developmental disabilities for whom competitive employment at or above the minimum wage is unlikely and who because of their disabilities need considerable ongoing support to perform in a regular work setting. A variety of regular work settings are used, particularly worksites in which persons without disabilities are employed. Community Integrated Employment services and supports encompass the following types of activities designed to assist eligible individuals to access and sustain employment in a regular work setting:
 - a. individualized assessment which may include community orientation and job exploration; and
 - b. individualized job development and placement services that produce an appropriate job match for the individual and his/her employer; and
 - c. ongoing support, training, and facilitation in obtaining a job, job skill acquisition, job retention, career development, and work-related activities; and
 - d. intervention and training needed to benefit from community integrated employment services and other supports which would help to remove or diminish common barriers to participation in employment and the building of community relationships; and
 - e. travel services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to services and supports identified in the Individualized Plan.
- 4. The activities provided under the definition of community integrated employment services and supports are not typically available as Section 110 services. Community Integrated Employment services and supports will provide supplemental and additional support to Colorado Rehabilitation Services during the time an individual receives transition services. Community Integrated Employment services and supports will provide long-term support for post-Colorado Rehabilitation Services. The services provided under the waiver are different from those provided by Colorado Rehabilitation Services.
 - a) Community Integrated Employment services and support are available only to individuals who have previously been discharged from a Nursing Facility (previously called a skilled nursing facility) or Intermediate Care Facility for the Mentally Retarded (previously called an Intermediate Care Facility).
 - b) Community Integrated Employment specifically exclude: incentive payments, subsidies, or unrelated vocational training expenses such as the following:
 - 1. Incentive payments made to an employer or beneficiaries to encourage or subsidize employer's participation in a community integrated employment

program; or

2. Payments that are passed through to beneficiaries of community integrated employment programs; or
3. Payments for vocational training that is not directly related to a beneficiary's community integrated employment program.
4. Transportation may be provided between the recipient's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the recipient receives habilitation services in more than one place) as a component part of habilitation services. When this cost is identified in the Individualized Plan, the cost of this transportation may be included in the rate paid to providers of the appropriate type of habilitation services.

E. Environmental Engineering

Environmental engineering consists of devices and adaptations identified in the Individualized Plan which are necessary to overcome environmental barriers which people with disabilities face in their daily lives, whether in their home or in their community. Such devices or adaptations minimize or eliminate the need for ongoing human assistance.

Environmental engineering can be included under this waiver when such devices or adaptations are not available under the regular Medicaid State Plan or third party payment.

Environmental engineering is available to make daily living easier by adapting or supplementing the person's environment through such means as:

1. Adaptations to living quarters including showers, toilets, control switches for the home, kitchen equipment for the preparation of special diets and accessibility such as ramps and railings; and
2. Mobility devices to help people move around including wheelchairs (general use and customized) and van adaptations; and
3. Expressive and receptive communication augmentation including electronic communication boards; and

8.500.97 SERVICE DESCRIPTIONS (Conclusion)

E. Environmental Engineering (Continued)

4. Skill acquisition supports which make learning easier including adapted computers, games, or age appropriate toys; and
5. Safety enhancing supports including security or emergency response systems, and specialized clothing (e.g., Velcro) if the cost is above and beyond that of normal personal needs expenses; and
6. Specialized medical equipment, nondurable medical equipment and supplies; and
7. Assessing the need for, arranging for, providing and maintaining such devices and/or adaptations.

Excluded items and services shall include those adaptations or devices for the person's environment which are not associated with a direct medical or remedial need of the individual such as carpeting, roof repair, central air conditioning, regular clothing, etc. All devices and adaptations shall be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation.

Environmental engineering is limited to a maximum of \$10,000 per individual within the duration of this waiver except that on a case-by-case basis the State may prior authorize additional funds for any individual.

8.500.98 SERVICE PROVIDERS

A. Supported Living Services shall be provided by or through agencies that meet the following criteria:

1. Have been designated by the Department of Human Services, Developmental Disabilities Services to be a Community Centered Board; and
2. Have received and/or maintained program approval from the Department of Human Services, Developmental Disabilities Services for the provision of Supported Living Services; and
3. Have a Medicaid Provider Agreement; and
4. Have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S. (1995 Supp.), and the rules and regulations promulgated there under, including cooperation with the following activities:
 - a. All State authorized on-site program reviews, whether for the purpose of program approval, on-going program monitoring, or State-initiated financial and program audits; and
 - b. All State efforts to collect and maintain information on the SLS waiver program, whether required for federal or state program review and evaluation efforts, including information collection; and
 - c. Any federal program reviews and financial audits of the SLS waiver program; and
 - d. County Departments of Social/Human Services shall be authorized access, as required, to the records of persons receiving services held by case management agencies to determine or re-determine Medicaid eligibility; and
 - e. All efforts by the case management agency to review the provider's programs, either generally or specifically for particular persons receiving services; and
 - f. All long-term care determinations and continued stay reviews conducted by the Department of Human Services/Developmental Disabilities Services Utilization Review Contractor.

B. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.500.99 INDIVIDUAL RIGHTS

The rights of a person receiving Supported Living Services are established in Title 27, Article 10.5, Sections 112 through 131, C.R.S. (1995 Supp.), and the rules and regulations regarding these rights are

promulgated with the Department of Human Services, Developmental Disabilities Services, rules and regulations, Chapter 6.

8.500.100 APPEAL PROCESS

An individual receiving SLS waiver services has a right to the appeal process established in the Department of Human Services, Developmental Disabilities Services, rules and regulations, Section 7.2 and 10 CCR 2505-10, Section 8.057.

8.500.101 QUALITY ASSURANCE

- A. The monitoring of services provided under the Supported Living Services waiver and the health and well-being of service recipients shall be the responsibility of the Department of Human Services, Developmental Disabilities Services, under the oversight of the Department of Health Care Policy and Financing.
- B. The Department of Human Services, Developmental Disabilities Services shall conduct on-site surveys or cause to have on-site surveys to be done in accordance with guidelines established by Developmental Disabilities Services. The survey shall include a review of applicable Colorado Department of Human Services, Developmental Disabilities Services rules and regulations and standards for SLS.
- C. The Department of Human Services, Developmental Disabilities Services, shall ensure that the case management agency/community centered board fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.
- D. The Department of Human Services, Developmental Disabilities Services, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials which pertain to the operation and service delivery of the SLS waiver program.
- E. Developmental Disabilities Services shall recommend to the Department of Health Care Policy and Financing the denial and/or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to Developmental Disabilities Services within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.
- F. After receiving the denial and/or termination recommendation and reviewing the supporting documentation, the Department of Health Care Policy and Financing shall take the appropriate action.

8.500.102 POST ELIGIBILITY TREATMENT OF INCOME (PETI)

For individuals who are determined to be Medicaid eligible for the SLS waiver through the application of the 300% income standard as described at §8.110.8, the case manager shall allow an amount equal to the 300% standard as the personal maintenance allowance (no other deductions are necessary). The PETI assessment form shall be completed monthly by the case management agency to ensure that the individual's income does not exceed the maximum allowed for continued eligibility.

8.503 DEFINITION

- A. The Children's Extensive Support (CES) waiver services are provided through a 1915(c) Home and Community-Based Services Waiver and an 1115 (a) Demonstration Waiver for children who have a developmental disability, or for children under the age of five who are at risk of a developmental

delay, in an Intermediate Care Facility for the Mentally Retarded (ICF/MR); or who are at risk of institutionalization and are subject to the availability of appropriate services and supports within existing resources.

- B. The services provided under this program serve as an alternative to ICF/MR services for children from birth through seventeen years of age who meet the targeting criteria and the Level of Care Screening Guidelines. Services provided through this Children's Extensive Support Waiver (CES) shall be provided in the home or community when deemed appropriate and adequate by the child's physician, and shall be limited to:
 - 1. Personal Assistance; and
 - 2. Home Modification; and
 - 3. Specialized Medical Equipment and Supplies; and
 - 4. Professional Services; and
 - 5. Community Connections.

8.503.10 PROGRAM ADMINISTRATION

- A. CES services or children with developmental disabilities shall be provided in accordance with these rules and regulations.
- B. The Children's Extensive Support waivers for children with developmental disabilities shall be administered by the Department of Human Services, Developmental Disabilities Services under the oversight of the Department of Health Care Policy and Financing.
- C. CES waiver services do not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services,
 - 1. CES waiver shall be subject to annual appropriations by the Colorado General Assembly.
 - 2. The Department of Human Services, Developmental Disabilities Services shall limit the utilization of the Children's Extensive Support waivers based on the federally approved capacity and cost effectiveness of the waiver and the total appropriations, and shall limit the enrollment when utilization of the CES waiver program is projected to exceed the spending authority.
- D. Designated Community Centered Boards will be responsible for performing all functions related to the provision of the Children's Extensive Support waiver, pursuant to 27-10.5-105, et seq, C.R.S. (1995 Supp.).

8.503.20 PROGRAM PROVISIONS

Colorado requested and was granted authority to provide the following services under Children's Extensive Support waivers:

- A. CES services shall be provided as an alternative to institutional placement for children with developmental disabilities and include personal assistance, home modification, specialized medical equipment and supplies, professional services, and community connection services.
- B. The Children's Extensive Support program is waived from the requirements of Section 1902(a)(10)(B) (comparability of services) and Section 1902(a)(1) (statewideness) of the Social Security Act

Therefore, the availability and comparability of services may not be consistent throughout the State of Colorado.

- C. Children eligible for services under the CES waivers shall be eligible for all other Medicaid services for which they qualify and shall first access all benefits available under the regular Medicaid State Plan and/or Medicaid EPSDT coverage prior to accessing funding for those same services under the CES waivers.
- D. Case management agencies shall provide case management services under administrative activity including: assessment of the individual's needs to determine if CES waiver services are appropriate; completion of the Individualized Plan (IP); and submission of the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for CES waiver services. These Individualized Plans shall be subject to review by the Department of Health Care Policy and Financing.
- E. The provision of Children's Extensive Support services may be subcontracted by the CES agency to other qualified agencies, professionals, individuals or vendors in order to provide additional opportunities for individual choice and the use of general services.
- F. The individual receiving services and/or his/her designated client representative, family or guardian are responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources; cooperating with the case management agency and service providers as agreed to in the Individualized Plan; and choosing between CES waiver services and institutional care.

8.503.30 ELIGIBILITY

- A. Children who meet all of the following program eligibility requirements will be determined eligible:
 - 1. The child has not reached his/her 18th birthday; and
 - 2. The child is living at home with his/her biological, adoptive parent(s) or guardian, or is in an out-of-home placement including an ICF/MR, hospital or nursing facility and can be returned home with the provision of CES services; and
 - 3. The child, if age five or older, has a developmental disability; or if less than five years of age, has a developmental delay, as determined by a community centered board (CCB); and
 - 4. Children enrolled in the 1915(c) waiver shall be eligible for Supplemental Security Income (SSI). Children enrolled in the 1115(a) demonstration waiver shall be ineligible for SSI and determined to meet the SSI disability criteria; and
 - 5. The quality and quantity of medical services and supports identified in the Individualized Plan (IP) are provided pursuant to a physician's order to meet the needs of the child in the home setting; and
 - 6. The income of the child shall not exceed 300% of the current maximum SSI standard maintenance allowance; and
 - 7. The resources of the child shall not exceed the maximum SSI allowance; and
 - 8. Enrollment of a child under this rule shall result in an overall savings when compared to the ICF/MR cost as determined by the State; and
 - 9. The Utilization Review Contractor (URC) certifies that the child meets the Level of Care for

ICF/MR placement; and

10. The child demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of medical status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

(a) A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition/situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others is evidenced by actual events and the events occurred within the past six months.

(b) Significant pattern of serious aggressive behaviors toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events, and the events occurred within the past six months.

(c) Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

11. The above conditions shall be evidenced by parent statement/data that is corroborated by written evidence that:

(a) The child's behavior(s) or medical need(s) have been demonstrated; or

(b) In the instance of an annual reassessment, it can be established that in the absence of the existing interventions or preventions provided through the CES Waiver that the intensity and frequency of the behavior or medical need would resume to a level that would meet the criteria listed above.

(c) Examples of acceptable evidence shall include but not be limited to any of the following: medical records, professional evaluations and assessments, educational records, insurance claims, Behavior Pharmacology Clinic reports, police reports, social services reports or observation by a third party on a regular basis.

12. The child receives at least one waiver service each month.

B. Pursuant to the terms of the Children's Extensive Support Waiver (CES), the number of individuals who may be served each year in the CES Program shall be limited to the federally approved capacity of the waiver.

C. Children enrolled in the 1115(a) CES Demonstration waiver shall be subject to a premium fee in accordance with Section 26-4-424, C.R.S. and 10 CCR 2505-10 Section 8.506.13

8.503.40 WAITING LIST PROTOCOL

A. Children determined eligible for services under the CES Program, which are not immediately available within the federally approved capacity limits of the waiver, shall be eligible for placement on a waiting list in the order in which the Utilization Review Contractor received the eligible application. Applicant children denied program enrollment shall be informed of their appeal rights in accordance with Section 8.057 of this manual.

- B. When an opening/slot becomes available, the first child on the waiting list shall be reassessed for eligibility by the Utilization Review Contractor and, if determined to still be eligible, shall be assigned that opening/slot.

8.503.50 RESPONSIBILITIES OF THE COUNTY DEPARTMENT OF SOCIAL/HUMAN SERVICES

- A. The County Department of Social/Human Services shall obtain an application for medical assistance, including an MS-10 form for private insurance coverage, from each applicant, not already Medicaid eligible, through his/her parent or guardian. In addition, the County Department of Social/Human Services shall obtain or determine and record all of the following on initial enrollment and at least annually thereafter, or more frequently if necessary due to changes in income, medical or living situation:
1. Written confirmation from the District Office, Social Security Administration, that the applicant is eligible or ineligible for SSI payments due to the deeming of parental income and/or resources; or
 2. Written confirmation from the District Office, Social Security Administration that the applicant is ineligible for SSI payments due to the child's own income and/or resources level; and
 3. Certification that the applicant's own income does not exceed 300% of the current SSI standard maintenance allowance on a monthly basis; and
 4. Obtain from the family the most current filed IRS Federal Tax return, certify the family monthly premium fee per section 8.506.13 and notify the Department of Health Care Policy and Financing;
 5. Inform the family of the applicability of the premium fee; and
 6. Document all changes in the family's monthly premium fee,
- B. In the event that the County Department of Social/Human Services is able to provide sufficient documentation to recommend approval of eligibility, either at the time of the initial application or during the redetermination process, the County Department shall notify the family in writing and forward a copy, within fifteen (15) working days, to the Community Centered Board (CCB), the recognized case management agency in the family service area.
- C. In the event that the County Department is unable to obtain sufficient documentation to recommend approval of eligibility, either at the time of the initial application or during the redetermination process, the County Department shall deny the applicant's request. The County Department shall notify the applicant, his/her parents or guardian in writing of the denial and of the applicant's right to an appeal in accordance with the procedures found in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1) Administrative Procedures Section (3.830). In these cases, the County Department shall not send any recommendations to the case management agency or the Department.
1. The County Department shall notify the case manager within five (5) working days of any changes in the child's income, which affect the applicant's eligibility status.
 2. An applicant shall not be enrolled in the program or have his/her name placed on the waiting list without a case manager being assigned to the case by a CCB.

8.503.60 RESPONSIBILITIES OF THE COMMUNITY CENTERED BOARD

The Community Centered Board (CCB) shall make a determination of eligibility for developmental

disabilities services for any child interested in applying for the CES Program.

8.503.61 DEFINITIONS

8.503.62 Case management services shall be defined as assistance on behalf of an eligible recipient to secure other needed services and supports to enable him/her to remain at home or in a non-institutional setting as an alternative to ICFMR placement when it is cost-effective to do so. Case management services shall include the following:

1. Documenting that the child's eligibility for Home and Community Based Services has been determined; and
2. Assessing the child's health care and social needs for CES services; and
3. Developing and implementing an Individualized Plan [§8.507.70]; and
4. Developing an Individual Support Plan (ISP) of services and projected costs [§8.507.80]; and
5. Coordinating and monitoring service delivery; and
6. Evaluating the effectiveness of services provided in the Plan; and
7. Reassessing the child's eligibility and need for CES services; and
8. Ensuring the child's parents) or guardian is informed of all Medicaid services available to the child including EPSDT Program services; and
9. Notifying the child's parents/guardian of adverse actions and appeal rights on a Department-designed form at least ten (10) calendar days prior to the effective date of such action.

Case management agency shall be defined as the Community Centered Board (CCB) in the service area where the child and family reside which has been approved through the Department of Human Services.

8.503.63 RESPONSIBILITIES OF THE CASE MANAGEMENT AGENCY

- A. A child's parent(s) or guardian may request assistance applying for the CES Program from the CCB or County Department of Social/Human Services in their service area.
- B. Upon receipt of a referral, the CCB shall be responsible to provide the following services:
 1. Arrange for a case manager to be assigned; and
 2. Inform the parent(s) or guardian of the purpose of the CES Program, the eligibility process, the minimum documentation required and the necessary agencies to contact; and
 3. Begin assessment activities within ten (10) calendar days of receipt of the referral; and
 4. Assist the parent(s) or guardian in completing the CES Application Packet and ensure completion of the ULTC-100 form; and
 5. Arrange for and complete at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible, within thirty (30) calendar days of receipt of the referral; and

6. Refer the child, as needed, to the County Department of Social/Human Services to determine eligibility for Medicaid or other services and benefits as appropriate, e.g., the EPSDT Program, and deliver services in coordination with the County Department; and
 7. Ensure that the child has been determined to meet the eligibility criteria for developmental disabilities services, and has a denial letter, if necessary, for SSI benefits; and
 8. Inform and explain the premium fee requirement; and
 9. Submit the completed CES Application Packet Statement and the ULTC-100 form to the Utilization Review Contractor for an eligibility determination.
- C. If there is an opening in the CES Program, the Utilization Review Contractor shall send an approved and date certified ULTC-100 form to the CCB. If the child has been on the waiting list, the Utilization Review Contractor shall first verify the continued eligibility of the child. The CCB shall notify the parent(s) or guardian and arrange for the development of the Individualized Plan (D?) and an Individualized Support Plan (ISP) within thirty (30) calendar days.
- D. If the child is eligible but there is no opening in the CES Program, the Utilization Review Contractor shall notify the CCB that the child has been placed on the waiting list and the order in which the child was placed on the list. The CCB shall notify the parent(s) or guardian within ten (10) calendar days.
- D. If the child is not Medicaid eligible, in his/her own right, and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department of Social/Human Services or other community agencies for possible services, as appropriate, within ten (10) working days of notification of denial.

8.503.70 INDIVIDUALIZED PLAN

8.503.71 DEFINITION

An Individualized Plan (IP) shall include information about why the child requires services and supports. All services and supports required to meet the needs in the home shall be listed. The purpose and the expected outcome of the services shall be included in the IP.

8.503.72 CONTENT OF THE INDIVIDUALIZED PLAN

- A. The Individualized Plan shall consist of a Child's Needs Section, a Plan Section and a Purpose Section.
1. Child's Needs Section shall identify and list specific (medical and/or behavioral) conditions and/or other areas in which services and supports are required to maintain the child in the community/home setting. The areas of need shall include, but not be limited to, the following:
 - (a) Medical needs; and
 - (b) Functional needs; and,
 - (c) Home/environmental needs.
 2. Plan Section shall identify and quantify all services and supports required to meet the needs of the child, including case management services. The service listing shall identify the payment sources (i.e. family or informal supports, parental out-of-pocket expenditures,

private insurance).

3. Purpose Section shall be a statement of a measurable goal that the case manager, child's parent(s) or guardian and service providers expect to obtain during the period covered by the Individualized Plan.
- B. The Individualized Plan shall include the date and signatures of both the case manager and parent or guardian of the child.
 - C. The case manager shall calculate the total costs to the CES Waiver, utilizing the Individual Support Plan (ISP) document. The costs to implement the Individualized Plan shall not include case management services.

8.503.73 REVISIONS TO INDIVIDUALIZED PLAN

- A. When a change in the Individualized Plan results in an increase in the cost of services/supports being provided, the case manager shall seek telephone approval from the Department of Human Services (DHS)/Develop mental Disabilities Services (DDS) Medicaid Section. Final authorization is contingent upon submission of a revised Individualized Plan and Individual Support Plan (ISP) within ten (10) working days.
- B. When a change results in a decrease in services/supports and the overall costs, a revised Individualized Plan and Individual Support Plan (ISP) shall be submitted the DHS/DDS Medicaid Section within ten (10) working days.

8.503.74 INDIVIDUALIZED SUPPORT PLAN (ISP)

8.503.75 DEFINITION

An individual support plan (ISP) provides an explanation of how the services/supports will assist the child to continue to reside within the family home. The plan shall provide a complete listing of CES services/supports to be provided to the child, including the frequency of the services/supports to the child, the agency providing the services/supports, and the cost of the services/supports.

8.503.76 PURPOSE

The purpose of the individual support plan shall be to:

- A. Provide an assessment of non-CES services and natural supports that assist the child to continue to live in the family home; and
- B. Identify the needs and preferences of the child/family which, when met, will allow the child to continue to live in the family home; and
- C. Identify safety, nutritional and medical needs to be addressed; and
- D. Develop a plan of services and supports from qualified CES providers, chosen by the individual/family, that enable the child to continue to live in the family home.

8.503.77 REIMBURSEMENT

Only services/supports specifically listed on the ISP shall be available for reimbursement under CES.

8.503.78 RELATIONSHIP BETWEEN ISP AND IP

- A. The Individualized Plan (IP) shall be the overall coordinating service plan for children with developmental disabilities who are receiving or on a waiting list for services/supports funded by Developmental Disabilities Services (DDS).
- B. The IP has many similar features to the ISP, i.e., evaluation and assessment of needs, description of services, etc. When appropriate, the IP can reference information included on the ISP, and vice versa, in order to reduce duplication of effort.
- C. Children receiving other DDS funded services, in addition to CES, shall have the IP as the overall coordinating plan. Children receiving CES, as the sole service program shall have the ISP be the primary service plan while the IP shall contain all needed elements and reference the ISP as the service plan.

8.503.80 COST CONTAINMENT

8.503.81 DEFINITION

The cost containment function of the case manager shall be to ensure, on an individual child basis, the cost of providing CES services is a cost effective alternative compared to the equivalent cost of appropriate ICF/MR institutional level of care. The case manager shall identify costs as part of each Individualized Plan to be submitted to the Department of Human Services for review. The Department of Human Services shall be responsible for ensuring that, on average, each plan is within the federally approved cost containment requirements of the waiver.

8.503.82 REQUIREMENTS

- A. If services must be added or units of service increased, the case manager shall submit a revised Individualized Plan including an ISP demonstrating continued cost-effectiveness.
- B. The Department of Human Services shall approve or disapprove the revised maximum authorization for services within thirty (30) calendar days of receipt of the revised IP and ISP. If there is an emergency need, the case manager shall telephone the Developmental Disabilities Services Medicaid Section at the Department of Human Services and request an expedited review.
- C. Children in the CES program shall continue to meet the cost containment criteria during subsequent periods of eligibility.
- D. The case manager shall send a copy of the Individualized Plan and the Individual Support Plan to the primary physician for review. The primary physician must attest that in his/her opinion, the quantity and quality of care planned for the child in the community/home is sufficient for the child's needs by signing the Individual Support Plan and returning it to the COB.

8.503.90 DOCUMENTATION: Program Enrollment

- A. The completed enrollment forms shall be submitted to the Developmental Disabilities Services Medicaid Section at the Department of Human Services within thirty (30) calendar days of receipt of the approved ULTC-100 form from the Utilization Review Contractor indicating that an opening has been designated for the child. A complete packet includes:
 - 1. A copy of the Individual Choice Statement; and
 - 2. A copy of the Individualized Plan; and
 - 3. A copy of the Individual Support Plan; and

4. A copy of the Utilization Review Contractor approved ULTC-100 form.
- B. After review by Developmental Disabilities Services, if all requirements are met, the Individual Support Plan shall be returned to the CCB with the authorization signature from the State.
- C. The case manager shall submit the following enrollment forms to the County Department of Social/Human Services for activation of a State Medicaid Identification Number:
 1. A copy of the Individual Choice Statement;
 2. A copy of the State authorized Individual Support Plan;
 3. A copy of the Utilization Review Contractor approved ULTC-100 form; and
 4. A copy of the SSI denial letter, if needed.
- D. The effective date/enrollment date shall be no earlier than the start date on the Utilization Review Contractor approved ULTC-100 form. An approved ULTC-100 form does not constitute Program Enrollment. No services may be authorized prior to the date of enrollment.
- E. An Individualized Plan, ULTC-100, and Individual Support Plan shall be valid for no more than a twelve (12) month period.

8.503.100 SERVICE DESCRIPTIONS

A. Personal Assistance Services

1. Child Care Services: The temporary care of a child which is necessary to keep a child in the home and avoid institutionalization.
2. Personal Supports: Personal supports shall include assistance with bathing and personal hygiene, eating, dressing and grooming, bowel and bladder care, menstrual care, transferring, basic first aid, giving medications, operating and maintaining medical equipment for a child who cannot perform these functions alone due to the developmental disability or medical condition.
3. Household Services: Household services shall include assistance in performing housekeeping tasks, which, due to the needs of the child with a developmental disability, are above and beyond the tasks generally required in a home and/or increase the parent(s) ability to provide care needed by the child with a developmental disability.

B. Home Modification Services

1. Home modification services may include those services which assess the need for, arrange for and provide modifications and/or improvements to the family home of a child with a developmental disability to help ensure the child's safety, security and accessibility in the home and community.
2. Home modification services include devices and services to make daily living easier, such as adapted showers or toilets, adaptations that make places accessible such as ramps and railings, and reinforcing or fencing for the child's protection.
3. Home Modification Services shall exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable State or local building codes.

C. Specialized Medical Equipment and Supplies:

Specialized medical equipment and supplies services shall be provided only if these services are not available under Medicaid EPSDT coverage, Medicaid State Plan, benefits, other third party liability coverage or other federal or state funded programs, services or supports.

1. **Assistive Technology Services:** Assistive technology services shall include the evaluation of the child's need for assistive technology related to the disability; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and training the child and/or family to use the devices effectively. Assistive technology services shall include devices and services that will help a child with a developmental disability and the child's family to overcome barriers related to the disability that they face in their daily lives. This may include the use of devices to help the child move around such as wheelchairs, wheelchair adaptations, and adaptations for vans (e.g., lifts for vans or roof storage for wheelchairs), devices that help the child communicate such as electronic communication devices; devices that make learning easier such as adapted games, toys or computers; and devices that control the environment such as switches.
2. **Other Equipment and Supplies:**
 - a. Kitchen equipment required for the preparation of special diets if this results in a cost saving over prepared foods.
 - b. General care items such as distilled water for saline solutions, supplies such as eating utensils, etc., required by a child with a developmental disability and related to the disability.
 - c. Specially designed clothing (e.g., Velcro) if the costs over and above the costs generally incurred for a child's clothing.

D. Professional Services:

Professional services shall be provided only if these services are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, other third party liability coverage or other-federal or state funded programs, services or supports. Professional services shall include:

1. Counseling and therapeutic services including individual and/or group counseling, behavioral or other therapeutic interventions related to the child's disability, needed to sustain the overall functioning of the child with a developmental disability; and
2. Consultation and direct service costs for training parents and other care providers in techniques to assist in caring for the child's needs. This includes acquisition of information for family members of children with developmental disabilities from support organizations and special resource materials, e.g., publications designed for parents of children with developmental disabilities; and
3. Diagnostic, evaluation and testing services necessary to determine the child's health and mental status and the related social, psychological and cognitive needs and strengths, including genetic counseling and family planning; and
4. Personal care functions requiring assistance by an RN, LPN, Certified Nurse Aide or Home Health Aide and not otherwise available under Medicaid EPSDT coverage, third party liability coverage, or other state funded programs, services or supports. These services may also include operating and maintaining medical equipment.

E. Community Connection Services:

The Community Connector shall explore community services appropriate to the individual in their community, natural supports available to the individual, match and monitor community connections to enhance socialization and community access capability. This shall include:

1. Recreational and Leisure Activities (for the child with a developmental disability). Recreational programs that allow the child with a developmental disability to experience typical community leisure time activities increase their ability to participate in these activities and develop appropriate physical and psychological-social skills. (This benefit shall be limited to \$500 per year).
2. Recreational equipment, such as a floatation collar for swimming, a bowling ramp, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a child with a developmental disability.

8.503.110 MAINTENANCE OF CASE RECORDS

The case manager shall maintain a record of each child referred to the CES program. The record shall include the initial assessment materials, documentation of all contacts by the case manager, copies of the home health agency plan of care, if applicable, and documentation of the disposition of the referral.

- A. For each CES child enrolled, the case manager shall create and maintain a case record including:
 1. Identifying information; and
 2. Documentation that eligibility for Medicaid has been determined by the County Department of Social/Human Services; and
 3. Documentation of the Utilization Review Contractor's level of care determination; the child's initial assessment materials including a copy of the CES Application Packet, the Individual Choice Statement, documentation of the disposition of the referral, Individualized Plan, and the Individual Support Plan; SS1 denial letter, if applicable; and verification of eligibility for developmental disabilities services; and
 4. Documentation of case management.
- B. Case management agencies, shall follow requirements and regulations contained in Section 8.409.33 in the Department of Health Care Policy and Financing Staff Manual, Volume 8.
- C. Case activity, including documentation of monitoring shall be included in the case record. All services, including case management, shall be evaluated as to effectiveness in reaching the goal of the Individualized Plan.
- D. Whenever the case manager fails to comply with any regulation for case management services for the CES Program, due to circumstances outside the case manager's control, the circumstances shall be documented in the case record.

8.503.120 REDETERMINATION OF ELIGIBILITY

Redetermination of eligibility for CES services shall be made as follows:

- A. At least annually and one (1) month prior to the expiration of the ULTC-100 form, the case

manager shall ensure that a new ULTC-100 form is submitted to the Utilization Review Contractor. The case manager shall initiate a level of care review more frequently when warranted by significant changes in the child's situation.

- B. At least annually, the case manager shall document verification of the child's Medicaid eligibility with the County Department of Social/Human Services income maintenance technician.
- C. If the child is not Medicaid eligible and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department of Social/Human Services or other community agencies for possible services, as appropriate, within ten (10) working days of notification of denial.

8.503.121 REASSESSMENT

A reassessment to redetermine or confirm a child's eligibility for the CES Program shall be conducted, at a minimum, every twelve (12) months and the following shall be renewed/revised and sent to the Developmental Disabilities Services Medicaid Section at the Department of Human Services no later than fifteen (15) working days prior to the expiration of the previous/current ULTC-100 form:

- A. ULTC-100 form;
- B. Individualized Plan; and,
- C. Individual Support Plan.

8.503.130 TRANSFER PROCEDURES BETWEEN CASE MANAGEMENT AGENCIES

- A. The sending Case Management Agency (CMA) shall complete the following procedures to transfer a child to another CMA:
 - 1. Contact the receiving case management agency by telephone and give notification that the child is planning to transfer, negotiate an appropriate transfer date and provide information; and
 - 2. If it is an inter-county transfer, notify the income maintenance technician to follow inter-county transfer procedures as outlined in the Colorado Department of Human Services Income Maintenance Staff Manual (9CCR 2503-1), Inter-county Transfer Section 3.140.3; and
 - 3. Forward copies of pertinent records and forms to the receiving case management agency within five (5) working days of the child's transfer; and
 - 4. Notify the Utilization Review Contractor and the Developmental Disabilities Services Medicaid Section at the Department of Human Services of the transfer within thirty (30) calendar days, using a State-designed form.
- B. For any CES child transferring to a new case management agency, the receiving case management agency shall complete the following procedure:
 - 1. Conduct a face-to-face visit with the child within ten (10) working days of the child's transfer; and
 - 2. Review and revise the Individualized Plan and the Individual Support Plan, and change or coordinate services and providers as necessary.

8.503.140 TERMINATION FROM CES

- A. The child shall be terminated from the CES Program when one of the following occurs:
1. The child no longer meets any one of the eligibility criteria at 8.503.30 of these rules; or
 2. The cost of services and supports provided in the home or community exceed the cost effectiveness of the program; or
 3. The parent/guardian chooses ICF/MR rather than the CES program; or
 4. The family chooses to discontinue the CES program (e.g., moves out of state, no longer needs the Medicaid coverage); or
 5. The child enrolls into another HCBS waiver program or is admitted for a long term stay in an institution (e.g. hospital or NF); or
 6. The child expires.
- B. The case manager shall inform the child's parent(s) or guardian in writing on a form provided by the Department of the termination from the CES Program, ten (10) calendar days before the effective date of the termination; and shall inform the child's parent(s) or guardian of his/her appeal rights as contained in the HOME AND COMMUNITY BASED SERVICES - CLIENTS RIGHTS section of this Staff Manual.
- C. Whenever a child is terminated from the CES Program, the case manager shall notify all providers listed on the Individual Support Plan within ten (10) working days prior to the effective date of termination; and shall notify the Utilization Review Contractor and the Developmental Disabilities Services Medicaid Section at DHS within ten (10) calendar days, on a State-designed form.
- D. The case manager shall provide appropriate referrals to other community agencies, including the County Department of Social/Human Services, if the child needs continued assistance to remain in the community, within five (5) working days of written notice of termination.
- E. The reasons for termination and all agency referrals shall be documented in the child's case record.

8.503.150 MONITORING AND COORDINATION

- A. Case managers shall document whether and how the services provided are meeting the child's needs, as defined in the Individualized Plan and Individual Support Plan, and ensure that the child continues to meet cost containment criteria. This monitoring shall include conducting child, parent/guardian and provider interviews and reviewing cost data and any written reports received from service providers. The case manager shall, at a minimum; document at least once every two (2) months whether and how the services are meeting the individual's needs as defined in the IP.
- B. Case managers shall be responsible to coordinate information with the parents) or guardian, primary physician, service providers, County Department of Social/Human Services, CCB, Social Security Administration and others, as necessary, to ensure the effective delivery of services and support for the child.

8.503.160 GENERAL CERTIFICATION PROCEDURES FOR CASE MANAGEMENT AGENCIES (CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM - CES)

- A. All CMAs for the CES Program shall be Community Centered (CDHS). The procedures and certification standards shall be Regulations, Chapter 2 (2 CCR 503-1).

- B. Community Centered Boards are required to apply for certification as a CES-Specific Medicaid provider and have a provider agreement with the Colorado Department of Human Services.
- C. Case management agencies shall meet all standards in the case management program section of the Colorado Department of Human Services Rules and Regulations, Chapter 5 (2 CCR 503-1).
- D. The qualifications for a case manager shall be those described in Department of Human Services, Developmental Disabilities Services Rules and Regulations, Section 15.6.4.
- E. Case management agencies shall maintain records that document their claims for case management services.

8.503.161 RENEWAL OF CASE MANAGEMENT AGENCIES CERTIFICATION (CES)

Renewal of case management agencies certification shall be* in accordance with established procedures of the Colorado Department of Human Services.

8.503.162 TERMINATION OR NON-RENEWAL OF PROVIDER AGREEMENTS WITH CASE MANAGEMENT AGENCIES (CES)

Termination or non-renewal of Provider Agreements with case management agencies (CES) shall be in accordance with established procedures of the Colorado Department of Human Services.

8.503.170 SERVICE PROVIDERS

Children's Extensive Support services shall be provided by or through agencies that meet the following criteria:

- A. Have been designated by the Department of Human Services, Developmental Disabilities Services to be a Community Centered Board; and
- B. Have received and/or maintained program approval from the Department of Human Services, Developmental Disabilities Services for the provision of Children's Extensive Support services; and
- C. Have a Medicaid Provider Agreement; and
- D. Have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S. (1995 Supp.), and the rules and regulations promulgated thereunder, including cooperation with the following activities:
 - 1. All State authorized on-site program reviews, whether for the purpose of program approval, ongoing program monitoring, or State initiated financial and program audits; and
 - 2. All State efforts to collect and maintain information on the CES waiver program, whether required for federal or state program review and evaluation efforts, including information collection; and
 - 3. Any federal program reviews and financial audits of the CES waiver program; and
 - 4. County Departments of Social/Human Services shall be authorized access, as required, to the records of persons receiving services held by case management agencies to determine or redetermine Medicaid eligibility; and

5. All efforts by the case management agency to review the provider's programs, either generally or specifically for particular persons receiving services; and
 6. All long-term care determinations and continued stay reviews conducted by the Utilization Review Contractor.
- E. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.503.180 INDIVIDUAL RIGHTS

The rights of a person receiving Children's Extensive Support services are established in Title 27, Article 10.5, Sections 112 through 131, C.R.S. (1995 Supp.), and the rules and regulations regarding these rights are promulgated in the Department of Human Services, Developmental Disabilities Services, rules and regulations, Chapter 6.

8.503.190 APPEAL PROCESS

An individual receiving CES waiver services has a right to the appeal process established in the Department of Human Services, Developmental Disabilities Services, rules and regulations, Section 7.2 and 10 CCR 2505-10, Section 8.057.

8.500.200 QUALITY ASSURANCE

- A. The monitoring of services provided under the Children's Extensive Support waiver and the health and well-being of service recipients shall be the responsibility of the Department of Human Services, Developmental Disabilities Services, under the oversight of the Department of Health Care Policy and Financing.
- B. The Department of Human Services, Developmental Disabilities Services shall conduct on-site surveys or- cause to have on-site surveys to be performed in accordance with guidelines established by Developmental Disabilities Services. The survey shall include a review of applicable Colorado Department of Human Services, Developmental Disabilities Services rules and regulations and standards for CES.
- C. The Department of Human Services, Developmental Disabilities Services shall ensure that the case management agency/CCB fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.
- D. The Department of Human Services, Developmental Disabilities Services, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials, which pertain to the operation and service delivery of the CES waiver program.
- E. Developmental Disabilities Services shall recommend to the Department of Health Care Policy and Financing the denial and/or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to Developmental Disabilities Services within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.
- F. After receiving the denial and/or termination recommendation and reviewing the supporting documentation, the Department of Health Care Policy and Financing shall take the appropriate action.

8.503.210 POST ELIGIBILITY TREATMENT OF INCOME (PETI)

For individuals who are determined to be Medicaid eligible for the CES waiver through the application of the 300% income standard at 8.110.8, the case manager shall allow an amount equal to the 300% standard as the personal maintenance allowance (no other deductions are necessary). The PETI assessment form shall be completed monthly by the case management agency to ensure that the individual's income does not exceed the maximum allowed for continued eligibility.

8.506 CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM

The Children's HCBS Waiver Program (formerly known as the Katie Beckett Waiver Program), is a waiver program for disabled children who are at risk of institutionalization in a hospital or nursing facility and who would not otherwise be eligible for Medicaid due to parental income and/or resources.

The services provided under this program serve as alternatives to Medicaid hospital or nursing facility services for children, birth through seventeen (17) years of age, and who meet the established minimum criteria for hospital or nursing facility level of care as determined by the Utilization Review Contractor. The services provided through this Children's HCBS Waiver Program shall include all state plan Medicaid benefits and case management services. These services, when deemed to be appropriate and adequate by the child's physician, shall be provided in the home or community. The Children's HCBS Waiver Program shall be administered by the Colorado Department of Health Care Policy and Financing (the State).

8.506.10 Eligibility

8.506.11 Program Eligibility

A. Services shall be provided to children who meet all the following program eligibility requirements:

1. The child has not reached his/her eighteenth (18th) birthday; and
2. The child is living at home with parent(s) or guardian and is at risk of institutional placement, as determined by the Utilization Review Contractor; or is in an acute care hospital or nursing facility and can be returned home and safely cared for in the home, and the child's parent(s) or guardian choose to receive services in the home or community instead of an institution, with the provision of Children's HCBS Waiver Program services; and
3. The child's physician certifies that the quality and quantity of services and supports identified in the Care Plan are sufficient to meet the needs of the child in the home setting; and
4. The Utilization Review Contractor certifies, through the ULTC-100 (Long Term Care Client Assessment Certification and Transfer) form, in conjunction with the Pediatric Functional Assessment Instrument, that the child meets the established minimum criteria for hospital or nursing facility level of care; and
5. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs; and
6. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State; and,
7. The child receives a waiver service on a monthly basis.

8.506.12 Financial Eligibility

Services shall be provided to children who meet all the following financial eligibility requirements:

- A. Parental income and/or resources will result in the child being ineligible for SSI; and
- B. The income of the child does not exceed 300% of the current maximum SSI standard maintenance allowance; and
- C. The resources of the child do not exceed the maximum SSI allowance; and
- D. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, SSI Financial Eligibility Requirements, Consideration of Trusts In Determining Medicaid Eligibility, Section 8.110.52 of this manual.

8.506.13 Premiums

- A. Families with children in the waiver shall pay a monthly premium fee as follows:

Family Income as a Percent of Federal Poverty Level	Monthly Premium First Child	Monthly Premium Additional Child
Under 300%	\$0	\$0
300% to 349%	\$42	\$42
350% to 399%	\$83	\$50
400% to 449%	\$104	\$50
450% to 499%	\$125	\$50
500% to 549%	\$167	\$50
550% to 559%	\$208	\$50
600%+	\$250	\$50

- B. For families with two or more enrolled children whose monthly premium fee for one enrolled child is fifty dollars or less, the amount of the monthly premium for each additional child shall not exceed the amount charged for the first child.
- C. For families with two or more enrolled children whose monthly premium fee for one enrolled child is greater than fifty dollars, the amount of the monthly premium fee for each additional child shall be fifty dollars.
- D. The monthly premium fee shall be based on the family's total income as reflected on the family's most recently filed IRS federal tax return. Documentation provided shall also include any late or amended returns.
- E. The family shall have the right to appeal the family's monthly premium fee amount pursuant to the recipient appeal rules at 8.057.
- F. Beginning July 1, 2003, if a family terminates or declines existing or readily available employer based health insurance for the sole purpose of avoiding multiple monthly premium payments, the family shall be subject to the recovery of Medicaid payments made for the applicable time period.

8.506.2 Waiting List Guidelines

- A. When an opening becomes available:

1. Children who are determined by the Utilization Review Contractor to have an exceptional or

immediate medical need shall be given priority based on medical need and shall be placed at the top of the waiting list; The Utilization Review Contractor shall be responsible for reviewing the initial request, and should an immediate medical need be identified, conduct the final review to determine if the client is appropriate for placement on the waiting list

2. Exceptional or immediate medical need means a life-threatening disease/illness or medical condition which requires acute medical intervention, as determined by the Utilization Review Contractor and such medical treatment is not considered to be experimental, and the child meets all other relevant eligibility criteria.
 3. Children who are not determined to have an exceptional or immediate medical need shall be placed on a waiting list in the order in which the application is received by the Utilization Review Contractor. The first child on the waiting list shall be reassessed for medical and financial eligibility and, if determined to still be eligible, assigned the next available opening.
- B. The Utilization Review Contractor is responsible for maintaining and monitoring the waiting list
- C. The Utilization Review Contractor is responsible for noticing the case management agency that the child has been placed on the waiting list.
- D. The Utilization Review Contractor shall assure that no more than 630 clients are served on the Program at any one time state-wide.

8.506.3 Roles and Responsibilities of the County Department

The County Department shall:

- A. Assist in completing an Application for Assistance;
- B. Obtain from the child's parent(s) or guardian an SSI Denial Letter which they have obtained from the Social Security Administration, District Office which documents that the parent's income and/or resources would render the child ineligible for Medicaid if it were deemed available to him/her;
- C. Certify that the child's income and/or resources does not exceed 300% of SSI;
- D. Obtain from the family the most current filed IRS Federal Tax return, certify the family monthly premium fee and notify the Department of Health Care Policy and Financing.
- E. Assist in completing an MS-10 (Recipient Insurance Information To Be Used By The Colorado Medicaid Program Form);
- F. Ensure the parent(s) or guardian are informed of all state plan Medicaid benefits available to the child;
- G. Provide a list of certified case management agencies; and
- H. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility.
- L. Any income changes during the certification period shall be reported within ten working days of the change.

8.506.4 Documentation

- A. In the event the County Department is able to provide the above documentation to recommend assessment, the following will occur:
1. Upon recommendation of assessment, the child's parent(s) or guardian must inform the County Department of the name of the certified Children's HCBS Waiver Program case management agency of their choice so the County Department can forward the assessment.
 2. The County Department shall forward the assessment within fifteen (15) working days to the certified Children's HCBS Waiver Program case management agency of choice.
 3. The County Department shall notify the case manager within five (5) working days of any changes in the child's income, which might affect the eligibility status.
 4. The County Department shall document all changes in the family's monthly premium fee.
- B. In the event the County Department is unable to obtain the above documentation to recommend assessment, the following will occur:
1. The County Department shall deny the child's request; and
 2. The County Department shall notify the child's parent(s) or guardian, in writing, of the denial and right to appeal in accordance with procedures found in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1), Administrative Procedures Section 3.830.

8.506.5 Case Management

Case management is assistance provided by a case management agency on behalf of an eligible child, which includes; referral of needed Medicaid services and supports, including In-Home Support Services, to enable the child to remain in his/her community-based setting.

Case management agency is a public, private, or private for non-profit agency which is certified by the State in accordance with procedures found in the General Certification Standards for Case Management Agencies, Section 8.506.97, of the Children's HCBS Waiver Program rules, to provide services throughout the State.

8.506.51 Roles and Responsibilities of the Case Management Agency

Case management agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at 26-1-114, C.R.S., as amended.

The case management agency shall:

- A. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact;
- B. Ensure the parent(s) or guardian are informed of In-Home Support Services and all state plan Medicaid benefits available to the child;
- C. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community based services (Individual Choice Statement). A signature is required on this State designated form

- D. Assist in completing the identification information on the ULTC-100.2 form; Submit the ULTC-100.2. to the Utilization Review Contractor to determine whether the level of care criteria is met;
- E. Advise the family of the monthly premium fee.
- F. Begin assessment activities within ten (10) calendar days upon receipt of the referral;
- G. Assess child's health and social needs to determine whether or not program services are both appropriate and cost effective;
- H. Verify that the child meets the appropriate level of care (hospital or nursing facility) criteria as determined by the Utilization Review Contractor;
- I. Arrange for and complete at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible within thirty (30) calendar days of receipt of the referral;
- J. Initiate a new level of care review by telephoning the Utilization Review Contractor should the face-to-face contact indicate that the child is more independent/functional than is indicated by the information on the certified ULTC-100.2, or that the child's medical condition has improved;
- K. Notify the child's parent(s) or guardian and arrange for the development of the Care Plan and Prior Approval Cost Containment Record within thirty (30) calendar days;
- L. Develop a Prior Approval Cost Containment Record form of services and projected costs. The case manager must identify costs as part of the Care Plan and the Cost Containment Record to be submitted to the State for review. The State shall be responsible for ensuring that, on average; each Care Plan is within the level of care State cost containment requirements. Approval of the Cost Containment Record form does not constitute automatic Medicaid reimbursement for Authorized Services identified. State approval only makes sure that the cost of services does not exceed the equivalent cost of appropriate institutional care;
- M. Develop and submit the In-Home Support Services Authorization as described in §8.552.3, In-Home Support Services, Program Eligibility,
- N. Submit a copy of the approved Enrollment Form to the County Department for activation of a Medicaid State Identification Number;
- O. Notify the child's parent(s) or guardian within ten (10) calendar days that the child has been placed on the waiting list;
- P. Document whether and how the services provided are meeting the child's needs, as defined in the Care Plan, and ensure that the child continues to meet cost containment criteria;
- Q. Evaluate effectiveness by monitoring services provided to the child in meeting the needs stated in the Care Plan. This monitoring shall include conducting child, parent(s) or guardian, and provider interviews and reviewing cost data and any written reports received. Such evaluations shall be performed at the discretion of the case manager, but no less frequently than quarterly;
- R. Complete a reassessment of each child, at a minimum, every twelve (12) months before the end of the length of stay assigned by the Utilization Review Contractor. A ULTC-100.2

may be valid for no more than a 12 month period.

- S. Submit a revised Care Plan and Prior Approval Cost Containment Record to the State demonstrating continued cost-effectiveness whenever a change in the Care Plan results in an increase or change in the services to be provided:

8.506.6 Roles and Responsibilities of the Utilization Review Contractor

The Utilization Review Contractor shall:

- A. Determine, at admission, that the level of care criteria is met in accordance with 8.506.11,A,4.;
- B. For continued stay review, renew or deny child assessment based on a twelve (12) month reassessment process;
- C. Maintain and monitor the waiting list (Utilization Review Contractor only);
- D. Notify case management agency when there is a Program opening;
- E. Notify the child's parents) or guardian, the County Department, case management agency, and the State, in writing, if the child does not require the level of care provided in an institution, and of the child's right to an appeal.

8.506.7 Care Plan

8.506.71 Definition

The Care Plan is a document that identifies how services and supplies provided will meet the child's needs.

The supplies that are identified are described in quantifiable terms. All services required to meet these needs in the home or community shall be listed. The purpose and the expected outcome of the services shall be included in the Care Plan.

8.506.72 Requirements of Care Plan

- A. The Care Plan shall consist of a Needs Section, Plan Section, and Purpose Section.
 - 1. Needs Section shall identify and list specific (medical) conditions and needs for which services, supplies, and providers are required to maintain the child in the home or community. The areas of need shall include, but not be limited to, the following:
 - a. medical needs;
 - b. functional needs; and
 - c. home/environmental needs.
 - 2. Plan Section shall identify and quantify all services and suppliers required to meet the needs of the child, including case management and In-Home Support Services. The service listing shall identify payment sources (i.e., family or informal supports, parental out-of-pocket expenditures, private insurance, case management costs).
 - 3. Purpose Section shall be a statement of a measurable goal that the case manager, child's parent(s) or guardian and service providers expect to obtain during the period covered by

the Care Plan.

- B. The case manager shall send a copy of the Care Plan and Signature Page to the parent(s) or guardian. The parent(s) or guardian must review and approve the Care Plan. The parent(s) or guardian must sign and date the Signature Page and return it to the case manager.
- C. The case manager shall send a copy of the Care Plan and Signature Page to the child's physician. The physician must review the Care Plan and attest that, in his/her opinion, the quantity and quality of care planned for the child in the home or community is sufficient for the child's needs, and that such care/services can be safely and adequately provided by the caregiver. The physician must sign and date the Signature Page and return it to the case manager.
- D. If a child is enrolled in more than one children's program and case management services are an authorized benefit, the case management agencies shall collaborate and specify in the Care Plan their unduplicated roles, responsibilities, and the services to be provided by each case management agency.

8.506.73 Revisions to Care Plan and Prior Approval Cost Containment Record

- A. When a change results in an increase in the cost of services/supplies being provided, the case manager may seek telephone approval from the State. Approval is contingent upon submission of a revised Care Plan, and Prior Approval Cost Containment Record and Authorization for In-Home Support Services within ten (10) working days of telephone approval.
- B. When a change results in a decrease in the cost of services/supplies being provided, no revision to the Care Plan or Prior Approval Cost Containment Record is necessary.

8.506.80 Cost Containment

8.506.81 Definition

The Prior Approval Cost Containment Record is a document that identifies the cost effective alternative compared to the equivalent cost of appropriate institutional (hospital or nursing facility) level of care.

8.506.82 State Calculation of Cost Containment Amount

For each level of care, the cost to Medicaid, on a per capita basis, is equal to or less than institutional (hospital or nursing facility) costs.

The State shall annually compute the equivalent monthly cost of nursing facility care in accordance with Section 8.485.100, HCBS-EBD, State Calculation of Cost Containment Amount.

The average daily per capita expenditures for acute care services to institutional (hospitalized) children shall be the per diem amount as reported on the most recent approved HCFA 372 report. This figure shall be computed annually to be effective January 1 for the current calendar year.

8.506.83 Requirements of Cost Containment Record

- A. The Cost Containment Record shall include date and signature of the case manager.
- B. The case manager shall determine that the total costs for services are less than or equivalent to the cost of appropriate institutional care, as calculated by the State, utilizing the Prior Approval Cost Containment Record. Such costs to implement the Care Plan shall include case management services.

8.506.84 Revisions to Cost Containment Record

The State shall approve or disapprove the revised maximum authorization for services within thirty (30) calendar days of receipt of the revised Prior Approval Cost Containment Record.

8.506.9 Program Enrollment Documentation

- A. Completed enrollment forms shall be submitted to the State within thirty (30) calendar days of receipt of the certified ULTC-100.2 form by the case manager from the Utilization Review Contractor indicating that an opening has been designated for the child. A complete packet includes:
1. Enrollment Form;
 2. Individual Choice Statement/Signature Page;
 3. Care Plan;
 4. Prior Approval Cost Containment Record;
 5. SSI Denial Letter which documents that the child is ineligible for Medicaid due to parental income and/or resources; and
 6. Verification of the family's monthly premium fee; and
 7. Utilization Review Contractor's certified ULTC-100.2 form; and
 8. In-Home Support Services Authorization.
- B. After review by the State, if all requirements are met, copies of the Enrollment Form and Prior Approval Cost Containment Record will be returned to the case manager with the authorization signatures from the State.
- C. The effective date/enrollment date shall be no earlier than the start date on the Utilization Review Contractor certified ULTC-100.2 form. A certified ULTC-100 form does not constitute program enrollment. No services, including case management, may be authorized prior to the date of Program enrollment
- D. An Enrollment Form, Care Plan, Individual Choice Statement/Signature Page, ULTC-100.2 and Prior Approval Cost Containment Record, and In-Home Support Services Authorization may be valid for no more than a twelve (12) month period.

8.506.91 Maintenance of Case Records

- A. The case manager must create and maintain a case record for each child referred to the Children's HCBS Waiver Program. The case record must include:
1. Name, address, date of birth, phone number and any other identifying information about the child;
 2. Documentation that eligibility for Medicaid has been determined by the County Department;
 3. Documentation of the Utilization Review Contractor's level of care determination (ULTC-100); Enrollment Form, initial assessment materials, including the Individual Choice Statement/Signature Page, documentation of the referral, Care Plan, Prior Approval Cost Containment Record, and SSI Denial Letter;

4. Documentation of case management;
5. Case activity, including documentation of monitoring. All services, including case management, shall be evaluated as to effectiveness in reaching the goal of the Care Plan; and
6. Whenever the case manager fails to comply with any regulation for case management services for the Children's HCBS Waiver Program, due to circumstances outside the case manager's control, the circumstances must be documented in the case record.

8.506.92 Monitoring and Coordinating

- A. Case managers shall document whether and how the services provided are meeting the child's needs, as defined in the Care plan, and ensure that the child continues to meet the cost containment criteria. Monitoring shall include conducting child, parent(s) or guardian and provider interviews and reviewing cost data and any written reports received from service providers. Case manager shall have, at a minimum, telephone contact with the child's parent(s) or guardian on a monthly basis. These contacts must be documented in the case file.
- B. Case managers shall be responsible for coordinating information with the parent(s) or guardian, child's physician, service providers, County Department, Community Centered Board, and others, as necessary, to ensure the effective delivery of services and support for the child.

8.506.93 Reassessment

- A. Reassessments are initiated by the case management agency, at a minimum, every twelve (12) months before the end of the length of stay on the ULTC 1002 form following Program Guidelines except for the Waiting List Guidelines outlined in Section 8.506.2. The following documents shall be renewed/revised and sent to the State no later than fifteen (15) working days prior to the expiration of the current ULTC 100.2 form:
 1. Enrollment form;
 2. ULTC 100.2 form;
 3. Care Plan;
 4. Prior Approval Cost Containment Record; and
 5. Individual Choice Statement/Signature Page.
- B. The case manager may initiate a level of care review more frequently, when warranted by significant changes in the child's situation.
- C. The case manager must document verification of the child's Medicaid eligibility with the County Department. If the child is Medicaid eligible and meets the level of care criteria, the case manager shall conduct a reassessment in accordance with this section.
- D. If the child is not Medicaid eligible and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department or other community agencies for possible services, as appropriate, within ten (10) working days of notification of Children's HCBS Waiver Program denial.

8.506.94 Case Management Agency/Intercounty Transfer Procedures

A. The sending case management agency shall:

1. Contact the receiving case management agency by telephone and provide notification that, the child is planning to transfer (per parent(s) or guardian choice); negotiate an appropriate transfer date, and forward case file to the receiving case management agency;
2. Forward copies of pertinent records and forms to the receiving case management agency within five (5) working days of the child's transfer;
3. Notify the State and the Utilization Review Contractor of the transfer within thirty (30) calendar days, using a State designated form, indicating effective date, name of new case management agency, and type of transfer,
4. If an intercounty transfer, notify the income maintenance technician to follow intercounty transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual (9 CCR 2503-1), Intercounty Transfer Section 3.140.3.

B. The receiving case management agency shall:

1. Conduct a face-to-face visit with the child within ten (10) working days of the child's transfer;
2. Review and revise the Care Plan and the Prior Approval Cost Containment Record and change or coordinate services and providers as necessary.

8.506.95 Termination

A. The child shall be terminated from the Program when one of the following occurs:

1. The child no longer meets the level of care criteria for hospital or nursing facility placement as determined by the Utilization Review Contractor;
2. The physician can no longer certify that the quality and quantity of services and supports provided are able to meet the needs of the child in the home or community;
3. The child's own income and/or resources put him/her in excess of the allowable 300% of the SSI standard maintenance allowance or SSI personal assets limit;
4. The parent's income and/or resources decrease, and the child becomes Medicaid eligible without the use of the Children's HCBS Waiver Program;
5. The cost of services and supports provided in the home or community exceed the cost effectiveness guidelines of the Program;
6. Eighteen (18) years of age;
7. The parent(s) or guardian choose hospital or nursing facility services rather than the Children's HCBS Waiver Program services;
8. The family chooses to discontinue the Children's HCBS Waiver Program (e.g., moves out of state, no longer needs the Medicaid coverage); or,
9. The child expires.

B. The case manager shall notify all providers listed on the Care Plan within ten (10) working days of

termination;

- C. The case manager shall notify the State, Utilization Review Contractor, and the County Department, within ten (10) calendar days of termination, on a State designated form;
- D. The case manager shall provide appropriate referrals to other community agencies, including the County Department, if the child needs continued assistance to remain in the home or community, within five (5) working days of written notice of termination;
- E. The reason for termination and all agency referrals shall be documented in the child's case record;
- F. The case manager shall inform the child's parent(s) or guardian in writing on a State designated form of the termination from the Children's HCBS Waiver Program, ten (10) calendar days before the effective date of the termination.

8.506.96 Client Rights

- A. The case manager shall inform the child's parent(s) or guardian of the client's rights in accordance with procedures found in the HCBS-EBD, Client Rights Section, 8.485.300.
- B. The case manager shall inform the child's parent(s) or guardian of the client's right to appeal the calculation of the monthly premium fee.
- C. Children denied Program enrollment shall be informed of their appeal rights in accordance with procedures found in the Recipient Appeals Protocols/Process, Section, 8.057 of this manual.

8.506.97 General Certification Standards for Case Management Agencies

- A. Certification standards for the Children's HCBS Waiver Program case management agencies shall be the same as those prescribed for provider agencies in accordance with procedures found in the HCBS-EBD, General Certification Process Section 8.487.20.
- B. Case management agencies operated by Community Centered Boards shall also meet the General Provisions set forth in the Community Centered Boards Section of the Department of Human Services, Developmental Disabilities Services, Rules and Regulations, Chapter 2 (2 CCR 503-1).
- C. Case management agencies operated by Community Centered Boards shall also meet all standards in the Case Management Services Section of the Department of Human Services, Developmental Disabilities Services, Rules and Regulations, Chapter 5 (2 CCR 503-1).
- D. Case management agencies are required to apply specifically for certification as a Children's HCBS Waiver Program provider and have a Provider Agreement with the State.
- E. Case management agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.506.98 Monitoring Process For Case Management Agencies

Case management agencies are subject to inspection, review and audit by the State Department.

8.506.99 Termination or Non-Renewal of Provider Agreements

Termination or non-renewal of Provider Agreements shall be in accordant: with procedures found in the HCBS-EBD, Termination or Non-Renewal of Provider Agreements Section 8.487.70.

8.506.100 Reimbursement For Case Management Services

Case management agencies shall bill the fiscal agent and shall be reimbursed for case management activity in fifteen minute increments.

8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

The Children's Habitation Residential Program is a residential services and support program for children and youth who are developmentally disabled as defined in Section 27-10.5-102(11), C.R.S. (See 8.508.170, E.) Children under the age of five who are developmentally delayed are included only when their developmental delay is accompanied by significant medical and/or behavioral needs. The children are placed through Colorado County Departments of Social/Human Services. The children are at risk of institutionalization and the program serves as an alternative: to placement to Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

The services provided through this program serve as an alternative to ICF/MR placement for children birth to twenty-one years of age who meet the eligibility criteria and the Level of Need Screening Guidelines. The services provided through the Children's Habitation Residential Program (CHRP) shall be limited to:

Self-Advocacy Training

Independent Living Training

Cognitive Services

Communication Services

Counseling and Therapeutic Services

Personal Care Services

Emergency Assistance Training

Community Connection Services

Travel Services

Supervision Services

when deemed to be appropriate and adequate by the child's physician, and these services shall be provided in the community, as available.

CHRP services for children with developmental disabilities shall be provided in accordance with these rules and regulations.

8.508.10 PROGRAM ADMINISTRATION

- A. The Children's Habilitation Residential Service Program for children with developmental disabilities is administered by the Colorado Department of Human Services (CDHS), Division of Child Welfare under the oversight of the Department of Health Care Policy and Financing.
- B. CHRP services do not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services.
- C. CHRP services are subject to approval of a waiver under Section 1915c of the Social Security Act by

the Center for Medicare and Medicaid Services.

- D. CHRP services are subject to annual appropriations by the Colorado General Assembly.
- E. The Department of Human Services, Division of Child Welfare shall limit the utilization of the CHRP based on:
 - 1. The federally approved capacity of the waiver;
 - 2. Cost effectiveness (see Section 8.508.80); and
 - 3. Within the total appropriation limitations when enrollment is, projected to exceed spending authority.

8.508.20 PROGRAM PROVISIONS

Colorado has authority to provide the following services under the CHRP:

- A. CHRP services are provided as an alternative to institutional placement for children with developmental disabilities and are limited to self-advocacy training, independent living training, cognitive services, communication services, counseling and therapeutic services, personal care services, emergency assistance training, community connection services, travel services, and supervision services.
- B. Children eligible for services under the CHRP waiver are eligible for all other Medicaid services for which they qualify and must first access all benefits available under the regular Medicaid State Plan and/or Medicaid EPSDT (Early and Periodic Screening, Diagnosis and Treatment) coverage prior to accessing funding for those same services under the CHRP.
- C. Case management services will be provided by the county department as an administrative activity and include:
 - 1. Assessment of the individual's needs to determine if CHRP services are appropriate;
 - 2. Completion of the Individualized Plan (IP); and
 - 3. Submission of the Individualized Plan to the Colorado Department of Human Services, Division of Child Welfare Services, for review and approval for CHRP waiver services. These Individualized Plans are also subject to review by the Department of Health Care Policy and Financing.
- D. The individual receiving services and his/her family or guardian and placing County Department of Social/Human Services are responsible for participating with the services provider in:
 - 1. Developing the Individualized Plan;
 - 2. Cooperating with implementation of the service plan;
 - 3. Choosing to receive services through the CHRP waiver.

8.508.30 ELIGIBILITY

- A. Services shall be provided to children with developmental disabilities who meet all of the following

program eligibility requirements:

1. The child shall be determined eligible for developmental disabilities services by the appropriate Community Centered Board (CCB).
 2. The child is a Colorado child placed in foster care through a Colorado County Department of Social/Human Services by court order. This includes children placed through a voluntary agreement with the Colorado County Department of Social/Human Services while awaiting the court to take jurisdiction.
 3. Waiver services to individuals age eighteen to 21 will be provided if the individual is in a court-ordered foster care placement through the County Department of Social/Human Services and the court order is in effect when the child reaches his/her eighteenth birthday.
 4. The child is at risk of or has been reported/found to be abused and/or neglected or dependent, as defined in 19-3-102, C.R.S.
 5. The child shall meet the out-of-home placement criteria as defined in Section 7.304.3, Colorado Department of Human Services Social Services Staff Manual (12 CCR 2509-4).
 6. The child shall meet the Target Group for Program Areas 4, 5, or 6 as outlined in 7.201.2, 7.202.2 and 7.203.21, Colorado Department of Human Services Staff Manual (12 CCR 2509-3).
 7. The Level of Need checklist documents that the child/youth is in need of the services available through the waiver.
 8. The CDHS CHRP waiver administrator verifies through the CHRP waiver eligibility process, including the ULTC 100 and LTC 102 - CHRP that the child meets the established minimum eligibility criteria for ICF/MR placement.
 9. The child's eligibility for Supplementary Security Income (SSI) benefits is established.
 10. The income of the child does not exceed 300% of the current maximum SSI standard maintenance allowance.
 11. The resources of the child do not exceed the maximum SSI allowance.
 12. The child's eligibility for Colorado Medicaid is established and reported in the Child Welfare automated system.
 13. Enrollment of a child in the CHRP will result in an overall savings when compared to the ICF/MR cost as determined by the State.
 14. The child receives at least one waiver service each month.
- B. Pursuant to the terms of the Children's Residential Habilitation Program (CHRP), the number of individuals who may be served each year in the CHRP is based on criteria found in Section 8.508.10(E).

8.508.40 WAITING LIST PROTOCOL

Children determined eligible for services under the CHRP which are not immediately available within the federally approved capacity limits of the waiver shall be eligible for placement on a waiting list in the order in which the eligible application was received by the CDHS CHRP waiver administrator. Guardians of

applicant children denied program enrollment shall be informed of their appeal rights in accordance with Section 8.057 of this Staff Manual.

When an opening becomes available, the first child on the waiting list shall be reassessed for eligibility by the CDHS CHRP waiver administrator and, if determined to still be eligible, assigned that opening.

8.508.50 RESPONSIBILITIES OF THE COUNTY DEPARTMENTS OF SOCIAL SERVICES

The County Department of Social/Human Services shall:

- A. Ensure that the eligibility requirements as defined in 8.503.30, A, 1 through 8 are met;
- B. Submit eligibility applications to the CDHS CHRP waiver administrator with a request for enrollment or placement on the waiting list.
- C. Provide services to children in out-of-home placement and their families as required in CDHS Social Services Staff Manual (12 CCR 2509-4, 7.300. Child Welfare Services).
- D. Determine whether a familial relationship as defined in 27-10.5-102, C.R.S. exists, between the licensed or certified provider and the child.
- E. Determine prior to referring to CHRP, that the extraordinary service, needs of the child exceed the maximum reimbursement the County Department of Social/Human Services is able to negotiate based on the child's individualized needs as authorized in 26-5-104(6), C.R.S. The County Department of Social/Human Services must negotiate based on the child's need and the service provider's ability to meet the needs.
- F. Exhaust appropriate community services available to the children before requesting similar services from the waiver.

8.508.60 RESPONSIBILITIES OF THE COMMUNITY CENTERED BOARD

The Community Centered Board (CCB) shall make a determination of eligibility for developmental disabilities services for any child being considered for enrollment in the Children's Habilitation Residential Program who is referred by a County Department of Social/Human Services.

8.508.70 INDIVIDUALIZED PLAN (IP)

A written IP describes the medical and other services to be furnished, their frequency, and the type of provider who will furnish each.

8.508.71 CONTENT OF THE INDIVIDUALIZED PLAN

- A. The Individualized Plan (IP) shall consist of a Child's Needs Section, a Plan Section, and an Expected Outcomes Section.
 - 1. Child's Needs Section shall identify and list specific conditions (needs) for which services and supports are needed to maintain the child in the community setting. The areas of needs shall contain and not be limited to:
 - a. medical needs;
 - b. functional needs; and
 - c. safety needs.

2. Plan Section shall:

- a. Identify and quantify all services and supports to be provided to meet the child's needs; and
- b. Identify the name or type of provider of services ;
- c. Identify payment responsibilities for the services, e. g., Parent, County Department of Social/Human Services, CHRP.

3. Expected Outcomes Section shall be a statement of measurable objectives expected to be obtained during the period covered by the Individualized Plan.

- B. The Individualized Plan shall include the date and signatures of the provider, the guardian, the County Department of Social/Human Services, and the child when appropriate.
- C. The provider shall calculate the total costs to the Children's Habilitation Residential Program, utilizing Individualized Plan document The costs to implement the Individualized Plan shall not include room, board, and personal needs allowance.

8.508.72 REVISIONS TO INDIVIDUALIZED PLAN

- A. When a change in the Individualized Plan results in an increase in the costs of services/supports being provided, the County Department of Social Services may seek telephone approval from the Department of Human Services, Division of Child Welfare Services. Final authorization is contingent upon submission and approval of a revised Individualized Plan to the Division of Child Welfare Services within ten working days. Continued cost effectiveness must be demonstrated when there is an increase in costs.
- B. When a change results in a decrease in the costs of CHRP services, a revised Individualized Plan must be submitted to the CDHS, Division of Child Welfare Services within ten working days of the change.
- C. CDHS shall approve or disapprove the revised maximum authorization of services within thirty (30) calendar days of receipt of the revised IP. If there is an emergency need, the provider shall telephone the CDHS, Division of Child Welfare Services and request an expedited review.

8.508.73 REIMBURSEMENT

Only services identified on the Individualized Plan are available for reimbursement under CHRP. Reimbursement will be made only to licensed or certified providers, as defined in Section 8.508.160 and services will be reimbursed on a daily rate basis through the Medical Management Information System (MMIS) for the habilitative services. Medicaid shall not pay for room and board. The equivalent of the full federal SSI benefit will provide for the room, board and personal needs allowance. Education costs will be reimbursed through the Department of Education and not by the Colorado Department of Human Services or Medicaid.

8.508.80 COST CONTAINMENT

Cost containment is to ensure, on an individual child basis, that the provision of CHRP services is a cost effective alternative compared to the equivalent cost of appropriate ICF/MR institutional level of care. The provider must identify costs as part of each Individualized Plan to be submitted to the CDHS for review. The State shall be responsible for ensuring that, on average, each plan is within the federally approved cost containment requirements of the waiver. Children enrolled in the CHRP shall continue to meet the cost containment criteria during subsequent periods of eligibility.

- A. The completed enrollment forms shall be submitted to the County Department of Social/Human Services CHRP waiver administrator. A complete packet includes a copy of the:
 - 1. Individual Choice Statement.
 - 2. Individualized Plan? within 30 calendar days.
 - 3. Level of Need document.
 - 4. ULTC 100.2 form.
 - 5. Request for Enrollment.
- B. The county department CHRP waiver administrator will immediately submit enrollment documentation to the CDHS CHRP waiver administrator for verification of eligibility. A complete packet includes a copy of the:
 - 1. ULTC 100.2; and
 - 2. Request for Enrollment; and
 - 3. Individual Choice Statement
 - 4. Individualized Plan within 45 calendar days.
- C. The effective date/enrollment date shall be no earlier than the start date on the CDHS CHRP waiver administrator's ULTC 100.2 verification form. No services may be authorized prior to the date of enrollment
- D. An Individualized Plan and ULTC 100.2 verification may be valid for no more than a twelve (12) month period.

8.508.100 SERVICE DESCRIPTIONS

- A. Self-advocacy training may include training in expressing personal preferences, self-representation, individual rights and making increasingly responsible choices. It may also include team building with volunteers, professionals, and/or family members to examine changing roles as service models shift from the traditional supervision/control model to a self-actualization model.
- B. Independent living training may include training in personal care, household services, child and infant care (for parents themselves who are developmentally disabled), and communication skills such as using the telephone, using sign language, facilitated communication, reading, and letter writing.
- C. Cognitive services may include training with money management and personal finances, planning and decision-making.
- D. Communication services may include professional training and assistance to maintain or improve communication skills. It may include a professional or individual who provides interpretation and facilitated communication services.
- E. Counseling and therapeutic services may include individual and/or group counseling, behavioral or other therapeutic interventions directed at increasing the overall effective functioning of an individual.

- F. Personal care services may include any personal care functions requiring training/assistance by an RN, LPN, or Certified Nurse Aide. It may also include operating, maintaining, and training in the use of medical equipment.
- G. Emergency assistance training includes developing responses in case of emergencies, prevention planning and training in the use of equipment or technologies used to access emergency response systems.
- H. Community connection services may explore community services available to the individual, and develop methods to access additional services/supports/activities desired by the individual. Community connection services can provide the individual with the resources to participate in the activities and functions of the community desired and chosen by the individual receiving the services. Typically, these will be the same type of activities available and desired by the general population.
- I. Travel services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to services and supports identified in the IP.
- J. Supervision services may include a person safeguarding an individual with developmental disabilities and/or utilizing technology for the same purpose.
- K. Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code.
- L. Only those services not available under Medicaid EPSDT, Medicaid State plan benefits, third party liability coverage, or other state funded programs, services or supports are available through the Children's Habilitation Residential Program (CHRP) Waiver. Appropriate community services must be exhausted before requesting similar services from the waiver. The CHRP Waiver does not reimburse services that are the responsibility of the - Colorado Department of Education.

8.508.110 MAINTENANCE OF CASE RECORDS

- A. Copies of the ULTC 100.2 shall be maintained by the County Department of Social/Human Services and the CDHS Division of Child Welfare Services. In addition, the County Department of Social/Human Services shall maintain a copy of the Individualized Plan and Level of Need Checklist for the Children's Habilitation Residential Program. A copy of the ULTC 100.2 verification form shall be maintained by the provider.
- B. Copies of evaluations and re-evaluations shall be maintained for a minimum period of three years by those cited in 8.508.110, A, with the exception of providers who are required to maintain records for a period of six years from the date services are rendered.
- C. Confidentiality of records shall be maintained in accordance with Section 8.100.8 of this manual, as well as with CDHS Social Services Staff Manual, Section 7.000.72 (12 CCR 2509-1).
- D. Documentation of case activity shall also meet requirements of CDHS, Division of Child Welfare Services as outlined in the CDHS Social Services Staff Manual, Section 7.000.72 (12 CCR 2509-1).

8.508.120 REDETERMINATION OF ELIGIBILITY

Redetermination of eligibility for CHRP services shall be made as follows:

- A. At least annually and one (1) month prior to the expiration of the ULTC 100.2 form, the County Department of Social/Human Services CHRP waiver administrator shall ensure that a new ULTC 100.2 form is submitted to the CDHS CHRP waiver administrator for verification if there is no significant change in the child's condition.
- B. At least annually, the County Department of Social/Human Services shall verify the child's continued Medicaid eligibility.

8.508.121 REASSESSMENT

A reassessment to redetermine or confirm a child's eligibility for the CHRP Program must be conducted, at a minimum, every twelve (12) months and the following shall be renewed/revised and submitted to the county department CHRP waiver administrator no later than one (1) month prior to the expiration of the previous/current ULTC 100.2 verification form:

- A. Individualized Plan
- B. Copy of the Level of Need worksheet
- C. Copy of the ULTC 100.2
- D. The county department CHRP waiver administrator shall submit a copy of the Individualized Plan to the CDHS CHRP waiver administrator.

8.508.130 TRANSFER PROCEDURES BETWEEN COUNTY DEPARTMENTS OF SOCIAL SERVICES

Transfer of cases shall occur in accordance with CDHS Social Services Staff Manual, Section 7.000.6, D (12 CCR 2509-1).

8.508.140 DISCONTINUATION FROM CHRP

- A. A child shall be discontinued from the CHRP Program when one of the following occurs:
 - 1. The child no longer meets one of the criteria as outlined in Section 8.508.30 of these rules;
 - 2. The costs of services and supports provided in the community exceed the cost effectiveness criteria of the program;
 - 3. The child enrolls in another HCBS waiver program or is admitted for a long-term stay in an institution (e.g., hospital); or
 - 4. The child reaches his/her 21st birthday or transitions into DDS Adult Residential Services.
- B. The County Department of Social/Human Services shall inform the child's parent(s) or guardian in writing on a form provided by the State of discontinuation from the CHRP Program, at least ten (10) calendar days before the effective date of discontinuation. The child's parent or guardian shall also be informed of his/her appeal rights as contained in the Home and Community Based Services - Client's Rights section of this Staff Manual. The reason and regulation supporting the discontinuation shall be clearly identified on this notice.
- C. Whenever a child is discontinued from the CHRP, the County Department of Social/Human Services shall notify all providers listed on the IP within ten (10) calendar days prior to the effective date of discontinuation; and shall notify the CDHS Division of Child Welfare Services within ten (10) calendar days, on a State designed form.

D. The reason for discontinuation shall be documented in the child's case record.

8.508.150 MONITORING AND COORDINATION

- A. County Departments of Social/Human Services shall document whether and how the services provided are meeting the child's needs, as defined in the IP. Documentation requirements shall be the same as those outlined in CDHS Social Services Staff Manual, Section 7.002.1 (12 CCR 2509-1), related to case planning.
- B. County Departments of Social/Human Services shall be responsible to coordinate information with the parent(s) or guardian, primary physician, service providers, community centered boards, Social Security Administration and others as necessary to ensure the effective delivery of services to the child.

8.508.160 SERVICE PROVIDERS

- A. Children's Habilitation Residential Program services shall be provided by the following residential provider types which shall meet all of the ; certification, licensing and Quality Assurance regulations related to the provider type as outlined in CDHS Social Services Staff Manual, Section 7.701 (12 CCR 2509-8):
 - 1. Family Foster Care Homes, as defined by the waiver, and certified and supervised by County Departments of Social Services or Child Placement Agencies (CPAs).
 - 2. Residential Child Care Facilities licensed through the CDHS Division of Child Care.
 - 3. Specialized group facilities licensed by the Division of Child Care and supervised by County Departments of Social/Human Services or Child Placement Agencies.
- B. Children's Habilitation Residential Program Service Providers may also include Providers as defined in Section 8.500.5 of this Staff Manual. Home and Community Based Services for the Developmentally Disabled (HCBS- DD) programs will be provided by agencies that meet the following criteria:
 - 1. Have received and/or maintained program approval from the Colorado Department of Human Services, Division for Developmental Disabilities Services for the provision of HCBS-DD waiver services; and
 - 2. Have a Medicaid Provider Agreement; and
 - 3. Have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S. and all the rules and regulations promulgated thereunder; and
 - 4. Have, if applicable, the current required license from the Colorado Department of Public Health and Environment.
- C. Service providers shall cooperate in all of the areas identified in Section 8.500.52.
- D. All eligible providers shall have a Medicaid Provider Agreement.
- E. Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department of Health Care Policy and Financing, and shall have written policies and procedures regarding emergency procedures.
- F. Service providers shall not be family members as defined in §27-10.5-102(15), C.R.S. for the children

they serve in the waiver.

- G. When a qualified provider contracts with or utilizes the services of a professional, individual, or vendor to augment a child's services under the waiver the definitions and qualifications contained in Section 8.508.170 apply.
- H. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

8.508.170 DEFINITIONS

Habilitative services are defined as those services which are recommended by a licensed practitioner, as defined in §26-4-527(3), C.R.S. to assist clients with developmental disabilities eligible under the State Plan to achieve their best possible functional level. All clients of Residential habilitation services and supports will receive some type of habilitation services in order to acquire, retain, or improve self-help, socialization, or other skills needed to reside in the community. Some clients may receive a combination of habilitative services (skill building) and support services (a task performed for the client, where learning is secondary or incidental to the task itself).

- A. Assessment: The process of collecting and evaluating information for the purpose of developing an individual child plan on which to base services and referral. The assessment process is both initial and ongoing.
- B. Case Management:: Activities that are intended to ensure that clients receive the services they need, that services are coordinated, and that services are appropriate to the changing needs and stated desires of the clients and families over time. The goals of case management are: 1) to bring about positive changes in client's status; 2) to assist clients in reaching their highest potential; and 3) to achieve the best possible quality of life for clients and their families in the community. Goals are developed to the extent possible among case managers, referral sources, families and clients.
- C. Client:: A child or youth who is receiving habilitative services in the Children's Habilitation Residential Program.
- D. County Caseworker:: A designated representative from the local County Department of Social/Human Services.
- E. Developmental Disability: A disability that is manifested before the child reaches twenty-two years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. It includes children less than five years of age with slow or impaired development at risk of having a developmental disability.
- F. Family: Defined in 27-10.5-102, C.R.S.
- G. Family Foster Care Home: A family care home providing 24-hour care for a child or children. It is a facility certified by either a County Department of Social/Human Services or a child placement agency. A family foster care home, for the purposes of this waiver, shall not be a family member as defined in 27-10.5-102(15), C.R.S. Qualifications: A qualified family foster home shall adhere to the service provision requirements of this waiver, as well as those specified and contained in CDHS Social Services Staff Manual (12 CCR 2509-6, 7.500 Resource Development).

- H. Individual: Any person, such as a co-worker, neighbor, etc., who does not meet definition of a family member as described in 27-10.5-102(15). C.R.S. Qualifications: Any individual providing a service or support must receive training commensurate with the service or support to be provided and must meet any applicable state licensing and/or certification requirements.
- I. Level of Need Worksheet: A format to assess the child's level of need for services.
- J. Professional: Any person, except a family member as described in 27-10.5-102(15), C.R.S. performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification. Qualifications: Any person performing a professional service must possess any and all license(s) and/or certifications(s) required by the State of Colorado for the performance of that profession or professional service.
- K. Programming: A plan that provides intensive, comprehensive, longitudinal instruction to help the child achieve his or her best possible functioning level.
- L. Vendor: The supplier of a product or services to be purchased for a recipient of services under this waiver. Qualifications: In order to be approved as a vendor, the product or service to be delivered must meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards. In addition, such expenses over \$1,000 should be chosen through a bid process. When a bid process is used and the lowest bid is not chosen, proper justification for selection of a vendor with a higher bid must be documented.

8.508.180 CHILDREN'S RIGHTS

Clients rights are defined in this section to provide the fullest possible measure of privacy, dignity and other rights to persons undergoing care and treatment in the least restrictive environment.

- A. Advisement of Children's Rights: Each authorized facility shall have written policy and procedures which address and ensure the availability of each of the following rights for clients in residence.
- B. All children and their guardians receiving services through the CHRP shall be advised in writing of the following rights on admission.
 - 1. A written copy of his or her rights shall be furnished;
 - 2. A list of such rights shall be posted prominently in the facility and translated into Spanish or any other appropriate language as needed.
 - 3. A child may be photographed upon admission for identification and administrative purposes of the facility. No other non-medical photographs shall be taken or used without the written consent of the client's parent or legal guardian.
 - 4. Every client has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status or disability.
 - 5. Every child's guardian has the right to request to see the child's medical records, to see the records at reasonable times, and to be given written reasons if the request is denied.
- C. Children's Rights as defined in CDHS Social Services Staff Manual, Section 7.714.50,

“CHILDREN'S RIGHTS” (12 CCR 2509-8) shall also apply.

8.508.190 APPEALS

An individual who has applied for or is receiving CHRP services has a right to the appeal process established in Section 8.058 of this Manual. When an individual disagrees with a Community Centered Board (CCB) determination of developmental disability services, the dispute resolution process in the Colorado Department of Human Services, Developmental Disabilities Services rules and regulations shall apply. Section 16.320 (2 CCR 503-1).

8.509 HOME AND COMMUNITY BASED SERVICES FOR PERSONS. WITH MENTAL ILLNESS (HCBS-MI)

8.509.10 GENERAL PROVISIONS

.11 LEGAL BASIS

- A. The Home and Community Based Services for PERSONS WITH MENTAL ILLNESS. (HCBS-MT) program in Colorado is authorized by a waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-MI program is also authorized under state law at 26-4-671 through 26-4-676, C.R.S. (1999). The number of recipients served in the HCBS-MI program is limited to the number of recipients authorized in the waiver.
- B. All congregate facilities where any HCBS client resides must be in compliance with the “Keys Amendment” as required under Section 1616(e) of the Social Security Act of 1935 and 45 CFR Part 1397 (October 1, 1991), by possession of a valid Assisted Living Residence license issued under 25-27-105, C.R.S. (1999), and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7. No amendments or later editions are incorporated. The staff assistant of the Community Based Long Term Care Section of the Colorado Department of Health Care Policy and Financing may be contacted at 1575 Sherman Street, Denver, Colorado 80203, for a copy of 45 CFR Part 1397; or the materials may be examined at any publications depository library.

8.509.12 SERVICES PROVIDED

A. HCBS-MI services provided as an alternative to nursing facility placement include:

- 1. Adult day services, and
- 2. Alternative care facility services, including homemaker and personal care services in a residential setting, and
- 3. Electronic monitoring, and
- 4. Home, modification, and
- 5. Homemaker services, and
- 6. Non-medical transportation, and
- 7. Personal care; and

8. Respite care.

B. Case management is not a service, of the HCBS-MI program, but shall be provided as an administrative activity through case management agencies.

C. HCBS-MI clients are eligible, for all other Medicaid State plan benefits.

8.509.13 DEFINITIONS OF SERVICES

A. Adult Day Services shall be as defined at Section 8.491, ADULT DAY SERVICES.

B. Alternative Care. Facility services means, services as defined at Section 8.495, ALTERNATIVE CARE FACILITY.

C. Electronic Monitoring services shall be as defined at Section 8.488, ELECTRONIC MONITORING.

D. Home Modification shall be as defined at Section 8.493.

E. Homemaker Services shall be as defined at Section 8.490.

F. Non-Medical Transportation shall be as defined at Section 8.494.

G. Personal Care shall be as defined at Section 8.489.

H. Respite shall be as defined at Section 8.492.

.14 GENERAL DEFINITIONS

A. Assessment shall be defined as a client evaluation according to requirements at Section 8.509.31, (B).

B. Case Management shall be defined as administrative functions performed by a case management agency according to requirements at Section 8.509.30.

C. Case Management Agency shall be defined as an agency that is certified and has a valid contract with the state to provide HCBS-MI case management.

D. Case Plan shall be defined as a systematized arrangement of information which includes the client's needs; the HCBS-MI services and all other services which will be provided, including the funding source, frequency, amount and provider of each service; and the expected outcome or purpose of such services. This case plan shall be written on a state-prescribed case plan form.

E. Categorically Eligible, shall be defined in the HCBS-MI Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-MI as three hundred percent eligible persons, as defined at 8.509.14(S).

F. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

G. UNCERTIFIED CONGREGATE FACILITY shall be defined as a facility as defined above that is not certified as an alternative care facility, as defined at 8.495.11.

- H. Continued Stay Review shall be defined as a re-assessment as defined at Section 8.402.60.
- I. Cost Containment shall be defined as the determination that, on an individual client basis, the daily cost of providing HCBS-MI services, plus care provided under the Home Care Allowance program, does not exceed the equivalent daily cost of nursing facility care.
- J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility services reimbursed by Medicaid, within forty-five calendar days of admission to HCBS-MI. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected HCBS-MI.
- K. Diverted shall be defined as HCBS-MI waiver recipients who were not deinstitutionalized, as defined in this section.
- L. Home and Community Based Services for Persons with Mental Illness (HCBS-MI) shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing facility care without the provision of HCBS-MI, and for whom HCBS-MI services can be provided at no more than the cost of nursing facility care.
- M. Intake/Screening/Referral shall be defined as the initial contact with clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long term care client assessment.
- N. Level Of Care Screen shall be defined as an assessment as described in Section 8.401.
- O. Non-Diversion shall be defined as a client who was certified by the Utilization Review Contractor (URC) as meeting the level of care screen and target group for the HCBS-MI program, but who did not receive HCBS-MI services for some other reason.
- P. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8393.6 and 8.487 are met
- Q. Reassessment shall be defined as a periodic revaluation according to the requirements at Section 8.509.32. C.
- R. Department shall be defined as the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency, or another state agency operating under the authority of a memorandum of understanding with the single state Medicaid agency.
- S. Three hundred percent (300%) eligible shall be defined as persons:
- 1) Whose income does not exceed 300% of the SSI benefit level, and
 - 2) Who, except for the level of their income, would be eligible for an SSI payment; and
 - 3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty consecutive days.

8.509.15 ELIGIBLE PERSONS

A. HCBS-MI services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility Clients shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual of the Colorado Department of Human Services at 9 CCR 2503-1, and the MEDICAL ASSISTANCE ELIGIBILITY section of this manual.
2. Level of Care AND Target Group. Clients who have been determined to meet the level of care AND target group criteria shall be certified by the URC as functionally eligible for HCBS-MI. The URC shall only certify HCBS-MI eligibility for those clients:
 - a. Determined to meet the target group definition for the mentally ill as defined at Section 8.400.16; and
 - b. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11-15; and
 - c. Who are determined to be persons with mental illness as defined by State Mental Health Services and documented by the case management agency;
 - d. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.
3. Receiving Services
 - a. Only clients who receive HCBS-MI services, or who have agreed to accept HCBS-MI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-MI program.
 - b. Case management is not a service and shall not be used to satisfy this requirement.
 - b. Desire or need for home health services or other Medicaid services that are not HCBS-MI services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.
 - c. HCBS-MI clients who have received no HCBS-MI services for one month shall be discontinued from the program.
4. Institutional Status
 - a. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-MI services while residing in such institutions.
 - b. A client who is already an HCBS-MI recipient and who enters a hospital may not receive HCBS-MI services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the client from the HCBS-MI program.
 - c. A client who is already an HCBS-MI recipient and who enters a nursing facility may not receive HCBS-MI services while in the nursing facility;
 - 1) The case manager must terminate the client from the HCBS-M3 program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ULTC-100 for the nursing facility placement, as verified by telephoning the URC.

- 2) A client receiving HCBS-MI services who enters a nursing facility for respite care as a service under the HCBS-MI program shall not be required to obtain a nursing facility ULTC-100, and shall be continued as an HCBS-MI client in order to receive the HCBS-MI service of respite care in a nursing facility.
5. Cost-effectiveness Only clients who can be safely served within cost containment, as defined at Section 8.509.14 (I), are eligible for the HCBS-MI program. The equivalent cost of nursing facility care is calculated by the State, according to Section 8.509.19.

8.509.16 START DATE

The start date of eligibility for HCBS-MI services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which HCBS-MI services can be reimbursed shall be the LATER of any of the following:

- A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100, of Staff Manual Volume 8. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.
- B. Level of Care This date is determined by the official URC stamp ;and the URC-assigned start date on the ULTC 100.2 form.
- C. Receiving Services This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept HCBS-MI services.
- D. Institutional Status HCBS-MI eligibility cannot precede the date of discharge from the hospital or nursing facility.

8.509.17 CLIENT PAYMENT OBLIGATION - POST ELIGIBILITY TREATMENT OF INCOME (PETI)

When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, of Staff Manual Volume 8, the State may reduce Medicaid payment for Alternative Care Facility services according to the procedures at Section 8.509.31, E, of Staff Manual Volume 8.

8.509.18 STATE PRIOR AUTHORIZATION OF SERVICES

- A. Upon receipt of the prior authorization request (PAR), as described at Section 8.509.31, G, of Staff Manual Volume 8, the state or its agent shall review the PAR to determine whether it is in compliance with all applicable regulations, and whether services requested are consistent with the client's documented medical condition and functional capacity, and are reasonable in amount, frequency, and duration. Within ten (10) working days the State or its agent shall:
 1. Approve the PAR and forward signed copies of the prior authorization form to the case management agency, when all requirements are met;
 2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear, or incorrect; or if services requested are not adequately justified;
 3. Disapprove the PAR when all requirements are not met Services shall be disapproved that are duplicative of other services that the client is receiving or services for which the client is receiving funds to purchase Services shall also be disapproved if all services, regardless

of funding source, total more than twenty-four hours per day care.

- B. When services are disapproved, in whole or in part the Department or its agent shall notify the case management agency. The case management agency shall notify the client of the adverse action and the appeal rights on a state-prescribed form, according to Section 8.057, et seq. Staff Manual Volume 8.
- C. Revisions received by the Department or its agent six months or more after the end date shall always be disapproved.
- D. Approval of the PAR by the Department or its agent shall authorize providers of services under the case plan to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for long term care medical assistance (Medicaid) on the dates of service; and upon providers' use of correct billing procedures.

8.509.19 STATE CALCULATION OF COST-CONTAINMENT AMOUNT

- A. The State shall annually compute the equivalent monthly cost of nursing facility care ACCORDING TO SECTION 8:485.100.

B. LIMITATIONS ON PAYMENT TO FAMILY

1. In no case shall any person be reimbursed to provide HCBS-MI services to his or her spouse.
2. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-MI program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.
3. The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.
4. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:
 - a. The total number of Medicaid personal care units for members of the client's family shall not exceed the equivalent of 444 personal care units per annual certification for HCBS-MI.
 - b. The maximum shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision and all other administrative costs.
 - c. The maximum number of personal care units per annual certification for HCBS-MI shall be 444 units. Family members must average at least 1.2164 hours of care per day (as indicated on the client's care plan) in order to receive the maximum reimbursement.
 - d. If the certification period for HCBS-MI is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the client is receiving care by the average units per day for a full year ($444/365=1.2164$).

5. If more than one family member provides personal care to the same client, the maximum reimbursement of 444 personal care units per annual certification for HCBS-MI shall be divided among all family members providing care. Each family member providing care and sharing in the reimbursement shall be employed by the personal care agency.
6. If two or more HCBS-MI clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.
7. When HCBS-MI funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance cannot be used to reimburse the family.
8. Services other than personal care shall not be reimbursed with the HCBS-MI funds when provided by the client's family.

C. CLIENT RIGHTS

1. The case manager shall inform clients eligible for HCBS-MI in writing, of their right to choose between HCBS-MI services and nursing facility care.
2. The case manager shall offer clients eligible for HCBS-MI, the free choice of any and all available and qualified providers of appropriate services.

8.509.20 CASE MANAGEMENT AGENCIES

.21 CERTIFICATION

- A. Case management agencies shall be certified, monitored and periodically recertified according to current Rules and Regulations For The Colorado Public Mental Health System.
- B. Case management agencies must have provider agreements with the Department that are specific to the HCBS-MI program.

.22 REIMBURSEMENT

Case management agencies shall be reimbursed for case management activities according to current procedures as approved by the State Mental Health Authority.

8.509.30 CASE MANAGEMENT FUNCTIONS

.31 NEW HCBS-MI CASES

A. INTAKE/SCREENING/REFERRAL

1. Case management agency staff shall complete a State-prescribed Intake form for each potential HCBS-MI applicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the applicant for purposes of establishing a start date. Additionally, at intake, clients shall be offered an opportunity to identify a third party to receive client notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to clients.
2. Case management agency staff shall verify the individual's current financial eligibility status, or refer the client to the county department of social services of the

client's county of residence for application. This verification shall include whether the applicant is in a category of assistance that includes financial eligibility for long term care.

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long term care client assessment (ULTC-100), and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request an assessment if the client disagrees with the case manager's decision.
4. If the case management agency staff has determined that a comprehensive uniform long term care client assessment (ULTC-100) is needed, or if the client requests an assessment, a case manager shall be assigned to schedule the assessment

B. ASSESSMENT

1. The URC/SEP case manager shall complete the Uniform Long Term Care Client Assessment Instrument (ULTC 1(0.2) in accordance with instructions provided by the State.
2. The URC/SEP case manager shall begin and complete the assessment within ten (10) days of notification of client's need for assessment.
3. The URC/SEP case manager shall complete the following activities for a comprehensive client assessment:
 - a. Obtain all required information from the client's medical provider including information required for target group determination;
 - b. Determine the client's functional capacity during a face-to-face interview, preferably with the observation of the client in his or her residential setting;
 - c. Determine the ability and appropriateness of the client's caregiver, family, and other collateral, to provide the client assistance in activities of daily living;
 - d. Determine the client's service needs, including the client's need for services not provided under HCBS-MI;
4.
 - e. If the client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;
 - f. Review service options based on the client's needs, the potential funding sources, and the availability of resources;
 - g. Explore the client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;
 - h. View and document the current Assisted Living Residence license, if the client lives, or plans to live, in a congregate facility as defined at Section 8.509.14, Staff Manual Volume 8, in order to assure compliance with the regulation at 8.509.11, B, Staff Manual Volume 8;

- i. Determine and document client preferences in program selection;
- j. Complete documentation on the ULTC 100.2 form.
- k. To de-institutionalize a client who is in a nursing facility under payment by Medicaid, and with a current ULTC 100.2 already certified by the URC/SEP agency for the nursing facility level of ULTC 100 completion date is older than six (6) months, the URC/SEP case manager shall complete a new ULTC 100.2 and determine if the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-MI, the case manager must obtain a new ULTC 100.2 and the client shall be treated as an applicant from the community rather than as a de-institutionalized client
- l. It is the URC/SEP case manager's responsibility to assess the behaviors of the client and assure that community placement is appropriate.

C. HCBS-MI DENIALS

1. If a client is determined, at any point in the assessment process, to be ineligible for HCBS-MI according to any of the requirements at Section 8.509.15, Staff Manual Volume 8, the case manager shall refer the client or the client's designated representative to other appropriate services. Clients who are denied HCBS-MI services shall be notified of denials and appeal rights as follows:
 - a. Financial EligibilityThe income maintenance technician at the county department of social services shall notify the applicant of denial for reasons of financial eligibility, and shall inform the applicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.
 - b. Level of Care AND Target GroupThe URC shall notify the applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the applicant of appeal rights in accordance with Section 8.059.12, of Staff Manual Volume 8. The case manager shall not make judgments as to eligibility regarding level of care or target group, and shall refer all applicants who request a URC review to the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.
 - c. Receiving ServicesThe case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determine that the applicant does not meet the HCBS-MI eligibility requirements at Section 8.509.15, of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance with Section 8.057, et. seq., of Staff Manual Volume 8. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is

independent of any action that may be taken by the URC in regard to level of care and target group determination.

- d. Institutional StatusThe case manager shall notify the applicant of denial, on state-prescribed form, when the case manager determine that the applicant does not meet the eligibility requirement 2 Section 8.509.15, of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance wit Section 8.057, et. seq., of Staff Manual Volume 8. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.
- e. Cost-effectivenessThe case manager shall notify the applicant of denial, on State-prescribed form, when the case manager determine that the applicant does not meet the eligibility requirement 8.509.15, of Staff Manual Volume 8, and shall inform the applicant of appeal rights in accordance with Section 8.05, et.seq., of Staff Manual Volume 8.The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available, and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-MI eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the URC in regard to level of care and target group determination.
- f. Waiver CapThe case manager shall notify the applicant of denial, on a State-prescribed form, when the waiver cap limiting the number of clients who may be served under the terms of the approved waiver has been reached.

D. CASE PLANNING

- 1. Case planning shall include, but not be limited to, the following tasks:
 - a. The identification and documentation of case plan goals and client choices;
 - b. The identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, finding source, and services needed but not available;
 - c. Documentation of the client's choice of HCBS-MI services, nursing home placement, or other services, including a signed statement of choice from the client;

- d. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;
 - e. The formalization of the case plan agreement on a State-prescribed case plan form, including appropriate signatures;
 - f. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision;
 - g. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community;
 - h. The explanation of complaint procedures to the client.
2. The case manager shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

E. CALCULATION OF CLIENT PAYMENT (PETI)

1. The case manager shall calculate the client payment (PETI) for 300% eligible HCBS-MI clients according to the following procedures:
 - a. For 300% eligible HCBS-MI clients who are not Alternative Care Facility clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.
 - b. For 300% eligible clients who are Alternative Care Facility clients, the case manager shall complete a State-prescribed form which calculates the client payment according to the following procedures:
 - 1) An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid: and
 - 2) For an individual with financial responsibility for only a spouse, an amount equal to the state Aid to the Needy and Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income: or
 3. For an individual with financial responsibility for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Aid to Families with Dependent Children (AFDC) grant level less any income of the spouse and or dependents (excluding part-time employment earnings of dependent children as defined at Section 8.112.3(F) of Staff Manual Volume 8). shall be deducted from the client's gross income; and

4. Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the client's gross income as follows:

- a) Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS: deductible or co-insurance charges: and
- b) Necessary dental care not to exceed amounts equal to actual expenses incurred: and
- c) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred: and
- d) Medications, with the following limitations:
- e) Other necessary medical or remedial care shall be deducted from the client's gross income, with the following limitations:
- f) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.
- g) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

5) Any remaining income shall be applied to the cost of the Alternative Care Facility services, as defined at Section 8.495, and shall be paid by the client directly to the facility; and

6) If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the client's income, the remaining income shall be kept by the client and may be used as additional personal needs or for any other use that the client desires, except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services.

2. Case managers shall inform HCBS-MI Alternative Care Facility clients of their client payment obligation on a form prescribed by the state at the time of the first assessment visit by the end of each plan period; or within ten (10) working days whenever there is a significant change in the client payment amount. Significant change is defined as fifty dollars (\$50) or more. Copies of client payment forms shall be kept in the client files at the case management agency, and shall not be

mailed to the State or its agent, except as required for a prior authorization request, according to Section 8.509.31.G, of Staff Manual Volume 8. or if requested by the state for monitoring purposes.

F. COST CONTAINMENTThe case manager shall determine whether the person can be served at or under the cost ceiling for long term care services for an individual recipient by using a state-prescribed Prior Authorization Request (PAR) form 10:

1. Determine the maximum authorized costs for all HCBS-MI services for the period of time covered by the case plan and compute the average cost per day by dividing by the number of days in we case plan period; and
2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:
 - a. Enter fin the designated space on the PAR form) the average monthly cost of nursing facility care as calculated by the State according to Section 8.485.100. of Staff Manual Volume 8: and
 - b. Subtract from that amount the client's gross monthly income: and
 - c. Subtract from that amount the client's Home Care Allowance grant amount, if any;and
 - d. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount which cannot be exceeded for the cost of HCBS services.
3. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.

G. PRIOR AUTHORIZATION REQUESTS

1. The case manager shall submit prior authorization requests (PARs) for all HCBS-MI services to the state or its agent in a timely manner.
2. Every PAR shall include the Long Term Care Plan form; the Prior Approval Request form; the Uniform Long Term Care Client Assessment (ULTC-100) form; and written documentation, from the income maintenance technician or the eligibility system, of the client's current monthly income. All units of service requested on the Prior Approval Request form must be listed on the Long Term Care Plan form. If a range of units is estimated on the Long Term Care plan, the number of units at the higher end of the range may be requested on the Prior Approval Request form. "PRN" services must be given a numerical estimate on the Long Term Care plan.
3. If a PAR is for a new admission, or a re-admission, the Intake form shall be included with the PAR.
4. If a PAR includes a request for home modification services, the PAR shall also include all documentation listed at Section 8.493, HOME MODIFICATION, of Staff Manual Volume 8.
5. If a PAR is for an Alternative Care Facility client who is 300% eligible, the most recent

state-prescribed Client Payment form shall be included in the PAR. All medical and remedial care requested as deductions on the Client Payment form must be listed on the LONG TERM Case Plan form.

6. The start date on the prior authorization request form shall never precede the start date of eligibility for HCBS-MI services, according to Section 8.509.16, START DATE, of Staff Manual Volume 8.
7. The PAR shall not cover a period of time longer than the length of stay assigned by the URC.
8. A PAR does not have to be submitted for a non-diversion, as defined at 8.509.14, M.
9. If a PAR is returned to the case management agency for corrections, the corrected PAR must be returned to the State or its agent within 30 calendar days after the case management agency receives the "return to provider" letter.

H. CASE MANAGEMENT AGENCY RESPONSIBILITY

1. The case management agency shall be financially responsible for any services which it authorized to be provided to the client, or which continue to be rendered by a provider due to the case management agency's failure to timely notify the provider that the client was no longer eligible for services, which did not receive approval by the state or its agent.

8.509.32 ONGOING HCBS-MI CASES

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The case manager shall monitor the services that are being provided, the appropriateness and effectiveness of services provided, the amount of care, the timeliness of service delivery, client satisfaction, the safety of the client, and shall take corrective actions as needed. Monitoring contacts must occur and be documented at least once every three months, or more frequently as determined by the client's needs.
2. The case manager shall contact each client on a face-to-face basis at least once every three months, or more frequently as determined by the client's needs.
3. The case manager shall refer the client for mental health services taking into account client choice. The case manager shall coordinate case management activities for those clients who are receiving mental health services from the Mental Health Assessment and Service Agencies (MHASAs).
4. On-going case management shall include, but not be limited to, the following tasks:
 - a. Review of the client's case plan and service agreements;
 - b. Contact with the client concerning whether services are being delivered according to the plan; and the client's satisfaction with services provided;
 - c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;
 - d. Contact with appropriate parties in the event any issues or complaints have been presented by the client or others;

- e. Conflict resolution and/or crisis intervention, as needed;
 - f. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;
 - g. Notification of appropriate enforcement agencies, as needed; and
 - h. Referral to community resources, and arrangement for non-HCBS-MI services, as needed.
4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.
5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or misutilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

B. REVISIONS

1. SERVICES ADDED TO THE CASE PLAN

- a. Whenever a change in the case plan results in an increase or change in the services to be provided, the case manager shall submit a revised prior authorization request (PAR) to the state or its agent.
 - 1) The revision PAR shall include the revised Long Term Care plan form and the revised Prior Authorization Request form.
 - 2) The revised case plan form shall list the services being revised and shall state the reason for the revision. Services on the revised case plan form, plus all services on the original case plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.
 - 3) The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.
- b. If a revised PAR includes a new request for home modification services, the revised PAR shall also include all documentation listed at Section 8.493, of Staff Manual Volume 8.

2. SERVICES DECREASED ON THE CASE PLAN

- a. A revised PAR does not need to be submitted if services on the case plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness
- b. If services are decreased without the client's agreement according to Section 8.057.5, of Staff Manual Volume 8, the case manager shall notify the client of the adverse action and of appeal rights, according to Section 8.057, et. seq., of Staff Manual Volume 8.

C. REASSESSMENT

1. The case manager shall complete a reassessment of each HCBS-MI client before the end of the length of stay assigned by the URC at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect HCBS-MI eligibility.
2. The case manager shall complete the reassessment, utilizing the Uniform Long Term Care Client Assessment Instrument (ULTC 100.2).
3. Reassessment shall include, but not be limited to, the following activities:
 - a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long term care benefits;
 - b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;
 - c. Evaluate continuing need for the HCBS-MI program, and clearly document reasons for continuing HCBS; or terminate the client's eligibility according to Section 8.509.32, E, of Staff Manual Volume 8;
 - d. Ensure that all information needed from the medical provider for the URC level of care review is included on the ULTC 100.2 form;
 - e. Reassess the client's functional status, according to the procedures in Section 8.509.31,B, of Staff Manual Volume 8;
 - f. Review the case plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.509.31, D, of Staff Manual Volume 8;
 - g. Refer the client to community resources as needed;
 - h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31,G, of Staff Manual Volume 8. For clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ULTC 1002. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the client and sent to the URC or to the Division of Administrative Hearings; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Division of Administrative Hearings to the client; or (c) a copy of the notice of a scheduled court date. Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be accepted as a substitute for the approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

D. TRANSFER PROCEDURES When clients move, cases shall be transferred according to the current statewide Mental Health Services Continuity of Care Policy.

E. TERMINATION

1. Clients shall be terminated from the HCBS-MI program whenever they no longer meet one or

more of the eligibility requirements at Section 8.509.15, of Staff Manual Volume 8. Clients shall also be terminated from the program if they die, move out of state or voluntarily withdraw from the program.

2. Clients who are terminated from HCBS-MI because they no longer meet one or more of the eligibility requirements at Section 8.509.15, of Staff Manual Volume 8, shall be notified of the termination and their appeal rights as follows:
 - a. Financial Eligibility Procedures at Section 8.509.31, C, of Staff Manual Volume 8, shall be followed for terminations for this reason.
 - b. Level of Care AND Target Group Procedures at Section 8.509.31, C, of Staff Manual Volume 8, shall be followed for terminations for this reason.
 - c. Receiving Services Procedures at Section 8.509.31, C, of Staff Manual Volume 8, shall be followed for terminations for this reason.
 - d. Institutional Status Procedures at Section 8.509.31, C, of Staff Manual Volume 8, shall be followed for terminations for this reason. In the case of termination for extended hospitalization, the case manager shall send the termination notice on the thirtieth day of hospitalization. The termination shall be effective at the end of the advance notice period. If the client returns home before the end of the advance notice period, the termination shall be rescinded.
 - e. Cost-effectiveness Procedures at Section 8.509.31(C) of Staff Manual Volume 8, shall be followed for terminations for this reason.
3. When clients are terminated from HCBS-MI for reasons not related to the eligibility requirements at Section 8.509.31(C) of Staff Manual Volume 8, the case manager shall follow the procedures below:
 - a. Death Clients who die shall be terminated from the HCBS-MI program, effective upon the day after the date of death.
 - b. Moved out of State Clients who move out of Colorado shall be terminated from the HCBS-MI program, effective upon the day after the date of the move. The case manager shall send the client a state-prescribed Advisement Letter advising the client that the case has been closed. Clients who leave the state on a temporary basis, with intent to return to Colorado, according to the Income Maintenance Staff Manual Section 1140.2, shall not be terminated from the HCBS-MI program unless one or more of the other eligibility criteria, as specified at Section 8.509.15 of Staff Manual Volume 8 is no longer met.
 - c. Voluntary Withdrawal from the Program Clients who voluntarily withdraw from the HCBS-MI program shall be terminated from the program, effective upon the day after the date on which the client either requests in writing to withdraw from the program, or the date on which the client enters a nursing facility. The case manager shall send the client a state-prescribed Advisement Letter advising the client that the case has been closed.
4. The case manager shall provide appropriate referrals to other community resources, as needed, upon termination.
5. The case manager shall immediately notify all providers on the case plan of any terminations.

6. If a case is terminated before an approved PAR has expired, the case manager shall submit, to the state or its agent, a copy of the current prior authorization request form, on which the end date is adjusted (and highlighted in some manner on the form); and the reason for termination shall be written on the form.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATIONIn addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the income maintenance technician of any and all changes in the client's participation in HCBS-MI, and shall provide the technician with copies of the first page of all URC-approved ULTC-100 forms.
2. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current state-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.
3. If the client has an open service case file at the county department of social services, the case manager shall keep the client's caseworker informed of the client's status and shall participate in mutual staffing of the client's case.
4. The case manager shall inform the client's physician of any significant changes in the client's condition or needs.
5. Within five (5) working days of receipt, from the State or its agent, of the approved Prior Authorization Request form, the case manager shall provide copies to all the HCBS-MI providers in the case plan.
6. The case manager shall notify the URC, on a form prescribed by the state of the outcome of all non-diversions, as defined at Section 8.509.14, of Staff Manual Volume 8.
7. The case manager shall report to the Colorado Department of Public Health and Environment any congregate facility which is not licensed.
8. The case management agency shall notify the state of any client appeals which are initiated as a result of denials or terminations made by the case management agency.

B. CASE RECORDING/DOCUMENTATION

1. The case management agency shall maintain records on every individual for whom intake was conducted, including a copy of the intake form. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the case management agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.
2. The case record shall include:
 - a. Identifying information, including the state identification (Medicaid) number, and
 - b. All state-required forms; and
 - c. Documentation of all case management activity required by these regulations.
3. Case management documentation shall meet all the following standards:

- a. A separate case record shall be maintained for each client receiving services in the Home and Community Based Services for Persons with Mental Illness Program.
 - b. Documentation shall be legible;
 - c. Entries shall be written at the time of the activity or shortly thereafter,
 - d. Entries shall be dated according to the date of the activity, including the year;
 - e. Entries shall be made in permanent ink;
 - f. The client shall be identified on every page;
 - g. The person making each entry shall be identified;
 - h. Entries shall be concise, but shall include all pertinent information;
 - i. All information regarding a client shall be kept together for easy access and review by case managers, supervisors, program monitors and auditors;
 - j. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact, or is a judgment or conclusion on the part of Anyone;
 - k. All persons and agencies referenced in the documentation shall be identified by name and by relationship to the client;
 - l. All forms prescribed by the State shall be filled out by the case manager to be complete, correct and accurate.
4. All records shall be kept for the period of time specified in the case management agency contract, and shall be made available to the state as specified in the contract.

8.509.40 HCBS-MI PROVIDERS

- A. Any provider agency with a valid contract to provide HCBS-EBD services, according to Section 8.487, of Staff Manual Volume 8, shall be deemed certified to provide the same services to HCBS-MI clients.

8.515.00 HOME AND COMMUNITY BASED SERVICES FOR PEOPLE WITH BRAIN INJURY (HCBS-BI)

8.515.11 LEGAL BASIS

The Home and Community Based Services for people with Brain Injury (HCBS-BI) program in Colorado is authorized by a waiver of the amount, duration, and scope of service requirements contained in Section 1902 (a)(10)(B). of the Social Security Act The rules governing the HCBS-BI program will be in effect after approval is received from the United States Department of Health and Human Services, under Section 1915 (c). of the Social Security Act. The HCBS-BI program is authorized under State law at 26-4-681 et seq., C.R.S. to 26-4-685, as amended.

8.515.12 KEYS AMENDMENT COMPLIANCE

All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616 (e) of the Social Security Act of 1935 and 45 CFR Part 1397

(October 1, 1991) by possession of a valid Assisted Living Residence license issued under C.R.S. 25-27-105, and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7. No amendments or later editions are incorporated. The staff assistant of the Community Based Health Programs Section may be contacted at 1575 Sherman, Denver, Co 80203 for a copy of 45 CFR. part 1397.

8.515.13 DEFINITIONS OF SERVICES PROVIDED

HCBS-BI services are provided as an alternative to hospital and inpatient rehabilitation facility placement and include:

- A. Adult Day Services means services as defined at Section 8.515.70. ADULT DAY SERVICES.
- B. Assistive Equipment means devices equipment and services as defined hi Section 8.515.50, ASSISTTVE AND SPECIAL MEDICAL EQUIPMENT.
- C. Behavioral Programming means, services as defined in Section 8.516.40. BEHAVIORAL PROGRAMMING.
- D. Case Management means services as defined in Section 8.515.30. CASE MANAGEMENT.
- E. Counseling and Training Including Substance Abuse Treatment and Family Counseling means services as defined in Section 8.516.60. COUNSELING.
- F. Day Treatment means services as defined in Section 8.515.80. DAY TREATMENT.
- G. Environmental Modification means services as defined in Section 8.5.6.00. ENVIRONMENTAL MODIFICATION.
- H. Independent Living Skills Training means services as defined in Section 8.516.20, INDEPENDENT LIVING SKILLS. TRAINING.
- I. Non-medical Transportation means services as defined at Section 8.524. NON-MEDICAL TRANSPORTATION.
- J. Personal Care means, services, as defined at Section 8.515.60. PERSONAL CARE SERVICES.
- K. Respite Care means services as defined at Section 8.515.90. RESPITE CARE.
- L. Supported Living means services as defined at Section 8.514.14. Q in GENERAL DEFINITIONS-SUPPORTED LIVING.
- M. Transitional Living means services as defined in Section 8.516:40. TRANSITIONAL LIVING.

8.515.14 GENERAL DEFINITIONS

- A. Agency means any public or private entity that operates in a for-profit or nonprofit capacity, and has a defined administrative and organizational structure. Any sub-unit of such agency that is not geographically close enough to the agency to share administration and supervision on a frequent and adequate basis shall be considered a separate agency for purposes of certification and contracts.
- B. Assessment means a comprehensive face-to-face interview with the client and appropriate collaterals (such as family members, friends and or caregivers) and an evaluation by the hospital discharge

planner or case manager, with supported diagnostic information from the client's physician. and other rehabilitation therapists to determine the client's level of functional ability, service needs, potential to benefit from further rehabilitative intervention, available community resources, and potential funding sources.

- C. Brain Injury is defined as an injury to the brain of traumatic or acquired origin, which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature, and includes the following ICD-9-CM codes:

310-310.9 specific non-psychotic mental disorders due to organic brain syndrome:

348.1 Anoxic brain damage:

431.0 Intracerebral hemorrhage:

436-438 cerebrovascular disease, acute, but ill-defined, other and ill-defined, and late effects of disease:

800.00-800.9 fracture of vault of skull:

801-801.9 fracture of base of skull:

803-803.9 other and unqualified skull fractures:

804-804.99 multiple fracture involving skull or face with other bones:

850-850.9 concussion;

851-854.19 intracranial injury and hemorrhage following injury:

904.0-907.0 late effects of fracture of skull and face bones and late effect of intracranial injury without mention of skull fractures (if admission to acute hospitalization is for a different primary diagnosis):

349.82 toxic encephalopathy:

198.3 -secondary malignant neoplasm of brain, spinal cord and other parts of nervous system.

Copies of the International Classification of Diseases Manual - Clinical Modification are available from the Brain Injury Program Coordinator. Office of Public and Private Initiatives of the Department of Health Care Policy and Financing at 1575 Sherman St. Denver. CO 80203. or may be examined at any State Publications Depository Library. Later amendments or additions are not included in this rule.

- D. Case Management Agency means an agency which is certified and has a valid contract with the department to provide HCBS-BI case management.

- E. Care Plan means a systematized arrangement of information which includes the client's needs: the HCBS-BI services and all other services which will be provided, including the funding source, frequency, amount and provider of each service: and the expected outcome or purpose of such services. This care plan shall be written on a state-prescribed care plan form and upon monthly reassessment of the client, shall be revised as dictated by the client's progress.

- F. Categorically Eligible as it is used in relation to the HCBS-BI Program. means any person who is eligible for medical assistance or for a combination of financial and medical assistance:

and who retains eligibility for medical assistance even when he or she is not a resident of a nursing facility or hospital or is not a recipient of an HCBS program. Persons who are eligible for financial assistance, but not for medical assistance, are not included in the definition of categorically eligible, as the term is used in relation to the HCBS-BI program. The term also excludes persons who are eligible for HCBS-BI as three hundred percent eligible persons, as defined in this section.

- G. Congregate Facility means a residential facility that Provides room and board to three or more adults who are not related to the owner and who. because of impaired capacity for independent living, elect protective oversight, personal services, and social care but do not require regular twenty four hour medical or nursing care.
- H. Continued Stay Review means a re-evaluation by the URC/SEP agency to determine the continued functional necessity of that level of care. Continued stay reviews will be performed every six months, for the 1st year, and annually or when the URC/SEP case manager determines that the client no longer meets the level of care necessary for continued program eligibility.
- I. Daily cost ceiling means the determination that, on an individual client basis, the daily cost of providing HCBS-BI services does not exceed the equivalent daily cost of hospital facility care.
- J. Department means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.
- K. Home and Community Based Services for Persons with Brain Injury (HCBS-BI) means service provided in a home or community based setting to individuals who are eligible for Medicaid for one of two levels of care:
 - a. Post acute care/long term care, for clients requiring continued hospitalization without the provision of intensive HCBS-BI services that can be provided at no more than the cost of hospital care.
 - b. Program services for those requiring nursing facility level of care without the provision of HCBS-BI services that can be provided at no more than the individual's calculated cost if institutionalized.
- L. Independent Living Skills training means skills and therapies as defined at 26-4-683(5), C.R.S.
- M. Community services may be provided in the client's residence, in the community or in a group living situation.

Intake/screening/referral for the HCBS-BI program means the initial contact with individuals by the URC/SEP case manager. This process shall include, but not be limited to, the following areas; an individual's need for long term care services; an individual's need for referral to other programs or services; and an individual's eligibility for financial and program assistance.
- M. Level of care screen means an assessment as described in Section 8.401, LEVEL OF CARE SCREENING GUIDELINES, LONG TERM CARE-GENERAL.
- O. Provider Agency means an agency, as defined in this section, which is certified by the Department to provide one of the services listed at Section 8.393.61 DEFINITIONS OF SERVICES, with the exception of case management provided by a single entry point agency, which is considered an administrative function rather than a service. However, a

single entry point agency may become a service provider if they meet all criteria at 8.393.61, PROVIDER OF DIRECT SERVICES.

- P. Reassessment means a comprehensive face-to-face interview conducted with the client and appropriate collateral contacts, which includes an evaluation by the case manager, collection of supporting diagnostic information from the client's physician to determine the client's level of functioning, service needs, available resources, and potential funding resources.
- Q. Supported Care Campus means a residential campus that provides supported living services.
- R. Single Entry Point Agency means an organization as described at Section 8.390. I.P, LONG TERM CARE SINGLE ENTRY POINT SYSTEM.
- S. Supported Living means assistance or support as defined at 26-4-638, C.R.S.
- T. Target Population for purposes of the HCBS-BI waiver program is defined as those individuals 16-64 years of age who have a diagnosis of brain injury as previously defined in 8.515.14, who continue to require the level of care offered in a hospital by evidencing all of the following:
1. They are currently receiving inpatient hospital care in an acute medical facility or rehabilitation facility;
 2. They continue to require goal oriented therapy with medical management by a physician with special training or experience in the field of brain injury rehabilitation;
 3. They continue to require and benefit from medically necessary specialized rehabilitation services including at least one of the following: neuropsychological intervention, social work, life skills training, behavioral management, counseling, respite care, personal care, non-medical transportation, adult day care, day treatment, transitional living, assistive equipment, environmental modification, speech therapy, physical therapy, occupational therapy, vocational rehabilitation, recreational therapy, or home health services;
 4. The client can not be therapeutically managed in the home without 24 hour supervision and structure, daily specialized therapy and support services; and
 5. They have a prognosis for continued functional improvement
 6. Three Hundred Percent 600%) Eligible means Persons whose income does not exceed 300% of the SSI benefit level; who, except for the level of their income, would be eligible for an SSI payment; and who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty consecutive days.

8.515.15 ELIGIBLE PERSONS

A. HCBS-BI services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

Individuals must meet the financial eligibility criteria as specified in Section 8.110.5 MEDICAL ASSISTANCE ELIGIBILITY. The parental income of non-emancipated children

between the ages of 16-18 will be counted in the determination of that child's eligibility for medical assistance.

2. Level of Care and Target Group

Persons determined to meet the target group criteria, disability determination and functional eligibility will be approved by the URC/SEP case manager as eligible for HCBS-BI. The functional eligibility determination shall be made using the ULTC 100.2.

- a. Who have undergone an initial screening assessment completed by the URC/SEP case manager indicating that the client meets the criteria for the appropriate continued rehabilitation hospitalization but could be adequately served with services in the community which are appropriate cost effective alternatives to hospital care.
- b. If an individual simultaneously qualifies for more than one HCBS program, he/she may select the program to apply for; however, primary consideration should be given to the most appropriate services available. In the case of individuals between the ages of 16 and 64 with a diagnosis of non-progressive brain injury, HCBS-BI should be considered if the individual is being discharged directly from the hospital setting.

3. Receiving HCBS-BI Services

Once all other eligibility criteria have been established, only persons who actually receive at least one HCBS-BI service, or who have agreed to accept HCBS-BI services are eligible for the HCBS-BI program. Desire or need for home health services or other Medicaid services that are not HCBS-BI services, as listed at Section 8.515.13, will not satisfy this eligibility requirement. Case management is provided as an administrative function of the waiver program and is not a service of the waiver program; therefore, it cannot be used to satisfy this eligibility requirement. HCBS-BI recipients who have received no HCBS-BI services for one month will be discontinued from the program.

4. Institutional Status

- a. Persons who are residents of nursing facilities or hospitals are not eligible for HCBS-BI services while residing in such institutions.
- b. An individual who is already an HCBS-BI recipient and who enters a hospital for treatment may not receive HCBS-BI service while in the hospital; and if the hospitalization continues for 30 days or longer, the URC/SEP case manager must terminate the client from the HCBS-BI program.
- c. An individual who is already an HCBS-BI recipient and who enters a nursing facility may not receive HCBS-BI service while in the nursing facility; and the URC/SEP case manager must terminate the client from the HCBS-BI program if Medicaid pays for all or part of the nursing facility care. However, a recipient of HCBS-BI services who enters a nursing facility for respite care as a service under the HCBS-BI program shall not be required to obtain a nursing facility ULTC 100.2, but shall be continued as an HCBS-BI waiver participant and recipient of respite care in a nursing facility.

5. Cost Ceiling

Only persons who can be safely served within the cost ceiling, as defined in Section 8.515.19, are eligible for the HCBS-BI program. The equivalent cost of hospital care is calculated by the Department according to Section 8.515.19, DEPARTMENT

CALCULATION OF COST CONTAINMENT AMOUNT.

8.515.16 START DATE FOR SERVICES

The period of eligibility for services will begin the day the Utilization Review Contractor certifies medical eligibility and will remain in effect as long as there is a current, valid certificate of medical necessity.

8.515.17 CLIENT PAYMENT OBLIGATION-POST ELIGIBILITY TREATMENT OF INCOME (PETI)

The case manager shall calculate the client PETI payment for 300% eligible HCBS-BI clients according to the following procedures:

- A. For 300% eligible HCBS-B1 clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.
- B. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.
- C. For clients who are temporary residents of a transitional living program, deductions of up to \$400/month are allowed as client contributions toward deferring the room and board expense of transitional living which is not a covered benefit of the Medicaid program.

8.515.18 PRIOR AUTHORIZATION OF SERVICES

This section defines the process of prior authorization for service. For further information on responsibilities for submission of prior authorization for services, please refer to 8.515.30.1.

- A. Upon receipt of the prior authorization request (PAR) as described at Section 8.515.30, I. PRIOR AUTHORIZATION REQUESTS, the Department or its agent shall review the PAR to determine whether it is in compliance with all applicable regulations, whether services requested are consistent with the client's documented medical condition and functional capacity, and whether services are reasonable in amount, frequency and duration. The Department or its agent shall:
 - 1. Approve the PAR and forward signed copies of the Prior Authorization form to the case management agency or hospital discharge planner, when requirements are met;
 - 2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear or incorrect; or if services requested are not adequately justified;
 - 3. Disapprove the PAR when any of the requirements are not met. Services shall be disapproved that are duplicative of any other services that the client is receiving or services for which the client is receiving funds to purchase.
- B. When the PAR is disapproved, in whole or in part, the Department or its agent shall notify the case management agency or hospital discharge planner, and the case management agency or hospital discharge planner shall notify the client of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et seq., RECIPIENT APPEALS AND HEARINGS. The denial of a Prior Authorization Request is an adverse action with respect to the client and may be appealed pursuant to Section 8.057 but cannot be appealed by the provider.
- C. Approval of the PAR by the Department or its agent shall authorize providers of services

under the case plan to receive payment for properly submitted claims. Payment is conditional upon the client financial eligibility for long term care medical assistance (Medicaid) on the dates of services.

8.515.19 DEPARTMENT CALCULATION OF COST-CONTAINMENT AMOUNT

The Department shall compute the equivalent average daily cost of hospital care for the person with a brain injury by averaging the reimbursement paid for the prior fiscal year for the 13 Diagnostic Related Groups pertinent to brain injury. The average expense of providing home and community based services, plus the average daily per capita expenditures for all other Medicaid services provided to these patients, must be equal to or less than the average cost of hospital level of care plus the average per capita expenditures of all other Medicaid services provided to these patients while residing in a hospital.

8.515.20 LIMITATIONS ON PAYMENT TO FAMILY

- A. In no case shall any person be reimbursed to provide HCBS-BI services to his or her spouse.
- B. Family members other than spouse or parent of a minor child may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-BI program subject to the conditions below. For purposes of this section, family is defined as all persons related to the client by virtue of blood, marriage, adoption or common law.
- C. The family member must meet all requirements for employment by a certified personal care agency, and must be employed and supervised by the personal care agency.
- D. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:
 - 1. The total number of Medicaid personal care units for the client's family members, shall not exceed an average of 222 personal care units per six-month certification or the equivalent of 444 personal care units for a one-year certification for HCBS-BI. The relative personal care units shall be calculated by multiplying the number of days covered for the certification period by 1.2164 units, to determine the total amount of reimbursement to family members, and dividing by the number of days covered by the care plan, to determine the average Medicaid cost per day. Family members must average at least 1.2164 hours of care per day (as indicated on the client's care plan) in order to receive the maximum reimbursement.
 - 2. When HCBS funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance can not be used to reimburse the family.

8.515.21 CLIENT RIGHTS

The hospital discharge planner shall inform persons eligible for HCBS-B1 of their right to choose between HCBS-BI services and continued hospital care.

The hospital discharge planner or Single Entry Point case manager shall offer persons eligible for HCBS-BI services the free choice of any and all available and qualified providers of appropriate services.

Persons eligible for HCBS-BI shall be entitled to all appeal rights as listed at Section 8.057, et. seq.,
RECIPIENTS APPEALS AND HEARINGS.

- A. The Utilization Review Contractor shall inform the person of appeal rights when the adverse

actions concern the level of care or the determination of client target group.

- B. The income maintenance technician shall inform the person of appeal rights when the adverse actions concern financial eligibility and shall also notify the hospital discharge planner or single entry point case manager of the adverse action.
- C. The case manager shall inform the client of appeal rights for all other adverse actions concerning HCBS-BI eligibility in accordance with Departmental regulations.

The case manager shall assure that persons eligible for HCBS-BI services receive the protection of client rights at Section 8.023.18, CLIENT RIGHTS, LONG TERM CARE SINGLE ENTRY POINT SYSTEM.

8.515.30 HCBS-BI CASE MANAGEMENT FUNCTIONS

A. HCBS-BI PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

Single Entry Point agencies must comply with single entry point rules governing case management functions at Section 8.393, et. seq., SINGLE ENTRY POINT SYSTEM, and must, in addition, comply with all specific requirements in the rest of the section on HCBS-BI case management functions.

B. INTAKE/SCREENING/REFERRAL

1. Assessment will be completed by hospital discharge planners and an initial plan of care will be developed prior to the client's release to the community based care.
2. The start date will be the date at which the Utilization Review Contractor approves the assessment and the client is discharged to community based care as defined in 8.515.16. If the applicant is unable to sign due to the medical condition of the applicant, any mark the applicant is capable of making will be accepted in lieu of a signature.
3. Consent to treatment shall be obtained from the client. If the applicant is unable to sign due to their medical condition, any mark that the applicant is capable of making will be accepted in lieu of a signature. If the applicant is not capable of making a mark or if the client is felt to be cognitively compromised to the extent that right to consent should be delegated to a family member, the signature of a family member or other person legally authorized to represent the applicant will be accepted.
4. Hospital staff will verify the individual's current financial eligibility status and initiate a call to the Brain Injury Program Coordinator. This verification shall include whether or not the applicant is in a category of assistance that includes financial eligibility for long term care and shall be confirmed in writing by a DSS-1 form from the county eligibility technician.
5. If financial eligibility is to be determined, the hospital staff will initiate contact with the county department of social services of the client's county of residence for Medicaid application.

C. ASSESSMENT

The discharge planner shall complete the following activities for a comprehensive client assessment:

1. Obtain all required information from the client's physician and inpatient treatment team and/or medical records.
2. Determine the client's functional capacity during a face-to-face interview, preferably with the observation of the client in functional settings outside the hospital environment when possible.

3. Determine the ability and appropriateness of the client's caregiver, family, and other collateral sources, to provide assistance in activities of daily living.
4. Determine the client's service needs, including the client's need for services not provided under HCBS-BI.
5. Review service options based on the client's needs, the potential funding sources, and the availability of resources.
6. Explore the client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with Departmental rules.
7. View and document the current Personal Care Boarding Home license or verify with the Department of Public Health and Environment, if the client lives, or plans to live, in a congregate facility as defined at Section 8.485.50, GENERAL DEFINITIONS, in order to assure compliance with Section 8.485.20, KEYS AMENDMENT COMPLIANCE.
8. Determine and document client preferences in program selection.
9. The case manager shall assure that:
 - a. The ULTC-100.2 assessment and plan of care is completed within two days of the hospital being notified that an applicant may be functionally eligible for the Brain Injury Waiver Program.
 - b. The Long Term Care Professional Medical Information section of the ULTC. 100.2 is completed by the individual's attending physician's office. A completed form shall include the provider's name and address, and the name and title of the person providing the information.
 - c. A completed copy of the ULTC 100.2 is submitted to the State Brain Injury Program Administrator and to the County Department of Human Services eligibility technician to notify them of admission into the HCBS-BI program.

D. HCBS-BIDENIALS

HCBS-BI services cannot be paid for if a person is determined, at any point in the assessment process, to be ineligible for the following reasons:

1. Financial Eligibility The income maintenance technician shall notify the applicant of denial for reasons of financial eligibility, and shall inform the applicant of appeal rights in accordance with the Colorado Department of Human Services Staff Manual Volume 3, INCOME MAINTENANCE. The case manager shall not attend the appeal hearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the State.
2. Level of Care and Target Group Denials
 - a. The URC/SEP agency shall notify the applicant of denial for reasons related to determination of level of care and target group eligibility, and shall inform the applicant of appeals rights in accordance with Section 8.8.057.
 - b. The URC/SEP case manager shall attend the appeal hearing to defend any denial action.
3. Continued Stay Review Denials

- a. For a client who has been receiving services under the HCBS-BI Waiver program, the URC/SEP case manager shall notify the client pursuant to Section 8.057.
 - b. The URC/SEP case manager shall attend the hearing to defend the denial action of continued program eligibility.
4. **Cost-effectiveness** Depending upon the timing of the denial of further services due to cost-effectiveness criteria, the SEP case manager shall notify the applicant of denial, on a State-prescribed form, when it is determined that the applicant does not meet the eligibility requirement at 8.515.19 for COST-EFFECTIVENESS and shall inform the applicant of appeal rights in accordance with Section 8.057 RECIPIENT APPEALS AND HEARINGS. The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available, and that the applicant is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-BI eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and which will satisfy the burden of proof required of the case manager making the decision. Denials and appeals for reasons of cost effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the Utilization Review Contractor in regard to level of care and target group determination.
5. **Institutional Status** The case manager shall notify the applicant of denial, on a Departmentally prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement at Section A.4, 8.515.15, INSTITUTIONAL STATUS, and shall inform the applicant of appeal rights in accordance with Section 8.057 et., seq., RECIPIENT APPEALS AND HEARINGS. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the Utilization Review Contractor in regard to level of care and target group determination.

E. CARE PLANNING

The hospital discharge planner shall initiate development of the care plan after completing the client assessment and shall complete the care plan (including all required paperwork) prior to discharge. Care Planning shall include, but not be limited to, the following tasks:

1. Identification and documentation of care plan goals and client choices;
2. Identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, funding source, and services needed but not available.
3. Documentation of the client's choice of HCBS-BI services or continued hospitalization including a signed statement of choice from the client or authorized representative;
4. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;

5. The formalization of the care, plan agreement of a Long Term Care Plan, including appropriate signatures. If the applicant is unable to sign due to a medical or cognitive condition, any mark that the applicant is capable of making will be accepted in lieu of a signature. If the applicant is not capable of making a mark, the signature of a family member or other person authorized to represent the applicant is acceptable.
6. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision.
7. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community.
8. Referral to state brain injury program coordinator for an explanation of complaint procedures to the client. When developing the care plan, the discharge planner shall make every effort to ensure that there is no duplication between those services requested under HCRS and services from any other funding source. This includes, but is not limited to, services provided or paid for through Home Health, Home Care Allowance, Veteran's Aid and Attendance, or Assisted Living Residence.

F. CALCULATION OF CLIENT PAYMENT (PETI)

This section explains responsibilities for calculation of PETI; for further information on the process of calculation and allowances, please refer to Section 8.515.17.

The case manager shall calculate the PETI client payment for 300% eligible HCBS-BI clients according to the following procedure:

For 300% eligible HCBS-BI clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required.

For 300% eligible HCBS-BI clients who are residing temporarily in Transitional Living Centers, the case manager shall complete a State-prescribed form which calculates the client payment according to specifications delineated for Alternate Care Facility clients according to Section 8.486.60 et. seq., CALCULATION OF CLIENT PAYMENT (PETI).

G. PRUDENT PURCHASE AND SERVICE FUNDING PRIORITIES.

1. The discharge planner or case manager shall attempt to meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.
2. Diligent effort will be made to assist the client in making informed choices by:
 - a. Presenting/outlining available service providers/options and providing a brief description of that service category in written format;
 - b. Assisting the family and client in weighing various factors in the selection of provider; and
 - c. Maintaining current and accurate knowledge of various community resources.
3. When services are available to the client at no cost from family, friends, volunteers or others, these services shall be utilized before the purchase of services, providing these services adequately meet the needs of the client and do not constitute an undue hardship on the family through the exhaustion of financial or emotional resources.
4. When public dollars must be used to purchase services, the discharge planner or case manager shall

encourage the client to make the most efficient use of the services available by selection of the lowest cost provider of service where quality of service is comparable.

H. COST CONTAINMENT

The hospital discharge planner shall determine whether the person can be served at or under the cost ceiling for hospital based service for an individual recipient by using a departmentally prescribed form to:

1. Determine the maximum authorized costs for all HCBS-BI services for the period of time covered by the case plan, and compute the average cost per day by dividing the number of days in the case plan period; and
2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount.

I. SUBMISSION OF PRIOR AUTHORIZATION REQUESTS

This section describes responsibilities for submission of prior authorization within the functions of case management; for further information regarding the processing of prior authorization requests, please refer to Section 8.515.18.

1. Discharge planners and case managers shall submit Prior Authorization Requests for transitional living, nonmedical transportation, environmental modifications, and assistive equipment only.
2. Every PAR shall include the Care Plan and the Prior Approval Request. For prior authorization of transitional living services, a tentative treatment plan and evaluation from the probable provider shall be submitted with the PAR. All units of service requested on the Prior Approval Request must be listed on the Care Plan. If a range of units is estimated on the care plan, the number of units at the higher end of the range may be requested on the Prior Approval Request.
3. If a PAR includes a request for environmental modification services, the PAR shall also include all documentation listed at Section 8.516.00, ENVIRONMENTAL MODIFICATION.
4. The start date of the prior authorization request form shall never precede the start date of eligibility for HCBS-BI services according to Section 8.515.16.
5. The PAR shall not cover a period of time longer than the length of stay assigned by the Utilization Review Contractor.
6. If a PAR is returned for corrections, the corrected PAR must be returned to the Department or its agent within two days after the discharge planner received the notification letter of correction.

J. COORDINATION, MONITORING, AND EVALUATION OF SERVICES

1. The case manager shall monitor the services that are being provided, the appropriateness and effectiveness of services provided, the amount of care, the timeliness of service delivery, the client's satisfaction, the safety of the client, and shall take corrective actions as needed. Monitoring contacts must occur and be documented at least once every month, or more frequently as determined by the client's needs and single entry point agency policy.
2. The case manager shall contact each client on a face-to-face basis at least once every three months, or more frequently as determined by the client's needs and single entry point agency policy.

during the initial year of program participation.

3. On-going case management shall include, but not be limited to, the following tasks:

- a. Review of the client's case plan and service agreements.
- b. Contact with the client concerning whether services are being delivered according to the plan; and the client's satisfaction with services provided.
- c. Contact with service providers to verify that services are being delivered according to the plan; and concerning service coordination, effectiveness and appropriateness, as well as to inquire into and/or remedy any complaints raised by the client, family members, caregivers or others who are involved in the immediate support of the recipient.
- d. Contact with caregivers, family members, or significant others in the recipient's immediate support system in the event any issues or complaints have been presented through the process of monitoring and sampling the recipients satisfaction with care provided through the HCBS-BI program
- e. Conflict resolution and or crisis intervention, as needed.
- f. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost effectiveness.
- g. Notification of appropriate enforcement agencies, as needed.
- h. Referral to community resources, and arrangement for non-HCBS-BI services as needed.

4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. REVISIONS ADDED TO THE CASE PLAN

- a. Whenever a change in the care plan results in an increase or change in the services to be provided, the case manager shall provide a revised care plan listing the services being revised and the reason for revision. A Revised cost containment sheet must be submitted reflecting resultant changes/Calculations
- b. If additional services include any one of the previously listed services requiring prior authorization, the case manager must submit a prior authorization request according to Section 8.515.30.

K. REASSESSMENT

1. The case manager shall complete a reassessment of each HCBS-BI client before the end of the length of stay assigned by the Utilization Review Contractor at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect HCBS-BI eligibility. In addition, a reassessment shall be completed every six months for the first year, and annually thereafter.

2. The case manager shall complete the reassessment, utilizing the ULTC 100.2 Assessment form.
3. Reassessment shall include, but not be limited to, the following activities:
 - a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long term care benefits.
 - b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;
 - c. Evaluate continuing need for the HCBS-BI program, and clearly document reasons for continuing HCBS-BI, transfer to the HCBS-EBD, HCA or other program, or terminate the client's eligibility according to Section 8.515.30, M.
 - d. Reassess the client's functional status, according to the procedures in Section 8.515.30, C, ASSESSMENT.
 - e. Review the care plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.515.30, E, CARE PLANNING.
 - f. Refer the client to community resources as needed; and
 - g. Submit the complete and correct ULTC 100.2 Assessment to the Utilization Review Contractor for a continued stay review, in accordance with the guidelines at ASSESSMENT.

L. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

Single entry point agencies shall comply with the procedures as detailed in 8.39332, A, et. seq., INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES for transferring clients to another county or single entry point district

M. DISCONTINUATION OF SERVICES

1. Clients shall be discontinued from the HCBS-BI program whenever they no longer meet one or more of the eligibility requirements in section 8.515.15 ELIGIBLE PERSONS. Clients shall also be discontinued from the program if they die, move out of state or voluntarily withdraw from the program; or if the client's physician fails to sign a required assessment form
2. Clients who are discontinued from HCBS-BI because they no longer immediately of the termination and their appeal rights as follows:
 - a. Financial Eligibility Procedures at Section 8.393.28 HCBS-EBD DENIALS shall be followed for discontinuation for this reason.
 - b. Level of Care and Target Group Procedures at Section 8.393.28, HCBS-EBD DENIALS shall be followed for discontinuation for this reason.
 - c. Receiving HCBS-BI Services Procedures at Section 8.393.28 HCBS-EBD DENIALS shall be followed for discontinuation for this reason.
 - d. Institutional Status Procedures at Section 8.393.28 HCBS-EBD DENIALS shall

Procedures at Section 8.393.28 HCBS-EBD DENIALS shall the Department shall assume responsibility for than the single entry point agency case manager.

N. COMMUNICATION

Communication requirements of case management functions within single entry point agencies will comply with all provisions of 8.393.28.

O. CASE RECORDING DOCUMENTATION

Documentation standards and requirements for the HCBS-BI program must comply with Section 8.393.26, et seq., of this Staff Manual.

8.515.40 HCBS-BI PROVIDER AGENCIES

A. GENERAL CERTIFICATION STANDARDS

1. Provider agencies shall conform to all State established standards for the specific services they provide under this program, shall abide by all the terms of the provider agreement with the State, and shall comply with all federal and state statutory requirements. A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.
2. Provider agencies shall have written policies and procedures for recruiting, selecting, retaining, training, and terminating employees.
3. Provider agencies shall have written policies governing access to duplication and dissemination of information from the recipient's records in accordance with state statutes on CONFIDENTIALITY OF INFORMATION at 26-1-114, C.R.S. as amended Provider agencies shall have written policies and procedures for providing employees with client information needed to provide the services assigned, within the agency policies for protection of confidentiality.
4. Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department, and shall have written policies and procedures regarding emergency procedures.
5. Provider agencies shall provide written human rights and post same in a readily visible area.
6. Provider agencies shall have written individualized treatment plans for each client with goals and objectives based on the clients needs. Progress toward goals shall be monitored and reported in objective measurable terms on a weekly basis. If a client is receiving services in a transitional living center, formal progress reports should be submitted on a monthly basis to the Brain Injury Program Coordinator. For other service providers, formal progress reports shall be submitted to the referring case manager on a bimonthly basis. Treatment goals will be mutually developed by the interdisciplinary team or professional the client, and the family, when appropriate.
7. Specific treatment modalities outlined in the treatment plans shall be systematically implemented with techniques that are consistent functionally based and active throughout the treatment period. Methods shall be appropriate to the goals, and treatment plans shall be reviewed and modified as appropriate. Goals of treatment shall reference outcomes in the degree of personal and living independence, work productivity, and psychological, social, and physical adjustment
8. Initial assessment and progress shall be communicated to the client, the family and the referral source

regularly in a manner which can be easily understood. The client and his/her family shall be offered a copy of the treatment plan and the client's signature shall be obtained on the care plan.

9. Provider agencies shall have written policies and procedures regarding the handling and reporting of critical incidents, including accidents, suspicion of abuse, neglect or exploitation, and criminal activity.
10. Provider agencies shall maintain a log of all complaints and critical incidents, which shall include documentation of the resolution of the problem.
11. Provider agencies shall maintain records on each client. The specific record for each client must include at least the following information:
 - a. Name, address, phone number and other identifying information about the client
 - b. Name, address and phone number of the discharge planner, case manager and case management agency.
 - c. Name, address and phone number of the clients primary care physician.
 - d. Special health needs or conditions of the recipient
 - e. Documentation of any changes in the client's condition or needs, as well as documentation of appropriate reporting and action taken as a result
 - f. Documentation of the services provided, including where, when, to whom and by whom the service was provided, and the exact nature of the specific tasks performed as well as the amount or units of service.
 - g. Documentation of supervision of care.
 - h. All information regarding a client must be kept together for easy access and review by supervisors, program monitors and auditors.
12. Provider agencies shall maintain a personnel record for each employee. The employee record must contain a copy of the employee's job description, documentation of employee training, education or work experience which qualifies them to provide the requisite service to people with brain injury, and documentation of supervision and performance evaluation.
13. A provider agency may become separately certified to provide more than one type of HCBS-BI service if all requirements are met for each certification. Administration of the different services provided shall be clearly separate for auditing purposes. The provider agency must also understand and be able to articulate its different functions and roles as a provider of each service, as well as all the rules that separately govern each of the types of services, in order to avoid confusion on the part of the clients and others.
14. Provider agencies shall send billing and other staff to the provider automated medical payment training offered by the fiscal agent. at least once each year.
15. An agency as defined in 8.515.14 A, GENERAL DEFINITIONS seeking certification as an HCBS-BI provider, shall submit a written request to the Department of Health Care Policy and Financing.
16. Upon receipt of the written request the Department or its agent shall forward certification

information and relevant departmental application forms to the requesting agency.

17. Upon receipt of the completed application from the requesting agency, the Department of Health Care Policy and Financing shall review the information and complete an on-site review of the agency based on the departmental regulations for the service for which certification has been requested.
18. Following completion of the on-site review the Department or its agent shall notify the provider agency applicant of its recommendation by forwarding the following information:
 - a. Results of the on site survey.
 - b. Recommendation of approval, denial, or provisional approval of certification.
 - c. If appropriate, a corrective action plan to satisfy the requirements of a provisional approval.
19. Determination of certification approval, provisional approval or denial shall be made by the department within thirty days of receipt of the completed application from the agency.

B. APPROVAL OF CERTIFICATION

If certification is approved, the agency shall initiate an agreement with the state's fiscal agent to implement the automated medical payment system (AMPS) and execute a provider agreement with the Department of Health Care Policy and Financing.

C. PROVISIONAL APPROVAL OF CERTIFICATION

If agencies do not meet all Department established certification standards, but the deficiencies do not constitute a threat to client's health and safety, such agencies may be provisionally certified for a period not to exceed sixty days at the discretion of the Department

If provisional approval has been granted, the Department or its agent shall assure that corrective action has been taken according to the approved plan, and shall conduct an on-site review, if necessary, within the designated time period.

D. DENIAL OF CERTIFICATION

If the agency is unable to complete an adequate corrective action plan within the prescribed time, certification shall be denied.

E. RECERTIFICATION PROCESS

Initial certification shall be for a period of one year. No later than thirty day prior to the end of the current certification, the department shall notify the provider agency of the certification decision, which may be certification, provisional certification, or denial of certification.

The Department or its agent shall follow the same procedures as; those followed for certification, as described at 8.487.20 GENERAL CERTIFICATION.

F. TERMINATION OR NON-RENEWAL OF PROVIDER AGREEMENTS

The Department shall initiate termination or non-renewal of a provider agreement if an agency is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The Department shall

follow procedures at 8.130, PROVIDER AGREEMENTS.

G. EMERGENCY TERMINATION OF PROVIDER AGREEMENTS

Emergency termination of any provider agreement shall be in accordance with procedures at 8.050 PROVIDER APPEALS AND HEARINGS.

H. TRANSFER OF OWNERSHIP

1. The provider shall notify the department or its agent within five working days of any change of ownership.
2. Upon transfer of ownership of the provider agency or facility, the new provider must initiate a new agreement with the Department

I. PROVIDER RIGHTS

The Department shall notify provider agencies in writing of any adverse action taken by the State against the agency, and shall inform the agency of its appeal rights in accordance with the procedures described in Section 8.050, PROVIDER APPEALS AND HEARINGS.

J. PROVIDER REIMBURSEMENT

1. Payment to certified HCBS-BI providers for services provided to eligible clients shall be made when claims are submitted in accordance with the following procedures.
 - a. Claims shall be submitted to the fiscal agent on Department system if available.
 - b. Claims shall be sustained in complete and correct format
 - c. Payment shall not exceed departmental limits as described under the reimbursement sections for each HCBS-BI service.
 - d. Payment shall be made only for the service or services for which the agency is certified;
 - e. Payment shall be made only for the Types and amounts of services that are authorized.
 - f. Payment shall be made only for services provided by persons employed by the agency at the time the services were provided.
 - g. For services of transitional living, behavioral programming, authorization process has been followed.
2. Provider agencies shall maintain adequate financial records for all 8.040.02. RULES GOVERNING SUBMISSION OF CLAIMS, Section 8.130. PROVIDER AGREEMENTS, and Section 8.487.10 GENERAL CERTIFICATION STANDARDS.

8.515.50 ASSISTIVE AND SPECIAL MEDICAL EQUIPMENT

A. DEFINITIONS

Specialized medical equipment and supplies includes devices, controls, or appliances specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Assistive Devices include equipment which meets one of the following criteria:

1. Is useful in augmenting an individual's ability to function at a higher level of independence and lessen the number of direct human service hours required to maintain independence;
2. Is necessary to ensure the health, welfare and safety of the individual;
3. Enables the individual to secure help in the event of an emergency;
4. Is used to provide reminders to the individual of medical appointments, treatments, or medication schedules; or
5. Is required because of the individual's illness impairment or disability, as documented on the screening assessment form and the plan of care.

B. INCLUSIONS

1. Items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.
2. Items which are not of direct medical or remedial benefit to the recipient are excluded.
3. Assistive devices to augment cognitive processes, "cognitive-orthotics" or memory prostheses are included in this service area. Examples of cognitive orthotic devices include informational data bases, spell checkers, text outlining programs, timing devices, security systems, car finders, sounding devices, cuing watches, telememo watches, paging systems, electronic monitoring, tape recorders, electronic checkbooks, electronic medication monitors, and memory telephone.

C. CERTIFICATION REQUIREMENTS

Certification standards refer to both the supplier of equipment as well as the actual product or equipment itself.

1. All items shall meet applicable standards of manufacture, design and installation.
2. All equipment materials or appliances used as part of monitoring systems shall carry a UL (Underwriter's Laboratory) number or an equivalent standard.
3. All telecommunications equipment shall be FCC registered
4. All equipment materials, or appliances shall be installed by properly trained individuals, and the installer shall train the client in the use of the device.
5. All equipment, materials or appliances shall be tested for proper functioning at the time of installation and at periodic intervals thereafter by a properly trained individual.
6. Any malfunction shall be promptly repaired by a properly trained technician supplied at the provider agency's expense. Equipment shall be replaced when necessary, including buttons and batteries.
7. Assistive equipment providers shall send written information to each client's case manager about the item, how it works, and how it should be used.

D. REIMBURSEMENT METHOD FOR ASSISTIVE DEVICES

Reimbursement for assistive devices will be on a per unit basis. If assistive devices are to be used primarily in a vocational application, devices should be funded through the Division of Vocational Rehabilitation with secondary funding from Medicaid.

8.515.60 PERSONAL CARE SERVICES

A. DEFINITION

Personal care services means services which are furnished to an eligible client in the client's home to meet the client's physical maintenance and support needs, when those services are not skilled personal care as described in the exclusions section below, do not require the supervision of a nurse, and do not require physician's orders. Assistance may include eating, bathing, dressing, personal hygiene, and activities of daily living.

1. Personal care provider means a provider agency as defined at Section 8.485.50(Q), GENERAL DEFINITIONS, which has met all the certification standards for personal care provider listed below.
2. Personal care staff means those employees of the personal care provider agency who perform the personal care tasks.
3. Skilled personal care means skilled care which may only be provided by a certified home health aide, as further defined at Section 8.520, HOME HEALTH SERVICES.
4. Unskilled personal care means personal care which is not skilled personal care, as defined above.

B. INCLUSIONS

All inclusions listed in Section 8.489 apply.

C. EXCLUSIONS AND RESTRICTIONS

All exclusions and restrictions listed in Section 8.489 apply.

D. CERTIFICATION STANDARDS

All certification standards for personal care services listed in Section 8.489 apply to the HCBS-BI waiver program providers.

E. REIMBURSEMENT

1. Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Total daily charges for personal care can not exceed the sum of ten hours of care. Reimbursement shall be per unit of one hour.
2. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as personal care services. The time billed for travel shall be listed separately from, but documented on the same form as, the time for service provision on each visit. Travel time must be summed for the week and then rounded to the nearest hour for billing purposes. If the travel time to and from a client's residence is 15 minutes one way-30 minutes round trip, then the travel time for one week shall be 210 minutes (rounded up to 4 hours) for the week.
3. When personal care services are used to provide respite for unpaid primary care givers, the exact

services rendered must be specified in the documentation.

4. When an employee of a personal care agency provides services to a client who is a relative, the personal care agency shall bill under a special procedure code, in hourly units, using rates and hours which shall not exceed a maximum of 222 units per 6 month certification, when averaged out over the number of days in the 6 month plan period or 444 units per 12 month certification.
5. If a visit by a Home Health Aide employed by a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.

8.515.70 ADULT DAY SERVICES

A. DEFINITIONS

1. Adult Day Services means both health and social services furnished on a regularly scheduled basis in an adult day services center two or more hours per day, one or more days per week to ensure the optimal functioning of the client. Services are directed towards recreation and socialization as well as maintaining a safe and supportive environment.
2. Adult Day Services Center means a non-institutional entity that conforms to requirements for maintenance
3. Maintenance Model means services in health monitoring and individual and group therapeutic and psychological activities which serve as an alternative to long-term nursing home care.
4. Adult day services include:
 - a. Daily monitoring to assure that clients are maintaining personal hygiene and participating in age appropriate social activities as prescribed; and assisting with activities prescribed; and assisting with activities of daily living (e.g., eating, dressing).
 - b. Emergency services including written procedures to meet medical crises.
 - c. Assistance in the development of self-care capabilities personal hygiene, and social support services.
 - d. Provision of nutritional needs appropriate to the hours in which the client is served.
 - e. Nursing services as necessary to supervise medication regimen of trained medication aides and carry out any of the services listed as SKILLED CARE in SECTION 8.489.30.
 - f. Social and recreational services as prescribed to meet the client's needs.
 - g. Any additional services if such services are included in the budget submitted to the Department in accordance with the section on REIMBURSEMENT METHOD FOR ADULT DAY CARE below, and determined by the Department to be necessary for adult day care.

B. CERTIFICATION STANDARDS

All adult day service centers shall conform to all of the following Departmental standards

1. All providers must conform to all established departmental standards in the general certification standards section.

2. All providers of adult service care shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.
3. The agency shall provide a clean environment, free of obstacle; that could pose a hazard to client health and safety.
4. Agencies shall provide lockers or a safe place for clients' personal items.
5. Adult day service centers shall provide recreational areas and activities appropriate to the number and needs of the recipients.
6. Drinking facilities shall be located within easy access to residents.
7. Adult day service centers shall provide eating and resting areas consistent with the number and needs of the clients being served.
8. Adult day service centers shall provide easily accessible toilet facilities, hand washing facilities and paper towel dispensers.
9. The center shall be accessible to clients with supportive devices for ambulation or who are in wheelchairs.

C. RECORDS AND INFORMATION

Adult day service providers shall keep such records and information necessary to document the services provided to clients receiving adult day services. Medical Information Records shall include but not be limited to:

1. Medications the client is taking and whether they are being self-administered.
2. Special dietary needs, if any.
3. Restrictions on activities identified by physician in the case plan.

D. STAFFING

All adult day service centers shall have staff who have been trained in current cardiopulmonary resuscitation, seizure prophylaxis and control and brain injury. Adequate staff shall be on the premises at all times to ensure:

1. Supervision of clients at all times during the operating hours of the program.
2. Immediate response to emergency situations to assure the welfare of clients.
3. Provision of prescribed recreational and social activities.
4. Provision of administrative, recreational, social and supportive functions of the adult day services center.

E. POLICIES

The center shall have a written policy relevant to the operation of the adult day services center. Such policy shall include but not be limited to statements describing:

1. Admission criteria that qualify clients to be appropriately served in the center.
2. Interview procedures conducted for qualified clients and/or family members prior to admission to the center.
3. The meals and nourishments that will be provided, including special diets.
4. The hours that the clients will be served in the center and days of the week services will be available.
5. The personal items participants may bring with them to the center.
6. A written signed contract to be drawn up between the client or responsible party and the center outlining rules and responsibilities of the center and of the client. Each party of the contract will have a copy.
7. A statement of the center's policy for providing drop in care or day respite.

F. REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

1. Reimbursement for adult day services shall be based upon a single all-inclusive payment rate per unit of service for each participating provider.
2. Each provider will be paid on a per diem statewide uniform rate. The rate of payment shall be subject to available appropriations and may be the lower of the billed amount or the Medicaid allowable rate which is determined by multiplying the number of units times a rate established by the Department.

8.515.80 DAY TREATMENT

A. DEFINITION

Day Treatment means intensive therapeutic services scheduled on a regular basis for two or more hours per day, one or more days per week directed at the ongoing development of community living skills. Services take place in a non-residential setting separate from the home in which the recipient lives.

B. PROGRAM COMPONENTS, POLICIES AND PROCEDURES

1. Treatment plans are coordinated by a comprehensive interdisciplinary team which includes the recipient and his/her family and provides for consolidation of services in one location.
2. Professional services including occupational therapy, physical therapy, speech therapy, vocational counseling, nursing, social work, recreational therapy, case management, and neuropsychology should be directly available from the provider or available as contracted services when deemed medically necessary by the treatment plan.
3. Certified occupational therapy aides, physical therapy aides, and communication aides may be used in lieu of direct therapy with fully licensed therapists to the extent allowed in existing state statute.
4. The provider shall network with all allied medical professionals and other community based resource providers.
5. Services include social skills training, sensory motor development, reduction/elimination of maladaptive behavior and services aimed at preparing the individual for community.

reintegration (reaching concepts such as compliance, attending, task completion, problem solving, safety, money management).

6. Crisis situations with family, client or staff shall be addressed through counseling and referral to appropriate professionals.
7. Behavioral programs shall contain specific guidelines on treatment parameters and methods.
8. There shall be regular contact and meetings with the clients and their families to discuss treatment plan progress and revision.
9. Discharge planning will include the development of a plan which considers safety, environmental modification to support individual function, education of the family and caregiver, recommendations for the future, and referral to additional community resources.
10. Each entity must have a process, verified in writing, by which a client is made aware of the process for filing a grievance.
11. Complaints by the client or family are handled within a 24 hour period from the time of complaint by at least telephone contact.
12. Transportation between therapeutic tasks in the community shall be included in the per diem cost of day treatment.
13. There shall be an inform and consent mechanism by which the client, family medical proxy or substitute decision maker is made aware of the inherent risks associated with community based rehabilitation programs. Examples of such risks might include a greater likelihood of falling accidents, traffic hazards and access to drugs or alcohol.

C. HUMAN RIGHTS

Every person receiving HCBS-BI services has the following rights:

1. Every person shall mutually develop and sign their treatment plan.
2. Every person has the right to enjoy freedom of thought, conscience, and religion.
3. Every person has the right to live in a clean, safe environment.
4. Every person has the right to have his or her opinions heard and be included, to the greatest extent possible when any decisions are being made affecting his her life.
5. Every person has the right to be free from physical abuse and inhumane treatment.
6. Every person has the right to be protected from all forms of sexual exploitation.
7. Every person has the right to access necessary medical care which is adequate and appropriate to their condition.
8. Every person has the right to communicate with significant others.
9. Every person has the right to reasonable enjoyment of privacy in personal conversations.
10. Every person has the right to have access to telephones, both to make and receive calls in

privacy.

11. Every person has the right to have frequent and convenient opportunities to meet with visitors.
12. Every person has the right to the same consideration and treatment as anyone else regardless of face, color, national origin, religion, age, sex, political affiliation, sexual orientation, financial status, or disability.
13. Every person who acts as his own legal guardian has the right to accept treatment of his/her own free will.
14. Nothing in this plan shall be construed to prohibit necessary assistance as appropriate, to those individuals who may require such assistance to exercise their rights.
15. Every person has the right to be free of physical restraint unless physical intervention is necessary to prevent such body movement that is likely to result in imminent injury to self or others, and only if alternative techniques have failed. Mechanical restraints are not allowed.

D. DOCUMENTATION

1. Intake information shall include a complete neuropsychological assessment and all pertinent medical documentation from inpatient and outpatient therapy and social history to identify key treatment components and communicate the functional implications of treatment goals.
2. Initial treatment plan development and evaluations will occur within a two week period following admission.
3. Treatment plan goals and objectives shall reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.
4. Specific treatment modalities outlined in the treatment plan shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and treatment plans will be reviewed and modified as appropriate.
5. Progress notes will be kept to support specific treatment modalities rendered by date and signed by the therapist providing the service.

E. CERTIFICATION STANDARDS

1. Directors of day treatment programs shall have professional licensure in a health related program in combination with at least 2 years of experience in head trauma rehabilitation programming.
2. All providers shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.
3. The agency shall provide a clean environment, free of obstacles that could pose a hazard to client health and safety.
4. Agencies shall provide lockers or a safe place for clients' personal items.
5. Day treatment centers shall provide age appropriate activities and provide eating and resting areas

consistent with the number and needs of the clients being served.

6. The center shall be accessible according to guidelines established by the Americans with Disabilities Act.
7. Personnel shall have training appropriate to the medical needs of the clients served including seizure management training, CPR certification, non-violent crisis intervention, and personal care standards according to SECTION-PERSONAL CARE 8.489.40.

F. REIMBURSEMENT

Day treatment services will be paid on a per diem basis at a rate to be determined by the Department. In order for a provider to be paid for a day of treatment, a client must have attended and received therapeutic intervention which is substantiated by case file notes signed by the rendering therapist.

8.515.90 RESPITE CARE

A. DEFINITIONS

Respite Care means an organized program whose purpose is to sustain the family or other primary caregiver of persons with brain injury by providing those individuals with time-limited and temporary relief from the ongoing responsibility of care. Services may be provided on a scheduled basis or in response to a crisis or emergency.

Respite care providers are trained personnel in a variety of settings including skilled nursing facilities, hospitals, drop in resource centers, and certified respite providers or any other facility which meets the certification standards for respite care specified below.

B. INCLUSION

Families will be eligible for unlimited days of respite care per year.

C. EXCLUSION

If the waiver participant is in a transitional living residence or out-of-home placement, no respite care services will be provided while the waiver recipient is in the transitional living program.

D. POLICIES

1. The information provided at referral and the medical, social, psychological and other information available should vary according to the circumstances for which respite is being sought, including the extent of the crisis or emergency present in the referral and the duration and scope of the Respite Program.
2. The design and schedule of the respite services is variable and should be based upon the needs and convenience of both the person with brain injury and his/her family or primary caregiver, whenever possible.
3. The program should minimize the disruption in the continuity of living patterns which may be created by the respite services.

E. CERTIFICATION STANDARDS

1. The nursing facility must have a valid contract with the Department as a Medicaid certified nursing facility. Such contract shall constitute an automatic certification for HCBS-BI respite care. A

respite care provider billing number shall be issued to all certified nursing faculties. OR Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services must meet the same competency standards as all other providers and be employed by the certified provider agency.

2. The respite program shall have or be part of a risk protection program that includes appropriate insurance, screening of personnel, ongoing training of personnel to enhance skills, and supervision.
3. If 24-hour respite services are provided by the organization at its own location, the living quarters should be homelike, age appropriate, and culturally sensitive and in compliance with all Assisted Living Residence regulations.

F. REIMBURSEMENT

1. Respite care reimbursement to nursing facilities shall be according to procedures identified in 8.492.50.
2. Nursing facilities shall agree to accept Medicaid reimbursement as full and final payment for respite services and are not allowed to solicit personal needs allowance monies from the client or his/her family.
3. Individual respite, providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

8.516.00 ENVIRONMENTAL MODIFICATION

A. DEFINITIONS

1. Environmental modification means specific adaptations or installations in an eligible client's home setting which:
 - a. Are necessary to ensure the health, welfare, and safety of the individual;
 - b. Enable the individual to function with greater independence in the home;
 - c. Are required because of the individual's illness, impairment or disability, as documented on the screening assessment and care plan form; and
 - d. Prevent institutionalization of the individual.
2. Environmental modification provider means a provider agency as defined at Section 8.515.14 0 GENERAL DEFINITIONS which has met all the certification standards for environmental modification services listed in Section 8.493.40 et seq. CERTIFICATION SERVICES FOR HOME MODIFICATIONS SERVICES.

B. INCLUSIONS

Such adaptations may include:

the installation of ramps

installation of grab-bars

widening of doorways

modification of bathroom facilities

installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient.

C. EXCLUSIONS AND RESTRICTIONS

1. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the HCBS-BI program client, such as carpeting, roof repair, central air conditioning, furnace replacement, etc. shall not be approved.
2. If the home modification is estimated to cost \$500 or more, the following procedures shall be followed:
 - a. An occupational therapist shall assess the client's needs and the effectiveness of the requested home modification and submit a written recommendation. In geographical areas where an occupational therapist is not available, the services of a physical therapist may be substituted. A report specifying how the home modifications would contribute to the person's ability to remain in or to return to his/her home, and how the modification would increase the individual's independence and decrease the need for other services such as personal care, must be completed by the therapist on a Department prescribed form and submitted with a PAR to the Brain injury Program Coordinator.
 - b. In conjunction with the occupational therapist, the case manager shall first consider less costly alternative methods of addressing the client's needs and shall send documentation of the activity with the Prior Authorization Review.
 - c. The case manager shall first consider alternative funding sources such as, but not limited to, Worker's Compensation Insurance, private automobile insurance, Medicare, vocational rehabilitation funds and funds raised or provided by volunteer organizations; and shall send documentation of this activity with the PAR.
 - d. The case manager shall follow a bid process as specified in 8.493.30, D.
 - e. The Department or its agent may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the request for environmental modification.
 - f. The Department reserves the right to deny requests for environmental modification that are not reasonable in cost, when compared to usual and customary charges.
 - g. There shall be a lifetime cap of \$10,000 per household on any HCBS Medicaid funds approved for environmental modification services.

D. CERTIFICATION STANDARDS FOR ENVIRONMENTAL MODIFICATIONS

1. Environmental Modification providers shall conform to all general certification standards and procedures at 8.487. HCBS-EBD Provider agencies.
2. Environmental modification providers shall be licensed in the city or county in which they propose to provide environmental modification services.
3. All environmental modifications shall be provided in accordance with the Uniform Building Code as adopted by the State of Colorado and all local building codes.
4. All environmental modifications shall be inspected and approved by a qualified individual such as:

A local county building inspector or

A licensed engineer, architect, contractor or any other person as agreed upon by the State.

In addition, copies of building permits and inspection reports shall be submitted to the case management agency, and all problems noted on inspections shall be corrected before the provider submits a claim for the environmental modification.

E. REIMBURSEMENT METHOD FOR ENVIRONMENTAL MODIFICATION SERVICES

Payment of environmental modification services shall be the lower of the billed charges or the prior authorized amount. The unit of reimbursement shall be one unit per service rendered. The date of service is considered to be the day of completion of the modification.

8.516.10 INDEPENDENT LIVING SKILLS TRAINING

A. DEFINITIONS

1. Independent Living Skills Training and Development means services designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community.
2. Skills training may be provided in the client's residence, in the community or in a group living situation.

B. INCLUSIONS

1. Services may include assessment, training, and supervision or assistance to an individual with self care, medication supervision, task completion, communication skill building, interpersonal skill development, socialization, therapeutic recreation, sensory motor skills, mobility or community transportation training, reduction or elimination of maladaptive behaviors, problem solving skill development, benefits coordination, resource coordination, financial management, and household management.
2. All independent living skills training and development shall be documented in the plan of care.
3. Independent Living Skills trainers must be supervised on a monthly basis by a fully licensed or certified occupational therapist, registered nurse, physical therapist, or speech therapist who has experience in the field of brain injury rehabilitation.

C. PROVIDER CERTIFICATION STANDARDS

1. Providers shall be a health care professional with one year of experience in providing functionally based assessment and skills training of individuals with disabilities, or an individual with a bachelors degree and two years of similar experiences, or an individual with an AA degree in a social service or human relations area with 3 years of experience.
2. All skills trainers must receive monthly supervision from a licensed or certified health care provider as listed above. Supervision of independent living skills trainers shall not be billable as an additional expense to Medicaid but shall be absorbed by the provider as an overhead expense of business.
3. Providers shall develop and administer a training program to all skills trainers which focuses on the specific needs of individuals with brain injury and demonstrates the completion of a 24 hour training program prior to the delivering of services.

D. REIMBURSEMENT

1. All independent living skills training must be documented in the plan of care. Monthly treatment plans shall include the goals of the treatment plan, goals met or accomplished, and progress made toward accomplishment of ongoing goals. All plans are subject to review of the Brain Injury Program Coordinator.
2. Reimbursement shall be on an hourly basis. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as independent living services. The time billed for travel shall be listed separately from the time for service provision on each visit but must be documented on the same form. Travel time must be summed for the week and then rounded to the nearest hour for billing purposes. If the travel time to and from a client's residence is 15 minutes one-way, 30 minutes round trip, then the travel time for one week shall be 210 minute (rounded up to 4 hours) for the week. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period.

8.516.20 NON-MEDICAL TRANSPORTATION

A. DEFINITIONS

1. Non-medical transportation services means services as defined in 8.494.10.
2. Non-medical transportation provider means providers as defined in 8.494.10.

B. INCLUSIONS

Non-medical transportation services shall include, but not be limited to, transportation between the client's home and non-medical services or resources such as adult day care, shopping, therapeutic swimming, dentist appointments, counseling sessions, and other services as required by the care plan to prevent institutionalization.

C. EXCLUSIONS

1. Non medical transportation services shall not be used to substitute for medical transportation which is subject to reimbursement under Section 8.680 through 8.691. OTHER HEALTH SERVICES-TRANSPORTATION.
2. Non medical transportation services shall only be used after the case manager has determined that free transportation is not available to the client.

D. CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES

Transportation providers shall conform to all standards listed in 8.494.40 CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES.

8.516.30 TRANSITIONAL LIVING

A. DEFINITIONS

1. Transitional living means programs, which occur outside of the client's residence, designed to improve the client's ability to live in the community by provision of 24 hour services, support and supervision.
2. Program services include but are not limited to assessment, training, and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household. Programs are normally limited in

duration to six months.

B. INCLUSIONS

1. All services must be documented in an approved plan of care and be prior authorized by the State Brain Injury Program Coordinator or designated agent.
2. Clients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs.
3. Clients must require available paraprofessional nursing assistance on a 24 hour basis due to dependence in activities of daily living, locomotion, or cognition.
4. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a client requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for high intensity therapy for a client must be documented and authorized individually through the Brain Injury Program Coordinator. "Extraordinary therapy needs" for purposes of this program, are defined by a client who needs more than three hours per week of any one therapeutic discipline: ie. physical therapy, occupational therapy, or speech therapy.

C. EXCLUSIONS

1. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges.
2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.
3. Room and board charges are not a billable component of transitional living services.
4. Items of personal need or comfort shall be paid out of money set aside from client's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program.
5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the State. Brain Injury Program Coordinator.

D. CERTIFICATION STANDARDS

Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-1-107, et, seq.,

1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs.
2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in SECTIONS following titled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS.
3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards.
4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site

reviews of all programs shall occur on at least a yearly basis.

5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.
2. The person must be medically stable as defined by having the need for less than one hour per eight hour shift of skilled nursing intervention and being able to actively participate in intensive therapy during the day.
3. Clients, families, medical proxies, or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.
4. Understanding that clients of transitional living programs frequently experience behavior which may be a danger to themselves or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.
5. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services; however, programs shall retain clinical discretion in refusing to serve clients for whom they lack adequate resources to ensure safety of program participants and staff.
6. Upon entry into the program, discharge planning shall begin with the client and family. Transitional living programs shall work with the client and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services.
7. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.
8. During daytime hours, the ratio of staff to clients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.
9. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Brain Injury Program Coordinator.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service related profession plus three years experience providing direct services to individuals with brain injury. A bachelor's degree with five years experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.
2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the client. These staff members will have successfully completed a training program of at least

40 hours duration.

3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.
4. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid, universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.
5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.
6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from inpatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.
2. Initial treatment plan development and evaluations will occur within a two week period following admission.
3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.
4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent, functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.
5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.
6. All transitional services must utilize licensed psychologists with two years experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.
7. Programs shall have a process verified in writing by which a client is made aware of the process for filing a grievance. Complaints by the client or family shall be handled via telephone or direct contact with the client or family.
8. Customer satisfaction surveys will be regularly performed and reviewed.
9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.
10. Client safety in the community will be assessed: safety status and recommendations will be documented.
11. Progress towards the accomplishment of goals is monitored and reported in objective measurable

terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.
2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the per diem reimbursement negotiated with the Department of Health Care Policy and Financing and will not bill the client in excess of his/her SSI payment or \$400 per month, whichever is less for room and board charges.

All transitional living services shall be prior authorized through submission to the Brain Injury Program Coordinator. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond six months duration, must be reauthorized with attached treatment plan justification and shall be submitted, if appropriate, through the reconsideration process established with the Departmental fiscal agent.

8.516.40 BEHAVIORAL PROGRAMMING

A. DEFINITION

Behavioral programming and education is an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the individuals ability to remain integrated in the community.

B. INCLUSIONS

1. Programs should consist of a comprehensive assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be necessary to ensure comprehensive application of the program in all facets of the person's environment.
2. Behavioral programs may be provided in the community or in the client's residence unless the residence is a transitional living center which provides behavioral intervention as a treatment component
3. All behavioral programming must be documented in the plan of care and reauthorized after 30 units of service with the Brain Injury Program Coordinator.

C. CERTIFICATION STANDARDS

1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a health care professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters level

Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of behavioral management concepts.

2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with brain injury if their work experience does not include at least one year of same.

D. REIMBURSEMENT

Behavioral programming must be documented on the client's care plan and prior authorized through the State Brain Injury Program Coordinator. Behavioral programming services will be paid on an hourly basis as established by the Department

8.516.50 COUNSELING

A. DEFINITIONS

Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries.

B. INCLUSIONS

1. Counseling is available to the program participant's family in conjunction with the client if they: a) have a significant role in supporting the client or b) live with or provide care to the client. "Family" includes a parent, spouse, child, relative, foster family, inlaws or other person who may have significant ongoing interaction with the waiver participant.
2. Services may be provided in the waiver participant's residence, in community settings, or in the provider's office.
3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.
4. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department of Health Care Policy and Financing as directed by certification standards listed below.
5. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as may be necessary to safely maintain the individual at home.
6. Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

1. Family training is not available to individuals who are employed to care for the recipient.
2. Family training/counseling must be carried out in the presence of and for the direct benefit of the client of the HCBS-BI program.

D. CERTIFICATION STANDARDS

1. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker, Certified Rehabilitation Counselor, Licensed Professional Counselor, or Licensed Clinical Psychologist.
2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years experience in providing counseling to individuals with brain injury and their families.
3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present) Individual Counseling, and Group Counseling.

8.516.60 SUBSTANCE ABUSE COUNSELING

A. DEFINITION

Substance abuse programs are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the waiver participant which, if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

B. INCLUSIONS

1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program
2. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver participant, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons directly involved in the support system of the client, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager
3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall be submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

Inpatient treatment is not a covered benefit.

D. CERTIFICATION STANDARDS

1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing.
2. Programs must demonstrate a fully developed plan entailing the method by which coordination will

occur with existing community agencies and support programs to provide ongoing support to individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury.

3. Counselors should be certified at the Certified Alcohol Counselor III level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any individual with a brain injury or their family members. A recommended training curriculum will include a three day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present), Individual Counseling, and Group Counseling.

8.520 HOME HEALTH SERVICES

8.521 LEGAL BASIS

The Medicaid Home Health Program in Colorado is authorized under 1905(a)(7) of the Social Security Act (P.L. 74-271); and by state law at 26-4-202(1) f, C.R.S. (1994 Supp.) and 26-4-302(l)m, C.R.S. (1994 Supp.).

8.522 COVERED SERVICES

Home Health services reimbursed by Medicaid shall be limited to skilled nursing services, home health aide services, occupational therapy services, physical therapy services, and speech/language pathology services, as defined at Section 8.525, SERVICES REQUIREMENTS.

8.523 ELIGIBILITY

.10 Home Health services are a benefit available to all Medicaid clients and to all Modified Medical Program clients when all program and services requirements are met. To be eligible for Long Term Home Health services, as set forth at Section 8.523.11.K, Medicaid clients 18 and over shall meet the Level of Care Screening Guidelines for Long Term Care Services at Section 8.401. Medicaid clients under the age of twenty-one may be eligible for special Home Health benefits according to rules at 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES.

.11 Home Health services are eligible for reimbursement under Medicaid only when the services meet all of the following requirements:

- A. Services are provided for the treatment of an illness, injury, or disability which may include mental disorders.
- B. Services are medically necessary.
- C. Services are reasonable in amount, duration, and frequency.
- D. Services are provided under a plan of care as defined at Section 8.524 DEFINITIONS.
- E. Services are provided on an intermittent basis, as defined at Section 8.524, DEFINITIONS.

- F. The only alternative to Home Health services is hospitalization or the emergency room; or the client's medical records accurately justify a medical reason that the services should be provided in the client's home instead of a physician's office, clinic, or other out-patient setting, according to one or more of the following guidelines:
1. The client, due to the client's illness, injury or disability, is not able to go to a physician's office, clinic or other out-patient setting for the needed service, for example, a client with quadriplegia who needs aide services to get in and out of bed.
 2. If, because of the client's illness, injury, or disability, going to a physician's office, clinic, or other out-patient setting for the needed service would create a medical hardship for the client. Any statement on the plan of care regarding such medical hardship must be supported by the totality of the client's medical records. Examples of medical hardship would include: a client who would require ambulance transportation, a client in severe pain, or a client who is just out of the hospital after major surgery. Some examples of conditions that would not by themselves be considered creation of a medical hardship would include: a client who is on oxygen, a client who walks with a limp, or a client who uses a cane.
 3. Going to a physician's office, clinic, or other out-patient setting for the needed service is contra-indicated by the client's documented medical condition, for example, a client who must be protected from exposure to infections.
 4. Going to a physician's office, clinic, or other out-patient setting for the needed service would interfere with the effectiveness of the service. Examples include a young child who would not benefit from out-patient therapy because of extreme fear of the hospital where the out-patient setting is located; clients living in regions where traveling to out-patient therapy would require hours of travel; a client who needs a service repeated at frequencies that would be extremely difficult to accommodate in the physician's office, clinic, or other out-patient setting, such as IV care three times per day, or daily insulin injections; a client who needs regular and pm catheter changes and having Home Health in place will prevent emergency room visits for unscheduled catheter changes due to dis-lodgement or blockage; a client who, because of the client's illness, injury or disability, including mental disorders, has demonstrated past failure to comply with going to a physician's office, clinic, or other out-patient setting for the needed service, and has suffered adverse health consequences as a result, including use of emergency room and hospital admissions.
 5. The client's medical condition requires teaching which is most effectively accomplished in the client's home on a short-term basis.
- G. Services are provided in the client's place of residence. The client's place of residence is where the client lives, except that home health services shall not be reimbursed if the client's place of residence is a nursing facility or hospital. Assisted living facilities of any kind are places of residence. If a client is visiting relatives or staying in a hotel during a trip, or similar temporary accommodations, the place where the client is staying will be considered the temporary place of residence for purposes of this rule. Services shall not be reimbursed if provided at the workplace, school, child day care, adult day care, or any other place that is not the client's place of residence, except when the services are prior authorized according to 8.527, PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES, or Section 8.531 through 8.539, HOME HEALTH AIDE PILOT PROGRAM.
- H. Services are provided by a Medicaid-certified Home Health agency.

- I. The Client is unable to perform the health care tasks for him or herself, and no unpaid family/caregiver able and willing to perform the tasks.
- J. When the client has Medicare or other third-party insurance, Medicaid Home Health shall be reimbursed only if the client's care does not meet the Home Health coverage guidelines for Medicare or other insurance.
- K. The Client's care falls under one of the following three categories:
 - 1. Acute Home Health, which means Medicaid-reimbursed Home Health services that are:
 - a. Provided for 60 calendar days; and
 - b. Provided for the treatment of any of the acute conditions listed below. A condition is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.
 - 1) Infections.
 - 2) New medical conditions such as, but not limited to, stroke, heart attack, cancer, injury, diabetes.
 - 3) Care related to post-surgical recovery.
 - 4) Post-hospital care provided as follow-up care for the condition that required hospitalization, including neonatal disorders.
 - 5) Exacerbation or severe instability of a chronic condition.
 - 6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.
 - 7) Complications of pregnancy.
 - 2. Long Term Home Health, which means Medicaid-reimbursed Home Health services that are:
 - a. Provided for 61 calendar days or longer; or
 - b. Provided for less than 61 calendar days when services are provided solely for the care of chronic conditions.
 - 3. Long Term with Acute Episode Home Health, which means Medicaid-reimbursed Home Health services that are:
 - a. Provided for care of long-term chronic conditions; and
 - b. Additionally provided for the treatment of any of the acute episodes listed below. An episode is considered acute only until it is resolved or until 60 calendar days after onset, whichever comes first.
 - 1) Infections.
 - 2) New medical conditions such as, but not limited to, stroke, heart

attack, cancer, injury, decubitus.

- 3) Care related to post-surgical recovery.
- 4) Post-hospital care provided as follow-up care for the condition that required hospitalization.
- 5) Exacerbation of a chronic condition.
- 6) New diagnosis of a long term chronic condition, such as, but not limited to, diabetes.
- 7) Complications of pregnancy.

8.524 DEFINITIONS

.10 HOME HEALTH AIDE ASSIGNMENT FORM

Home health aide assignment form means the form which the home health agency uses to list the duties to be performed by the home health aide at each visit.

.11 HOME HEALTH SERVICES

Home Health Services means those services listed at Section 8.522, COVERED SERVICES, and described at Section 8.525, SERVICES REQUIREMENTS.

.12 INTERMITTENT

Intermittent is defined as no more than the combined number of all visits and/or other units of service which will cause the reimbursement per calendar day to equal the maximum reimbursement limits as set forth in the Reimbursement section of these rules. Visits and/or units or combinations thereof may directly follow each other without any break and still be considered intermittent, as long as the maximum reimbursement limit per day is not exceeded.

.13 PLAN OF CARE

A plan of care means a coordinated plan developed by the Home Health agency as ordered by the attending physician for provision of services to a client at his or her residence, and periodically reviewed and signed by the physician in accordance with Medicare requirements.

.14 STATE

State means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

8.525 SERVICES REQUIREMENTS

.10 NURSING SERVICES

- A. Nursing services include those skilled nursing services that are provided by a registered nurse under applicable state and federal laws, and professional standards.
- B. Nursing services also includes skilled nursing services which are provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws.

.11 HOME HEALTH AIDE SERVICES

- A. Home health aide services may be provided when a nurse or therapist determines that an eligible client requires the services of a qualified home health aide, as such services are defined in this section.
- B. Home health aide services must be supervised according to Medicare Conditions of Participation for Home Health Agencies found at 42 CFR 84.36 (d). No later amendments to or editions of 42 CFR 484.36 (d) are included. Copies of 42 CFR 484.36 (d) are available for public inspection during normal business hours and will be provided at cost upon request to the : Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.
 - 1. If the client receiving home health aide services also requires and receives skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse or therapist must make on-site supervisory visits to the client's home no less frequently than every two weeks.
 - 2. If the client receiving home health aide services does not require skilled nursing care or physical, occupational or speech therapy, the supervising registered nurse must make on-site supervisory visits to the client's home no less frequently than every 62 days. Each supervisory visit must occur while the home health aide is providing care. Visits by the registered nurse to supervise and to reassess the care plan are considered costs of providing the home health aide services, and shall not be billed to Medicaid as nursing visits.
 - 3. Registered nurses and physical, occupational and speech therapists supervising home health aides must comply with applicable State laws governing their respective professions. In addition, the Nurse Aide Practice Act at § 12-38.1-102(5) C.R.S. (1998). which requires supervision of the practice of nurse aide services, must be followed. No later amendments to or editions of § 12-38.2-102(5) C.R.S. (1998) are included. Copies of § 12-38.1-102(5) C.R.S. (1998) are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street. Denver, Colorado 80203-1714; or may be examined at any state publications depository library.
- C. Before providing any services, all home, health aides shall be trained and certified according to Federal Medicare regulations at 42 CFR 484.36 and all applicable. State and Federal laws and regulations governing nurse, aide certification, as amended, except that later amendments to or editions of 42 CFR 484.36 shall not be. included in this rule. Copies, of 42 CFR 484.36. are available for. public inspection or will be. provided at cost upon request by the Home. Health Program Administrator, at the. Colorado. Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or. may be examined at any state, publications depository library.
- D. Home, health aide services include, skilled personal care, unskilled personal care, and homemaking as. defined below:
 - 1. Skilled personal care includes nurse aide tasks performed by a certified. nurse aide pursuant to. the. nurse aide scope of practice defined by the State Board of Nursing, but does not include those tasks that are allowed as unskilled personal care, in HCBS personal care regulations at Section 8.489, PERSONAL CARE.

2. Unskilled personal care means those, tasks which are allowed ;as unskilled personal care at Section 8.489, HOME AND COMMUNITY BASED. SERVICES-EBD, PERSONAL CARE. Unskilled care shall be. provided only as secondary to. required skilled personal care, provided within contiguous units of service.
3. Homemaking includes those, tasks, that are allowed as homemaking tasks at Section 8.490, HOME AND COMMUNITY BASED SERVICES. - EBD, HOMEMAKER SERVICES. Homemaking services shall be provided only as secondary to required skilled personal care provided within contiguous units of service.
4. Home health aide services solely for the. purpose of behavior management are not a benefit under. Medicaid Home. Health, because behavior management is outside the nurse aide scope of practice.

.12 PHYSICAL THERAPY SERVICES

- A. Physical therapy includes any evaluations and treatments allowed under state law at 12-41-101 through 130, C.R.S. (1991, as amended), which are applicable to the home setting.
- B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training or the use of the equipment.
- C. Treatment must be provided by or under the supervision of a licensed physical therapist who meets the qualifications prescribed by federal regulation for participation under Medicare, at 42 CFR 484.4; and who meets all requirements under state law. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.
- D. For clients who do not require skilled nursing care, the physical therapist may open be case and establish the Medicaid plan of care.
- E. Effective September 1, 2002, physical therapy services are available for Acute Home Health clients when medically necessary and clients under 18 years of age when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.13 OCCUPATIONAL THERAPY SERVICES

- A. Occupational therapy includes any evaluations and treatments allowed under the standards of practice authorized by the American Occupational Therapy Association, which are applicable to the home setting.
- B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request and shall assist in training on the use of the equipment.
- C. Treatment must be provided by or under the supervision of a certified occupational therapist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not

be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or may be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.

- D. For clients who do not require skilled nursing care or physical or speech therapy, the occupational therapist may open the case and establish the Medicaid plan of care.
- E. Effective September 1, 2002, occupational therapy services are available for Acute Home Health clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201.A.

.14 SPEECH/LANGUAGE PATHOLOGY SERVICES

- A. Speech/language pathology services include any evaluations and treatments allowed under the American Speech-Language-Hearing Association (ASHA) authorized scope of practice statement, which are applicable to the home setting.
- B. When devices and equipment are indicated by the therapy plan of care, the therapist shall assist in initiating or writing the request in accordance with Section 8.590 through 8.594.03, Durable Medical Equipment, and shall assist in training on the use of the equipment.
- C. Treatment must be provided by a speech/language pathologist who meets the qualifications prescribed by federal regulations for participation under Medicare at 42 CFR 484.4. Later amendments to or editions of 42 CFR 484.4 shall not be included in this rule. Copies of 42 CFR 484.4 are available for public inspection or will be provided at cost upon request by the Home Health Program Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714; or may be examined at any state publications depository library.
- D. For clients who do not require skilled nursing care, the speech therapist may open the case and establish the Medicaid plan of care.
- E. Effective September ; 1, 2002; speech/language pathology services are available for Acute Home Health, clients when medically necessary and for clients under 18 when medically necessary. EPSDT-Extraordinary home health services are available for clients under 21 years of age. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201A.

8.526 PROVIDER AGENCY REQUIREMENTS

- .10 A Home Health agency must be a public agency or private organization or part of such an agency or organization which:
 - A. Is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act; and
 - B. Has a valid agreement with the State, according to Section 8.130, PROVIDER AGREEMENTS, of this manual, to provide Medicaid Home Health services, as defined above. The Medicaid agreement will cover only those services which are covered by the

agency's Medicare certification; and

C. Maintains liability insurance for the minimum amount set annually by the Colorado Department of Health Care Policy and Financing.

- .11 Home Health agencies which perform procedures in the client's home that are considered waived clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 must possess a certificate of waiver from the Health Care Financing Administration or its designated agency.
- .12 Home Health agencies must have written policies regarding nurse delegation.
- .13 For all clients who are expected to need home health aide services for at least a year, the supervising nurse must, during supervisory visits:
 - A. Obtain the client's, or the client's designated representative's, input into the home health aide assignment form, including all home health aide tasks to be performed during each scheduled time period. Details such as, but not limited to, housekeeping duties and standby assistance, must be negotiated and included on the home health aide assignment form so that all obligations and expectations are clear. The home health aide assignment form shall contain information regarding special functional limitations and needs, safety considerations, special diets, special equipment, and any other information that is pertinent to the care that will be given by the aide. The client or the client's designated representative must sign the form, and must be given a copy, at the beginning of services, and at least once per year thereafter. For purposes of complying with this rule, once per year shall be defined as sometime within the certification period which includes the anniversary date of the last signature on a home health aide assignment form.
 - B. Give each client, and/or the client's designated representative, a new copy of the Patient's Rights form, and explain those rights whenever the home health aide assignment form is renegotiated and rewritten.
- .14 Home Health agencies shall obtain the official Medicaid rules, 10 CCR 2505-10 also known as Volume 8, and shall subscribe annually to the official updates. These rules shall be made available to all staff.
- .15 Home Health agencies shall have written policies regarding maintenance of clients durable medical equipment, and shall make full disclosure of these policies to all clients with durable medical equipment in the home. The policies shall provide such disclosure to the client at the time of intake.
- .16 Home Health agencies shall have written policies regarding procedures for communicating with case managers of clients who are also enrolled in HCBS programs. Such policies shall include, at a minimum, how agencies will inform case managers that services are being provided or are being changed; and procedures for sending copies of plans of care if requested by case managers. These policies shall be developed with input from case managers.
- .17 Any Home Health Agency applying to become a Medicaid participating Home Health Agency shall submit an acceptable compliance plan as a condition of eligibility for entering into a Medicaid provider agreement in Colorado. The plan must demonstrate how the agency will assure compliance with Colorado Medicaid rules, and must demonstrate that the applicant agency knows and understands the rules.
- 18. A home health provider shall not discontinue or refuse services to a client unless documented efforts

have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

19. A Home Health Agency may be denied or terminated from participation in Colorado Medicaid independently of participation in Medicare, according to procedures found at Section 8.050 through Section 8.051.44, based on good cause, as defined at 8.051.01. Good cause for denial or termination of a Home Health Agency shall include, but not be limited to, the following:

A. Medicare Conditions Out of Compliance. For purposes of this section, the applicable Medicare Conditions of Participation are found in 42 CFR 484, at 484.10, 484.12, 484.14, 484.16, 484.18, 484.30, 484.32, 484.36, 484.48, and 484.52. No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on the first re-certification survey after initial certification, or on a complaint investigation prior to the first re-certification survey.
2. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on two consecutive surveys and/or complaint investigations.
3. Any Home Health Agency that is found to be out of compliance with the above-referenced Medicare Conditions of Participation on three non-consecutive surveys and/or complaint investigations.

B. Medicare Standards Out of Compliance. For purposes of this section, the applicable Medicare Standards are the Standards under each of the above-referenced Medicare Conditions of Participation, with special emphasis on standards found at 484.10 (b)(4), (b)(5), and (c); 484.12 (a) and (c); 484.14 (c)(d) and (g); 484.18 (b) and (c); 484.30 (a); 484.36 (c); and 484.52 (b). No later amendments to or editions of 42 CFR 484 are included. Copies of 42 CFR 484 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203 or the material may be examined at any State Publications Depository Library.

1. Any Home Health Agency that receives repeated deficiency citations on the same standard, or standards, more than twice, or less often if the scope and severity is high.
2. Number of, as well as severity and scope of deficiency citations against standards shall be considered as factors in decisions to deny or terminate provider agreements.

C. Improper Billing Practices: Any Home Health Agency that is found by the State or its agent(s) to have engaged in the following practices may be denied or terminated from participation in Colorado Medicaid:

1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and

time out of the client's home. Providers shall submit or produce requested documentation in accordance with rules at 8.079.62.

2. Billing for unnecessary visits, or visits that are unreasonable in amount, frequency and duration; especially nursing visits solely for the purpose of assessment and teaching.
3. Billing for home health aide visits on which no skilled tasks were performed and documented, or the skilled tasks performed were not medically necessary.
4. Billing for home health services provided at locations other than the client's, place of residence. This rule shall not apply for out-of-home Services provided with prior authorization as EPSDT extra-ordinary Home Health.
5. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any Home Health Agency that is also certified as a personal care/homemaker provider, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:
 - a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.
 - b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 2 ½ hours plus the number of hours billed for personal care and homemaker.
 - c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2½ hours.
 - d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.
 - e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 ½ hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.
 - f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.
 - g. If any of the above practices occur, the Home Health Agency shall not be absolved from liability by failure or refusal to include personal care and/or

homemaking needs on the Home Health plan of care.

1. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 5 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

Billing for excessive units of home health aide services for all time periods during which regulations are in effect defining the unit for home health aide as hour and/or half hour increments.

8. Billing for any services that are found to be out of compliance with any of the rules in this section, including but not limited to, those found in post-payment review rules at 8.529.

D. Prior Termination From Medicaid Participation. A Home Health Agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a Home Health Agency or any other type of service provider.

E. Abrupt Prior Closure. A Home Health Agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

20. Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. 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 State, the Medical Services Board, or the State's fiscal agent.

21. When a Home Health Agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.527 PRIOR AUTHORIZATION

.10 ACUTE HOME HEALTH

Acute Home Health services, as defined at Section 8.523, ELIGIBILITY, do not require prior authorization. This includes episodes of Acute Home Health for Long Term Home Health clients.

.11 LONG TERM HOME HEALTH

Long Term Home Health services, as defined at Section 8.523, ELIGIBILITY, shall be prior authorized according to the requirements below.

A. PRIOR AUTHORIZATION PROCESS

Long Term Home Health services provided to clients 18 and over shall be prior authorized by the Single Entry Point Agencies. Long Term Home Health services provided to clients under 18 shall be prior authorized by the Medicaid fiscal agent.

1. Upon admission of a client 18 and over to Long Term Home Health services, the Home Health Agency shall contact the Single Entry Point Agency to inform the case manager of the client's need for Home Health services.
2. The Home Health Agency shall submit the formal written prior authorization request to the Single Entry Point Agency for clients 18 and over and to the Medicaid fiscal agent for clients under 18, within 10 working days of the "from" date on the Home Health plan of care. Physician signature on the plan of care is not needed for prior authorization purposes. The SEP shall not send the prior authorization to the fiscal agent until the Home Health Agency submits the formal, complete, written prior authorization request (PAR).
3. The complete formal written PAR shall include:
 - a. A completed State-prescribed Prior Authorization Request Form;
 - b. A Home Health plan of care which shall include nursing and/or therapy assessments for clients under 18 and nursing assessments for clients over 18, and current clinical summaries or updates of the client. The plan of care shall be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form shall be completed. For clients under 18, all therapy services requested shall be included in the plan of care or addendum, which shall list the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.528.11.B and C, are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided.
 - c. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a home health aide visit;
 - d. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, the record shall document that the client's pharmacy was contacted and advised/the Home Health Agency that the pharmacy will not provide medication set-ups.
 - e. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, the record shall provide documentation supporting the current need for two person transfers and the reason adaptive equipment cannot be used instead.
4. Authorization time frames:
 - a. Prior authorization requests shall be submitted and may be approved for up to a one year period. For clients 18 and over, the Single Entry Point Agencies shall communicate this date to the Home Health Agencies. For clients under 18, the Medicaid fiscal agent shall communicate this date to the Home Health Agencies.
 - b. Home Health Agencies shall not be required to change dates on the Home Health plans of care to match the SEP program certification dates.

- c. For clients 18 and over, Home Health Agencies shall send Single Entry Point Agencies new plans of care every two (2) months, and other documentation as requested by the SEP agency. For clients under 18, the information referred to in this section shall be sent to the Medicaid fiscal agent.
 - d. Single Entry Point Agencies, for clients 18 and over, and the Medicaid fiscal agent, for clients under 18, may initiate PAR revisions if the plans of care indicate significantly decreased services.
 - e. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the HCFA-485.
- 5. The prior authorization request shall be reviewed by the Single Entry Point Agency or the Medicaid fiscal agent, as applicable, to determine compliance with Medicaid rules, and shall be approved, denied, or returned for additional information within 10 working days of receipt. The PAR shall not be backdated to a date prior to the 'from' date of the HCFA-485.
- 6. The Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall approve or deny according to the following guidelines for safeguarding clients:
 - a. PAR Approval: If services requested are in compliance with Medicaid rules, the services shall be approved retroactively to the start date on the PAR form.
 - b. PAR Denial:
 - 1. The Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall notify Home Health Agencies of denials based on non-compliance with Medicaid rules on the appropriate PAR form. Denials based on medical necessity, (the PAR is not consistent with the client's documented medical needs and functional capacity), shall be determined and signed by a registered nurse or physician. The Utilization Review Contractor shall notify the client of a determination of denial for level of care.
 - 2. SEPs, through the Medicaid fiscal agent, shall notify clients of LTHH denials, including partial denials, and appeal rights in accordance with Section 8.393.28 and Section 8.059.16, APPEALS RELATED TO REQUESTS FOR PRIOR AUTHORIZATIONS.
 - 3. If any services have already been provided, but are subsequently denied on the prior authorization request, the Single Entry Point Agency or the Medicaid fiscal agent, as applicable, shall notify the Home Health Agency. Services already provided shall be approved for payment, retroactive to the start date on the PAR form, or 30 working days whichever is shorter. (This 30 working days includes a 10 day period for the HHA to submit the PAR, a 10 day period for the Utilization Review Contractor to determine level of care for adult clients, and a 10 day period for the SEP to complete an assessment or the Medicaid fiscal agent, as

applicable, to approve, deny, or request further information.) If denied, services shall be approved for 15 additional days after the date on which the notice of denial is mailed to the client, so that the client's right to advance notice is preserved. An informal case conference may be arranged to discuss disagreements, If the disagreement is not satisfactorily resolved, the Home Health Agency may file a provider appeal in accordance with Section 8.050, PROVIDER APPEALS.

7. Neither the presence nor the absence of a preliminary authorization or a formal written PAR approval from the authorizing agent shall exempt a Home Health Agency at any time from:
 - a. Following all applicable Medicaid rules;
 - b. Providing only services that are medically necessary to the needs of the client; or
 - c. Ensuring the accuracy of preliminary and formal written PAR information provided to the SEP.
8. EXPEDITED AUTHORIZATION PROCESS If requested by a Home Health Agency, for extreme emergencies or complicated cases, following the initial assessment by the Home Health Agency, and after receipt of HCFA-485 or care notes in writing, the SEP or the Medicaid fiscal agent, as applicable, may use the information provided by the Home Health Agency to take one of the following actions:
 - a. Provide preliminary authorization of the services, including a Case Manager (CM) signed, department approved, preliminary authorization form, in writing, until the formal written PAR procedure delineated at 8.527.11,A, 1-8 above is completed. If an expedited authorization was provided by the SEP or the Medicaid fiscal agent, as applicable, the date of service effective under the expedited authorization (never dated back prior to "from" date on HCFA-485) shall be indicated on the prior authorization form that is forwarded to the fiscal agent.
 - b. Provide preliminary authorization of the services, including a CM signed, department approved, preliminary authorization form, in writing, for a lesser amount of time than a) above, based on the needs of the client or the need for additional information;
 - c. Postpone/deny preliminary authorization until such time as the Home Health Agency provides full documentation as delineated at 8.527.11,A, 3 above. The Home Health Agency shall submit a formal written PAR in order for due process to occur as delineated at 8.527.11,A,6.
9. If the client has an acute episode, the Home Health Agency shall bill for Acute Home Health, in accordance with billing manual instructions, without obtaining prior authorization from the applicable agency. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within ten (10) working days of the beginning and within ten (10) working days of the end of the acute care episode.
10. Transition

- a. SEP CLIENTS For clients already receiving Long Term Home Health services prior to July 1, 2001, the Home Health Agency shall contact the SEP Agency prior to the beginning of the next Home Health certification period, and submit prior authorization requests to the SEP for services beginning with the next Home Health certification period as delineated in 8.527.11.A.3.a-e.

Note: The Section numbered 8.527.11 B was deleted effective July 1, 2002.

.12 EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES

Extra-ordinary Home Health services may be provided when identified as medically necessary through an Early Periodic Screening Diagnosis and Treatment (EPSDT) screen, and prior authorized according to the requirements below.

- A. Extra-ordinary Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530.103 shall include:

1. Any combination of necessary Home Health services that exceed the maximum allowable limit per day;

8.527.12 EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES

2. Any Home Health services that must, for medical reasons, be provided at locations other than the child's place of residence;

3. Home Health aide services for the purpose of providing only unskilled personal care.

- B. Extra-ordinary Home Health services above and beyond the restrictions in these rules at SECTION 8.520 through 8.530.10,B shall not include services that are available under other Colorado Medicaid benefits, and for which the client is eligible, including but not limited to, Private Duty Nursing, Section 8.540; HCBS personal care, Section 8.489; School Health and Related Services, Section 8290, or out-patient therapies, Section 8.330. Exceptions may be made if extra-ordinary Home Health services Will be more cost-effective, provided that client safety is assured. Such exceptions shall in no way be construed as mandating the delegation of nursing tasks.

- C. Prior authorization requests for EPSDT extra-ordinary Home Health shall be submitted and processed as follows:

1. The complete prior authorization request shall include a State-prescribed Prior Authorization Request Form; a plan of care which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client; written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and any other medical information which will document the medical necessity for the extraordinary Home Health services. The plan of care shall be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form shall be completed. All therapy services requested shall be included in the plan of care, which shall list the specific procedures and modalities to be used and the amount, duration and frequency. The prior authorization request shall include detailed information on each planned Home Health visit, including the approximate times in and out, all tasks to be performed on each visit, and the place of service for each visit All Home Health services to be provided, both ordinary Home Health and extra-ordinary Home Health, shall be included in the

prior authorization request Physician signature on the plan of care is not needed for prior authorization purposes.

2. The prior authorization request shall be sent to the State or its agent.
3. The prior authorization request shall be reviewed by the State or its agent to determine compliance with EPSDT guidelines, and shall be approved, denied, returned as incomplete or referred for Private Duty Nursing review, within 10 working days of receipt.
4. No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent
5. The State or its agent shall notify' clients of adverse decisions and appeal rights in accordance with Section 8.057 through 8.059.147, RECIPIENT APPEALS PROTOCOLS/PROCESS. If services have already been provided, but will not be reimbursed by Medicaid because of late submission of me prior authorization request, only the Home Health Agency shall be notified, and the Home Health Agency may file a provider appeal according to Section 8.049, RECONSIDERATION APPEAL OF ADVERSE ADMINISTRATIVE ACTION.

8.527 PRIOR AUTHORIZATION OF EXTRA-ORDINARY HOME HEALTH AS EPSDT EXPANDED SERVICES

.13 Prior authorization requests shall be submitted and processed as follows:

- A. The complete prior authorization request must include a State-prescribed Prior Authorization Request Form; a physician-signed plan of care which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client; written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance; and any other medical information which will document the medical necessity for the extraordinary Home Health services. The plan of care must be on the HCFA-485 form or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services requested must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.
- B. The prior authorization request must be sent to the State or its agent.
- C. The prior authorization request shall be reviewed by the State or its agent to determine compliance with EPSDT guidelines, and shall be approved, denied, returned as "unable to approve or deny due to insufficient information", or referred for physician review, within 10 working days of receipt
- D. No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent
- E. The State or its agent shall notify clients of adverse decisions and appeal rights in accordance with Section 8.057 through 8.059.147, RECIPIENT APPEALS PROTOCOLS/PROCESS. If services have already been provided, but will not be reimbursed by Medicaid because of late submission of the prior authorization request, only the Home Health Agency shall be notified, and the Home Health Agency may file a provider appeal according to Section 8.049, RECONSIDERATION APPEAL OF ADVERSE ADMINISTRATIVE ACTION.

8.528 REIMBURSEMENT

.10 CLAIMS

Claims shall be submitted to the fiscal agent according to Section 8.040, RULES GOVERNING SUBMISSION OF CLAIMS, and Section 8.043, TIMELY FILING REQUIREMENTS.

Home Health providers shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.2, RULES GOVERNING SUBMISSION OF CLAIMS, and Section 8.130, PROVIDER AGREEMENTS.

.11 UNIT OF REIMBURSEMENT

- A. The unit of reimbursement for the Home Health services of nursing, physical therapy, occupational therapy, and speech therapy shall be one visit, which is defined as the length of time required to provide the needed care, up to a maximum of two and one-half hours spent in client care or treatment.
- B. The Basic Unit of reimbursement for home health aide services shall be up to one hour. A unit of time that is less than fifteen minutes shall not be reimbursable as a basic unit.
- C. For home health aide visits that last longer than one hour, Extended Units may be billed in addition to the Basic Unit. Extended Units shall be increments of fifteen minutes up to one-half hour. Any unit of time that is less than fifteen minutes shall not be reimbursable as an extended unit.]
- D. Reimbursement for supplies used by Home Health agency staff is included in the reimbursement for nursing, home health aide, physical therapy, occupational therapy, and speech/language pathology services, to the following extent:
 - 1. Supplies used during provision of any Home Health services by Home Health agency staff for the practice of universal precautions shall be the financial responsibility of the Home Health agency. This excludes gloves used for bowel programs and catheter care but includes all other supplies required for the practice of universal precautions by Home Health agency staff. If a Home Health agency asks a client to provide such supplies, this will constitute a failure to accept Medicaid payment in full, in violation of Section 8.012, PROHIBITION OF CHARGES TO RECIPIENTS.
 - 2. Supplies other than those required for practice of universal precautions which are used by the Home Health agency staff to provide Home Health care services shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.
 - 3. Supplies used for the practice of universal precautions by the client's family or other informal caregivers shall not be the financial responsibility of the Home Health agency. Such supplies may be requested by the physician as a benefit to the client under Section 8.590, DURABLE MEDICAL EQUIPMENT.

.12 The following restrictions shall be placed on Home Health services for purposes of reimbursement:

- A. Nursing visits shall not be reimbursed by Medicaid if solely for the purpose of psychiatric counseling, because that is the responsibility of the Mental Health Assessment and Services Agencies. Nursing visits for mentally ill clients shall be reimbursed under Medicaid Home Health for pre-pouring of medications, venipuncture, or other nursing tasks, provided that all other requirements in this section are met.

- B. The state shall not authorize nor reimburse home health aide services for the purpose of providing only unskilled personal care and/or homemaking services. Units during which unskilled personal care and/or homemaking services are provided and billed under the home health aide benefit must be contiguous with units during which services defined as skilled personal care are provided. For clients who are also eligible for HCBS personal care and homemaker services, the units spent on unskilled personal care and homemaker services and billed as aide services shall be reasonable in relation to the skilled care provided on the contiguous units. For example, if the transfer and bath are skilled, it would be reasonable for the aide to also dress the client, and to wipe up any water spills on the bathroom floor, and to prepare a meal if the aide is there at mealtime. It would not be reasonable for the aide to stay four more hours to do all the weekly cleaning and laundry, unless the client is not eligible for homemaker services under HCBS.
- C. The maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed \$270, effective July 1, 2002, for Acute Home Health Services or Long Term with Acute Episode Home Health Services; and shall not exceed \$211, effective July 1, 2002, for Long Term Home Health Services. Effective September 1, 2002, the maximum reimbursement for any twenty-four hour period, as measured from midnight to midnight, shall not exceed \$291 for Acute Home Health Services or Long Term with Acute Episode Home Health Services, and shall not exceed \$227 for Long Term Home Health Services. Criteria for the three different categories of care are found at 8.523.11, K in this section. The maximum daily reimbursement includes reimbursement for nursing visits, home health aide units, physical therapy visits, occupational therapy visits, speech/language pathology visits, and any combinations thereof.
- D. Medicaid will not reimburse for two nurses during one visit, two home health aides at the same time, two physical therapists during one visit, two occupational therapists during one visit, or two speech therapists during one visit. An exception to this rule is for two home health aides, when two are required for transfers, and there are no other persons available to assist, and when there is a justifiable reason why adaptive equipment cannot be used instead. Another exception is for two nurses when two are required to perform a procedure. For these exceptions, the provider may bill for two visits, or for all units for both aides. Reimbursement for all visits or units will be counted toward the maximum reimbursement limit.
- E. If a client is seen simultaneously by two persons to provide a single service, for which one person supervises or instructs the other, the Home Health agency shall only bill and be reimbursed for one employee's visit or units. For example, if two nurses visit the client, and the first nurse provides care and also orients and trains the second nurse in the client's care, only the first nurse's time counts as a reimbursable visit.
- F. Any visit made solely for the purpose of supervising the home health aide shall not be reimbursed.
- G. Any visit made by a nurse or therapist to simultaneously serve two or more clients residing in the same household shall be reimbursed as one visit only, unless services to each client are separate and distinct. If two or more clients residing in the same household receive Medicaid home health aide services, the personal care for each client shall be documented and billed separately for each client. Any homemaker services provided during units contiguous to skilled personal care units shall be billed to any one of the clients in the household, but the homemaker services shall not be duplicated and/or billed for more than one client. For example, if more than one client in the household needs meal preparation, it is expected that one aide prepare the meal for all of them. If the clients in the same household use different agencies, the agencies shall coordinate with each other to prevent duplication of homemaking.

H. No more than one Home Health agency shall be reimbursed for providing Home Health services during a specific plan period to the same client, unless the second agency is providing a Home Health service that is not available from the first agency. The first agency must take responsibility for the coordination of all Home Health services. Home and Community Based Services, including personal care, are not Home Health services.

I. Physical, occupational, or speech therapy visits shall be reimbursed only when:

1. Improvement of functioning is expected or continuing;
2. The therapy assists in overcoming developmental problems;
3. Therapy visits are necessary to prevent deterioration;
4. Therapy visits are indicated to evaluate and change ongoing treatment plans for the purpose of preventing deterioration; and to teach home health aides or others to carry out such plans, when the ongoing treatment does not require the skill level of a therapist; and/or
5. Therapy visits are indicated to assess the safety or optimal functioning of the client in the home, or to train in the use of equipment used in implementation of the therapy plan of care.

J. Nursing visits provided solely for the purpose of assessing and/or teaching shall be reimbursed by Medicaid only under the following guidelines:

1. For an initial assessment visit ordered by a physician when there is a reasonable expectation that ongoing nursing or home health aide care may be needed. Initial nursing assessment visits shall not be reimbursed if provided solely to open the case for physical, occupational, or speech therapy.
2. If a nursing visit involves the nurse performing a nursing task for the purpose of demonstrating to the client or the client's unpaid family/caregiver how to perform the task, that visit shall not be considered as being solely for the purpose of assessing and teaching. A nursing visit during which the nurse does not perform the task, but observes the client or unpaid family/caregiver performing the task to verify that the task is being performed correctly shall be considered a visit that is solely for the purpose of assessing and teaching.
3. Nursing visits solely for the purpose of assessing the client and/or teaching the client or the client's unpaid family/caregiver shall not be reimbursed unless the care is Acute Home Health or Long Term Home Health With Acute Episode, as defined in Section 8.523, ELIGIBILITY, or the care is for extreme instability of a chronic condition under Long Term Home Health, as defined in Section 3.523, ELIGIBILITY.
4. Nursing visits provided solely for the purpose of assessment and/or teaching shall not exceed the frequency that is justified by the client's documented medical condition and symptoms, up to the maximum reimbursement limits. Assessment visits shall continue only as long as there is documented clinical need for assessment, management, and reporting to physician of specific conditions and/or symptoms which are not stable and/or not resolved. Teaching visits shall be as frequent as necessary, up to the maximum reimbursement limits, to teach the client or the client's unpaid family/caregiver, and shall continue only as long as needed for the client or the client's unpaid family/caregiver to demonstrate

understanding or to perform care, or until it is determined that the client or unpaid family/caregiver is unable to learn or to perform the skill being taught. The visit on which the nurse determines that there is no longer a need for assessment and/or teaching shall be reimbursed if it is the last visit provided solely for assessment and/or teaching.

5. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if the client is capable of self-assessment and of contacting the physician as needed; and if the client's medical records do not justify a need for client teaching beyond that already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment
 6. Nursing visits provided solely for the purpose of assessment and/or teaching shall not be reimbursed if there is an available and willing unpaid family/caregiver who is capable of assessing the client's condition and needs and contacting the physician as needed; and if the client's medical records do not justify a need for teaching of the client's unpaid family/caregiver beyond the teaching already provided by the hospital and/or attending physician, as determined and documented on the initial Home Health assessment.
- K. Nursing visits provided solely for the purpose of assessment and/or teaching and foot care shall not be reimbursed unless the visit meets the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, and/or the guidelines to be reimbursed as a foot care visit. Nursing visits provided solely for the purpose of providing foot care shall be reimbursed by Medicaid only if the client has a documented and supported diagnosis that supports the need for foot care to be provided by a nurse, and the client and/or unpaid family/caregiver is not able or willing to provide the foot care. This will include documented and supported diagnoses that involve severe peripheral involvement, anti-coagulation therapy, or other conditions such as, but not limited to, spasticity and compromised immune system which could lead to a high risk of medical complications from injuries to the feet. Documentation in the medical record shall specifically, accurately, and clearly show the signs and symptoms of the disease process at each visit. The clinical record must indicate and describe an assessment of the foot or feet, physical and clinical findings consistent with the diagnosis and the need for footcare to be provided by a nurse. Severe peripheral involvement shall be supported by documentation of more than one of the following:
1. absent (not palpable) posterior tibial pulse;
 2. absent (not palpable) dorsalis pedis pulse;
 3. three of the advanced trophic changes such as:
 - a. hair growth (decrease or absence),
 - b. nail changes (thickening),
 - c. pigmentary changes (discoloration),
 - d. skin texture (thin, shiny),
 - e. skin color (rubor or redness);
 4. claudication (limping, lameness);

4. temperature changes (cold feet);
5. edema;
6. parasthesia;
7. burning.

L. Nursing visits provided solely for the purpose of assessment and/or teaching and pre-pouring of medications shall not be reimbursed unless the visit meets either the guidelines to be reimbursed as a visit provided solely for assessment and/or teaching, or the guidelines for reimbursement as a visit solely for the purpose of pre-pouring medications. Nursing visits provided solely for the purpose of pre-pouring medications into medication containers such as med-minders or electronic medication dispensers shall be reimbursed by Medicaid under the following guidelines:

1. The client is not living in a licensed personal care boarding home, including Adult Foster Home or Alternative Care Facility, where the facility staff is trained and qualified to pre-pour medications under the medication administration law at §25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015. No later amendments to or editions of §25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015 are included. Copies of §25-1-107 (ee) (1.5), C.R.S., as amended by House Bill 98-1015 are available for public inspection during normal business hours and will be provided at cost upon request to the Home Health Administrator at the Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714 or the material may be examined at any State Publications Depository Library; and
2. The client is not physically or mentally capable of pre-pouring his/her own medications or has a medical history of non-compliance with taking medications if they are not pre-poured; and
3. The client has no unpaid family/caregiver who is willing or able to pre-pour the medications for the client; and
4. There is documentation in the client's chart that the client's pharmacy was contacted upon admission to the Home Health Agency, and that the pharmacy will not provide this service; or that having the pharmacy provide this service would not be effective for this particular client.

M. Nursing visits solely for the purpose of performing venipuncture, or for venipuncture and assessment and/or teaching, shall be reimbursed only if all the regulations in Section 8.520 through Section 8.530.10, B, HOME HEALTH SERVICES, are met.

.13 RATES OF REIMBURSEMENT

A. Payment for Home Health services, other than nursing visits, shall be the lower of the billed charges or the maximum unit rate of reimbursement. For nursing visits the payment shall be the lower of the billed charges, the maximum unit rate of reimbursement or prior authorized charges. Prior authorized charges for stable clients requiring daily visits shall not exceed \$50.00 for the first brief nursing visit of the day and \$35.00 for the second or subsequent brief nursing visit of the day.

B. Maximum interim payment unit rates are:

Effective My 1,2002:

1. Nursing visits: \$67.85
2. Acute Home Health Aide Basic unit: \$22.37
3. Long Term Home Health Aide Basic unit: \$30.08
4. Home Health Aide Extended unit: \$8.99
5. Physical Therapy visits: \$58.36
6. Occupational Therapy visits: \$61.98
7. Speech Therapy visits: \$63.60

Effective September 1, 2002:

1. Nursing visits: \$71.42
2. Any Home Health Aide Basic unit \$31.66
3. Home Health Aide Extended unit: \$9.46
4. Physical Therapy visits: \$61.43
5. Occupational Therapy visits: \$65.24
6. Speech Therapy visits: \$66.95

Effective February 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 99-00. The interim rates shall not be reduced, if total Medicaid home health expenditures in State FY 99-00 do not exceed \$73,571,787. If total expenditures for the Home Health budget do exceed \$73,571,787, the Department shall determine which Home Health Agencies received average per unduplicated client payments for State FY 99-00 Home Health services which were more than 16.5% over State FY 98-99 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each agency's unit rates, retro-active to February 1, 2000, by a percentage that will bring each agency's average payment per unduplicated client for State FY 99-00 to no more than a 16.5% increase over its State FY 98-99 average per unduplicated client payment. Agencies that became newly certified as Medicare/Medicaid providers in State FY 99-00 and have no Medicaid Home Health payment history for State FY 98-99 shall be exempt.

D. Effective September 1, 2000, interim payment rates shall be adjusted to equal no more than 16.5% average increase per unduplicated client for State Fiscal Year 00-01 with the following exemptions:

1. Exempt Agencies

- a) Agencies that became newly certified as Medicare/Medicaid providers in State FY 00-01 and have no Medicaid Home Health payment history for State FY 99-00 shall be exempt,
- b) Agencies that had total Medicaid Home Health payments of less than \$125,000 in FY 99-00 shall be exempt.

2. Exempt Clients

- a) Clients who are newly enrolled in Medicaid shall be exempt if they receive Medicaid Home Health services within thirty days of their very first Medicaid enrollment. Clients with prior spans of Medicaid eligibility shall not be considered newly enrolled even if there was a period of non-enrollment between eligibility spans,
 - b) Clients who are deinstitutionalized from nursing facilities shall be exempt if the nursing facility care was billed to Medicaid and was not billed as respite care; if they begin receiving Home Health services no later than thirty days after discharge, from the nursing facility; and if they do not return to nursing facility placement after an interim period of Home Health care.
- E. The FT 00-01 interim rates shall not be reduced if total Medicaid community long term care expenditures in State FY 00-01 do not exceed \$198,862,688. If total expenditures for the community long term care budget do exceed \$198,862,688, the Department shall determine which non-exempt Home Health Agencies received average per non-exempt unduplicated client payments for State FY 00-01 Home Health services which were more than 16.5% over State FY 99-00 average per unduplicated client payments, and shall recoup from those agencies the amounts over the 16.5% average per unduplicated client increase. This shall be accomplished by decreasing each non-exempt agency's unit rates, retroactive to September 1, 2000, by a percentage that will bring each agency's average payment per non-exempt unduplicated client for State FY 00-01 to no more than 16.5% increase over its State FY 99-00 average per unduplicated client payment.
- F. Services shall be billed according to category of service upon publication of instructions in the provider-billing manual.
 - 1. For Acute Home Health Services, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health.
 - 2. For Long Term Home Health Services provided to a minor, Home Health Agencies shall bill nursing, home health aide, physical therapy, occupational therapy, and speech therapy as Long Term Home Health. For Long Term Home Health Services provided to an adult, Home Health Agencies shall bill nursing, and home health aide services as Long Term Home Health. Clients 18 years and over may obtain long-term therapy services in an outpatient hospital setting or by a qualified nonphysician practitioner described at 8.201. A.
 - 3. For Long Term with Acute Episode Home Health Services, Home Health Agencies shall bill all nursing, home health aide, physical therapy, occupational therapy, and speech therapy, as Acute Home Health, until the client's care becomes Long Term Home Health again.
 - 4. For all nursing visits provided solely for the purpose of assessment and teaching, not including initial assessment visits at the start of care, Home Health Agencies shall bill a revenue code assigned for nursing assessment and teaching visits.
- G. Maximum unit rates may be adjusted by the State as funding becomes available.

.14 SPECIAL REIMBURSEMENT CONDITIONS

- A. Reimbursement for third party resource and Medicare crossover claims shall not exceed Medicaid costs.

- B. When Home Health agencies provide Home Health services, in accordance with these regulations, to clients who receive Home and Community Based Services for the Developmentally Disabled (HCBS-DD), the Home Health agency shall be reimbursed:
 - 1. Under normal procedures for Home Health reimbursement, if the client resides in an Intensive Adult Residential Service group home, a personal care host home, or personal care alternatives home; or
 - 2. By the group home provider, if the client resides in a Moderate Supervision Group Home, or Specialized Group Home, because the group home has already received Medicaid funding for the home health services and is responsible for payment to the Home Health agency.
- C. Acute Home Health services provided to Medicaid HMO clients, including Medicaid HMO clients who are also HCBS recipients, shall not be reimbursed under the Medicaid Home Health program, but shall be reimbursed under Medicaid HMO rules. If a client's Home Health service need exceeds 60 days, the Home Health Agency shall submit a Prior Authorization for Long Term: Home Health to the Single Entry Point agency, if the client is 18 years old: or more; or to the Medicaid fiscal agent if the client is less than 18 years old.

.15 COST REPORTING

- A. All Home Health agencies shall report and submit to the Department cost report information on a Department prescribed form for home health aides, nurses, occupational, physical and speech therapists.
- B. By dates set forth by the Department, home health providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or State fiscal year.
- C. Providers that do not comply with Section 8.528.15 shall have their Medicaid provider agreement terminated.

8.529 POST-PAYMENT REVIEW

.10 The Medicaid Quality Assurance Unit shall periodically conduct post-payment reviews of selected Home Health services.

.11 Home Health agencies shall submit or produce requested documentation of services to the Medicaid Quality Assurance Unit in accordance with rules at 8.079.62. Such documentation shall include, at a minimum:

- A. Physician-signed plans of care, which shall include nursing and/or therapy assessments, or current clinical summaries or updates of the client. The plan of care must be on the HCFA-485 form, or a form that is identical in format to the HCFA-485, and all sections of the form must be completed. All therapy services provided must be included in the plan of care, which must list the specific procedures and modalities to be used and the amount, duration and frequency.
- B. Records documenting the nature and extent of the care actually provided such as, but not limited to, nursing notes.

.12 The Medicaid Quality Assurance Unit shall review all information available from any source, shall contact clients, and may conduct on-site visits to Home Health agencies and/or clients.

.13 The Medicaid Quality Assurance Unit shall initiate appropriate administrative, civil, or criminal investigations and/or sanctions for all services which:

- A. Are found to be out of compliance with all applicable regulations;
- B. Are not consistent with the client's documented medical needs and functional capacity,
- C. Are not reasonable in amount, frequency, and duration;
- D. Are duplicative of any other services that the client received or that the client received funds to purchase;
- E. Total more than twenty-four hours per day of paid care, regardless of funding source (An example of care totaling more than 24 hours per day would be 5 home health visits plus 12 hours of personal care);
- F. Consist of visits or contiguous units which are shorter or longer than the length of time required to perform all the tasks prescribed on the care plan.

.14 Clients and families of clients shall not be billed by home health agencies for any services for which Medicaid reimbursement is recovered as a result of post-payment review.

.15 Providers may appeal post-pay sanctions in accordance with Section 8.050, PROVIDER APPEALS AND HEARINGS.

8.530 DENIAL, TERMINATION, OR REDUCTION IN SERVICES

.10 When services are denied, terminated, or reduced by action of the Home Health agency, the Home Health agency shall notify the client.

- A. Termination of Services to. Clients Still Medically Eligible, for Coverage of Medicaid Home. Health ServicesWhen a Home Health agency decides to terminate services to a client who needs and wants continued Home. Health services, and who. remains eligible for coverage of services under the Medicaid Home Health rules, the. agency shall give the client, and/or the client's designated representative, written advance, notice of at least fifteen business days, and the. attending physician shall also be notified. Notice shall be provided in person or by certified mail, and shall be considered given when it is. documented that the recipient has received the notice. The notice shall provide the. reason for the. change in services. The agency shall make a good faith effort to assist the client in securing the services of another agency. If there is indication mat ongoing services from another source can not be arranged by the end of the advance notice period, the terminating agency shall ensure client safety by making referrals to. appropriate case management agencies and/or County Departments of Social Services; and the attending physician shall be informed about the situation. Exceptions will be made. to. the requirement for 15 days advance notice when the. provider has documented that there is danger to the. client, Home Health agency, staff, or when the client has. begun to receive Home Health services through a Medicaid HMO. Clients who. believe that a Home. Health agency has. not acted properly, in terminating services may call me. Home Health Hotline, at 1-800-842-8826 to. request an investigation.

NOTE: Section 8.530.10.B.was.deleted effective September 1,2002.

8.540 PRIVATE DUTY NURSING SERVICES

.10 The Medicaid Private Duty Nursing benefit is available to all Medicaid clients who meet the

requirements in these rules.

8.541 DEFINITIONS

.10 Attending Physician shall be defined as a properly licensed physician who is currently treating the client.

.11 Early Periodic Screening Diagnosis and Treatment (EPSDT) shall be defined as the early and periodic screening and diagnosis of Medicaid clients under age 21 to ascertain physical and mental defects, and the provision of treatment to correct or ameliorate defects and chronic conditions which are found.

.12 Family/In-Home Caregiver shall be defined as any individual who assumes a portion of the client's Private Duty Nursing care in the home, when home health agency staff are not present. Family/in-home caregivers may live in the client's home, or may come to the client's home to provide care.

.13 Initial Hospital Discharge shall be defined as the first hospital discharge that occurs after the client's birth, or the first hospital discharge after the onset of the condition that resulted in the need for Private Duty Nursing.

.14 Utilization Review Contractor shall be defined as a physician-sponsored or physician-access organization which has been designated by the federal government as capable of performing peer review of services furnished by physicians and other health care professionals.

.15 Primary Care Physician shall be defined as a physician who serves as the client's medical case manager and is responsible for authorizing, coordinating, and monitoring all health care services.

.16 Private Duty Nursing shall be defined as face-to-face skilled nursing that is more individualized and continuous than the nursing care that is available under the Home Health benefit or routinely provided in a hospital or nursing facility.

.17 Re-Hospitalization shall be defined as any hospital admission that occurs after the initial hospitalization as defined at §8.541.13.

.18 Skilled Nursing shall be defined as services provided under the licensure, scope and standards of the Colorado Nurse Practice Act, by a registered nurse under the direction of a physician, or a licensed practical nurse under the supervision of a registered nurse and the direction of a physician.

.19 Technology-Dependent shall be defined as:

- A. Dependent at least part of each day on a mechanical ventilator; or
- B. Requiring prolonged intravenous administration of nutritional substances or drugs; or
- C. Dependent daily on other respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support, or tube feedings when they are not intermittent

8.542 GENERAL ELIGIBILITY REQUIREMENTS

.10 A Medicaid client shall be determined to be eligible for Private Duty Nursing services when the following requirements are met:

- A. The client shall be technology-dependent as defined above;
- B. The client shall meet at least one of the medical criteria for Private Duty Nursing in the

Medical Criteria section below;

- C. The client shall be medically stable, except for acute episodes that can be safely managed under Private Duty Nursing, as determined by the attending physician;
- D. The client shall be able to be safely served under the requirements and Limitations of the Private Duty Nursing benefit and within the availability of services;
- E. The client shall not reside in a nursing facility or hospital at the time of the delivery of the Private Duty Nursing services; and
- F. The client shall be eligible for Medicaid in a non-institutional setting.

.11 Private Duty Nursing is usually provided in the home.

- A. Clients who are eligible and authorized to receive Medicaid Private Duty Nursing services in the home may receive care outside the home during those hours when the client's activities of daily living take him or her away from the home.
- B. The total hours authorized shall not exceed the hours that would have been authorized if the client received all care in the home.
- C. Private Duty Nursing shall never be utilized in a hospital or nursing facility.

.12 Clients who meet the eligibility requirements for Private Duty Nursing, and who also meet the eligibility requirements for Home Health, shall be allowed to choose whether to receive care under Private Duty Nursing or under Home Health. The client may also choose a combination of the two benefits if regulations are met, the care is not duplicative, and the resulting combined care does not exceed the medical needs of the client.

8.543 MEDICAL CRITERIA

.10 The following medical criteria for Private Duty Nursing shall be applied effective May 1, 2002, by the Utilization Review Contractor according to procedures at §8.547 and §8.548.

.11 Clients from birth through twenty (20) years of age shall be considered to be pediatric clients. The medical criteria for pediatric clients are:

- A. Mechanical ventilation: The pediatric client has a medical need for Private Duty Nursing during the hours spent on the ventilator.
- B. Weaning from mechanical ventilation: The pediatric client has a medical need for Private Duty Nursing for ventilator weaning during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions from tracheostomy, vital signs that are stable, blood gases that are stable with oxygen greater than 92%, and a pulse oximetry greater than 92%.
- C. Tracheostomy: The pediatric client has a medical need for Private Duty Nursing during all hours that the client has a tracheostomy.
- D. Tracheostomy decannulation: The pediatric client has a medical need for Private Duty Nursing after tracheostomy decannulation during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions, not using auxiliary muscles for breathing, vital signs that are stable, blood gases that are stable with oxygen greater than 92%, and a pulse oximetry greater than 92%.

- E. Continuous Positive Airway Pressure (C-PAP): The pediatric client has a medical need for Private Duty Nursing during the hours spent on C-PAP, until the client is medically stable.
- F. Oxygen: The pediatric client has a medical need for Private Duty Nursing for oxygen administration only if there is documentation of rapid desaturation without the oxygen as evidenced by a drop in pulse oximeter readings below 85% within 15-20 minutes, and/or respiratory rate increases, and/or heart rate increases, and/or skin color changes. If oxygen is the only technology present, the Utilization Review Contractor shall review the case to determine medical necessity for Private Duty Nursing.
- G. Intravenous infusions, including Total Parenteral Nutrition (TPN), medications, and fluids: The pediatric client has a medical need for Private Duty Nursing during the hours required for the infusion.
- H. Tube feedings, including nasogastric tube, gastric tube, gastric button, and jejunostomy tube: A pediatric client with tube feedings may have a medical need for Private Duty Nursing. A pediatric client with tube feedings, whether intermittent or not, who is not on mechanical ventilation, shall be referred to the Utilization Review Contractor for an individual determination of the client's medical need for Private Duty Nursing.

.12 Clients twenty-one (21) years of age and older shall be considered adult clients. The medical criteria for adult clients are:

- A. Mechanical ventilation: The adult client has a medical need for Private Duty Nursing during the hours spent on the ventilator.
- B. Weaning from mechanical ventilation: The adult client has a medical need for Private Duty Nursing for ventilator weaning during the hours necessary to stabilize the client's condition. A stable condition shall be evidenced by the ability to clear secretions, vital signs that are stable, blood gases that are stable with oxygen greater than 92%, and pulse oximetry greater than 92%.
- C. Tracheostomy: An adult client with a tracheostomy, may have a medical need for Private Duty Nursing. An adult client with a tracheostomy, who is not on mechanical ventilation or being weaned from mechanical ventilation, shall be referred to the Utilization Review Contractor for an individual determination of medical need for Private Duty Nursing. The Utilization Review Contractor shall consider the client's combinations of technologies and co-morbidities when making this determination.
- D. Tracheostomy decannulation: An adult client with a tracheostomy decannulation may have a medical need for Private Duty Nursing. An adult client with a tracheostomy decannulation, who is not on mechanical ventilation or being weaned from mechanical ventilation, shall be referred to the Utilization Review Contractor for an individual determination of medical need for Private Duty Nursing. The Utilization Review Contractor shall consider the client's combinations of technologies and co-morbidities when making this determination.
- E. Continuous Positive Airway Pressure (C-PAP): An adult client with C-PAP may have a medical need for Private Duty Nursing. An adult client who has C-PAP, but is not on mechanical ventilation or being weaned from mechanical ventilation, shall be referred to the Utilization Review Contractor for an individual determination of the client's medical need for Private Duty Nursing. The Utilization Review Contractor shall consider the client's combinations of technologies and co-morbidities when making this determination.
- F. Oxygen: An adult client with oxygen supplementation may have a medical need for Private Duty Nursing. An adult client with oxygen supplementation, who is not on mechanical

ventilation or being weaned from mechanical ventilation, shall be referred to a Utilization Review Contractor for an individual determination of the client's medical need for Private Duty Nursing. The Utilization Review Contractor shall consider the client's combinations of technologies and co-morbidities when making this determination.

G. Intravenous infusions, including Total Parenteral Nutrition (TPN), medications, and fluids: An adult client receiving intravenous infusions may have a medical need for Private Duty Nursing. An adult client receiving intravenous infusions, who is not on mechanical ventilation or being weaned from mechanical ventilation, shall be referred to the Utilization Review Contractor for an individual determination of the client's medical need for Private Duty Nursing. The Utilization Review Contractor shall consider the client's combinations of technologies and comorbidities when making this determination.

H. Tube feedings, including nasogastric tube, gastric tube, gastric button, and jejunostomy tube: An adult client with tube feedings may have a medical need for Private Duty Nursing. An adult client with tube feedings, whether intermittent or not, who is not on mechanical ventilation nor being weaned from mechanical ventilation, shall be referred to the Utilization Review Contractor for an individual determination of the client's medical need for Private Duty Nursing.

.13 For both pediatric and adult clients, the Utilization Review Contractor shall consider the client's combinations of technologies and co-morbidities when making medical criteria determinations.

.14 Wherever the medical criteria are not defined by specific measurements (for example, "vital signs stable" or "rapid desaturation"), the medical judgment of the attending physician and the Utilization Review Contractor shall be used to determine if the criteria are met.

.15 Any client receiving Medicaid Private Duty Nursing prior to October 1, 1997, who is determined to be medically ineligible for Private Duty Nursing, or, is eligible for fewer hours of Private Duty Nursing than those already approved at the time the criteria are first applied, shall be approved for continuing Private Duty Nursing benefits at the same level until an alternate care plan is in place. These Private Duty Nursing Benefits shall be continued for no longer than six months after the determination. The Department staff shall work with the home health agency case coordinator on the alternate care plan, and explore alternate services including, but not limited to, Home Health benefits.

8.544 BENEFIT LIMITATIONS

.10 The Medicaid reimbursable hours of Private Duty Nursing shall never exceed the hours per day that are medically necessary in accordance with the medical criteria, as determined by the Utilization Review Contractor.

.11 Family/in-home caregivers are required to provide some of the Private Duty Nursing care. A client who meets the medical criteria for twenty (20) to twenty-four (24) hour Private Duty Nursing care shall receive no more than twenty (20) hours of Medicaid-reimbursed Private Duty Nursing per calendar day, except as described at §8.544.12(A) through §8.544.12(F).

.12 A client who meets the medical criteria for more than twenty (20) hour Private Duty Nursing care may be authorized by the Utilization Review Contractor to receive the maximum hours of Medicaid-reimbursed Private Duty Nursing per calendar day, determined to be necessary under the medical criteria, in the following situations:

A. For up to one calendar month after the initial discharge from the hospital, as needed to enable the family/in-home caregivers to become trained in care and procedures in the home; or

B. For up to fourteen (14) calendar days after subsequent re-hospitalizations, as needed to

enable the family/in-home caregivers to become trained in any changes in care and procedures in the home; or

- C. For up to fourteen (14) calendar days per episode if the client has an acute episode, which would otherwise require hospitalization; or
- D. For up to fourteen (14) calendar days per episode if the primary family/in-home caregiver is unable to provide care due to caregiver illness or temporary incapacity; or
- E. For up to twenty-one (21) calendar days per calendar year if the primary family/in-home caregiver is unable to provide care due to temporary absence for any reason, including but not limited to vacations and funerals; or
- F. For services prescribed as a result of an EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance.

.13 The Utilization Review Contractor shall work with the attending physician and the home health agency when it appears that the maximum time limits should be extended based on the client's medical condition, care changes, or other circumstances. The Utilization Review Contractor may grant an extension if warranted, and shall consult with the home health agency, and the attending physician or primary care physician, to provide medical case management, with the goal of resolving the problem that precipitated the need for extended Medicaid-reimbursed care of more than twenty (20) hour Private Duty Nursing care.

8.545 OTHER REQUIREMENTS

.10 CLIENT/FAMILY/IN-HOME CAREGIVER REQUIREMENTS

A. There must be documented evidence of:

- 1. A family/in-home caregiver who is able to assume some portion of the client's care; and
- 2. Demonstration by the family/in-home caregiver of the specific skills necessary to care for the client; and
- 3. Completion by all family/in-home caregivers of cardiopulmonary resuscitation (CPR) instruction or certification, and/or training specific to the client's emergency needs prior to admission to Private Duty Nursing; and
- 4. Family/in-home caregiver ability to maintain a home environment that allows for safe home care, including a routine for emergency situations.

B. The family/in-home caregiver(s) shall:

- 1. Participate in the planning, implementation and evaluation of Private Duty Nursing services; and
- 2. Communicate changes in care needs and any problems to service providers and physicians as needed; and
- 3. Work toward maximum independence, including finding and using alternative resources as appropriate.

.11 HOME ENVIRONMENTAL REQUIREMENTS

A. Living arrangements that will allow safe home care must be demonstrated. including:

1. Adequate electrical power including back-up power system; and
2. Adequate space for equipment and supplies; and
3. Adequate fire safety and adequate exits for medical and other emergencies; and
4. A clean environment to the extent that the client's life or health is not at risk; and
5. A working telephone available 24 hours a day; and
6. Notification to power companies, fire departments, and other pertinent agencies, of the presence of a special needs person in the household, to ensure appropriate response in case of power outage, fire, or other emergency; and
7. Financial stability of family/in-home caregiver, which is adequate to continue environmental support

.12 ATTENDING PHYSICIAN REQUIREMENTS

A. The attending physician shall:

1. Determine that the client is medically stable, except for acute episodes that can be managed under Private Duty Nursing; and that the client can be safely served under the requirements and limitations of the Private Duty Nursing benefit and within the availability of services; and
2. Cooperate with the Utilization Review Contractor in establishing medical eligibility by providing all relevant information; and
3. Prescribe a plan of care at least every sixty-two (62) days; and
4. Coordinate with any other physicians who are treating the client; and
5. Communicate with the home health agency about changes in the client's medical condition and care, especially upon discharge from the hospital; and
6. Empower the client/family/in-home caregivers by working with them and the home health agency to maximize independence

.13 HOSPITAL DISCHARGE PLANNER REQUIREMENTS

- A. If the client is hospitalized at the time Private Duty Nursing services are first requested by the client or the client's designated representative, the hospital discharge planner shall submit an application to the Utilization Review Contractor, prior to hospital discharge as described at §8.547.
- B. The hospital discharge planner shall refer the client or the client's authorized representative to appropriate agencies for Medicaid eligibility determination in the non-institutional setting, as needed.
- C. During the initial hospitalization, and during all re-hospitalizations, the hospital discharge planner shall plan for hospital discharge by:

1. Arranging services with home health agencies, medical equipment suppliers, and other health care service providers as needed; and
2. Coordinating, in conjunction with the physician and the home health agency, a home care plan that is safe and meets Medicaid requirements; and
3. Communicating with home health agencies any changes in medical condition and care needs; and
4. Ensuring that the client, family, and caregivers are educated about the client's medical condition and trained to perform the home care.

.14 HOME HEALTH AGENCY PROVIDER REQUIREMENTS

A. A Medicaid certified home health agency may be authorized to provide Private Duty Nursing services if the agency:

1. Has previous experience, or staff experienced, in providing care to technology dependent persons; and
2. Has available nursing personnel with appropriate documented skills for the client's care; and
3. Is willing to contract with a supplemental Medicaid certified home health agency, if necessary, to meet the staffing needs of the client, with assurance that this relationship is adequately supervised, and meets the conditions of Medicare/Medicaid; and
4. Is willing to have the primary nurse and other personnel, as appropriate, spend time in the hospital prior to the initial hospital discharge, to refine skills and become familiar with individualized care requirements; and prior to discharge after re-hospitalization when warranted by changes in medical condition and care needs; and
5. Is willing to provide a case coordinator who will assume responsibility for managing home care; and
6. Is able and willing to provide adequate supervision and training for all nursing staff; and
7. Has had experience, or has staff experienced or trained, in providing services to the client's particular demographic or cultural group.

B. The home health agency shall designate a case coordinator whose responsibilities in the management of home care shall include the following:

1. Assisting with the hospital discharge planning process by providing input and information to, and by obtaining information from, the hospital discharge planner and attending physician, regarding the home care plan; and
2. Assessing the home prior to the initial hospital discharge, and on an ongoing basis, for compliance with 8.545.11; and
3. Submitting an application for Private Duty Nursing to the Utilization Review Contractor if the client is not in the hospital at the time services are requested by the client

or the client's designated representative; and

4. Referring the client or the client's designated representative to the appropriate agency for Medicaid eligibility determination if needed; and
5. Ensuring that Prior Authorization Requests (PAR's) are submitted to the Utilization Review Contractor prior to the start of care and before the previous PAR expires; and that PAR's are completed in accordance with requirements at 8.548, and
6. Providing overall coordination of home services and service providers; and
7. Involving the client/family/in-home caregiver in the plan for home care and the provision of home care; and
8. Assisting and empowering the client/family/in-home caregiver to reach maximum independence by encouraging and building on strengths and by assisting with finding other resources; and

.14 HOME HEALTH AGENCY PROVIDER REQUIREMENTS (Conclusion)

9. Communicating changes in the case status with the attending physician and with the Utilization Review Contractor on a timely basis', including changes in medical conditions and/or psychological/social situations which may affect safety and home care needs; and
10. Assisting with communication and coordination between the primary care physician and all specialists, as needed; and
11. Making regular on-site visits to monitor the safety and quality of home care, with referrals to appropriate agencies as necessary; and
12. Ensuring that complete and current care plans and nursing charts are in the client's home at all times. Charts must include interim physician orders, current medication orders, and nursing notes. Records of treatments and interventions must clearly show accordance with the times indicated as necessary on the care plans; and
13. Communicating with case managers as needed regarding service planning and coordination.

C. The home health agency shall provide Private Duty Nursing services by personnel who have:

1. Appropriate licensure to practice nursing in Colorado; and
2. Appropriate documented general nursing skills and skills for the specific care required by the client; and
3. Appropriate nursing skills orientation and on-going inservice education to meet the client's specific nursing care needs; and
4. Recently completed cardiopulmonary resuscitation (CPR) instruction and certification.

D. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

.15 DURABLE MEDICAL EQUIPMENT/SUPPLY PROVIDER REQUIREMENTS

A. A Medicaid-enrolled company supplying life-sustaining and other equipment in the home for a Private Duty Nursing client shall be able to provide:

1. Twenty-four (24) hour availability of professionals, for equipment repair or phone assistance, as necessary; and
2. Pediatric expertise if serving clients less than twenty-one (21) years of age; and
3. Preventative maintenance of equipment; and
4. Written instructions in the home for the operation and maintenance of equipment, including emergency procedures.

8.546 CLIENT RIGHTS

.10 The client, or client's designated representative, shall have the right to participate in all care planning and to choose any qualified and available provider.

.11 The client shall have the right to appeal as specified at §8.057 through §8.059.

8.547 APPLICATION PROCEDURES

.10 If the client is hospitalized at the time Private Duty Nursing services are first requested by the client or the client's designated representative, the hospital discharge planner shall submit an application to the Utilization Review Contractor. If the client is not in the hospital at the time that services are first requested, the home health agency case coordinator shall submit the application to the Utilization Review Contractor.

.11 Applications may be submitted up to six months prior to the anticipated need. Updated medical information shall be sent to the Utilization Review Contractor as soon as the service start date is known.

.12 The application shall be submitted on a state-prescribed Private Duty Nursing Application Form that is completed and signed. Any medical information helpful in determining the client's medical need shall be sent with the application form, e.g., History and Physical, and hospital discharge summary records.

.13 If the client has other insurance, which has denied coverage of Private Duty Nursing, a copy of the denial letter and the insurance policy shall be induced with the application. If all Medicaid Private Duty Nursing, requirements are met, approval shall not be delayed due to investigation of insurance denials.

.14 If the client is in a medical foster care placement, a copy of the foster care plan shall be included.

.15 If services are being requested beyond the twenty (20) hour per day benefit limitation as a result of an EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance, written documentation of those screening results shall be included with the application. The EPSDT claim form will not meet this requirement.

.16 The Utilization Review Contractor shall review applications for Private Duty Nursing according to the following procedures:

A. The Utilization Review Contractor Nurse Reviewer shall review information according to the requirements at §8.542.

B. The Utilization Review Contractor Nurse Reviewer shall apply the medical criteria as described at §8.543.

- C. If the application is not complete, the Utilization Review Contractor Nurse Reviewer shall return the application to the submitting party for more information within seven (7) working days of receipt of the incomplete application.
- D. The Utilization Review Contractor Nurse Reviewer shall approve the application, or refer the application to the Utilization Review Contractor Physician Reviewer, within ten (10) working days of receipt of the complete application.
- E. The Utilization Review Contractor Physician Reviewer shall process referrals and approve or deny the application within ten (10) working days of receipt of the referral. The Physician Reviewer shall attempt to contact the attending physician or the primary care physician for more information prior to denial of Private Duty Nursing services.
- F. The Utilization Review Contractor shall notify the client or the client's designated representative and the submitting party of application approval.
- G. If the application is denied, the Utilization Review Contractor shall notify the client, the client's designated representative and the submitting party of the client's appeal rights, by placing written notification in the mail within one (1) working day of the decision.
- H. The Utilization Review Contractor shall convene a reconsideration panel of at least two physicians within thirty (30) working days of receipt of the client's notice of intent to appeal. The Utilization Review Contractor shall notify the client in writing, within five (5) working days, of the decision of the reconsideration panel, with information about the next level of appeal. The panel may convene telephonically to expedite the reconsideration, unless the client or client's designated representative requests otherwise.
- I. The Utilization Review Contractor shall expedite reviews in situations where adhering to the time frames above would seriously jeopardize the client's life or health.

.17 Clients who are approved and who subsequently discontinue Private Duty Nursing for any reason do not need an application to request resumption of Private Duty Nursing services within six (6) months. Service may be resumed upon approval of a Prior Authorization Request (PAR), as described at §8.548.

8.548 PRIOR AUTHORIZATION PROCEDURES

.10 The home health agency shall submit the initial Prior Authorization Request (PAR) to the Utilization Review Contractor prior to the start of Private Duty Nursing, and at least every six (6) months for ongoing care. The PAR shall meet the following requirements:

- A. The Prior Authorization Request (PAR) shall be submitted on a State-prescribed Private Duty Nursing PAR form. A copy of the current plan of care must be submitted with each PAR. For new clients admitted to Private Duty Nursing directly from the hospital, a copy of the documented verbal physician orders may be substituted for the plan of care, if the client has been approved for admission to the program.
- B. All PAR'S shall be legible, and completed according to instructions on the PAR form. All PAR'S shall include the client's correct and current address and telephone number.
- C. The plan of care must be on the HCFA 485 form, or a form that is identical in format to the HCFA 485. All sections of the form relating to nursing needs must be completed.
- D. The plan of care shall include a signed nursing assessment, a current clinical summary or update of the client's condition, and a physician's plan of treatment. The plan of care will

be accepted prior to the physician's signature for prior authorization purposes. A hospital discharge summary shall be included if there was a hospitalization since the last PAR.

- E. The plan of care shall indicate the frequency and the times of day that all technology-related care are to be administered.
- F. A PAR for Private Duty Nursing shall include only the Private Duty Nursing services of Private Duty Nursing-RN, and/or Private Duty Nursing-LPN. If any other services are included on the PAR, the Utilization Review Contractor shall return the PAR without processing it.
- G. A PAR shall cover a period of no longer than six (6) months.
- H. When a change in the plan of care results in an increase in hours, the home health agency shall submit a revised PAR to the Utilization Review Contractor, with a revised plan of care or a copy of the physician's verbal orders for the increased hours including the effective date, within one (1) working day.
- I. When a change in the client's condition occurs which could affect the client's eligibility for Private Duty Nursing, or the number of hours for which the client may be eligible, the home health agency shall notify the Utilization Review Contractor within one (1) working day of the change. Failure to notify the Utilization Review Contractor may result in recovery of inappropriate payments, if any, from the home health agency.
- J. When a client is discharged prior to the end date of a PAR, a revised PAR shall be submitted, within five (5) working days of the discharge, to revise the end date and the number of service units.
- K. If the PAR includes increased services because other insurance has denied or decreased coverage of Private Duty Nursing since the last PAR, a copy of the denial letter and the insurance policy shall be included with the PAR. If all Medicaid Private Duty Nursing requirements are met, approval of the additional hours shall not be delayed due to any investigation of insurance denials.
- L. If the client is in a medical foster care placement, a copy of the foster care plan shall be included, and also whenever the foster care plan is changed or renewed.
- M. If services are being requested beyond the twenty (20) hour per day benefit limitation as a result of an EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance, written documentation of those screening results shall be included with the prior authorization when the additional services are first requested. The EPSDT claim form alone will not meet this requirement

.11 The Utilization Review Contractor shall review Prior Authorization Requests (PAR's) for Private Duty Nursing according to the following procedures:

- A. The Utilization Review Contractor shall review information according to the requirements at §8.542.
- B. The Utilization Review Contractor shall apply the medical criteria as described at §8.543.
- C. Incomplete PARS shall be returned to the home health agency for correction within ten (10) working days of receipt
- D. The Utilization Review Contractor Nurse Reviewer shall approve the PAR, or refer the PAR to the Utilization Review Contractor Physician Reviewer, within ten (10) working days of

receipt of the complete PAR.

- E. The clients and submitting party shall be notified in writing of all PAR denials and the client's appeal rights, within one (1) working day of the decision.
- F. If a PAR is referred to the Utilization Review Contractor Physician Reviewer and is approved, subsequent PAR'S may be approved by the Nurse Reviewer without referral to the Physician Reviewer, if the client's condition and the requested hours have not changed.
- G. The Utilization Review Contractor shall notify the Department of Health Care Policy and Financing of all extraordinary Private Duty Nursing services approved as a result of an EPSDT screen.
- H. The Utilization Review Contractor Physician Reviewer shall process referrals and approve, partially approve, or deny the PAR within ten (10) working days of receipt of the referral from the Nurse Reviewer. The Utilization Review Contractor shall attempt to contact the attending physician or the primary care physician for more information prior to a denial or reduction in services.
- I. The Utilization Review Contractor shall notify the submitting party of all PAR approvals.
- J. The Utilization Review Contractor shall convene a reconsideration panel of at least two physicians within thirty (30) working days of receipt of the client's notice of intent to appeal; and will notify the client in writing, within five(5) working days, of the decision of the reconsideration panel, with information about the next level of appeal. The panel may convene telephonically to expedite the reconsideration, unless the client or client's designated representative requests otherwise.
- K. The Utilization Review Contractor shall expedite PAR reviews in situations where adhering to the time frames above would seriously jeopardize the client's life or health.

.12 No services shall be approved for dates of service prior to the date the Utilization Review Contractor receives a complete Prior Authorization Request (PAR). This rule applies to new admissions, re-admissions, and on-going clients. PAR revisions for increased services may be approved back to the day prior to receipt by the Utilization Review Contractor if the revised PAR was received within one (1) working day of the increase in services. Facsimiles will be accepted.

.13 No services shall be authorized nor reimbursed if all services, regardless of funding source, total more than twenty four (24) hours per day.

.14 No services shall be authorized nor reimbursed if the care is duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health, other insurance or medical foster care.

.15 Approval of the PAR by the Utilization Review Contractor shall authorize the home health agency to submit claims to the Medicaid fiscal agent for authorized Private Duty Nursing services provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service, and the provider's use of correct billing procedures.

.16 In addition, the Utilization Review Contractor Nurse Reviewer may attend discharge planning conferences; and may conduct on-site visits to each client at admission and every six months thereafter, or as needed or useful.

8.549 REIMBURSEMENT

- .10 All Private Duty Nursing services must be prior authorized by the Utilization Review Contractor.
- .11 No services shall be reimbursed for dates of service prior to the PAR start date as authorized by the Utilization Review Contractor.
- .12 Skilled nursing services under the Medicaid Private Duty Nursing benefit shall be reimbursed under Special Program Code 81, in units of one hour, at the Providers usual and customary charge or the maximum Medicaid allowable rates established by the Department, whichever is less, and in accordance with available funding. Units of one hour may be billed for registered nurse (RN), licensed practical nurse (LPN), RN group rate (registered nurse providing Private Duty Nursing to more than one client at the same time in the same setting), LPN group rate (licensed practical nurse providing Private Duty Nursing to more than one client at the same time in the same setting, or Blended RN/LPN rate (group rate by request of the home health agency only).
- .13 The decision to use an LPN shall be at the discretion of the attending physician, the home health agency and the RN responsible for supervising the LPN. This decision shall not be made by the Department or the Utilization Review Contractor.
- .14 Maximum reimbursement rates may be adjusted by the State as funding becomes available.

8.550 HOSPICE SERVICES

Hospice services are a comprehensive program of palliative and supportive medical services elected by Medicaid clients who are terminally ill. Hospice services may be provided in the client's place of residence on a routine or continuous basis. Inpatient hospice services can be provided at the general inpatient or respite care levels in an inpatient facility meeting Medicare inpatient hospice standards. Such services are provided within a continuum of inpatient care and home care.

8.550.1 DEFINITIONS

"Attending physician" is a doctor of medicine or osteopathy who is identified by the client, at the time he or she elects to receive hospice care, or subsequently, as having the most significant role in the determination and delivery of the client's medical care.

"Certification" is affirmation by a Medicaid client's physician that the prognosis of the client's life expectancy is six months or less if the terminal illness runs its normal course.

"Election" refers to the written expression of the Medicaid client to choose hospice care pursuant to the Medicaid Hospice Benefit as the client's care preference for a terminal illness. Should the Medicaid Hospice Benefit be discontinued for a client who has previously elected the Benefit, either due to discharge, revocation, or loss of Medicaid coverage, the client may pursue "re-election" of the Medicaid Hospice Benefit if and when the client again qualifies.

"Home care services" are hospice services which are provided primarily in the client's home but may be provided in a residential facility and/or licensed health care facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, home health aide, homemaker, physical therapy, counseling, trained volunteer and social services.

"Hospice" is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual, and sociological care to terminally ill clients and their families. The hospice shall meet the Medicare conditions of participation for hospices and be licensed as a hospice by the Colorado Department of Public Health and Environment

"Interdisciplinary team" or "interdisciplinary group" is a group of qualified individuals, consisting of at least a physician, registered nurse, clergy/counselors, volunteer director and/or trained volunteers, and

appropriate staff who collectively have expertise in meeting the special needs of hospice clients/families.

“Palliative and supportive medical services” are those services and/or interventions which are not curative but which produce the greatest degree of relief from the symptoms of the terminal illness.

“Re-certification” refers to the written statement of affirmation concerning the prognosis of life expectancy that must be obtained at the beginning of each Medicaid Hospice Benefit period subsequent to the first period within which a client has elected the Medicaid Hospice Benefit.

“Terminally ill client” means a client whose medical prognosis of his or her life expectancy is six months or less.

8.550.2 GENERAL ELIGIBILITY REQUIREMENT

A program client shall be determined to be eligible to elect hospice care when the following requirements are met:

- A. The place of residence for the Medicaid client electing the Medicaid Hospice Benefit is either a private residence, residential care facility, licensed hospice facility, intermediate care facility for the mentally retarded (ICF-MR), or a skilled nursing facility (unless the client is in a waiver program which does not allow residency in an ICF-MR or skilled nursing facility).
- B. The person is certified by an attending physician and/or hospice medical director, as appropriate, as being terminally ill as defined above; and
- C. Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions, for the person's comfort not for the prolongation of life; and
- D. The client must elect hospice care in accordance with ELECTION PROCEDURES Section of this manual; and
- E. An initial plan of care must be established by the hospice provider before services are provided.
- F. Hospice clients residing in ICF-MRs or skilled nursing facilities must meet the medical and financial eligibility criteria for institutional care as required by Medicaid Nursing Facility regulations.
- G. Eligibility for, and access to, the Medicaid Hospice Benefit does not fall within the purview of the long term care Single Entry Point system.

8.550.3 PHYSICIAN CERTIFICATION OF TERMINAL ILLNESS REQUIREMENTS

The benefit periods for hospice services shall correspond to Medicare benefit periods, provided no one benefit period exceeds 210 days in length. The hospice must obtain the certification that a client is terminally ill in accordance with the following procedures:

- A. For the first benefit period of hospice coverage, or re-election following revocation or discharge from the hospice benefit, the hospice must obtain:
 - 1. a verbal certification statement from either the medical director of the hospice or the physician member of the hospice interdisciplinary group and the client's attending physician (if the client has an attending physician) no later than two calendar days after hospice care is initiated; (The verbal certification must include the statement that the medical prognosis of the client's life expectancy is six months or less if the terminal illness runs its normal course, and the approval of the physician(s).); and

2. a written certification statement signed by either the medical director of the hospice or the physician member of the hospice interdisciplinary group and the client's attending physician (if the client has an attending physician) must be obtained and on file prior to submittal of any claim for reimbursement to the Medicaid fiscal agent. (The certification must include the statement that the medical prognosis of the client's life expectancy is six months or less if the terminal illness runs its normal course, and must be signed by the physician.
- B. At the beginning of each subsequent period, the hospice must obtain a subsequent written recertification statement prepared by either the attending physician, the medical director of the hospice, or the physician member of the hospice interdisciplinary group. (The recertification must include the statement that the medical prognosis of the client's life expectancy is six months or less if the terminal illness runs its normal course, and must be signed by the physician.

8.550.4 ELECTION

An election to receive hospice care will be considered to continue through the initial election period and through any subsequent election periods without a break in care as long as the client remains in the care of the elected hospice and does not revoke that election.

- A. If a client elects to receive hospice care, the client or the client's representative must file an election statement that must include the following:
1. Identification of the particular hospice that will provide care to the client.
 2. The client's or representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the client's terminal illness.
 3. The effective date of the election.
 - a. A client or representative designates an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care.
 - b. A client or representative may not designate an effective date that is earlier than the date that the election is made.
 4. For the duration of the election of hospice services, the client must waive all rights to Medicaid payments for the following services:
 - a. Hospice services provided by a hospice other than the hospice provider designated by the client (unless contracted by the designated hospice provider).
 - b. All other Medicaid services which duplicate hospice services.
 5. The signature of the client or the client's representative as allowed by Colorado law.
- B. The Medicaid Hospice Benefit client may revoke the election of hospice care at any time during a benefit period, thereby ending that benefit period. To revoke the election, the client or representative must file a signed statement with the hospice that the client or representative revokes the election for hospice care. The statement must include the following information:
1. The date that the revocation is to be effective. A client may not designate an effective date earlier than the date that the revocation is made.

2. The client, upon revocation of the benefit period, will resume coverage of the benefits waived at the time hospice services were elected. The client may, at any time, re-elect to receive hospice care for any other hospice benefit periods that he or she is eligible to receive.
- C. A client may change, once in each benefit period, the designation of the hospice provider from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the client must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:
1. The name of the hospice from which the client has received care and the name of the hospice which he or she plans to receive care; and
 2. The date that change is to be effective; and
 3. The signature of the client or representative.

8.550.5 HOSPICE SERVICES COVERED

To be covered, the hospice services must be reasonable and necessary for the palliation or management of the terminal illness as well as any related condition, and not for the prolongation of life.

All services covered under hospice services are listed in 42 CFR 418.202 (Subpart D) section on COVERED SERVICES. This cited section as well as subsequent sections are from Part 418 section on HOSPICE CARE of the Code of Federal Regulations, 42 CFR Chapter IV (10-1-96 Edition); Health Care Financing Administration, Department of Health and Human Services. No amendments are incorporated. The Code of Federal Regulations, 42 Parts 400 to 429, Revised as of October 1, 1996, published by the Office of the Federal Register National Archives and Records Administration, may be obtained for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Copies are maintained at the Denver Public Library, 1357 Broadway, Denver, CO 80203. Copies are also maintained for public inspection during regular business hours or available at cost from the Colorado Department of Health Care Policy and Financing, 1575 Sherman St., Denver, Colorado 80203-1714.

.51 MEDICAID HOSPICE BENEFIT SERVICES INCLUDE, BUT ARE NOT LIMITED TO:

- A. Nursing care provided by or under the supervision of a registered nurse.
- B. Medical social services provided by a qualified social worker or counselor under the direction of a physician.
- C. Counseling services, including dietary and spiritual counseling, provided to the terminally ill client and the family members or other persons caring for the client
- D. Bereavement counseling, up to one year following the death of the hospice client, as described at 42 CFR 418.88.
- E. Short term general inpatient care necessary for pain control and/or symptom management.
- F. Short term inpatient respite care of up to five (5) consecutive days to provide respite for the client's family or other persons caring for the client at home.
- G. Medical appliances and supplies, including drugs and biologicals, which are used primarily for symptom control and relief of pain related to the terminal illness.
- H. Intermittent Home Health Aide services provided by a certified nurse aide under the general

supervision of a registered nurse, including personal care and homemaker services (incidental to a visit) as described at 42 CFR 409.45(b).

- I. Physical therapy, occupational therapy, and speech-language therapy appropriate to the terminal condition and provided for the purposes of symptom control or to enable the terminal client to maintain activities of daily living and basic functional skills.

.52 SERVICES NOT COVERED BY THE MEDICAID HOSPICE BENEFIT INCLUDE, BUT ARE NOT LIMITED TO:

- A. Services provided before or after the hospice election period.
- B. Services of the client's attending or consulting physician.
- C. Services received for the treatment of an illness or injury not related to the client's terminal condition.
- D. Services clearly not included in the Medicaid Hospice Benefit, such as electronic monitoring, nonmedical transportation, and home modification under a Home and Community-Based Services (HCBS) program.
- E. Medicaid personal care and homemaker services beyond the scope provided under the Medicaid Hospice Benefit, such as use of personal caregivers under the HCBS program for the Elderly, Blind and Disabled (HCBS-EBD) to accompany the client outside the home or to provide protective oversight as described at Section 8.489.20 of this manual.

8.550.6 HOSPICE REIMBURSEMENT

Medicaid reimbursement for hospice care will be made at one of four predetermined rates for each day in which a client is under the care of the hospice. If no other level of care is indicated on a given day, it is presumed that routine home care is the applicable rate.

Reimbursement follows the method prescribed in 42 CFR 418.302-306 (Subpart E) section on REIMBURSEMENT METHODS (source cited in the section on HOSPICE SERVICES COVERED in this manual).

A. Reimbursement Rates

1. Rates equal those published by HCFA for Medicaid hospice reimbursement.
2. Each care-level per-diem rate is subject to a wage index multiplier, to compensate for regional differences in wage costs, plus a fixed non-wage component.
3. The wage indices are published in the Federal Register.
4. Continuous home care is reimbursed at the applicable hourly rate (the per-diem rate divided by 24 hours) times the number of hourly units billed (from 8 up to 24 hours per day of continuous care).
5. Rates are adjusted for cost-of-living increases and other factors as published by HCFA.
6. Reimbursement for routine home care and continuous home care shall be based upon the geographic location at which the service is furnished and not on the business address of the hospice provider.

B. Care Level Determination and Reimbursement

1. Routine home care. The hospice will be paid the routine home care rate for each day the client is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.
 2. Continuous home care The hospice will be paid the continuous home care rate when continuous home care is provided. Continuous home care is to be provided only during a period of medical crisis to maintain a client at home. A period of crisis is a period in which a client requires continuous care, which is primarily nursing care, to achieve palliation or for the management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse. A nurse must be providing more than half of the period of care. Homemaker and aide services may also be provided to supplement nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.
 3. Inpatient respite care The hospice will be paid at the inpatient respite care rate for each day on which the client is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine hospice provider's 20 percent aggregate inpatient days cap as outlined in paragraph G in this section.
 4. General inpatient care. Payment at the inpatient rate will be made when general inpatient care is provided. Payment for general inpatient care is subject to the hospice provider's 20 percent aggregate inpatient days cap as outlined in paragraph G in this section.
- C. Physician services. All physician services for Medicaid Hospice Benefit clients are reimbursed to the physician according to the usual and customary Medicaid reimbursement policies for physician services. Medicaid Hospice Benefit clients enrolled in Health Maintenance Organizations (HMOs) may choose to remain in the HMO so as not to interrupt the physician-patient relationship.
- D. Nursing Home Reimbursement. When hospice care is provided to Medicaid Hospice Benefit clients residing in intermediate care facilities for the mentally retarded (ICF-MRs) or skilled nursing facilities, the hospice is paid a room and board fee in addition to the hospice per-diem for each routine home care day and continuous care day provided under hospice. The additional payment for room and board is reimbursed to the hospice provider on behalf of the client residing in the facility at a rate equal to 95 percent of the amount the State would have paid under the State plan for that facility' less any patient payments. Payments for room and board are exempt from the computation of the Medicaid Hospice Benefit payments cap.
- E. Reimbursement for Date of Discharge.
1. For the day of discharge from inpatient care (general or respite), the appropriate home care rate (routine or continuous care) is paid unless the client dies at an inpatient level of care. When the client dies at an inpatient level of care, the applicable inpatient rate (general or respite) is paid for the discharge date.
 2. When the client is discharged (alive or deceased) from the Medicaid Hospice Benefit reimbursement is made for services delivered up to the time of discharge including applicable per-diem payment for the date of discharge.
- F. Aggregate Payments Cap. Aggregate payment to the hospice provider under the Medicaid Hospice Benefit is subject to an annual indexed aggregate cost cap. The method for determining and

reporting the cost cap shall be identical to the Medicare Hospice Benefit requirements as contained in 42 CFR (Sections 418.308, 418.309).

- G. Aggregate Inpatient Days Cap. Aggregate days of care provided by the hospice under the Medicaid Hospice Benefit is subject to an annual limitation of no more than 20 percent inpatient care days (general and respite). The method for determining and reporting the inpatient days percentage shall be identical to the Medicare Hospice Benefit requirements as contained in 42 CFR (Sections 418.301, 418.302). Inpatient days in excess of the 20 percent limitation will be reimbursed at the routine home care rate.

.61 Neither the State nor hospice providers shall collect co-payments (i.e., deductible, cost sharing or similar charge) on hospice care benefits including biologicals and respite care. Patient payments for room & board charges will be collected for hospice clients residing in skilled nursing facilities or intermediate care facilities for the mentally retarded (ICF-MRs) as required by Medicaid Nursing Facility regulations. While the Medicaid skilled nursing facility and ICF-MR room & board payments must be made directly to the hospice provider, the patient payment may, at the hospice provider option, be collected by the facility.

.62 The benefit periods for reimbursement of hospice shall correspond to Medicare benefit periods, provided that no one benefit period exceeds 210 days in length.

8.550.7 HOSPICE QUALIFICATIONS

The hospice must be licensed by the Colorado Department of Public Health and Environment, have a valid provider agreement with the State, and meet the Medicare conditions for participation requirement in order to provide Medicaid Hospice Benefit services.

8.550.8 CONDITIONS OF PARTICIPATION

.81 Conditions of participation for hospice services are identical to those required by Medicare Hospice under 42 CFR 418.50 through 418.100 (Subpart C) (source cited in the section on HOSPICE SERVICES COVERED in this manual). These sections establish the requirements for:

- A. Administration (i.e., governing body, medical direction, professional management, plan of care, continuation of care, informed consent, in service training, quality assurance, interdisciplinary group, volunteers, licensure, and central clinical records).
- B. Core Services (i.e., nursing services, medical social services, physician services, counseling services).
- C. Other Services (i.e., physical therapy, O.T., and speech language pathology, home health aide, and homemaker services, medical supplies, short term inpatient care).
- D. Freestanding Hospice with Inpatient Unit.

.82 Laboratory services provided by hospices enrolled in the Medicaid program are subject to the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as set forth in sections 8.660 - 8.666 of this manual. Hospice providers that collect specimens, including drawing blood, but do not perform testing of specimens, are not subject to CLIA requirements.

8.550.9 PROTOCOL FOR SERVICE DELIVERY

.91 Prior authorization of Medicaid Hospice Benefit services is not required, but the Department or its agent(s) may retrospectively review any hospice case for appropriateness of care level.

.92 Hospice Services

- A. Each hospice provider will perform case management as part of its care service to a Medicaid Hospice Benefit client. The hospice provider will not be reimbursed separately by Medicaid for this responsibility.
- B. The hospice provider will determine the amount, frequency, and duration of client services, in accordance with the client's plan of care developed by the hospice provider, in consultation with the client and his or her physician. This documentation will be kept in the client's file.
- C. An individual client record must be maintained by the designated hospice. The qualifications for hospice must be documented in each client's record. The hospice provider will also maintain a record of the services delivered to the client based on the hospice plan of care in the client file. Documentation must be adequate to support the care level for which the hospice provider has claimed reimbursement. Inadequate documentation shall be a basis of recovery for overpayment by the Department. The hospice provider may appeal such an adverse action in accordance with Section 8.050. PROVIDER APPEALS AND HEARINGS.
- D. Notice of the client's election of the Medicaid Hospice Benefit and benefit periods shall be provided to the Medicaid fiscal agent in such form and manner as prescribed by the State.
- E. The hospice will submit all billing to the Medicaid fiscal agent within such timeframes and in such form as prescribed by the State.
- F. The hospice provider must provide reports and keep records as the State or its designee determines necessary to administer the Medicaid Hospice Benefit, including records which document the cost of providing care to Medicaid Hospice Benefit clients.

8.551.1 GENERAL DEFINITIONS

- A. Attendant means the individual(s) who provides Attendant Support services as defined below.
- B. Attendant Support means supportive services, which include skilled nursing services and home health aide services, as defined under the Home Health Program at §8.525.10 and §8.525.11 and Personal Care and Homemaker Services, as defined under the Long-Term Care Program at §8.489 and §8.490. Attendant Support does not include occupational therapy services (§8.525.13), physical therapy services (§8.515.12) or speech/language pathology services (§8.525.14). Additionally, Attendant Support includes Long Term Home Health and Long Term with Acute Episode Home Health, but does not include Acute Home Health.
- C. Attendant Support Management Training means the required training, including a final, comprehensive test, provided by the Department or its designee to program applicants who meet program eligibility and who have been selected for the program.
- D. Case Manager means the individual employed by Single Entry Point agency who provides case management services to participants under Home and Community Based Services waivers.
- E. Intermediary Service Organization means the entity or entities under contract with the Department to provide financial and personnel administration for Program Participants.
- F. Fund for Additional Services means the account that reflects a portion of accumulated savings by Program Participants resulting from their use of less than their full Individual Allocation, and which shall be available to Program Participants by application.
- G. Individual Allocation means the funds made available by the Department to Program Participants and administered by an Intermediary Service Organization. These funds shall be made available each month that a Program Participant meets program eligibility, and shall be calculated based on the

Program Participant's history of utilization of Attendant Support.

- H. Program Participant means an individual who meets all program eligibility criteria, who has completed the Attendant Support Management Training, who has been notified by the Department of his or her enrollment in the program, and who desires to continue participating in the program.

8.551.2 COVERED SERVICES

Services offered to Program Participants in the Consumer Directed Attendant Support Program (CDAS) shall include the services constituting Attendant Support, as defined at §8.551.1(B). These services are nursing, home health aide, unskilled personal care, and homemaking as defined below. No other services are covered.

- A. Nursing services include those skilled nursing services that are typically provided by a registered nurse under applicable state laws and professional standards.
- B. Nursing services also include skilled nursing services, which are typically provided by a licensed practical nurse under the direction of a registered nurse to the extent allowed under applicable state laws.
- C. Home health aide services includes nurse aide tasks typically performed by a certified nurse aide pursuant to the nurse aide scope of practice defined by the State Board of Nursing.
- D. Unskilled personal care includes those tasks as described under Home and Community-based Services - Elderly, Blind, and Disabled. Personal Care.
- E. Homemaking includes those tasks as described under Home and Community-based Services - Elderly, Blind, and Disabled, Homemaker Services.

8.551.3 PROGRAM ELIGIBILITY

A. Referral/Screening/Intake

- 1. Individuals wishing to apply for CDAS shall submit applications and supporting documentation to the Consumer Directed Attendant Support program at the Department.
- 2. Individuals shall submit a statement from the individual's primary care physician or treating physician that indicates that the individual has sound judgment and is in stable condition, both physically and emotionally.
- 3. The Eligibility Review Committee, a subcommittee of the CDAS Advisory Committee, may review applications for program eligibility, if the Department requests such a review. (See §8.551.3(D).) The Department makes the final determination of program eligibility.
- 4. All applicants shall be given written notification as to whether they have been determined eligible.
- 5. Applicants who are denied admission to the program shall be given a written notification within 15 calendar days of that denial explaining the reasons for denial and providing information on rights to fair hearing and appeal procedures, described at §8.057 through §8.059 regarding Recipient Appeals.

B. Medicaid Eligibility

- 1. Individuals participating in CDAS shall meet requirements for Medical Assistance eligibility.

2. Individuals who receive Home and Community-based Services (HCBS) personal care as the only Home and Community-based Services service, and who are eligible for Medicaid only because of eligibility for an HCBS waiver, shall be considered to be enrolled in the HCBS waiver when they substitute CDAS services for HCBS personal care.
3. For individuals participating in CDAS, Individual Allocations and contributions to the Fund for Additional Services shall not constitute income or assets and shall not impact financial eligibility for Medicaid.

C. Program Eligibility Criteria

To be eligible for CDAS, an individual shall:

1. Be willing to participate in the pilot program.
2. Be eligible for Medicaid.
3. Demonstrate a current need for Attendant Support and have received Medicaid-funded Attendant Support for the twelve months prior to application.
4. Document a pattern of stable health, which is a condition of health that necessitates a predictable pattern of Attendant Support, allowing for variation that is consistent with a medically predictable progression or variation of disability or illness. The documentation may include the individual's history of utilization of Medicaid-funded Attendant Support.
5. Provide a statement from his or her primary care physician or treating physician that indicates the individual has sound judgment and is in stable condition.
6. Demonstrate the ability to handle the financial aspects of self-directed Attendant care, either through prior experience or through completion of the Attendant Support Management Training. Ability to handle the financial aspects of self-directed Attendant care means:
 - a. The ability, to determine how the Individual Allocation should be spent, so as to ensure that the individual receives necessary Attendant Support, both in quantity and quality, and to ensure that Attendants receive appropriate compensation; and,
 - b. The ability to verify the accuracy of financial and personnel records as provided by the Intermediary Service Organization.

An individual, who, because of a cognitive disability, lacks the ability to handle the financial aspects of self-directed Attendant care, may designate a family member, friend or other support person to be responsible for financial management. A designated support person shall not direct the Attendant care, nor shall he or she receive reimbursement for financial management assistance.

7. Demonstrate the ability to manage the health aspects of his or her life, either through prior experience or through completion of the Attendant Support Management Training. Managing the health aspects of one's life includes the ability to understand principles and monitor conditions of basic health, and the knowledge of how, when and where to seek medical help of an appropriate nature.
8. Demonstrate the ability to supervise Attendants, either through prior experience or through completion of the Attendant Support Management Training. Ability to supervise Attendants means the knowledge and ability:
 - a. To recruit and hire Attendants,

- b. To communicate expectations,
- c. To provide training, guidance and review for Attendants in the accomplishment of Attendant tasks,
- d. To manage necessary paperwork, and
- e. To dismiss Attendants when necessary.

9. Receive services on a monthly basis.

D. Review of Continuing Eligibility

A Program Participant, whose continuing eligibility for CDAS has been questioned by a Single Entry Point (SEP), Case Manager or by the Department, shall receive a review of continuing eligibility for CDAS by the Department, with input from the Program Participant and the Eligibility Review Committee, as described below. The review shall assess whether the Program Participant can take any actions to establish continuing program eligibility. The Program Participant shall be provided with the results of the review and the recommended actions.

The Eligibility Review Committee shall be a subcommittee of the CDAS Advisory committee, shall be appointed by the Department, and shall be comprised of individuals who are knowledgeable in the fields of home health, Attendant care and consumer direction, who demonstrate a commitment to consumer directed services, who understand the diversity of backgrounds and circumstances of users of Attendant Support, and who are familiar with the intent and design of the program. The Eligibility Review Committee shall include a nurse, a home health agency administrator and two individuals who are users of Attendant Support. Members of the Eligibility Review committee shall not receive information that would provide the identity of the applicant or Program Participant.

E. Termination from CDAS

When the Department determines that a Program Participant is no longer eligible for CDAS, the Program Participant shall be informed by the Department through a written advance notice of at least fifteen calendar days that he or she is no longer eligible for CDAS, and that the Program Participant should contact his or her Case Manager for assistance in obtaining other home care services. The notice shall provide the Program Participant with the reasons for termination and with information about the Program Participant's rights to fair hearing and appeal procedures, in accordance with §8.057 through §8.059. Exceptions will be made to (he requirement for 15 days advance notice when the Department has documented that there is danger to the Program Participant or to the Attendants. The Program Participant's SEP Case Manager and the Intermediary Service Organization shall receive notice, of the date on which the Program Participant is being terminated from CDAS.

8.551.4 PARTICIPANT SELECTION

The number of Program Participants is limited to 150 eligible Program Participants at any one time. Eligible individuals shall be selected according to the following process.

A. Applicant Pools

All eligible applicants shall be assigned to either of two applicant pools:

1. The "Metro Pool" consisting of applicants from the counties of Adams, Arapahoe, Boulder, Douglas, Denver, El Paso, Jefferson, Larimer, Mesa, Pueblo and Weld; and
2. The "Rural Pool" consisting of applicants from all other counties.

B. Random Drawing

A random drawing twice a year of qualified applicants from the two applicant pools shall fill open program slots. The number of applicants selected from each pool shall be determined so as to maintain an appropriate rural/metro ratio as described below. Applicants who are selected shall be referred for Attendant Support Management Training.

C. Rural Metro Ratio

Participation in CDAS shall reflect a rural/metro ratio, as determined each year by the CDAS advisory committee. The rural/metro ratio shall be not less than 5%/95% and not greater than 20%/80%.

D. Waiting List

If the number of qualified applicants exceeds the number of open slots for a given applicant pool at the time of the selection process, the random drawing described above shall be used, and applicants not selected shall be placed on a waiting list for the appropriate applicant pool. Applicants placed on waiting lists shall be assigned a date-received code. During the next selection process, open slots in a given pool shall be filled first from that pool's waiting list and then by selection of new applicants. Selection from waiting lists shall be based on chronological order of the date-received codes. For all applicants having the same code, the selection process shall be random. The process shall continue until all slots are filled or all applicants have been selected.

8.551.5 SERVICES REQUIREMENTS

A. Conditions for Services

An individual can receive CDAS services only after:

1. The individual meets all program eligibility criteria;
2. The individual is selected for the program;
3. The individual completes the Attendant Support Management Training, including passage of a final, comprehensive test and the development of an Attendant Support management plan, as described at §8.551.5(C);
4. The Department approves the Attendant Support management plan;
5. The Department and the Program Participant determine an appropriate start date for services;
6. The Department notifies the appropriate Case Manager and Intermediary Service Organization of the effective date that the Program Participant will be participating in CDAS;
7. The Program Participant completes and signs a contract for services with the Intermediary Service Organization;
8. The Program Participant signs a Program Participant responsibilities form;
9. The Program Participant has provided his or her existing Medicaid-Funded Attendant Support provider(s) with a provider notification form, informing the provider(s.) of the date on which Attendant Support shall cease;
10. The Program Participant's service start date has occurred.

B. Training Requirement

In order to receive CDAS services, eligible applicants must complete the Attendant Support Management Training and pass the comprehensive test offered by the Department. In order to complete the training, applicants shall demonstrate facility with a variety of relevant topics including, but not limited to:

1. Recruiting, hiring, training and supervising Attendants:
2. Recognizing and getting quality Attendant Support:
3. Managing one's own health:
4. Effective communication:
5. Financial management:
6. Effective use of the Case Manager and the Intermediary Service Organization, and
7. Program Participants' rights and responsibilities.

C. Attendant Support Management Plan

In order to complete the Attendant Support Management Training, each Program Participant shall develop an Attendant Support management plan. The plan shall describe the Program Participant's:

1. Current status;
2. Needs and requirements for Attendant Support;
3. Plans for securing Attendant Support:
4. Assurances and plans regarding direction of health maintenance activities, as described below, if applicable:
5. Plans for handling emergencies, and
6. Plans for using the Fund for Additional Services.

D. Direction of Health Maintenance Activities

Health maintenance activities are those routine and repetitive activities of daily living which are necessary for health and normal bodily functioning. and which would be carried out by an individual with a disability if he or she were physically able, or by family members or friends if they were available. These activities include, but are not limited to. catheter care. administration of medication and ventilator monitoring.

A Program Participant, who needs Attendant Support for health maintenance activities, shall direct Attendants in such activities under the following conditions:

1. The Program Participant indicates on the Attendant Support management plan that he or she has received adequate instruction from health professionals, and is therefore qualified and able to train his or her Attendants in specified health maintenance activities.
2. The Program Participant lists the specific health maintenance activities on his or her Attendant Support management plan for which he or she will be providing training.

3. The Program Participant verifies on the Attendant Support management plan that Attendants, who will perform health maintenance activities, have had or will receive necessary training, either from the Program Participant or from appropriate health professionals.

E. Plans for Use of the Fund for Additional Services

As part of the Attendant Support management plan, approved by the Department, a Program Participant shall identify goals for use of the Fund for Additional Services, defined at §8.551.1(F). Program Participants may apply for grants from the Fund for Additional Services to cover costs for other services and equipment that promote the person's independence or that ameliorate conditions related to the Program Participant's disability, as long as the costs for such services and equipment are not covered through other available Medicaid programs. Other services and equipment include, but are not limited to, assistive devices, home modifications related to independent living, and skills training which supports independent living in the community.

F. Continuation of Existing In-Home Services

Individuals applying for CDAS shall continue with their existing Medicaid-funded Attendant Support arrangements until the conditions for services have been met and the start date for CDAS services occurs.

G. Start Date for Services

Once a Program Participant completes the Attendant Support Management Training, and has received notification of that completion from the Department, the Program Participant, in conjunction with the Department, shall establish a services start date. The Program Participant shall have a 30-day window of time in which to finalize Attendant Support arrangements and to contact the Department to set the start date.

H. Service Substitution

Once enrolled in CDAS, Program Participants shall be disenrolled from any other Medicaid-funded Attendant Support.

8.551.6 CALCULATION OF INDIVIDUAL ALLOCATIONS

A. Initial Calculation

The initial Individual Allocation for each Program Participant shall be calculated as follows.

1. The service categories in which payments have been made for the Program Participant during the previous twelve months, for those service categories that constitute Medicaid-funded Attendant Support, are identified.
2. Payments made on behalf of the Program Participant during the twelve-month period are summed for each service category.
3. The number of months of service within each service category for each Program Participant is determined.
4. For each appropriate service category, the total payments for the twelve months are divided by total service months, yielding monthly per capita payments for each service category.
5. The service category per capita payments for the Program Participant are summed to get a preliminary monthly allocation per Program Participant.

6. The allocation is adjusted to the fiscal year of the Program Participant's service start date, incorporating the effect of non-CDAS Attendant Support rate changes occurring in the prior twelve months and considering the cost neutrality guidelines set forth in the terms and conditions from the Centers for Medicare and Medicaid Services.

B. Adjustments to Individual Allocations

A Program Participant, who believes that he or she needs more Attendant Support than the existing Individual Allocation will cover, may request the Case Manager to perform a reassessment, as described at §8.551.10(D). If the reassessment indicates that more Attendant Support is justified, the Program Participant and Case Manager shall recommend, for approval by the Department, adjustments to the Attendant Support management plan with a concomitant increase in the Individual Allocation.

In recommending an increase in the Individual Allocation. Case Managers shall use professional judgment, and they shall consider:

1. Any change in the Program Participant's condition that would necessitate more Attendant Support:
2. Discrepancies between the Program Participant's utilization history and current needs for Attendant Support:
3. The appropriateness of Attendant wages paid by the Program Participant for services received:
4. The quality and quantity of services provided by Attendants for the wages they receive;
5. Revisions in the Program Participant's budgeting of the current Individual Allocation to more effectively pay for needed services. Individual Allocations shall not be reduced during the first year of CDAS. so that the Department can gather data on service utilization in order to determine appropriate parameters for making such reductions in future years.

8.551.7 PAYMENTS

A. Attendant Reimbursement

Attendants providing services under CD AS shall be paid an hourly wage based on the rate negotiated between the Attendant and the Program Participant hiring the Attendant. All payments shall be made from the Program Participant's individual Allocation, and shall be made by the Intermediary Service Organization, acting under the direction of the Program Participant. The Intermediary Service Organization shall receive notification each month from the Department indicating the Individual Allocations for Program Participants being served. The Intermediary-Service Organization shall make payments to Attendants only upon receipt of timesheets. signed by both the Program Participant and the Attendant. which show the hours of Attendant Support services provided. Attendants shall be paid on a weekly basis.

B. Employer of Record

The Intermediary Service Organization shall be the employer of record for all Attendants under CDAS and shall be responsible for compliance with federal, state and local law. Specifically, the Intermediary Service Organization shall be responsible for worker's compensation insurance, unemployment compensation insurance, withholding of all federal and state taxes, compliance with federal and state laws regarding overtime pay and minimum wage requirements, and compliance with any other relevant federal, state or local laws.

C. Duplication of Provider Payments

Once the Department and the Program Participant agree on the service start date, the Intermediary Service Organization and the Single Entry Point (SEP) Case Manager shall receive notice from the Department of the Program Participant's enrollment and projected service start date. The services start date shall be confirmed by the Department with the Program Participant within 72 hours of that date. The state fiscal agent shall receive notice from the case manager to cease payments for all existing Medicaid-funded Attendant Support for the participant as of that person's service start date.

The Program Participant and his or her current Medicaid provider shall receive notice of the date that existing payments shall cease. Duplicate payments for CDAS Attendant Support and non-CDAS Attendant Support are not allowed.

In order to minimize the instance of accidental duplicate services, a Program Participant shall provide his or her existing Attendant Support provider(s) with a provider notification form, informing the provider(s) of the date on which Attendant Support from that provider shall cease. A copy of each form shall be provided to the Department.

D. Unspent Portion of an Allocation

Any unspent portion of a Program Participant's monthly Individual Allocation shall be divided equally between the Department and a Fund for Additional Services. The Intermediary Service Organization shall assist the Department in the management of this fund, and shall track the amount of contribution to the fund by each Program Participant. The Intermediary Service Organization shall provide each Program Participant with an accounting of that individual's contribution for the month and of his or her accumulated contributions, as part of monthly reporting.

Program Participants may apply to the Department for a grant from the Fund for Additional Services to cover costs for other services and equipment. The grant request shall be consistent with the Program Participant's current Attendant Support management plan, and the cost of the services and equipment being requested shall not exceed the total amount contributed to the Fund for Additional Services by the Program Participant up to that point. A committee of users of Attendant Support shall be convened to review applications to the fund and to recommend awards based on these criteria.

Any grants awarded to Program Participants shall be in the form of services or equipment, purchased by the Intermediary Service Organization from the Fund for Additional Services, under the direction of the Department. In no circumstance shall cash grants be made to Program Participants.

8.551.8 PROGRAM PARTICIPANT ROLE AND RESPONSIBILITIES

A. Health and Attendant Management

Participants in CDAS are responsible for their own health management. Nurses and Case Managers shall not be available on a regular basis to provide health monitoring. In order to receive CDAS services, individuals shall sign a Program Participant responsibilities form acknowledging that they are taking full responsibility for their own health management.

To manage Attendant Support, an individual shall sign a Program Participant responsibilities form acknowledging that they are taking full responsibility for their own Attendant Support management, including temporary or permanent lack of an employed Attendant (e.g. backup Attendant Support).

B. Program Participant's Responsibilities as Supervisor

As the supervisor of Attendants, participants shall:

1. Determine wages and benefits for each Attendant:
2. Establish hiring agreements with each Attendant, outlining wages, benefits, services to be provided, schedules and working conditions:
3. Follow all relevant laws and regulations regarding the employment of Attendants:
4. Explain the role of the Intermediary Service Organization to the Attendant;
5. Communicate with the Intermediary Service Organization regarding the hiring of Attendants, including wage and benefit information for each Attendant:
6. Review all Attendant time sheets for accuracy and completeness;
7. Ensure that time sheets are signed by the Program Participant and the Attendant in order for the Intermediary Service Organization to issue a paycheck to the Attendant: and
8. Authorize the Intermediary Service Organization to make any changes in Attendant wages or benefits.

C. Quality Assurance Activities

Participants in CDAS shall take part in assuring the quality of program services. In order to assess quality of care on an ongoing basis. Program Participants shall:

1. Devise and utilize an Attendant Support management plan, as described at §8.551.5(C). Program participants shall review their plans at least annually, and modify or develop new plans as needed.
2. Submit weekly timesheets for all Attendants to the Intermediary-Service Organization, along with comments on the quality of care provided by the Attendants.
3. Complete a self-assessment every 3 months. The self-assessment shall identify the individual's strengths, areas of growth and areas of concern, as they relate to the individual's overall health. Attendant Support management, quality of care and general satisfaction with the program. Copies of the self-assessment shall be sent to the Case Manager and the Department.

D. Financial Reconciliation

Program Participants, or their designated support persons, shall review the monthly reports from the Intermediary Service Organization for the purpose of financial reconciliation. Discrepancies and inaccuracies shall be brought to the attention of the Intermediary Service Organization.

8.551.9 PARTICIPANT RIGHTS

Participants in CDAS shall have the rights to fair hearing and appeal procedures regarding any program or Medicaid decision, as described in §8.057 through §8.059.

A. Appropriate Information

Training material, client rights information, other notices and communications shall be provided in language and formats understandable to and usable by the individual.

B. Review of Disapproval of Management Plan

A Program Participant, whose Attendant Support management plan is disapproved by the Department, has the right to a review of that disapproval. The Program Participant shall submit a written request to the Department stating the reasons for requesting the review and justifying the proposed management plan. The eligibility review committee, described at §8.551.3(D), shall be convened to review the Department's disapproval of the plan to determine if it is consistent with the criteria for Attendant Support management plans as described at §8.551.5(C). Based on this review, the committee shall recommend either that the plan in question should be approved, or that the Department's disapproval is consistent with the criteria, and that the plan should be revised. The Program Participant's most recently approved management plan shall remain in effect while the review is in process.

C. Attendant Support Management

A participant in CDAS has the right:

1. To hire persons of his or her choice to provide Attendant Support.
2. To determine what credentials, if any, individuals must have in order to be employed as Attendants.
3. To train Attendants to meet his or her own particular needs.
4. To terminate Attendants who are not meeting his or her needs.
5. To request a reassessment as described at §8.551.10(0), if he or she believes that his or her level of service needs to be adjusted.
6. To revise his or her Attendant Support management plan at any time, as long as the Department approves the revised plan.

D. Withdrawal from Program

Program Participants can withdraw from CDAS at any time. A Program Participant who wishes to withdraw must contact the Single Entry Point (SEP) Case Manager or the Department in order to be disenrolled from CDAS.

E. Previous Program

A Program Participant, who leaves the CDAS program, whether by choice, because the program ends, or because the Department has determined that the Program Participant is no longer eligible for CDAS, has the right to return to his or her previous Medicaid-funded Attendant Support program. The Program Participant must continue to need Attendant Support, continue to qualify for the previous program and continue to be otherwise eligible for Medicaid.

8.551.10 CASE MANAGEMENT FUNCTIONS

Single Entry Point (SEP) agencies shall provide CDAS case management, and shall comply with single entry point rules governing case management functions as set forth at §8.390 through §8.394, except that they shall comply with the following requirements when providing case management under CDAS.

A. Referral/Screening/Intake

Case Managers shall provide their clients with information on CDAS and refer interested individuals to the Department for screening and intake.

B. Planning

Case Managers shall be available to assist Program Participants in planning Attendant Support, though the Program Participants are ultimately responsible for devising and implementing their own Attendant Support management plans. Case Managers may assist Program Participants to identify potential providers and to negotiate fees, if desired by the Program Participant. They may assist Program Participants in establishing contracts with the Intermediary Service Organization.

The Case Managers shall not negotiate on behalf of Program Participants. They may advise Program Participants who wish to obtain or require support from other community resources.

C. Coordination, Monitoring, and Evaluation of Services

As part of the process of coordination, monitoring, and evaluation of services, Case Managers shall:

1. Contact Program Participants twice a month during the first three months of each individual's program to assess their Attendant management, their satisfaction with care providers and the quality of services received.
2. Contact Program Participants quarterly, after the first three months, to assess their implementation of service plans, Attendant Support management issues, quality of care, Attendant Support expenditures and general satisfaction.
3. Contact the Intermediary Service Organization as needed to determine status of the Program Participant's activities.
4. Assist Program Participants in securing related services as needed.'
5. Notify the Department when problems arise.
6. Make additional monitoring contacts with Program Participants if requested by the Department.
7. Refer cases to the Department to determine whether a Program Participant continues to meet program eligibility.

D. Reassessment

Case Managers shall conduct a reassessment with each Program Participant every six months. A reassessment under CDAS is a comprehensive face-to-face interview conducted with the Program Participant and appropriate collateral contacts to determine the Program Participant's level of functioning and service needs. Such a reassessment includes an evaluation by the Case Manager, collection of supporting information from the Program Participant's physician, and the Program Participant's self-assessment of his or her needs. Case Managers shall conduct additional reassessments if requested by the Program Participant or the Department. In addition to the issues monitored during the quarterly contacts, the Case Managers shall use the six-month reassessments to review any need for adjusting individual Allocations.

8.552 DEFINITIONS

Activities of Daily Living include mobility, taking medication or other health-related needs, bathing, grooming, dressing, range of motion exercises, eating/feeding, meal preparation and clean-up, and bowel and bladder care.

Authorization for In-Home Support Services (IHSS) means the document prepared by the Case Manager, which lists the services the Eligible Consumer can receive and the number of hours that can be allotted.

Back-Up Services means twenty-four hour IHSS coverage that must be available to Eligible Consumers when the selected Attendant cannot provide the necessary services listed on the IHSS Plan.

Case Manager means an individual who determines eligibility and provides case management services to individuals eligible under the (HCBS-EBD) program or an individual -who determines eligibility and provides case management services to children eligible under the Children's HCBS Waiver Program

Eligible Consumer means an individual or the parent/guardian of a child who meets the eligibility requirements to participate in this program.

Health Maintenance Activities are those routine and repetitive Activities of Daily Living, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available

IHSS Plan means a written plan of IHSS services set forth in a contract between the Eligible Consumer and the IHSS Agency. The contract shall include a statement of allowable attendant and personal care service hours, a dispute resolution process, and must be signed by the Eligible Consumer, an eligible child's parent/guardian or an Authorized Representative, where appropriate, and the IHSS Agency.

8.552.2 ELIGIBILITY

8.552.2A

To be eligible for IHSS, an individual shall:

Meet Medical Assistance eligibility requirements, and

Be eligible for HCBS for HCBS-EBD or the Children's HCBS Waiver, and

Have a health condition or functional disability that limits his/her ability to perform Activities of Daily Living, and

Provide a statement from his/her primary care or treating physician that indicates the individual has sound judgment and the ability to direct his/her own care, or the eligible child's parent/guardian has sound judgment and the ability to direct the eligible child's care, or the person has an Authorized Representative who has the judgment and ability to assist in acquiring and using services. An individual whose treating physician has diagnosed an unstable medical condition may participate in IHSS; however, the treating physician shall determine whether or not additional in-home monitoring is necessary and if so, the amount and scope of such monitoring.

8.552.3 DISCONTINUATION OF SERVICES

8.552.3A.

An IHSS Agency may discontinue IHSS services to an Eligible Consumer when the Eligible Consumer, the IHSS Agency or the Case Manager has secured other equivalent care in the community.

8.552.3B.

An IHSS Agency may discontinue IHSS services to an Eligible Consumer when the Eligible Consumer exhibits inappropriate behavior toward Attendants. Inappropriate behavior includes documented verbal, sexual and/or physical abuse. Verbal abuse is defined as consistent verbal threats, insults or extremely rude language from the Eligible Consumer to the Attendant over a period of time.

8.552.3C

An IHSS Agency shall not discontinue services to an Eligible Consumer unless documented efforts have been made to resolve the situation that triggers such discontinuation. Efforts shall include, but are not limited to, providing independent living skills training, mediation, revising the IHSS Plan, changing or appointing an Authorized Representative or changing the Attendant.

8.552.3D.

The IHSS Agency shall provide thirty (30) days advanced written notice that the inability to maintain a relationship with an Attendant or the eligible Consumer's behavior will result in discontinuation of services. The Eligible Consumer will be allowed thirty (30) days to correct the problem and the IHSS Agency staff shall work with the Eligible Consumer to address and modify the behavior during the 30-day warning period.

8.552.4 TERMINATION FROM THE PROGRAM

8.552.4A.

An Eligible Consumer shall be terminated from the program for one or more of the following reasons:

1. Loss of Medicaid eligibility and loss of HCBS-EBD eligibility or Children's HCBS Waiver eligibility;
2. Progression of a medical condition that causes an unsafe situation for the Eligible Consumer, as determined by the primary care or treating physician; or
3. Refusal to designate an Authorized Representative if the Eligible Consumer is unable to direct his/her own care, as determined by the primary care or treating physician.; and

8.552.5 ELIGIBLE CONSUMER RIGHTS AND RESPONSIBILITIES

8.552.5A.

An Eligible Consumer or the parent/guardian of an eligible child has the right:

1. To present a person(s) of his or her own choosing to the IHSS Agency as a potential Attendant;
2. To train and schedule Attendants to meet his or her own particular needs; and
3. To dismiss Attendants who are not meeting his or her needs.

8.552.6 ATTENDANT TRAINING

8.552.6A.

IHSS Agencies shall assure and document that all IHSS Attendants have received at least basic training in the provision of IHSS. In lieu of basic training, the IHSS Agency's Health Professional may administer a skills validation test. Training shall include interpersonal skills, needs of persons with disabilities, overview of tasks the Attendant may be performing, instruction in basic first aid, safety and emergency procedures; and training in infection control techniques, including universal precautions. Training may be modified if any of the individuals demonstrate competence in a given area. A skills qualification test may be utilized to determine competence, as required by the IHSS Agency's Health Professional.

8.552.6B.

Training or skills validation shall be completed prior to service delivery unless waived by the Eligible Consumer or the Authorized Representative to prevent interruption in services, but in no event shall be postponed more than thirty days after services begin.

8.552.6C

IHSS Agencies shall provide functional skills training to assist Eligible Consumers and Authorized Representatives in developing skills and resources to maximize independent living and management of personal health care. Such training shall be provided by independent liveing staff, whenever practicable and feasible.

8.552.6D

The Eligible Consumer or the Authorized Representative shall provide individualized training to the Attendant that is specific to the Eligible Consumer's own needs and preferences.

8.552.7 IHSS AGENCY RESPONSIBILITIES

8.552.7.A

IHSS agencies shall conform to all general certification standards and procedures at §8.487, HCBS-EBD PROVIDER AGENCIES, and shall meet all the additional IHSS certification requirements, set forth below.

8.552.7B

An IHSS Agency shall offer peer counseling, including cross-disability peer counseling; information and referral services; independent living skills training; and individual and systems advocacy as defined at § 26-8.1-102(3) C.R.S. (2002).

8.552.7C

The IHSS Agency shall provide 24 hour back-up services to Eligible Consumers at any time a scheduled Attendant is not available, whether the attendant's absence is anticipated or unforeseen.

8.552.7D

If needed, the IHSS Agency shall assist the Eligible Consumer in selecting an Attendant. IHSS Agencies shall assure and document that all IHSS Attendants have adequate skills to provide health maintenance services.

8.552.7E

IHSS Agencies shall either contract with or have on staff a Health Professional, who shall have monitoring responsibilities, defined as oversight of training of Attendants, verification of adequate skills and competence of Attendants to perform IHSS, and assessment of consumer safety. The Health Professional shall counsel staff on difficult cases, and potentially dangerous situations. He/she shall be available to consult with the Eligible Consumer, the Authorized Representative or the Attendant in the event a medical issue arises, and shall investigate complaints and critical incidents.

8.552.7F

IHSS Agencies shall provide intake and orientation services to Eligible Consumers or the parent/guardians of eligible children who are new to in-home support services. Orientation shall include

instruction in the philosophy, policies and procedures of IHSS and information concerning rights and responsibilities of the Eligible Consumer.

8.552.8 IHSS AGENCY TERMINATION

8.552.8A

An IHSS Agency may be terminated from participation in Colorado Medicaid for good cause, pursuant to §8.076.1. Additionally, an IHSS Agency may be terminated as a result of a documented pattern of abandonment by and/or unresolved client complaints about the Agency.

8.552.9 SERVICE UTILIZATION MONITORING

8.552.9.A.

The Case Manager shall ensure cost effectiveness and non-duplication of services by:

1. Documenting the discontinuation of previously authorized long-term home health services that are to be replaced by IHSS attendant services;
2. Documenting, for new clients, the long term home health services that would have been authorized had IHSS not been available;
3. Documenting and justifying, in the eligible consumers' plan of care, any need for both long-term home health services and IHSS services;
4. Ensuring that all required documentation is in the eligible consumer's plan of care and in the prior authorization for IHSS services; and
5. Providing the Department, for monitoring purposes, a copy of the justification of need for both long-term home health services and IHSS services.

8.560

Clinic Services rendered by certified health agencies shall be a benefit of the Colorado Medical Assistance Program for categorically eligible individuals.

8.560.1 DEFINITIONS

For the purposes of this Section 8.560, the following definitions shall apply:

- A. Certified health agency: a county/district health department, regional health department or local board of health established pursuant to part 5, 6, or 7 of article 1 of title 25, C.R.S., that is certified by the Colorado State Department of Health.
- B. Nurse/Nurse practitioner: a registered professional nurse who is currently licensed to practice in the State of Colorado and who meets the qualifications established by the Nurse Practice Act.
- C. Nurse-midwife: a registered professional nurse currently licensed to practice in the State of Colorado who meets the following requirements: is certified as a nurse-midwife by the American College of Nurse-Midwives; is authorized under state statute to practice as a nurse-midwife; and whose services are rendered pursuant to the Colorado Medical Practice Act.
- D. Physician assistant/child health associate: a certified individual who performs under the supervision of a physician and meets the qualifications of the Colorado State Board of Medical Examiners.

- E. Physician: a doctor of medicine, osteopathy, legally authorized to provide medicine or surgery in Colorado.
- F. Medicaid primary care physician: a physician enrolled in the Primary Care Physician Program under the Colorado Medical Assistance Program.
- G. Visit: a face-to-face encounter between a clinic patient and nurse/nurse practitioner/nurse-midwife, physician assistant/child health associate, or physician providing services reimbursable under the Medicaid Program. If a patient sees more than one health professional, or meets more than once with the same health professional, on the same day and at a single location, this shall be counted as one visit.

8.561 REQUIREMENTS FOR CERTIFICATION

- A. Participating health agencies must be certified by the Colorado State Department of Health in accord with federal regulations 42 CFR 431.610, October 1991 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Manager, Health and Medical Services, Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203-1714. Certified health agencies performing laboratory services must be certified as a clinical laboratory in accordance with regulations cited at 8.660 through 8.666. Certified health agencies must obtain a certificate of waiver from the Health Care Financing Administration or its designated agency if the health agency only performs waived tests as defined by Clinical Laboratory Improvement Amendments of 1988 (CLIA).
- B. All certified health agencies and staff shall comply with all applicable federal, state and local regulations concerning the operation of such clinic services. These include but are not limited to the following: certification, organization, staffing, licensure of personnel, service provision responsibilities, maintenance of health records and program evaluation.
- C. Termination of certification or non-renewal of certification will be determined by the Colorado State Department of Health.

8.562 REQUIREMENTS FOR PARTICIPATION

Health agencies providing clinic services must be certified by the Colorado State Department of Health, must enroll in the Medical Assistance Program and provide proof of their certification status in order to participate under Medicaid. The certification document must be attached to the Medical Assistance enrollment form. Medical Assistance enrollment and/or reimbursement cannot be accomplished without proof of certification on file with the State's fiscal agent for the effective date of enrollment and date of service for which reimbursement is claimed.

8.563 BENEFITS AND LIMITATIONS

Clinic Services are a benefit of the Medical Assistance Act in Colorado when:

- A. The services are benefits of the Colorado Medicaid Program as determined by the Colorado State Department of Social Services;
- B. The services which are performed are medically necessary;
- C. The services are provided by certified health agencies;
- D. The services which are performed are within the scope of the providers' Medical and/or Nurse Practice Acts;

- E. The services are provided by a registered nurse, qualified nurse practitioner, or certified nurse-midwife or by a physician or physician's assistant (including child health associates) certified by the Colorado State Board of Medical Examiners;
- F. The services provided are obstetrical services which are benefits of the Medicaid program; or
- G. The services provided are EPSDT medical screening services which meet the requirements set forth in sections 8.285.02 through 8.287.01.

8.564 BILLING PROCEDURES

- A. Certified health agencies providing clinic services must bill the Medical Assistance Program directly using the designated billing method and the prescribed procedure codes recognized by the Colorado State Department of Social Services. The amount of the provider's usual and customary charges to the general public will be billed if applicable.
- B. Obstetrical services and adjunctive services, except for EPSDT medical screenings, must be billed directly on the Colorado 1500 Claim Form.
- C. EPSDT medical screening services must be billed directly on the EPSDT Screening/Claim Form.

8.565 REIMBURSEMENT

Reimbursement shall be made according to the following:

- A. Payment for benefit services shall be in accord with the physician reimbursement policies as cited in Section 8.200.20.
- B. Each certified health agency will be reimbursed for only those services performed for which it is certified and for only one visit per recipient per day.
- C. Reimbursement for injectable vaccines obtained through the Infant Immunization Program is limited to the maximum allowed administrative fee.
- D. A health agency must be certified on any date for which reimbursement is being claimed. If reimbursement is claimed for a date of service on which the health agency is not certified, reimbursement shall be denied.

8.566 APPEALS

Provider grievances and appeals, resulting from State actions under this section of regulations, shall be handled in accordance with existing appeals regulations delineated in Sections 8.049 through 8.051.44.

8.567 CERTIFIED HEALTH AGENCY/PHYSICIAN RELATIONSHIP

- A. Obstetrical services require referral from the Medicaid Primary Care (PCP) or "Lock-In" physician. The certified agency will contact the PCP to obtain the appropriate referral for obstetrical services.
- B. EPSDT medical screenings require referral from the Medicaid Primary Care (PCP) or "Lock-In" physician. The certified agency will contact the PCP to obtain the appropriate referral for EPSDT Medical screening services.
- C. Medical support and approval for the policies and procedures of the local certified health agency's Well Child Clinics and Prenatal Clinics may be provided by the agency health officer, medical

director or other physician (pediatrician, family practitioner or obstetrician) agreed upon by the public health nursing staff and their health officer. A physician must sign and annually review the agency's emergency procedures for reactions to biologicals.

- D. The certified health agency shall assure that a physician is available during agency hours by direct means of communication for assistance in emergencies and for consultation and referral if medical diagnosis and/or treatment is needed. This requirement may be satisfied by agreements with one or more physicians. Whenever possible, the certified health clinic practitioner will interact with the client's primary care physician when medical consultation is needed and will provide the primary care physician a copy of each EPSDT medical screening and obstetrical service record.

8.570 CLINIC SERVICES-AMBULATORY SURGERY CENTERS

Medical Services provided in Ambulatory Surgery Centers shall be reimbursable within the following guidelines.

A. Definition

An ambulatory surgery center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing surgical procedures for its patients not requiring hospitalization. An ASC may be part of a hospital; however, the building space constituting an ASC must be physically separated from any other health services offered by a hospital.

B. Requirements for Participation

In order to receive payment for services provided to eligible recipients, a facility must be certified to participate in the Medicare program as an Ambulatory Surgical Center and licensed by the Colorado Department of Public Health and Environment.

C. Services Covered

The allowable surgical procedures identified for Medicare coverage are reimbursable and covered Medicaid benefits. All allowable surgical procedures are grouped by service classification. Additional surgical procedures may be included when approved by the Department of Health Care Policy and Financing. There will be no reimbursement if the surgical procedures do not appear on the state approved list.

D. Payment for Services

1. Approved surgical procedures, which are identified in one of eight surgical groupings, will be reimbursed on the lower of the following: 1) billed charges; or 2) 80% of the Medicare rate. Payment for multiple or subsequent procedures performed on the same patient, the same day will be paid at 50% of the applicable rate.
2. Items and services Included in the facility fee or charge shall be as a minimum:
 - a. Nursing and other technical personnel services,
 - b. The patient's use of the ASC facilities,
 - c. Drugs, surgical or medical supplies and services,
 - d. Diagnostic or therapeutic items and services,
 - e. Administrative, record keeping and housekeeping items and services,

- f. All blood products and services, and
 - g. Materials for anesthesia.
- 3. Items not included are:
 - a. Physician services including surgeon, assistant surgeon, anesthesiologist, and certified registered nurse anesthetist,
 - b. Sale, lease, or rental of durable medical equipment,
 - c. Surgically implanted prosthetics,
 - d. Ambulance services, and
 - e. Services furnished by a certified independent laboratory.
- 4. Physician services performed in an Ambulatory Surgical Center will be reimbursed separately when the surgical procedures appear on the Medicare approved list or have been added by the Department, as described in Paragraph C of this Section.

E. Emergency Services

The ASC shall have policies and procedures which provide for adequate care and transportation of the facility's patients in the event of an emergency.

8.571 CLINIC SERVICES - AMBULATORY SURGERY CENTER, PHYSICIAN PRIOR AUTHORIZATION

The physician performing the surgery shall be responsible for obtaining all necessary Prior Authorizations for those procedures requiring pre-procedure approval by the Department.

8.580 OXYGEN AND OXYGEN EQUIPMENT IN CLIENT'S OWN HOMES

In a client's home, or place used as his/her home, and prescribed by the attending physician, oxygen and oxygen equipment is provided by the medical assistance program. For any client supplied oxygen in his/her own home or place used as his/her home, payment for oxygen and oxygen equipment shall be made by the fiscal agent directly to the vendor or supplier.

8.585 OXYGEN, OXYGEN EQUIPMENT, AND SUPPLIES

Medically necessary oxygen, oxygen equipment, and supplies are a benefit of the Colorado Medicaid Program. Medical necessity shall be provided in a manner approved by the Department, and shall be maintained in the provider's files for a minimum of six (6) years. The Department reserves the right to request copies of documentation of medical necessity.

.01 With the exception of liquid or gaseous oxygen provided in a nursing facility, and the supplies and equipment necessary to administer each, medical equipment and/or supplies for Medicaid clients residing in a nursing facility, or group home receiving daily Medicaid reimbursement, must be provided by the facility. Costs of equipment and/or supplies unrelated to the use of gaseous or liquid oxygen are included in the facility's cost report and reimbursed through the Medicaid per diem.

.02 Any form of oxygen for use by clients in an inpatient hospital setting must be provided by the hospital and is included in the Medicaid payment. Oxygen concentrators for use by clients residing in a nursing facility, or group home receiving daily Medicaid reimbursement, may be provided in one of two ways.

A. Nursing facilities or group homes committed to a program of purchasing concentrators for use by their Medicaid residents may bill a monthly fee to the Department using the Nursing Home Claim Form, in accordance with 8.465. All necessary oxygen -related disposable supplies shall also be provided by the facility.

B. Residents of facilities which do not wish to purchase concentrators for patient use shall obtain needed equipment from an authorized Medicaid oxygen supplier. The oxygen supplier shall bill a monthly fee using the Supply Claim. Reimbursement will be the lower of billed charges or the Department's fee schedule.

.03 Liquid and gaseous oxygen, as well as equipment and supplies provided by the medical equipment supplier for administration in a nursing facility or group home, shall be billed directly to the Department's fiscal agent by a Medicaid supply provider, in accordance with Department policy.

.04 Medical suppliers providing oxygen to Medicaid clients shall provide equipment, supplies and oxygen for use by a specific client, based upon the physician's prescription.

.05 In order to assure accurate and appropriate billing by the medical supplier, the nursing facility or group home shall be responsible for providing the following information to the medical supplier within 20 days following the date the supplier delivers the item to be billed. The required information shall be in the form of a certification statement and shall contain the following, as a minimum:

A. the name and state ID number for all Medicaid clients provided liquid or gaseous oxygen, or the equipment/supplies necessary for administration by the medical supplier.

B. an indicator of Medicare Part A or B, or other third party resources.

C. the name and state ID number for all Medicaid clients utilizing an oxygen concentrator being rented from the oxygen supplier. This applies only to patients in those facilities which choose not to commit to the purchase of concentrators.

D. certification guaranteeing that equipment, supplies, and oxygen were used only by the patient for which they were supplied; or in the case of centralized oxygen systems, each client's oxygen usage, expressed in liters.

.06 The medical supplier shall bill the Medicaid program based upon the above information provided by the nursing facility, using the appropriate HCPCS coding. Reimbursement shall be made in accordance with the Department's fee schedule or the provider's usual and customary charges, whichever is lower.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.591 GENERAL PROVISIONS

.01 Durable medical equipment and disposable medical supplies are a benefit of the Colorado Medicaid Program for eligible clients, when ordered by a physician within the scope of the program, and determined by the Department to be medically necessary. The purpose is to enable the client to cost-effectively remain outside an institutional setting by promoting, maintaining, or restoring health; or by minimizing the effects of illness, disability, or a handicapping condition.

.02 Definitions

A. Abuse - the intentional destruction of or damage to equipment which results in the need for repairs or replacement.

B. Consumer Client - a person to whom a wheelchair or facilitative device purchased by the Colorado

Medicaid Program is transferred for purposes other than resale, if such transfer occurs before expiration of the express and other warranties applicable to such wheelchair or facilitative device, and who may enforce the express and other warranties applicable to the wheelchair.

- C. Consumer Purchaser - the Colorado Medicaid Program which purchases a wheelchair or facilitative device from a dealer or manufacturer for the purpose of providing mobility or self-sufficiency assistance to a Medicaid client
- D. Disposable medical supplies (supplies) - supplies prescribed by a physician which have a medical purpose, are specifically related to the active treatment or therapy of the client for a medical illness or physical condition, and which are consumable; and/or expendable and non-durable. Supplies must meet the definition of medical necessity, may be recommended by an appropriate licensed practitioner, and must be prescribed by a doctor of medicine or a doctor of osteopathy.
- E. Durable medical equipment (DME) - equipment which is suitable for use outside of a medical facility, which can withstand repeated use, which has a medical purpose, and which would not be useful to the client in the absence of illness, injury, or disability. Such equipment must meet the definition of medical necessity, may be recommended by an appropriate licensed practitioner, and must be prescribed by a doctor of medicine or a doctor of osteopathy.
- F. Education - the act or process of cultivating non-medical intellectual faculties or knowledge.
- G. EPSDT - the Early Periodic Screening, Diagnosis, And Treatment Program for the categorically needy Medicaid eligible client under the age of 21.
- H. Facilitative Device - durable medical equipment with a retail price equal to or greater than one hundred dollars (\$100), that is exclusively designed and manufactured to assist a person with a disability with such person's specific disability, through the use of facilitative technology, to be self sufficient or to maintain or improve quality of life. "Facilitative Device" does not include wheelchairs, but does include the following:
 - 1. Telephone communication devices for the hearing impaired and other facilitative listening devices, except for hearing aids, as defined in Section 6-1-105.5(1)(b)(I), C.R.S., and cochlear implants, as defined in Section 6-1-105.5(1)(b)(II).
 - 2. computer equipment and reading devices with voice input or output. optical scanners, talking software, braille printers, and other aids and devices that provide access to text by a person with a disability;
 - 3. computer equipment with voice output, artificial larynges, voice amplification devices, and other alternative and augmentative communication devices;
 - 4. voice recognition computer equipment software and hardware accommodations, and other forms of alternative access to computers for persons with disabilities; and
 - 5. any other device, other than a wheelchair, that enables a person with a disability to communicate, see, hear, or maneuver, including artificial limbs and medically necessary orthopedic footwear.
- I. Facilitative technology - technology used to develop technological devices to be used exclusively for the purpose of assisting a person with a disability with respect to such person's specific disability by facilitating or enhancing that person's ability to be self-sufficient.
- J. Facilitative devices dealer - a person or entity that is in the business of selling facilitative devices, or any agents of that person or entity. "Facilitative devices dealer" includes an alternative warranty

service provider, as described in Section 6-1-502(4)(a), C.R.S.

- K. Invoice - documentation received by the service provider of a purchase from the manufacturer of equipment or supplies, or from an unrelated wholesale distributor of equipment or supplies, indicating the actual costs to the service provider for acquisition of the purchased item.
- L. Manufacturer -the original producer of equipment supplies, or of the component parts of equipment or prosthetic devices, or in the case of wheelchairs, a person or entity that manufactures or assembles wheelchairs and any agents of that person or entity, including an importer, a distributor, an authorized servicer, a factory branch, a distributor branch and warrantors of the manufacturer's wheelchairs. "Manufacturer" does not include a dealer.
- M. Medical necessity for DME or for disposable medical supplies -equipment prosthetic devices, or supplies which are necessary in the treatment, prevention, or alleviation of an illness, injury, condition, or disability. Determination of medical necessity shall be made in accordance with the following criteria:
 - 1. It is prescribed by a doctor of medicine or a doctor of osteopathy;
 - 2. It is a reasonable, appropriate, and effective method for meeting the client's medical need;
 - 3. The expected use is in accordance with current medical standards or practices;
 - 4. It is cost effective, meaning less costly and medically appropriate alternatives either do not exist or do not meet treatment requirements.
 - 5. It provides for a safe environment or situation for the client as documented by a medical professional;
 - 6. For the purpose stated, utilization is not experimental, investigational, or not generally accepted by the medical community; and
 - 7. Its primary purpose may not be to enhance the personal comfort of the client, nor to provide convenience for the client or the client's caretaker.
- N. Misuse - the intentional utilization of equipment, prosthetic device, or supplies in a manner not prescribed or recommended, resulting in the need for repairs or replacement; or utilization by persons other than that for whom the use is prescribed or intended according to Department records.
- O. Modular Assembly - a device added to a wheelchair base to accommodate the special needs of the consumer, such as seating systems, tilt or recline systems, and specially adapted control modules.
- P. Neglect - failure to maintain equipment or a prosthetic device as specified by the manufacturer's or provider's instructions, which results in the need to repair or replace the equipment or prosthetic device.
- Q. Owner - an individual with 5% or more ownership interest in a business and one entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business.
- R. Personal hygiene - cleanliness or sanitary practices unrelated to medical care.
- S. Point of sale - the provider from which purchase or rental occurred.

- T. Prescribed - the provider has on file signed and dated documentation that the client's physician has ordered the service or item.
- U. Prosthetic devices - replacement, corrective, or supportive devices prescribed by a doctor of medicine or a doctor of osteopathy to:
1. Artificially replace a missing portion of the body;
 2. Prevent or correct physical deformity or malfunction; or
 3. Support a weak or deformed portion of the body.
- V. Provider - supplier of durable medical equipment or disposable medical supplies to Medicaid clients. In order to obtain reimbursement for services rendered, a provider must be enrolled in the Colorado Medicaid Program.
- W. Reasonable - being in accordance with current accepted standards of medical practice in the treatment of the client's condition, without excess or extreme function or expense beyond that which is necessary.
- X. Rehabilitation equipment - equipment medically necessary to bring or restore a client to a condition of maximum health.
- Y. Related Party - a provider which, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the equipment, prosthetic device, or supplies. An owner related individual shall be considered an individual who is a member of an owner's immediate family, including a spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, sibling or stepsibling, in-laws, grandparents, and grandchildren.
- Z. Universal precaution requirements - those requirements of the Occupational Safety And Health Administration, imposed on health care workers, requiring that health care workers shall use appropriate barriers to blood and body fluids to prevent exposing the skin and mucous membranes of one individual to the blood and/or body fluids of another.
- AA. Wheelchair -any wheelchair, scooter, or modular assembly, including a demonstrator, that is motor driven or manually operated that a consumer purchases or accepts transfer of in this state for the purposes of mobility assistance.
- AB. Wheelchair Dealer -a person or entity that is in the business of selling wheelchairs, or any agents of that person or entity. "Wheelchair dealer" includes an alternative warranty service provider, as described in 6.1-403(5)(a), C.R.S.
- AC. Wholesale distributor - a company which obtains large quantities of goods at discounted prices from the manufacturer for the purpose of resale to retail providers.
- AD. Wrongful disposition - the mismanagement of equipment, prosthetic devices, or supplies provided by Medicaid by selling or giving them away to someone other than the client for whom purchase or rental was intended.

8.592 ROLES AND RESPONSIBILITIES

.01 Colorado Department of Health Care Policy and Financing

- A. The Colorado Department of Health Care Policy and Financing, DME/supply program is responsible for meeting the reasonable, medically necessary equipment and supply needs of eligible

Medicaid clients.

- B. The Department is responsible for determining and applying reasonable limitations on the numbers, reimbursement amounts and frequency of providing prosthetic devices, supplies and equipment to meet the medical needs of clients.

.02 DME/Supply Providers

Colorado enrolled Medicaid DME/Supply providers are responsible for the following:

- A. Filing claims in accordance with Department policy.
- B. Complying with the requirements outlined in Title 6, Article 1, Part 4 of Colorado Revised Statutes, relating to wheelchair express warranties, and for assuring that refunds resulting from the return of a nonconforming wheelchair to the wheelchair dealer or manufacturer will be directed to the Department, as the Consumer Purchaser.
- C. Complying with the requirements outlined in Title 6, Article 1, Part 5 of Colorado Revised Statutes, relating to facilitative technology express warranties, and for assuring that refunds resulting from the return of a nonconforming facilitative device to the dealer or manufacturer will be directed to the Department, as the Consumer Purchaser.
- D. The provision of documentation required by the Department.
 - 1. Providers shall maintain the following in client files for all equipment and supplies provided to the client:
 - a. Physician prescriptions;
 - b. Approved prior authorization requests, when appropriate;
 - c. Other medical documentation, as appropriate (e.g., letters from physicians or other health care practitioners supporting the medical need for services);
 - d. Documentation that the client or caregiver has been provided with manufacturer's instructions, warranty information and registration documents, service manual and operating guides, when such documents are provided by the manufacturer or are otherwise available;
 - e. Documentation that the service provider has provided instructions to the client or client caregiver, when appropriate and necessary, regarding the effective and safe operation of DME or prosthetic devices; or verification that the responsibility for such instruction was assumed by other health care professionals; and
 - f. Documentation concerning all equipment purchased, used or new, reimbursed by Medicaid; including the manufacturer's name and address, date acquired from the manufacturer or other party, acquisition cost, model number, serial number when appropriate for major equipment, accessories, attachment or special features included.
 - 2. When necessary, providers shall submit documentation with claims, including but not limited to invoices, reports, and serial numbers. Changes shall be communicated to providers through Medicaid bulletins, letters, or other notices as the Department determines necessary.

3. Providers shall retain documentation concerning all equipment purchased or rented used or new, reimbursed by Medicaid; including manufacturer's name and address, date acquired from the manufacturer or other party, acquisition cost, and when appropriate, model number, serial number, accessories, attachments or special features included. When requested in writing by the client or the client's caretaker, the provider shall supply a copy of claims submitted to the Department for payment of Medicaid funds for services rendered to the client.
 4. Providers shall verify, to the extent possible, that equipment requiring repairs belongs to the client presenting it for repairs.
 5. Providers shall retain all such documentation, for review, for a period of at least six years.
- E. Providers shall be responsible for the delivery of the correct, ordered/authorized equipment or supplies. After delivery, if an item is determined to be inappropriate or incorrect, the provider is responsible for picking up the equipment or supplies within five (5) working days after being notified of the problem. Claims for items known to be awaiting pickup by the provider cannot be billed to the Medicaid program. If billing occurs prior to notice that pickup is necessary, the provider shall submit a credit adjustment within twenty (20) working days following the date of pickup.
- F. Providers shall be responsible for confirmation of continued need for disposable supplies by contact with client or client caretaker prior to shipment of supplies.

G. Purchased New Equipment

1. All purchased equipment shall be new at the time it is made available to the client, except as allowed for elsewhere in these regulations. Providers shall provide equipment, prosthetic devices, supplies, repairs and services to Medicaid clients without discrimination with regard to quality of product or service.
2. Equipment provided shall be warranted by the manufacturer and the provider in accordance with the manufacturer's warranty. The provider shall not bill Medicaid or the client for equipment, parts, or service covered by the warranty within the warranty period. No replacement or repairs shall be reimbursed by Medicaid until the warranty period has expired.
3. The Mowing requirements apply to warranted equipment:
 - a. the client shall contact the point of sale for service and repairs covered by the warranty;
 - b. the provider shall honor all warranties held by the client;
 - c. the provider shall be able to provide appropriate service for all equipment sold;
 - d. the provider shall complete service or repairs in a timely manner, and shall advise the client of the approximate time required;
 - e. in the absence of client-owned backup equipment, and when necessary to meet client health safety, and mobility needs, the provider shall arrange for appropriate alternative equipment. Such equipment shall be provided at no cost by the provider, or if appropriate equipment is unavailable as "loaner" equipment, the provider shall arrange the provision of temporary equipment through rental by the Department;

- f. replacement of equipment or repairs to equipment no longer able to meet client needs due to changes in anatomical and/or medical condition occurring after purchase, are excluded from warranty requirements:
 - g. warranty services refused due to alleged misuse, abuse, or neglect shall be subject to the requirements located in 8.592.03; and
 - h. The foregoing requirements do not prevent a willing client and provider from making other arrangements regarding the purchase of used equipment, in accordance with 8.592.02 (H).et seq.
- 4. Medicaid reimbursement for purchase or rental of DME shall include, but is not limited to:
 - a. all elements of the manufacturer's warranty or express warranties as required by Sections 6-1-403, C.R.S. and 6-1-502, C.R.S.
 - b. all routine or special equipment servicing to the extent it is provided to non-Medicaid persons;
 - c. all adjustments and modifications needed by the client to make the item useful and functional;
 - d. delivery, set-up and installation of equipment in the home and, if possible, to the appropriate room in the home;
 - e. training and instruction to the client or caregiver in the safe, sanitary, effective and appropriate use of the item, and necessary servicing and maintenance to be done by the user, and
 - f. providing the client and/or caregiver with all manufacturer's instructions, servicing manuals and operating guides needed for routine service and operation.
- 5. Except for Wheelchairs and facilitative devices, for which a refund is due to the Medicaid Purchase Consumer under the terms of Title 6. Article 1, Parts 4 and 5 of Colorado Revised Statutes, equipment previously provided to the client, and for which Medicaid has reimbursed the allowable amount, is owned by the client unless the client and provider are notified otherwise by the Department at the time of purchase. Wheelchairs and facilitative devices for which the Department is due the refund cited above must be returned to the dealer or manufacturer, both of which are responsible for determining that the refund is provided to the Department.
- 6. When an item is no longer suitable because of growth, development or changes to the client's condition, and must be replaced, the client and the provider may negotiate a good faith trade-in of the unneeded item. Such a trade-in shall be used to reduce the charges billed to level of reimbursement required from the Medicaid program for replacement equipment
- 7. The Department may authorize a standard item. as well as appropriate accessories and/or necessary modifications. If the manufacturer of the approved item supplies the accessories or custom items as part of the price for the standard item, the provider may not bill for the standard item and for the individual accessories and custom items. In addition, providers shall give credit to the Medicaid program for any parts or accessories removed from new equipment before delivery. Such credits shall be applied proportionally reducing the billed charge for the item, and shall be credited whether the item removed is or is not replaced by another prescribed pan or accessory.

H. Purchased Used Equipment

If the client and the provider agree, the provider may provide used DME. Reimbursement for used DME, if provided, shall be based on the following terms:

1. The provider shall have a written, signed, and dated agreement from the client accepting the used equipment.;
2. The provider shall bill Medicaid at 60% of the maximum allowable reimbursable amount indicated in the most recent Medicaid bulletin, or 60% of the provider's usual and customary fee for comparable new equipment, whichever is less;
3. The provider shall assure the item provided:
 - a. is fully serviced and reconditioned;
 - b. is functionally sound and in good operating condition;
 - c. shall be repaired and have parts replaced in a manner equivalent to an item which is new. In addition, there shall be parts available for future repairs in a manner equivalent to the manufacturer's warranty on a like item which is new,
 - d. shall receive all routine or special equipment servicing, to the extent it is provided to non-Medicaid persons;
 - e. shall receive all adjustments and modifications needed by the client to make the item useful and functional during the first year of use, except for changes and adjustments required due to growth or other anatomical changes, or to repairs not required by a manufacturer's warranty on a similar new item;
 - f. shall include delivery and set-up of equipment in the home and, if possible, to the room appropriate in the home; and
 - g. shall include all manufacturer's instructions and training for the safe and effective operation of the equipment provided to the client; and
 - h. shall include all manufacturer's instructions, servicing manuals and operating guides, if available, as well as a history of repairs, if available. In the case of a wheelchair, and in accordance with 6-1-407, C.R.S., a wheelchair returned to the manufacturer or wheelchair dealer due to nonconformity, may not be provided to a client and billed to the Medicaid Program without full disclosure to the client of the reasons for the return; and
 - i. shall include all manufacturer's instructions, servicing manuals and operating guides, if available, as well as a history of repairs, if available. In the case of a facilitative device, and in accordance with Section 5-1-506, C.R.S. a facilitative device returned to the manufacturer or dealer due to nonconformity, may not be provided to a client and billed to the Medicaid Program without full disclosure to the client of the reasons for the return.

I. Rental Equipment

The provider shall provide rental equipment, repairs and services to Medicaid clients without discrimination with regard to quality of product or service. Reimbursement shall be by the Department in installment amounts following each month of rental service. Rental reimbursement shall end when the

medical necessity ends, the client is no longer eligible for Medicaid, or the Department determines that purchase is more cost-effective. Certain specialized equipment is highly technical and costly to maintain; therefore, it is fiscally more responsible to furnish such equipment to a client on a permanent rental basis.

Monthly rental payment shall include services as follows:

1. The provider shall be able to provide appropriate service for all rented equipment.
2. The provider shall complete service or repairs in a timely manner, and shall advise the client of the approximate time required.
3. The provider shall arrange for appropriate alternative equipment during periods of repair, when necessary.
4. The provider shall be responsible for the provision and replacement of all expendable items, including but not limited to hoses, fuses, batteries.
5. Medicaid shall not accept responsibility for loss, theft abuse, misuse, repairs or modifications to rented equipment by the client
6. Providers may not bill for rental if the location of the equipment is unknown.

.03 Clients

A. Clients or client caregivers shall be responsible for the prudent care and use of supplies, equipment, and prosthetic devices provided by Medicaid to meet the client's medical needs. When continued use of equipment is medically necessary, and when repairs or replacement are required due to Circumstances beyond the client's control, such repairs or replacement are a benefit of the Medicaid program, except as noted below.

1. The Medicaid Program is not responsible for repairing or replacing medical equipment that is covered by a manufacturer's warranty. The client, or the client's representative, is responsible in such instances for contacting the point of sale for services and repairs covered by the warranty, in accordance with section 8.592.02,G.3.a. of these regulations.
2. The Medicaid Program is not responsible for repairing or replacing wheelchairs or facilitative devices covered by express warranties as required by Title 6, Article 1, Parts 4 and 5 of Colorado Revised Statutes. When a wheelchair or facilitative device does not conform to the applicable express warranty, the client, or the client's representative, shall be responsible for reporting the nonconformity to the manufacturer, the dealer, or the alternative warranty service provider, and for making the wheelchair or facilitative device available for repair, in accordance with the statutes cited above.

B. Repairs and the replacement of equipment may not be reimbursed by Medicaid in documented cases of repeated misuse, abuse, neglect or loss of equipment/supplies/prosthetic devices, or in situations involving the wrongful disposition of equipment, prosthetic devices and/or supplies. Determination of misuse, abuse, neglect or wrongful disposition shall be the responsibility of the Department. Upon making such a determination, the Department shall provide to the client information relating to available access to an informal reconsideration panel and to appeal rights.

C. Following a determination of misuse, abuse, neglect, or wrongful disposition by the Department, the client may appeal the ruling in accordance with Section 8.057.7 of this Staff Manual, or the client may request review of the allegations by an informal reconsideration panel comprised of consumers, providers, and Department representatives. If the process of review by the informal reconsideration panel is selected, appeal requirements will be suspended until completion of the

informal reconsideration panel process, at which time the client may request appeal of an adverse finding by the informal reconsideration panel or by the Department. The Department reserves the right of final agency action.

- D. In the case of theft of a client's equipment, a prior authorization may be submitted requesting replacement. However, the request for replacement shall not be considered without an accompanying copy of the police report of theft.
- E. The client, and/or the client's caregiver, is responsible for routine maintenance of all equipment purchased for the client. Routine maintenance is that servicing of DME described in the manufacturer's operating manuals as being performed by the user to properly maintain the equipment. Such routine maintenance consists of, but is not limited to, periodic servicing such as cleaning, lubricating moving parts, adding water to batteries, checking air in tires, when appropriate, or other maintenance prescribed by the manufacturer. Such routine maintenance shall be done by the client, caregiver, or other support person. Reimbursement for routine maintenance is not provided to the client or the provider. If such maintenance is not performed routinely, and in accordance with manufacturer and provider instructions, repairs to or replacement of the equipment may be refused by Medicaid and become the responsibility of the client.
- F. The client utilizing rented equipment in his/her home is responsible for notifying the provider of any change in address. The client is accountable for the condition and location of all rental equipment. If the client fails to notify the provider of a current address for the client and the rented equipment, the provider is unable to maintain the equipment appropriately and the client's medical needs may cease to be met, due to poorly maintained equipment. Further, no Medicaid reimbursement shall be allowed for equipment the location of which is unknown; consequently, the client may be responsible for any rental costs incurred.
- G. The client shall not remove rented equipment from the State of Colorado permanently. Except as provided for elsewhere in these regulations, there is no benefit for services outside the State of Colorado unless prompted by a medical emergency.
- H. Except as noted elsewhere in these regulations (8.592.02G.), equipment previously provided the client, and for which Medicaid has reimbursed the allowable amount, is owned by the client unless the client and provider are notified otherwise at the time of purchase. When an item is no longer suitable because of growth, development or changes to the client's condition and must be replaced, the client and the provider may negotiate a good faith trade-in. Such a trade-in shall be used to reduce the charges billed to the Medicaid program for replacement equipment.
- I. The Medicaid program shall determine that approved services are medically appropriate and cost effective. Clients wishing services in addition to those authorized by the Department or its designees (e.g., equipment color requiring additional reimbursement, component parts not authorized, or more technologically advanced services or equipment) shall be responsible for all reimbursement in excess of that authorized.
 - 1. The provider shall obtain and maintain in the client's file a statement signed by the client and the provider.
 - 2. The signed statement shall indicate the accessories, modifications, and upgrades requested by the client that were not authorized by the Department.
 - 3. The statement shall clearly state that the client was not required or otherwise forced to request the unauthorized equipment, and that the client fully understands his/her financial responsibility for the requested items.

8.593 SCOPE OF BENEFIT COVERAGE

Except as provided for elsewhere in these regulations (Section 8.442, et. seq. and 8.500.2), durable medical equipment prosthetic devices, and disposable supplies may be provided only to eligible clients residing outside of a hospital nursing facility, or other facility reimbursed utilizing cost-related per diem rate setting methodologies (e.g., moderate supervision group home or a specialized care group home).

Supplies, prosthetic devices, and DME provided shall be considered a benefit only when reasonable and necessary for the treatment of a client's physical illness, disability, or injury. Supplies, prosthetic devices, and DME provided shall be of standard or conventional usage and cost, and shall not include items which are considered experimental or investigational for the intended purpose. DME, prosthetic devices, and supplies covered by Medicaid shall not be duplicative or serve the same purpose as equipment already being utilized by the client unless medically required for emergency or backup support. The DME, prosthetic devices, and supplies provided shall not be more costly than is medically appropriate or than realistically feasible alternative treatments.

.01 Regular Benefit Items

The following durable medical equipment and supplies are considered Medicaid benefits for clients of all ages if medical necessity has been established and use in the home setting determined to be appropriate. The Department or its designees may require submission of a Medicaid request for prior authorization for selected items of equipment and supplies.

- A. Ambulation devices and accessories (canes, crutches, walkers)
- B. Bath and bathroom equipment
- C. Bed and bedroom equipment and accessories, including specialized beds and mattress overlays
- D. Manual or power wheelchairs, seating system orthosis used for wheelchair positioning
- E. Diabetic monitoring equipment and related disposable supplies
- F. Elastic supports/stockings
- G. Monitoring equipment and supplies
- H. Oxygen and oxygen equipment in the client's own home, a nursing facility setting, moderate supervision group home, or specialized care group home (see 8.585 for additional information relating to institutional oxygen)
- I. Transcutaneous and/or neuromuscular electrical nerve stimulators (tens) and related supplies
- J. Trapeze/traction/fracture frames
- K. Lymphedema pumps/compressors
- L. Rehabilitation equipment (specialized use)
- M. Enteral formulas and supplies
- N. Parenteral equipment and supplies
- O. Repairs and replacement parts

1. Repairs and extensive maintenance which, based on the manufacturer's recommendations, is to be performed by authorized technicians; and repairs needed to keep the DME item functional, are a benefit of the Colorado Medicaid program.
2. Repairs and replacement parts are Medicaid benefits under the following circumstances:
 - a. the DME was purchased by Medicaid; or
 - b. the equipment is owned by the client or client's family or guardian (i.e., the equipment is not being rented nor is it furnished by another agency, organization, or source with the expectation that the equipment will be returned after the need is over); and
 - c. the equipment is in regular use exclusively by the client; and
 - d. no other source is available to pay the needed repairs or maintenance and
 - e. documentation is available that the item is still medically necessary for the client; and
 - f. the needed repairs are not caused by repeated misuse, abuse, neglect, or willful damage or destruction of the DME by the client; and
 - g. the item is no longer warranted by the manufacturer or provider. The provider shall be responsible for determining that the warranty period is no longer in effect.
3. To the extent possible, the provider is responsible for verifying that the equipment being repaired is owned by the client.
4. Maintenance, repairs, replacement parts for rented durable medical equipment shall be the responsibility of the provider.
5. When repairs are frequent and costs approach the purchase price of a replacement the provider shall initiate a prior authorization request for consideration of new equipment. The request shall be accompanied by documentation supporting the need for replacement, including cost estimates for both repairs and replacement purchase.
6. Documentation required for submission with requests for prior authorization or with claims for repairs shall be determined by the Department and shall be made known to the provider through Medicaid bulletins.

P. Disposable supplies

1. Reimbursable medical supplies shall be related to one of the following categories:
 - a. surgical, wound, and bum care;
 - b. syringes/needles;
 - c. bowel and bladder care;
 - d. antiseptics/solutions;
 - e. gastric feeding sets and supplies;
 - f. tracheostomy and endotracheal care supplies; and

g. diabetic monitoring.

2. Coverage of medical supplies shall be governed by the following policies:

- a. medical supplies shall be for a specific purpose, not incidental or general purpose usage;
- b. quantities delivered or shipped shall not generally exceed one month's supply, except when packaged by the manufacturer only in larger quantities;
- c. medical supplies are for the exclusive use of the client for whom they are ordered and, when necessary, approved; and
- d. dressings are covered only while a client is undergoing active medical treatment

Q. The following prosthetic and orthotic devices, including but not limited to the following list, may be considered Medicaid benefits for clients of all ages if medical necessity has been established and use in the home setting has been determined to be appropriate. The Department or its designees may require submission of a Medicaid Request for Prior Authorization, including a statement of medical services which may be required without the provision of the requested device. Medical necessity shall be determined based on criteria established by the Department, and in accordance with Vol. VIII, 8.591.02(M):

- 1. artificial limbs;
- 2. facial prosthetics;
- 3. ankle-foot/knee-ankle-foot orthotics;
- 4. recumbent ankle positioning splints;
- 5. thoracic-lumbar-sacral orthoses (TLSO);
- 6. lumbar-sacral orthoses (LSO);
- 7. rigid and semi-rigid braces;
- 8. therapeutic shoes;
- 9. orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements when a medically necessary and integral part of a leg or ankle brace;
- 10. specialized eating utensils and other medically necessary activities of daily living aids; and
- 11. augmentative communication devices and communication boards.

In order for Medicaid to reimburse for medically necessary services, the client's medical need must be documented by following methods, in accordance with Department policy.

- A. Prescribed by the attending physician and prior authorize\ill\ Department of Health Care Policy and Financing or its designation \ill\
- B. Statement of medical necessity from the attending physician;
- C. Written prescription provided by the attending physician.

Medicaid bulletins periodically distributed by the Department's fiscal a which equipment may be purchased, rented, or is available through bot\\ill\\ information relating to the policies surrounding approval, and the type 01 documentation required.

The Department reserves the right to make the final determination whether to provide requested equipment through rental or through purchase. Certain specialized equipment is highly technical in nature, and costly to maintain. In such instances, it is fiscally more responsible to furnish the equipment to a \\ill\\ through a permanent rental arrangement.

.02 Prior Authorization

- A. Certain items of equipment, prosthetic devices, and disposable supplies require authorization by the Department or its designee prior to the provision of the service and subsequent reimbursement by Medicaid. Those items requiring prior authorization are noted in periodic Medicaid bulletins distributed to the providers.
- B. For such items, a request for prior authorization (Form 10013), signed by the ordering physician, shall be submitted to the Department's designee. The physician's signature may also be obtained by the attachment of additional medical documentation bearing the physician's signature to the prior authorization. Requests for prior authorization shall be fully completed, and include the following information, as a minimum:
 - 1. A full description of the item or items which are reasonable and medically necessary for the client's well being, in accordance with accepted standards of medical practice in the treatment of the client's condition;
 - 2. A description of all attachments, adjustments and modifications needed to the basic equipment;
 - 3. Any specific instructions for the client regarding the use and frequency of use of the item being ordered to obtain the intended medical benefit;
 - 4. The effective date and estimated length of time the item(s) will be required;
 - 5. The diagnosis, prognosis, previous and current treatments, and other clinical information necessary to establish medical necessity;
 - 6. Serial numbers for all wheelchair repairs;
 - 7. Any specific physical limitation of the client which may be significant for the provider of service to know, and
 - 8. The name and identification numbers for the client, ordering physician, primary care physician, and the DME provider who will be rendering the requested service.
- C. Diagnostic information shall be completed by the physician prior to the physician's signature, or may be completed based on verbal or written orders prior to the physician's signature. The provider shall not complete or add information after the physician has signed the request for prior authorization.
- D. Requests for prior authorization shall be submitted in a timely fashion. Requests submitted with a beginning date in excess of three months prior to the date of submission shall be submitted with documentation attached indicating the reason for the late submission. Retroactive approval beyond three months without such documentation shall be considered only in the situation of a client determined to be retroactively eligible for Medicaid.

- E. The Department reserves the right to deny the provision of any equipment, even in situations of medical necessity, when it appears that the client cannot operate the equipment safely following training and necessary modifications.
- F. The Department or its designee reserves the right to request documentation that a less expensive, comparable alternative to requested equipment or supplies is not available or practical. If a more cost-effective alternative is determined to be available, the Department shall deny the original request or specify that only the less costly equipment/supplies are approved.
- G. Prior authorization granted by the Department indicates that the requested item is medically necessary. Approval does not guarantee payment or constitute waiver of any claims processing requirements, including eligibility and timely filing.
- H. Medicaid clients for whom wheelchairs, wheelchair component parts, and other specialized equipment, in accordance with Department policy, which were authorized and ordered prior to HMO enrollment, but for which delivery is delayed until after the HMO enrollment period begins, shall have those services provided by the Medicaid DME/Supply Program. However, all other DME and disposable supplies shall be the responsibility of the HMO plan. Until an appropriate transition plan is completed, and continuity of care is assured, the previous Medicaid provider of service shall be reimbursed by the HMO plan at the Medicaid reimbursement rate.

Equipment requiring maintenance which the client is medically unable to provide for him/herself shall be provided through the HMO plan network.

.03 Routine Non-Benefit Items

- A. Equipment and disposable supplies are not considered medically necessary and reimbursable if the planned use primarily includes, but is not limited to, the following non-medical purposes:
 - 1. Routine personal hygiene (including but not limited to shampoo, bath/face soap, tooth paste, tooth brushes, sanitary napkins, etc.)
 - 2. Education
 - 3. Exercise
 - 4. Participation in sports
 - 5. Client or caretaker convenience
 - 6. Cosmetic purposes
 - 7. Personal, rather than medical, comfort
- B. There is no additional reimbursement allowable for the disposable supplies necessary for the delivery of services utilizing rented equipment, in accordance with Department policy.
- C. Supplies or equipment utilized by the client when (s)he is voluntarily out of the state, for either pleasure or unapproved medical purposes, and which must be supplied by an out-of-state provider, shall not be a benefit unless the need for such services arises from a medical emergency occurring in the other state, or as allowed elsewhere in these regulations.
- D. Supplies and equipment utilized by the staff of a home health agency, during the course of a home visit, for the purpose of meeting universal precaution requirements, with the exception of gloves, shall be provided by the agency, and shall not be a benefit of the DME/supply program. See

8.528.12.

- E. Supplies and equipment required by a client residing in a nursing facility, Home and Community Based Services for the Developmentally Disabled facility and/or other facility reimbursed utilizing cost-related per diem rates are not a benefit of the DME/supply program. (See Section 8.442, et. seq. and 8.500.2).
- F. Equipment repairs or replacement due to documented client misuse, abuse, or neglect
- G. Fees for delivery, set-up, calibration, training or instruction, or other services defined as already included in reimbursement for equipment and supplies elsewhere in these regulations, are not reimbursable, in accordance with 8.528.

.04 Adult Non-Benefit Items

For clients over 20 years of age, the following items are not a benefit:

- A. Orthopedic footwear and related modifications, inserts, and heel/sole replacements when not a medically necessary and integral pan of a leg or ankle brace;
- B. Hearing aids and accessories;
- C. Phonic ears;
- D. Environmental control units, unless requested for a client living unattended and requiring the equipment to assure his/her medical safety;
- E. Therapeutic toys;
- F. Computers and computer software unrelated to medically necessary communications;
- G. Vision correction unrelated to eye surgery.

.05 Coverage For Children Under The EPSDT Program

If the medical need for an item listed in 8.593.04 (A)-(K) is identified during an EPSDT screening, Medicaid coverage will be considered. In that instance, a copy of the EPSDT screening results identifying the medical need for that particular item must be attached to a request for prior authorization and submitted to the Department's fiscal agent for review. If the request substantiates medical necessity, Medicaid funding will be approved. Such items shall not be approved without the EPSDT screening identification. Such items may include, but are not limited to, the following:

- A. Prosthetics
- B. Orthotics
- C. Specialized body or limb braces
- D. Orthopedic shoes and modifications
- E. Augmentative communication devices
- F. Hearing aids (provided through Colorado Department of Public Health and Environment, Health Care Programs for Children with Special Needs)

- G. Therapy balls for use in trained parental or caregiver conducted physical or occupational therapy sessions
- H. Specialized eating utensils or other activity of daily living aids
- I. Therapeutic toys
- J. Computers and computer software when utilization is intended predominantly to meet the medical, rather than educational, needs of the client.

NOTE: Section 8.593.06 was deleted effective July 1, 2002.

8.594 COORDINATION/REIMBURSEMENT OF BENEFITS

.01 The Colorado Medicaid program may be utilized under the following circumstances:

- A. The client is eligible for Medicaid only.
- B. The client is eligible for both Medicare and Medicaid, and the service is denied or partially paid for by the Medicare program; or a wheelchair or wheelchair repairs are needed and provider access is not available to the dually-eligible client.
- C. The client is eligible for Medicaid and has insurance coverage through a third-party insurance carrier, and the service is denied or partially paid for by the insurance carrier.

.02 Claims for services rendered shall be submitted to the Department's fiscal agent with the appropriate Health Care Finance Administration Common Procedure Coding System (HCPCS), or in cases where a HCFA assigned HCPCS code does not exist, a local code assigned to the service by the Medicare or Colorado Medicaid programs. HCPCS codes shall be listed in regularly updated Medicaid bulletins distributed by the Department's fiscal agent to providers supplying equipment and supplies.

- A. Medicaid shall be the payer of last resort. For clients eligible for both Medicare and Medicaid, the provider shall accept assignment for Medicare, except for wheelchairs and wheelchair repairs excluded by Department policy. All claims submitted shall indicate reimbursement or denial received from Medicare or other insurance carriers.
- B. The deadline for timely filing of a Medicaid claim will not be extended for a claim submitted to another carrier or to Medicare in order to obtain a denial, when the provider knows that the client is not a beneficiary of the other carrier or of Medicare.

8.594 COORDINATION/REIMBURSEMENT OF BENEFITS

.03 Reimbursement shall be made as follows:

- A. Fee schedule

If a HCPCS code for a piece of equipment or supply item has been assigned a maximum allowable cost (MAC), Medicaid reimbursement will be the provider's usual and customary charge or the MAC, whichever is less. The usual and customary charge is considered that amount usually charged to non-Medicaid customers and other third party carriers; it may also be considered the retail charge.

A list of MACs will be distributed to providers periodically by Medicaid bulletin.

The maximum allowable cost shall be determined by the State Department, and shall be considered reimbursement in full, except as provided elsewhere in these regulations. No additional reimbursement

will be allowed for shipping and tax paid by the provider except when billing "by invoice".

B. Manually Priced Services

If a HCPCS code has not been assigned a MAC, Medicaid reimbursement shall be the lesser of the provider's usual and customary charge or the sum of the manufacturer's invoice cost, plus 20%, plus documented tax and shipping expenses paid by the provider. Invoice cost shall be documented by a copy of an invoice from the manufacturer or a wholesale distributor.

Reimbursement for items purchased by one Medicaid provider from another, or by a Medicaid provider from a related party, shall be made in accordance with section 8.594.03 (a) or 8.594.03 (b). Invoices received from other than an unrelated manufacturer or wholesale distributor shall not be recognized as documentation of allowable costs.

C. Medicare Crossover

If a client is Medicare/Medicaid, Medicare shall be billed first, except as excluded by 8.594.02 (A), using the codes found in the Medicare provider manual.

1. If Medicare makes payment, Medicaid payment of any deductible or copayment amounts due and payable from Medicaid, in accordance with section 8.0622.1, will usually be made automatically. If not, the provider is responsible for billing the Department's fiscal agent within the Medicaid timely filing period.
2. If Medicare refuses payment, the provider is responsible for directly billing the Department's fiscal agent within the timely filing period. A copy of the Explanation of Medicare Benefits must be maintained in the provider's files when billing electronically, or must be attached to a paper claim.
 - a. If Medicare denial is based upon an error in the submission of the Medicare claim, Medicaid reimbursement shall not be made, or shall be recovered upon identification of the situation.
 - b. If the manner in which the Medicare claim is submitted to Medicare automatically results in denial (e.g., inappropriate coding), Medicaid reimbursement shall not be made, or shall be recovered upon identification of the situation.

D. The use of any device or strategy that may have the effect of increasing the total amount claimed or reimbursed for any equipment or supply item beyond the maximum allowable amount payable for such a service shall not be allowed. Identification of the situation shall result in reduced reimbursement, denial, or recovery of the inappropriate reimbursement amount. For example:

1. Duplicate billing or billing for services not provided; or
2. Overstating or inappropriately describing services by utilizing a HCPCS code for billing which would allow higher reimbursement, but the provision of which is not supported by the medical needs of the client or by client files.

8.660 LABORATORY AND X-RAY

Laboratory and X-Ray Services are a benefit of the Medical Assistance Program in Colorado under all of the following conditions:

A. The services have been authorized by a licensed physician.

- B. The services are performed to diagnose conditions and illnesses with specific symptoms.
- C. The services are performed to prevent or treat conditions which are reimbursable under the Medical Assistance Program.
- D. The services are not routine diagnostic tests performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.
- E. The laboratory services are performed by a certified laboratory in accordance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

8.661 DEFINITIONS

"Independent Certified Laboratory" is a certified laboratory which performs diagnostic tests and is independent both of the attending or consulting physician's office and of a hospital. A laboratory located in a hospital or, if outside the hospital, which is operated under the supervision of the hospital or its organized medical staff and serves the hospital's patients is not an independent laboratory. However, a hospital laboratory may obtain Medicare certification as an independent laboratory and bill Medicaid directly for certified laboratory tests performed for recipients who are not admitted as patients in the hospital. A laboratory maintained by a physician or a group of physicians for performing diagnostic tests in conjunction with his or their practice is not an independent laboratory.

"Clinical Laboratory" is a certified provider who performs microbiological, serological, chemical, hemotological, radiobioassay, cytological, immunohematological, pathological or other examinations of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or the assessment of a medical condition.

"Certified Clinical Laboratory" is a provider who possesses a certificate of waiver or a certificate of registration from the Health Care Financing Administration or its designated agency as meeting Health Care Financing Administration guidelines and whose personnel and director are qualified to perform laboratory services.

"X-Ray Services" are services performed by a provider whose x-ray equipment has been certified by the Colorado Department of Health as meeting Medicare guidelines and whose personnel and director are qualified to operate said equipment.

8.662 CONDITIONS OF PARTICIPATION

Certified clinical laboratories and providers of x-ray services must enroll as providers in the Medical Assistance Program. All certified laboratories, including out-of-state independent clinical laboratories, must be certified by the appropriate state agency to participate under Medicaid. All laboratories must provide proof of certification status through the provision of the CLIA (Clinical Laboratory Improvement Act of 1988) number to the Medicaid fiscal agent. Medical assistance enrollment and/or reimbursement cannot be accomplished without proof of certification on file with the state's fiscal agent for the effective date of enrollment and date of services for which reimbursement is claimed.

Providers of x-ray services must be certified by the appropriate state agency to participate under Medicare and must provide proof of the Medicare certification on the medical assistance enrollment forms.

8.663 LIMITATIONS AND BENEFITS

.01 Tests, profiles, and screens which fit the description in 8.660 and are performed and billed by a certified clinical laboratory or a provider of x-ray services are a benefit.

.02 Collection, handling, and/or conveyance of specimens for transfer from physicians' offices to a certified independent clinical laboratory is reimbursable to the physician.

.03 Collection, handling, and/or conveyance of specimens for transfer from the patient's home, a nursing home or a facility other than the physician's office or place of practice is a benefit only if the patient is homebound, bedfast, or otherwise non-ambulatory. However, when a specimen of this type could be reasonably mailed, the pickup is no longer considered medically necessary and therefore is non-reimbursable. The physician may be required to certify the medical necessity for the pick-up.

.04 Transfer of a specimen from one certified independent clinical laboratory to another is a benefit and reimbursable to the first certified laboratory only if the laboratory's equipment is not functioning or the laboratory is not certified to perform the tests ordered by the physician.

8.664 BILLING PROCEDURES

.01 Certified providers of clinical laboratory and x-ray services must bill the Medical Assistance Program directly using the designated billing method, the prescribed procedure codes recognized by the Colorado Department of Social Services and billing the amount of the provider's usual and customary charges to the general public.

.02 Laboratory tests and x-rays performed under the personal supervision of the authorizing physician must be billed directly on the physician's services claim form.

.03 Laboratory tests and x-rays not performed by the authorizing physician or under his direct personal supervision cannot be billed by the physician to the Medical Assistance Program except for physicians in a certified clinical laboratory group practice. A certified clinical laboratory group practice may only bill for those laboratory and x-ray services actually performed or supervised by a physician member of the group or performed by a qualified employee of the group. In those cases, payment will be made to the authorizing physician or the group practice.

8.665 REIMBURSEMENT

.01 Reimbursement for certified independent clinical laboratory and x-ray services shall be the lowest of the following;

- A. Submitted charges.
- B. Fee schedule as determined by the Department.
- C. 60% of the Medicare area prevailing fee.

.02 Each certified independent clinical laboratory provider will be reimbursed for only those tests performed in the specialties or sub-specialties for which it is certified.

.03 Reimbursement for out-of-state certified independent clinical laboratory or x-ray services shall be subject to Colorado reimbursement rates.

8.666

Exception to the above reimbursement methodology are payments for those services/procedures which are reimbursed under a capitated or contracted agreement accomplished through competitive bid or other arrangement.

When services/procedures are reimbursed under capitated, competitive bid or other arrangement the following payment methodology shall apply:

.01 Pre-determined fixed capitation rate. Capitation rates for covered services/procedures shall be established in accordance with competitive bidding principles considering medical costs of covered services/procedures. The capitation rate may not exceed the Medicare rate of reimbursement paid on a "fee-for-services" basis for the service/procedure; or

.02 Payment shall be made in accordance with the terms of the contractual arrangement negotiated with the Colorado State Department of Social Services.

8.680 NON EMERGENT MEDICAL TRANSPORTATION

8.680.1 DEFINITIONS

Advanced Life Support (ALS) means special services designed to provide definitive medical care en route from the client's pickup point to the medical facility or during interfacility transfers and until responsibility for medical care is assumed by the staff of the receiving medical facility. During non-emergent medical transportation, ALS services may include cardiac/hemodynamic monitoring en route, cardiac defibrillation, advanced airway management, intravenous therapy, chemical restraints, administration of specified drugs and other invasive techniques.

Transport of clients requiring cardiac/hemodynamic monitoring is considered to be non-emergent only if such monitoring is required both before and after transport. Advanced airway management shall include clients who are ventilator dependent, require intubation and/or deep suctioning en route, or are on an apnea monitor before, during and after transport. Administration of intravenous (IV) medication en route shall not include self-administered IV medications.

Ambulance means any publicly or privately owned vehicle that is specially designed, constructed, modified or equipped to be used, maintained and operated on streets or highways to transport clients to a hospital or other treatment facility in cases of accident, trauma or severe illness.

At-Risk Adult means an adult who is unable to make medical determinations or provide necessary self-care.

Basic Life Support (BLS) means transportation by an ambulance vehicle and medically necessary supplies and services to include cardiopulmonary resuscitation as required to maintain life during transport from the client's pickup point to the provider's facility or during an interfacility transfer, without cardiac/hemodynamic monitoring or other invasive techniques. Services during BLS transport may include suctioning en route (not deep suctioning) and airway control/positioning.

Bed Confined means the status of a client who meets all three of the following conditions:

1. Unable to get up without assistance; and
2. Unable to ambulate; and
3. Unable to sit in a chair or wheelchair.

Escort means a person who accompanies a Medicaid client when it has been determined by the State Designated Entity that:

1. The client cannot travel independently, or
2. The client is unable to make his or her own medical decisions; or
3. The client is unable to provide necessary medical self-care.

Medical Treatment means those Medicaid covered services rendered by a participating provider in the Medicaid program.

Mobility Impairment means the impairment in a client's ability to ambulate without an assistive device including a cane, walker or the intermittent use of a wheelchair, or assistance from a caregiver or escort in ambulating between two points.

Mobility Vehicle means a passenger carrying vehicle as regulated by the Public Utilities Commission, including those designed, constructed, modified or equipped to meet the needs of wheelchair users, passengers with mobility impairments, escorts, and other Medicaid clients. A mobility vehicle may or may not also be wheelchair accessible.

Multiple Segments means those services rendered when a passenger requires pick up and transportation between several different destinations as part of a continuum while the transportation provider waits, prior to a return to the point of origin. Each segment is considered one part of the complete round trip.

Non-Emergent Medical Transportation means transportation to or from medical treatment that is not emergent in nature. Non-emergency care may be scheduled or unscheduled.

Physician Certification means a signed statement from the attending physician, physician assistant, nurse practitioner, therapist or other licensed mental healthcare professional providing treatment to the client who has personal knowledge of the client's condition at the time the transport is ordered or the service is furnished.

Prior Authorization means approval from the State Designated Entity for a Medicaid client to receive non-emergent transportation services.

State Designated Entity means an agency (or agencies) whose functions is (are) to coordinate non-emergent medical transportation services for Medicaid clients.

Transportation provider means a carrier providing transportation services to clients.

Wheelchair User means a client with severe permanent or temporary mobility impairments who is unable to ambulate without a wheelchair and whose condition requires the use of a vehicle lift or ramp as certified by a physician. Clients using wheelchairs due to safety policies of the facility or the transportation provider are not considered wheelchair users.

Wheelchair Van means a vehicle that has been specifically designed, constructed, modified or equipped to meet the needs of wheelchair users. Wheelchair vans may also be used to transport State approved escorts and other Medicaid clients.

8.680.2 PROGRAM COVERAGE

8.680.2.A.

Non-emergent transportation is covered only when a client's medical and physical condition does not allow that recipient to travel by passenger car, taxicab or another form of public or private conveyance. Public conveyance is allowed if the client's condition meets medical necessity criteria and public conveyance is the least costly method of transportation. Transportation is not covered if the care to be obtained is not a covered Medicaid service. Approved out-of-State travel may include bus, train or airline.

8.680.2.B.

Non-emergent transportation is not a benefit when a medical service is provided by or through a Medicaid provider school district.

8.680.2.C.

Non-emergent transportation necessary to obtain medical services is covered subject to a written certification by an attending physician, physician assistant, nurse practitioner, therapist or other licensed mental healthcare professional. A physician certification shall be submitted to the State Designated Entity for prior authorization. If appropriate, the physician certification may cover the entire length of treatment up to six months. The physician certification shall include the following:

1. Purpose of the trip;
2. Frequency of necessary medical visits/trips or the inclusive dates of the requested medical transportation up to six months;
3. Medical or physical condition that makes normal public or private transportation inadvisable.
4. Request for client meals and lodging if travel cannot be completed in one calendar day.
5. When transportation is requested on an ongoing basis, physician certification shall include the chronic nature of a recipient's medical or physical condition and a treatment plan. A diagnosis alone, such as "renal failure" without a treatment plan shall not satisfy this requirement.

8.680.2.D.

Non-emergent transportation may cover the cost of transporting a client escort if the certification clearly states why the client cannot travel alone. Escort travel may be approved if the client is:

1. A minor child; or
2. An at-risk adult.

8.680.2.E.

Non-emergent transportation may cover the cost of transporting a second client escort if:

1. The client has a behavioral or medical condition which may cause the client to be a threat to self or others if only one escort is provided; or
2. The client's primary caregiver has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay; or
3. The client is a minor child with a medically unstable condition or the travel maybe prolonged and the presence of both parent/legal guardians is required.

8.680.2.F.

Out-of-State transportation services are allowable only when:

1. For routine treatment:
 - a. When the client lives in a border community where the nearest routine medical services are located in an adjacent state.
2. For specialized treatment:

- a. The treatment shall not be available within the State of Colorado.
- b. The request for travel shall include a physician certification indicating why the service is not available or cannot be provided within Colorado.
- c. The request for travel shall include the anticipated period of travel.
- d. The request for travel may include client meals and lodging if the client will not be housed in a hospital setting.
- e. The request for travel may include escort meals and lodging if the client is a minor child or at-risk adult

8.680.3 TYPES OF MEDICAL TRANSPORTATION

8.680.3.A.

In state non-emergent ground medical transportation shall be provided by ambulance, mobility vehicle, wheelchair van or other public conveyance equipped with a wheelchair lift. Air ambulance may be a viable means of transportation if the distance to be traveled within Colorado is too vast to be covered by appropriate ground transportation. Use of an air ambulance requires prior approval from the Department.

8.680.3.B.

The least expensive mode of transportation shall be utilized. Clients are required to go to the closest qualified provider to receive services.

8.680.3.C.

Ambulances may provide non-emergent transportation for:

- 1. Transfers between facilities for clients who require continuous intravenous medication, advanced or basic life support services, medical monitoring or observation; or
- 2. Transfers for clients who are on oxygen - not to include clients with chronic respiratory disorders who carry their own oxygen for continuous use; or
- 3. Transfers for clients who are premature or sick newborns who require supportive medical equipment during transport; or
- 4. Transfers for clients who are bed confined or who must be transported in a prone or supine position because the client is not able to sit for the period of time needed for transport; or
- 5. Transfers from one acute care facility to another acute care facility.

8.680.3.D.

Mobility vehicles may provide non-emergent transportation for:

- 1. Transfers that require specialized equipment and/or more space than is normally available in passenger cars, taxicabs or other forms of public transportation; or
- 2. Transfers that do not require specialized services, equipment and personnel of an ambulance because the client is in a stable condition and does not need constant observation.

8.680.3.E.

Wheelchair vans may provide non-emergent transportation for:

1. Transfers when the client is certified wheelchair user, or
2. Transfers when the client is unable to transfer unassisted from a residence to a public or private conveyance because of a disabling physical limitation.

8.680.3.F.

Public conveyance equipped with a wheelchair lift may be used by clients able to access public modes of transportation, who also meet the requirements for needing assistance under a physician certification.

8.680.4 REIMBURSEMENT REQUIREMENTS/INSTRUCTIONS

8.680.4.A.

General Guidelines

8.680.4.B.

Except as described below, reimbursement shall be made at the provider's usual and customary charge as registered with the Public Utilities Commission or the maximum Medicaid allowable rate established by the Department, whichever is less, and in accordance with available funding.

8.680.4.C.

Providers not required by Federal or State law to register rates with the Public Utilities Commission shall be reimbursed at the rates normally charged to the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities, or the maximum Medicaid allowable rates established by the Department, whichever is less and in accordance with available funding.

8.680.4.D.

The State Designated Entity is authorized to selectively contract in order to maximize service dollars and establish a rate for reimbursement other than that described in 8.680.4.B

8.680.4.E.

Physician certification acceptance for services is not a guarantee of payment. The State shall reserve the right to audit physician certifications to determine if the services authorized and rendered were the least costly and most medically appropriate form of transportation for the client.

8.680.4.F.

Transportation providers shall submit claims for reimbursement to the State Designated Entity or the Fiscal Agent as directed by the Department.

8.680.4.G.

The State Designated Entity or Fiscal Agent, as directed by the Department, shall reimburse the client or client's designated representative for approved meals, lodging and public conveyance transportation.

8.680.4.H.

Span billing for transportation services is prohibited. Services shall be billed to reflect the actual date of service and the number of units provided on each date.

8.680.4.I.

The Department reserves the right to disallow, any costs upon audit of the State Designated Entity's or client's case file if the file indicates any of the following:

1. Incorrect billing; or
2. Incorrect physician certification.

8.680.4.J.

All claims shall be submitted in accordance with Departmental billing procedures and or instructions and shall meet all requirements set forth in these regulations.

8.680.4.K.

Medicaid shall be the payer of last resort.

8.680.5 REIMBURSEMENT GUIDELINES

8.680.5.A,

Public conveyance shall be reimbursed by the State Designated Entity directly to the client or client designated representatives. The amount reimbursed shall be the actual fare, or the State Designated Entity shall provide passes, tokens or vouchers.

8.680.5.B

Ambulance transport reimbursement shall consist of the following:

1. Base rate that is an all-inclusive service and shall include all functions normally considered as part of emergency services.
 - a. BLS shall include reusable devices, non-reusable supplies and use of equipment and personnel as well as general vehicle costs.
 - b. ALS shall include reusable devices, non-reusable supplies, equipment, personnel and EKG monitoring as well as general vehicle costs.
 - c. In all cases, the amount of reimbursement shall be the lower of the provider's submitted charges or the Medicaid allowable rate.
2. Mileage charges in addition to the base rate shall be reimbursed at the maximum Medicaid allowable rates established by the Department or the State Designated Entity.
 - a. Mileage shall be billed at one unit of service per mile.
 - b. Mileage shall be allowable only for the portion of the trip when the client is in the ambulance.
3. Oxygen is an allowable charge in addition to the base rate.

- a. Oxygen shall be billed separately and includes administration and supplies.
- b. Oxygen is not allowable when the client is capable of self-administration of portable or home oxygen. The charge is allowable if the client requires oxygen and is frail enough to need assistance in administering as certified by a physician.
- c. Oxygen and oxygen equipment shall be reimbursed at the lower of the provider's submitted charges or the Medicaid allowable rate.
- d. Oxygen shall be billed as one unit per one-way trip.

8.680.5.C.

Mobility vehicle transport reimbursement shall consist of the following:

1. Except as described in 8.680.4.D, reimbursement shall be made at the lower of the provider's usual and customary charge as registered with the Public Utilities Commission or the maximum Medicaid allowable rates established by the Department or the State Designated Entity.
 - a. Mobility vehicles shall bill and be reimbursed for a one-way trip as one unit of service regardless of the number of segments that may be included in a trip when the segments are provided as part of a multiple segment continuum.
 - b. Mobility vehicles shall bill and be reimbursed for a round trip as two units of service regardless of the number of segments that may be included in a trip.
 - c. Mobility vehicles shall not bill using ambulance or wheelchair codes. A wheelchair code may be allowed if the client is a certified wheelchair user and the mobility vehicle is wheelchair accessible.
2. When a mobility vehicle transports multiple riders, the provider shall submit claims according to the billing instructions and procedures of the Fiscal Agent for multiple riders. Multiple riders include the following:
 - a. Multiple clients picked up at the same location and transported to the same destination. Mileage is not a benefit.
 - b. Multiple clients picked up at the same location and transported to different locations within the same vicinity. Mileage is not a benefit.
 - c. " Multiple clients picked up at different locations within the same vicinity and transported to the same destination. Mileage is not a benefit.
 - d. Multiple clients picked up at different locations within the same vicinity and transported to different destinations within the same vicinity. Mileage is not a benefit.
 - e. The Department reserves the right to assume multiple rider transportation when billing involves Medicaid clients transported on the same date of service in the same vehicle to and from approximately the same location and to or from approximately the same destination, unless the provider's documentation supports individual transports.

8.680.5 D.

Wheelchair vehicle transport reimbursement shall consist of the following:

1. Base rate and mileage payments shall be based the lower of the provider's submitted charges or the maximum 'Medicaid allowable rates established by the Department or the State Designated Entity.
 - a. Mileage shall be billed at one unit of service per mile.
 - b. Mileage shall be allowable only for the portion of the trip when the client is in the wheelchair van.
 - c. Wheelchair vans shall bill and be reimbursed for a one-way trip as one unit of service regardless of the number of segments that may included in a trip when the segments are provided as part of a multiple segment continuum.
 - d. Wheelchair vans shall bill and be reimbursed for a round trip as two units of service regardless of the number of segments that may be included in a trip.
2. Wheelchair vans shall bill using wheelchair van codes only when the client transported is a certified wheelchair user. Mileage may be charged for the transport of wheelchair users.
3. If the wheelchair van services provided during a trip include Medicaid clients or approved escorts who are not certified wheelchair users, the services for the non-wheelchair users transported during the trip shall be billed using mobility vehicle codes. No mileage may be charged when mobility vehicle codes are used.
4. Oxygen and oxygen equipment
 - a. Oxygen is an allowable charge in addition to the base rate.
 - b. Oxygen shall be billed separately and includes administration and supplies.
 - c. Oxygen is not allowable when the client is capable of self-administration of portable or home oxygen. The charge is allowable if the client requires oxygen and is frail enough to need assistance in administering as certified by a physician.
 - d. Oxygen and oxygen equipment shall be reimbursed at the lower of the provider's submitted charges or the Medicaid allowable rate.
 - e. Oxygen shall be billed as one unit per one-way trip.

8.680.5.E.

Air ambulance transport reimbursement shall consist of me following:

1. Reimbursement for air ambulance services shall include a base rate plus oxygen charges as described in 8.680.5.B.3.
2. Reimbursement for an air ambulance's base rate shall include all services necessary to maintain client welfare during transport.
3. Reimbursement for an air ambulance shall be the lower of the provider's submitted charges or the Medicaid allowable rate.

8.680.5.F.

Commercial bus, air or train transport for out-of-state reimbursement shall consist of the following:

1. Reimbursement for claims shall be submitted with a copy of the commercial bus, airline or train ticket or payment receipt.
2. Reimbursement for claims shall be limited to the lower of the fare that was authorized by the State Designated Entity or the actual cost of the ticket.

8.700 MEDICAID REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES

Services provided in accordance with the provision of Section 6404 of OBRA-89 by federally qualified health centers are a benefit of the Colorado Medical Assistance Program.

8.700.1 DEFINITIONS

For purposes of Section 8.700, the following definitions shall apply:

- A. Federally Qualified Health Center (FQHC) means a federally qualified facility certified as a FQHC by the U.S. Department of Health and Human Services. FQHCs may either be: (1) free-standing or (2) affiliated with a hospital.
- B. Medicaid Primary Care Physician (PCP) means a physician enrolled in the Primary Care Physician Program under the Medicaid program.
- C. Mid-level practitioner means a non-physician practitioner such as a nurse-midwife, nurse-practitioner, or physician assistant who is either licensed and/or certified to practice in Colorado.
- D. Certified nurse-midwife means a registered professional nurse who is licensed and certified to practice in Colorado.
- E. Nurse-practitioner means a registered professional nurse who is licensed and certified to practice in Colorado.
- F. Physician assistant means a person who is certified to practice in Colorado.
- G. Physician means a doctor of medicine or osteopathy legally authorized to practice medicine in Colorado.
- H. Health professional means a physician, physician assistant, nurse practitioner, nurse midwife, licensed psychologist, licensed social worker, dentist, or other appropriately certified/licensed health care professional as defined by these rules.
- I. Incident services and supplies means services/supplies prescribed by a health professional as an integral part of the patient's course of health care treatment.
- J. Encounter means a face-to-face contact between a clinic patient and any health professional providing services reimbursable under the program. A clinic patient eligible for dental care may have one medical encounter and one dental encounter on the same day, at the single location, which will count as two separate encounters. If a patient meets more than once with the same medical and/or dental health professional on the same day and at a single location, this shall be counted as one encounter. If the patient requires services or supplies incident to a health professional's services, but cannot obtain these services on the same day, the encounter for the incident service shall not be counted as an additional encounter. If the patient suffers illness or injury requiring additional diagnosis or treatment after the initial visit, the subsequent encounter shall be counted as a new encounter.

- K. Core services mean outpatient services that include physician services, physician assistant services; nurse practitioner services; nurse midwife services; licensed psychologist services; licensed social worker services; pneumococcal and influenza vaccines and administration; services and supplies incident to health professional services; part-time or intermittent nursing care and related medical supplies to a homebound individual, in the case of those FQHCs that are located in an area that is determined to have a shortage of home health agencies; and any other reimbursable ambulatory services offered by the FQHC that are covered by the State Plan. Core services are provided in outpatient settings only, including a patient's place of residence. Core services do not include inpatient hospital stays.
- L. The Department means the Department of Health Care Policy and Financing.
- M. Outstationing costs means the FQHC administrative costs associated with the acceptance of Medicaid eligibility applications.
- N. Primary care services means core services, as defined in 8.700.1(K), provided in hospital-affiliated FQHCs.

8.700.2 REQUIREMENTS FOR PARTICIPATION

- A. Participating providers must be designated as FQHCs by the U.S. Department of Health and Human Services in accordance with Section 1902(a) and Section 1905(a)(2)(c) of the Social Security Act.
- B. FQHCs must enroll in the Medical Assistance Program.
- C. FQHCs and staff shall comply with all applicable federal, state, and local regulations concerning the administration and operation of such FQHCs.
- D. FQHCs performing laboratory services must be certified as clinical laboratories in accordance with regulations cited at 8.660 through 8.666. FQHCs must obtain a certificate of waiver from the Health Care Financing Administration or its designated agency if they only perform waived tests as defined by Clinical Laboratory Improvement Amendments of 1988 (CLIA).

8.700.3 BENEFITS AND LIMITATIONS

FQHC services are benefits of the Medical Assistance Act in Colorado when:

- A. The services are core services as defined in 8.700.1.
- B. The services provided are medically necessary.
- C. The services are provided by health care professionals employed by or under contract with the FQHC.
- D. The services provided are not billed to the Colorado Medical Assistance Program for reimbursement by other providers under contract with the FQHC. The FQHC shall establish procedures to prevent duplicate billing for services by both the FQHC and providers under contract with the FQHC. The provider that billed erroneously shall be responsible for costs incurred in relation to duplicate reimbursement under these circumstances.
- E. The FQHC shall contact the Medical recipient's PCP, prior to rendering services, for authorization to provide services which require a PCP referral.

8.700.4 ADMINISTRATIVE GUIDELINES

If the Department's rules do not cover a particular issue, the Department will use: the Health Care

Financing Administration's (HCFA) Medicaid regulations, or HCFA Medicare regulations.

8.710 BILLING PROCEDURES

FQHCs shall bill the Medical Assistance Program using the claim forms and the procedures designated by the Department.

8.711.1 REIMBURSEMENT OF FREE-STANDING FQHCs

A. All free-standing FQHC services shall be reimbursed on the basis of an all-inclusive encounter rate for each patient visit for core services. The encounter rate shall be determined according to the following methodology:

1. The Department shall calculate a base rate for each FQHC. The first base rate for all FQHCs shall be calculated using the cost reports for fiscal years ending December 1994 through November 1995.
2. Beginning July 1, 2003, expenditures will be reduced by \$2,794,985 through reductions in the FQHC. encounter rates.

Beginning July 1, 2004 the base encounter rate shall be inflated annually using the Medicare Economic Index to coincide with the federal reimbursement methodology for FQHCs.

3. FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters.
 4. Annual encounter rates for a FQHC shall be the lesser of its current year's calculated inflated rate, after audit, or its inflated base rate.
 5. The base encounter rate shall be recalculated (rebased) every three years. The new base encounter rate shall be the calculated, inflated weighted average encounter rate, after audit, for the past three years.
 6. New free-standing FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set a reimbursement rate for the first year. A base rate shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as a FQHC. This shall be the FQHCs base rate until the next rebasing period.
 7. The base encounter rate may be calculated using the most recent audited Medicaid FQHC cost report for those FQHC's that have received their first federal Public Health Service grant within the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.
- B. Free-standing FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of each FQHC's fiscal year. Failure to submit a cost report within 180 days after the end of a FQHC's fiscal year shall result in suspension of payments.
- C. After receipt of a FQHC's cost report, the Department shall audit the cost report and calculate the new reimbursement rate. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within 10 working days. Unsupported costs shall be unallowable for the calculation of the FQHC's new encounter rate.
- D. The Department shall notify the FQHC of its rate. The new reimbursement rate shall be effective 120 days after the FQHC's fiscal year end.

- E. The old reimbursement rate (if less than the new audited rate established) shall remain in effect for an additional day above the 120 day limit for each day the required information is late; if the old reimbursement rate is more than the new rate, the new rate shall be effective the 120th day after the FQHCs fiscal year end.
- F. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Health Care Financing Administration (HCFA) in HCFA Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual." If a FQHC does not meet the minimum productivity standards, the productivity standards established by HCFA shall be used in the FQHCs rate calculation.

8.711.5 REIMBURSEMENT OF HOSPITAL-AFFILIATED FQHCS

- A. All hospital-affiliated FQHC services shall be reimbursed 100% of reasonable costs according to the following rules:
 - 1. All hospital-affiliated FQHCs shall submit two separate sub-provider sections on the Medicare Cost Report for their facilities: (1) primary care FQHC services and (2) non-primary care services (outpatient hospital services). The audited Medicaid costs and utilization data, as reported on the Medicare Cost Report for the primary care provider, shall be used for FQHC reconciliations and for establishing future reimbursement factors. Non-primary care services shall be reimbursed according to Section 8.332 (Outpatient Hospital Services Payment).
 - 2. The Department shall audit the Medicaid data contained in the Medicare Cost Report to verify the primary care cost to charge ratio and the reimbursement factor. After the audit is completed, a retroactive settlement shall be made.
 - 3. Only charges designated for primary care FQHC services shall be allowable for reimbursement at the FQHC rate.
 - 4. The Department shall calculate a base reimbursement factor for hospital-based FQHCs. The first base reimbursement factor shall be calculated using the December 31, 1992 Medicare Hospital Cost Report. For new hospital-based FQHCs, the base reimbursement factor shall be calculated using the first submitted Medicare Hospital Cost Report. Reimbursement shall be made using a 1.0 reimbursement factor, until the audit of the first cost report is completed. A provider can appeal the base reimbursement factor using the process described in 8.050.3.
 - 5. Costs associated with primary care FQHC services shall be adjusted for the current year using the inflation factor for free-standing FQHCs outlined in 8.711.1. Inflated costs shall be compared to annual Medicaid reimbursement to determine the new reimbursement factor.
 - 6. The annual reimbursement factor shall be the lesser of the current year's calculated reimbursement factor, after audit, or the inflated base reimbursement factor.
 - 7. The base reimbursement factor shall be recalculated every three years. The new base reimbursement factor shall be the average, non-inflated reimbursement factor for the past three years.
 - 8. For hospital-affiliated FQHC providers, the productivity screens described in 8.711.1 (F) shall apply. If a FQHC does not meet the minimum productivity requirements, the productivity standards established by HCFA shall be used in the FQHC's reimbursement factor calculation.

- B. If a hospital-based FQHC fails to provide the required documentation, the costs associated with those activities shall be presumed to be non-primary care services (outpatient hospital services) and shall be settled using the Outpatient Hospital reimbursement rate.

8.712 FQHC REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

The Department shall reimburse FQHCs for reasonable costs associated with accepting applications to determine Medicaid eligibility. To receive payment, FQHCs shall submit logs reflecting the applicant's name, date of application, and social security number to the Department with their cost report. Reimbursement shall be determined according to the following rules:

- A. Free-standing FQHCs shall report on a supplementary schedule (to be submitted with the cost report annually) the administrative and general direct pass-through costs associated with outstationing activities. The Department shall allocate appropriate overhead costs (not separately identified) to calculate the total facility outstationing administrative expenses incurred. Free-standing FQHCs shall receive an annual lump sum retrospective payment based on the audited cost report.
- B. Hospital-affiliated FQHCs shall submit on an extra line on the Medicaid Cost Report (related to Worksheet A - Trial Balance) the administrative and general pass through direct costs associated with outstationing activities. This additional retrospective reimbursement shall be separately identified on the Medicaid Settlement Sheet.
- C. Payment for taking of the initial applications and initiating the process of determining Medicaid eligibility shall be made to recognize FQHCs' administrative costs. This outstationing payment shall be made based upon actual cost with a reasonable cost-per-application limit to be established by the Department, based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall reimbursement exceed a maximum cap of \$60,000 per facility per year for all administrative costs associated with outstationing activities.

8.715 BREAST AND CERVICAL CANCER PROGRAM

8.715.1 DEFINITIONS

Breast and Cervical Cancer Program (BCCP) means the Medicaid program established, operated and monitored by the Department.

Colorado Women's Cancer Control Initiative (CWCCI) means the program administered by the Colorado Department of Public Health and Environment and funded by the Centers for Disease Control and the National Breast and Cervical Cancer Early Detection Program.

In Need of Treatment means services necessary to determine the extent and proper course of cancer or precancerous treatment as well as definitive cancer treatment itself. Treatment can include surgery, radiation, chemotherapy and approved medications following treatment as determined by the client's physician and the Department.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP) means the program where the Centers for Disease Control (CDC) provides breast and cervical screening services to underserved women. In Colorado, the CDC provider is the Department of Public Health and Environment's Colorado Women's Cancer Control Initiative.

Presumptive Eligibility for BCCP means the temporary eligibility for benefits that begin on the date a Qualified Entity determines the client meets eligibility requirements for the BCCP and the client signs the presumptive eligibility form. Women identified by the CWCCI as being In Need of Treatment for breast or cervical cancer or a precancerous condition shall apply for presumptive eligibility on a simplified Medicaid

application.

Qualified Entity means a provider contracted with the Department of Public Health and Environment under a cooperative agreement with the CDC to support activities related to the NBCCEDP. A qualified entity shall provide breast and cervical cancer assessment services for the CWCCI.

State Designated Entity means an agency acting on behalf of and at the direction of the Department and whose function may include, but is not limited to, processing eligibility determinations and assisting clients with the application process.

8.715.2 ELIGIBILITY REQUIREMENTS

8.715.2.A. Clients shall meet all requirements of the CWCCI program.

8.715.2.B. Clients shall enroll for screening at participating Breast and Cervical Cancer assessment sites through the CWCCI.

8.715.2.C. Clients shall:

1. Be a woman who has not yet attained the age of 65.
2. Be a resident of Colorado.
3. Be a citizen of the United States or a qualified alien as described in 8.100.53(A)(2) through 8.100.53(A)(4).
4. Have been screened by a Qualified Entity and found to be In Need of Treatment for breast or cervical cancer, including precancerous conditions as determined through pathological tests.
5. Not have creditable coverage as described in 8.715.3.
6. Not be eligible under another Medicaid program.
7. Be a client who has previously qualified and enrolled in a NBCCED program in another state and chooses to transfer her enrollment to CWCCI.

8.715.2.D. Clients shall not have been previously screened or received treatment for breast or cervical cancer prior to July 1, 2002.

8.715.2.E. Clients shall not be considered to be In Need of Treatment if it is determined she only requires routine follow-up monitoring services.

8.715.2.F. Clients shall be willing to seek Medicaid approved breast or cervical cancer or precancerous treatment within three months of the date of eligibility. If a client does not seek such treatment within three months of the date of presumptive eligibility, the client shall be removed from the program on the last day of the third month. The client will be re-entered in the BCCP program at such time as treatment is scheduled to begin. If treatment has not been started within one month of the scheduled date, the client will be disenrolled.

8.715.3 CREDITABLE COVERAGE

8.715.3.A. Creditable coverage shall include coverage of any individual as defined at 10-16-102, C.R.S. (2002).

8.715.3.B. The following are not considered creditable coverage:

1. Limited scope coverage such as that which covers only dental, vision or long term care;
2. Coverage only for a specific disease or illness (unless the specific disease or illness includes breast or cervical cancer); or
3. A medical care program run by the Indian Health Services or a tribal organization.

8.715.3.C. An individual who otherwise has creditable coverage may qualify for the program if:

1. The individual is in a period of exclusion for treatment of breast or cervical cancer; or
2. The individual has exhausted her lifetime limits on benefits under the plan for breast or cervical cancer.

8.715.3.D. Individuals who have coverage that contains yearly limited drug benefits, yearly limits on outpatient visits or high deductibles shall be considered to have creditable coverage.

8.715.4 PRESUMPTIVE ELIGIBILITY

8.715.4.A. Presumptive eligibility shall be determined by Qualified Entities.

8.715.4.B. The Department shall make available to Qualified Entities:

1. Information on the BCCP presumptive eligibility form and card;
2. Information on how to obtain the Medicaid application; and
3. Information on how to assist CWCCI personnel and individuals on application completion and filing.

8.715.4.C. Qualified Entities shall determine presumptive eligibility based on verbal confirmation by the potential client that she meets CWCCI criteria and shall enroll the clients who appear to be eligible.

8.715.4.D. Presumptive eligibility shall begin on the date the client completes the BCCP presumptive eligibility form and the Qualified Entity determines the client meets all eligibility criteria.

8.715.4.E. All potential clients shall be required to complete the BCCP presumptive eligibility form and the Medicaid application at the same time.

8.715.4.F. The Qualified Entity shall submit the presumptive eligibility form, a copy of the presumptive eligibility card, the CWCCI history and physical, the diagnosis pathology report and the signed consent form to the Department.

8.715.4.G. The Designated Entity shall process the Medicaid application within thirty calendar days of receipt.

8.715.4.H. The presumptive eligibility period shall end on the following:

1. The date on which a formal determination is made on the client's Medicaid application; or
2. If a full determination cannot be made on the basis of the BCCP presumptive eligibility form and the client fails to complete the Medicaid application, then eligibility will end on last

day of the month following the month in which the client was determined to be presumptively eligible.

8.715.5 ELIBILITY PERIOD

8.715.5.A. Eligibility shall begin on the date the client is determined to be presumptively eligible.

8.715.5.B. The client shall be eligible to receive services for up to one year from the date of initial eligibility unless she is no longer In Need of Treatment or no longer meets program eligibility requirements.

8.715.5.C. If the client remains in treatment beyond one year, renewed eligibility shall be determined consistent with BCCP and Medicaid requirements.

8.715.5.D. A period of renewed eligibility begins each time the client is screened under the CWCCI program and is found to be In Need of Treatment for breast or cervical cancer and meets all other eligibility criteria.

8.715.5.E. A client may be determined no longer eligible for the program if:

1. She does not complete the Medicaid application; or
2. She is no longer In Need of Treatment for breast or cervical cancer or qualified precancerous conditions when the client's provider notifies the Department; or
3. She reaches the age of 65; or
4. She obtains other creditable coverage describe in 8.715.3.

8.715.5.F. Clients who are determined no longer eligible shall be notified in writing as described in 8.715.6(B).

8.715.6 NOTIFICATION

8.715.6.A. The BCCP presumptive eligibility form shall include a statement of the applicant's rights and responsibilities.

8.715.6.B. .The Department shall notify clients who are no longer In Need of Treatment for the BCCP in writing thirty days prior to their disenrollment date. This notice will be provided only to those clients who have completed their course of treatment per their provider.

1. Copies of the notice shall be sent to the client, her designated representative if applicable, the CWCCI site, the State Designated Entity and the client's provider.
2. The notification shall include information regarding appeal rights described in 10 C.C.R. 2505-10, Section 8.057.

8.715.6.C. The Department shall notify clients who no longer meet the BCCP eligibility criteria at least ten days prior to program termination.

8.715.7 BENEFITS

8.715.7.A. Eligible clients shall receive all Medicaid benefits included in the State Plan.

8.715.7.B. Breast reconstructive surgery shall be a covered benefit when completed up to seven months

following a mastectomy.

8.715.7.C. Breast or cervical cancer or precancerous treatment provided prior to the NBCCED program implementation or client enrollment into the BCCP is not a covered benefit.

8.715.7.D. Clients eligible for this program shall receive all mental health services through the Mental Health Assessment Service Agency of the county in which the client resides.

8.715.8 ROLES/RESPONSIBILITIES

8.715.8.A. County Departments of Human/Social Services shall:

1. Assist in providing information to the client about services and benefits available through the program;
2. Assist the client in accessing health care services or contact the appropriate agencies for services, such as the enrollment broker, mental health provider and transportation provider;
3. Assist the client in applying for and accessing other benefits for which she may qualify, such as home care allowance, food stamps and financial assistance; and
4. Assist the Department by notifying the Department when a client's eligibility status changes.

8.715.8.B. Clients shall notify the Department and healthcare providers if the client receives creditable coverage or if a third party is responsible for illness or injury to the client.

8.715.8.C. Providers shall respond to inquiries from the Department and provide information required to verify the client's In Need of Treatment status within ten calendar days of the Department's request.

8.715.8.D. Provider's shall follow Medicaid billing instructions and obtain prior authorizations when necessary.

8.715.8.E. The State Designated Entities shall have the following responsibilities:

1. To determine whether a client is eligible for Medicaid in any other eligibility group;
2. To complete review of the Medicaid application form within fifteen days of receipt;
3. To notify the client she has thirty days to submit addition information if needed and if the information is not received the client will be found ineligible;
4. To inform the client of her appeal rights if eligibility is denied; and
5. To disenroll the client from the BCCP when notified the client is no longer in Need of Treatment.

8.726 TEEN PREGNANCY PREVENTION PILOT PROGRAM

8.726.1 DEFINITIONS

At Risk Teenager means a person under nineteen years of age who resides in a neighborhood in which there is a preponderance of poverty, unemployment and underemployment, substance abuse, crime, school dropouts, a significant public assistance population, teen pregnancies and teen parents or other

conditions that put families at risk.

Support Services means individual or group counseling, which includes a component on delayed parenting, health guidance and health services such as home visits or visiting nurse services.

8.726.2 CLIENT ELIGIBILITY

The client shall be identified as an At Risk Teenager by a school, health care provider, social service or other community agency.

8.726.3 PROVIDER ELIGIBILITY

Eligible providers shall meet all the following criteria;

1. Be enrolled as a participating provider.
2. Submit an application to the Department and be approved as a Teen Pregnancy Prevention Pilot Program provider. The provider application shall include at a minimum:
 - a. A method of identifying and targeting At Risk Teenagers.
 - b. An overview of strategies and principles to promote self-sufficiency, self-reliance and the ability to make appropriate family planning decisions.
 - c. A method of securing a minimum of 10% local funds that will be reviewed by the Department for compliance with federal Medicaid matching requirements.
 - d. A specific package of Support Services.
 - e. A methodology for tracking teens to determine success in preventing pregnancy.
 - f. A description of established community support and collaboration to provide educational, vocational and other services that are not inclusive in the provider's package of Support Services.

8.726.4 REIMBURSABLE SERVICES

The Teen Pregnancy Prevention Pilot Program includes a package of support services developed to reduce teen pregnancy. The support service package may include, but shall not be limited to:

1. Intensive individual or group counseling, which includes a component on delayed parenting.
2. Guidance promoting self-sufficiency, self-reliance and the ability to make appropriate family planning decisions.
3. Home visits or visiting nurse services.

The service package must be specified in the Teen Pregnancy Prevention Pilot Program provider application and provided as approved. Teen Pregnancy Prevention Pilot Program services are in addition to the currently reimbursed family planning services available to clients.

8.726.5 REIMBURSEMENT

Reimbursement is dependent upon receipt of 90% federal financial funds under the family planning provision. Reimbursement shall be the lower of:

1. Submitted charges; or
2. Fee schedule as determined by the Department.

8.730 FAMILY PLANNING SERVICES

8.730.1 DEFINITIONS

Family Planning Services means physical examinations, diagnoses, treatments, supplies, prescriptions and follow-up services provided to individuals of child-bearing age, including minors who can be considered to be sexually active, in a physician's office, physician's clinic, outpatient or inpatient hospital setting, family planning provider, Federally Qualified Health Center, Rural Health Clinic or a Colorado Department of Health and Environment facility.

Institutionalized Individual means an individual who is (a) involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of a mental illness; or (b) confined, under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

Life-Endangering Circumstance means:

1. The presence of a medical condition, other than a psychiatric condition, as determined by the attending physician, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term; or
2. The presence of a psychiatric condition, which represents a serious and substantial threat to the life of the pregnant woman if the pregnancy continues to term. In such cases, unless the pregnant woman has been receiving prolonged psychiatric care, the attending physician shall obtain consultation from a licensed physician specializing in psychiatry confirming the presence of such a psychiatric condition.

Mentally Incompetent Individual means an individual who has been declared mentally incompetent by a federal, state or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

Sterilization means any medical procedure, treatment or operation (except for a hysterectomy) for the purpose of rendering an individual permanently incapable of reproducing and requires informed consent.

8.730.2 STERILIZATION

8.730.2.A.

Sterilization may be provided as a benefit of the Colorado Medical Assistance Family Planning benefit when the individual has voluntarily given written informed consent and at least 30 days, but no more than 180 days have passed between the date of informed consent and the date of sterilization.

8.730.2.B.

The time limitations in 8.730.2A do not apply in the case of premature delivery or emergency abdominal surgery, if at least 72 hours have passed since the date of consent. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

8.730.2.C.

Sterilization is not a Colorado Medical Assistance Family Planning benefit for an individual who is under

the age of 21, mentally incompetent, or institutionalized.

8.730.2.D.

An individual shall have given informed consent for sterilization when the person to whom consent was given offered to answer any questions concerning the procedure, provided a copy of the consent form, obtained a signed copy of the consent form and orally provided the following information:

1. The individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled.
2. A description of available alternative methods of family planning and birth control.
3. The sterilization procedure is considered to be irreversible.
4. An explanation of the specific sterilization procedure to be performed.
5. A description of the discomforts and risks that may accompany or follow the sterilization procedure including an explanation of the type and possible effects of any anesthetic to be used.
6. A description of the benefits or advantages that may be expected as a result of the sterilization.
7. The sterilization will not be performed for at least 30 days from consent except under the circumstances specified in 8.730.2.B.

8.730.2.E.

Arrangements shall be made to ensure the information specified in 8.730.2.D is effectively communicated to any individual who is blind, deaf or otherwise handicapped.

8.730.2.F.

An interpreter shall be provided if the individual to be sterilized does not understand the language used on the consent form or the language used by the person obtaining consent.

8.730.2.G.

The individual to be sterilized may have a witness of his or her choice present when consenting to the procedure.

8.730.2.H.

The consent form requirements of 8.730.2.J shall be met.

8.730.2.I.

Informed consent for sterilization cannot be obtained when an individual is:

1. In labor or childbirth;
2. Seeking to obtain or obtaining an abortion; or

3. Under the influence of substances that impair the individual's decision making capabilities.

8.730.2.J.

A sterilization consent form shall be signed and dated by:

1. The individual to be sterilized;
2. The interpreter, if one was provided;
3. The person who obtained the consent; and
4. The physician who will perform the sterilization procedure.

8.730.2.K.

If an interpreter is provided, the interpreter shall, by signing the consent form, certify that he or she translated the information presented orally, read the consent form and explained its contents to the individual and that to the best of the interpreter's knowledge the individual understood the information provided.

8.730.2.L.

The person who obtained the consent shall, by signing the consent form, certify that he or she provided the individual with all of the information set forth in 8.730.2.D above and to the best of best or her knowledge, the individual appeared mentally competent, and knowingly and voluntarily consented to be sterilized.

8.730.2.M.

The physician performing the sterilization shall, by signing the consent form, certify that:

1. He or she provided the individual with all of the information set forth in 8.730.2.D above.
2. To the best of his or her knowledge the individual appeared mentally competent, and knowingly and voluntarily consented to be sterilized.
3. Except in the case of premature delivery or emergency abdominal surgery, the physician shall further certify that at least 30 days have passed between the date of the individual's signature on the consent form and the date upon which the sterilization was performed.
 - a. In the case of premature delivery or emergency abdominal surgery performed within 30 days of consent, the physician shall certify that the sterilization was performed less than 30 days, but more than 72 hours after informed consent was obtained because of premature delivery or emergency abdominal surgery, and
 - b. In the case of premature delivery, shall state the expected date of delivery, or
 - c. In the case of abdominal surgery, shall describe the emergency.

8.730.3 HYSTERECTOMIES

8.730.3.A.

A hysterectomy is a benefit of the Colorado Medical Assistance Program when performed solely for

medical reasons and when the following conditions are met:

1. The person who secures the authorization to perform the hysterectomy has informed the individual or her representative if any, orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing; and;
2. The individual or her representative, if any, has acknowledged in writing receiving that information.

8.730.3.B.

The fiscal agent for the Medical Assistance Program shall be provided with a copy of that written acknowledgment. The acknowledgment must be received before reimbursement for any services related to the procedure will be made.

8.730.3.C.

Hysterectomy is not a benefit of the Medical Assistance Program when:

1. It is performed solely for the purpose of rendering an individual permanently incapable of reproducing; or
2. There was more than one purpose to the procedure and the hysterectomy would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing.

8.730.3.D.

A written acknowledgment of sterility from the recipient is not required if the following circumstances exist:

1. The individual is already sterile at the time of the hysterectomy; or
2. The individual requires a hysterectomy because of a life-threatening emergency in which the physician determines prior acknowledgement is not possible.

8.730.3.E.

If an acknowledgement of sterility is not required because of the above exceptions, the physician who performs the hysterectomy must certify in writing either

1. The individual was already sterile, stating the cause of that sterility; or
2. The hysterectomy was performed under a life-threatening emergency situation in which the physician determined prior acknowledgement was not possible. The physician must include a description of the emergency.

8.730.3 F.

The fiscal agent must receive the physician's certification before reimbursement for the services will be made.

8.730.4 ABORTION SERVICES

8.730.4.A.

Abortion services shall only be a benefit of the Colorado Medical Assistance Program when the pregnancy is causing a life-endangering circumstance or in cases of sexual assault or incest.

8.730.4.B.

In cases of a life-endangering circumstance, the physician must make every reasonable effort to preserve the lives of the pregnant woman and the unborn child. A licensed physician shall perform the procedure in a licensed health care facility. Such services may be performed in other than a licensed health care facility if, in the medical judgment of the physician, the life of the pregnant woman is substantially threatened and a transfer to a licensed health care facility would further endanger the life of the pregnant woman. Such medical services may be performed in other than a licensed health care facility if the medical services are necessitated by a life-endangering circumstance and if there is no licensed health care facility within a thirty-mile radius of the place where such medical services are performed.

8.730.4.C.

Any claim for payment must be accompanied by a case summary which includes the following information:

1. Name, address and age of the pregnant woman;
2. Gestational age of the unborn child;
3. Description of the medical condition which necessitated the abortion;
4. Services performed;
5. Facility in which the abortion was performed; and
6. Date of service.

8.730.4D.

A claim for payment must also be accompanied by at least one of the following forms with additional supporting documentation that confirms the life-endangering circumstances:

1. Hospital admission summary.
2. Hospital discharge summary.
3. Consultant findings and reports.
4. Laboratory results and findings.
5. Office visit notes.
6. Hospital progress notes.

8.730.4.E.

An evaluation by a licensed physician specializing in psychiatry must accompany the claim for reimbursement for the abortion if a psychiatric condition represents a serious and substantial threat to the pregnant woman's life if the pregnancy continues to term.

8.740 RURAL HEALTH CLINIC SERVICES RENDERED BY CERTIFIED PROVIDERS SHALL BE A

BENEFIT OF THE COLORADO MEDICAL ASSISTANCE PROGRAM FOR CATEGORICALLY ELIGIBLE INDIVIDUALS.

8.740.10 DEFINITIONS

For purposes of this Section 8.740, the following definitions shall apply.

- A. Rural Health Clinic means a clinic that is located in a rural area, as defined by the pertinent federal regulations, is not a rehabilitation facility or a facility primarily for the care and treatment of mental diseases, and has been certified as a rural health clinic under Medicare.
- B. Nurse-midwife means a registered professional nurse who is currently licensed to practice in the state, and who meets the qualifications established under Medicare.
- C. Nurse-practitioner means a registered professional nurse who is currently licensed to practice in the state and who meets the qualifications established under Medicare.
- D. Physician assistant means a person who meets the qualifications established under Medicare, for such assistants.
- E. Visit means a face-to-face encounter between a clinic patient and any health professional providing services reimbursable under the program. If a patient sees more than one health professional, or meets more than once with the same health professional, on the same day and at a single location, this shall be counted as one visit. The exception to this is if the patient suffers illness or injury requiring additional diagnosis or treatment after the initial visit.
- F. Physician means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in Colorado.

8.741 INCLUDED SERVICES

All of the following are benefits of the program when provided by a rural health clinic that has been certified in accordance with these regulations insofar as these services provided are otherwise reimbursable under the Program:

- A. Services furnished by a physician:
- B. Services furnished by a physician assistant, nurse practitioner, or nurse midwife; under the medical supervision of a physician.
- C. Services and supplies that are furnished as an incident to professional services under (a) and (b) above:
- D. Part-time or intermittent visiting nurse care and related medical supplies (other than pharmaceuticals).
- E. Other ambulatory service that are otherwise a benefit of the program which meets specific programmatic requirements for the furnishing of that service. Such services are not subject to physician supervision requirements unless such supervision is generally required for such services under the Medicaid program.
- F. EPSDT services furnished by a rural health clinic which are not part of rural health clinic services. Such services may be provided only if the clinic meets any supervision or other requirements for EPSDT that are generally applicable wherever these services are furnished.

8.742 REIMBURSEMENT

Reimbursement will be provided to certified rural health clinics for included services provided in accordance with all pertinent federal and state regulations.

Reimbursement shall be made according to the following:

- A. For provider clinics, payment will be made on a cost per visit basis according to the principles specified in the appropriate Medicare regulations. A “provider clinic” is a clinic which is an integral part of an institution which participates in Medicare. Such a clinic must also be operated under common licensure, governance and professional supervision with other departments of the institution.
- B. For any clinic that is not a “provider clinic,” and does not furnish any ambulatory services other than rural health clinic services, payment will be at the reasonable cost per visit rate established for the clinic by the Medicare carrier.
- C. Ambulatory services covered by the program which are not rural health services will be reimbursed according to the approved level for such services. Rural health clinic services, however, will be paid at the Medicare reimbursement rate as specified above.
- D. The rural health clinic service rate per visit will be subject to reconciliation after the close of the reporting period.
- E. The rural health clinic service rate per visit is also subject to federal screening guidelines or tests of reasonableness as set forth in 42 C.F.R. 405.2428, October 1991 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Manager, Health and Medical Services, Colorado Department of Social Services, 1575 Sherman Street, Denver, Colorado 80203-1714.

8.743 CERTIFICATION

- A. Certification procedures: A rural health clinic certified under Medicare will be deemed to have met the standards for certification under Medicaid. A rural health center providing laboratory services must be certified as a clinical laboratory in accordance with regulations cited at 8.660 through 8.666. Rural health clinics which perform procedures that are considered waived clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 must possess a certificate of waiver from the Health Care Financing Administration or its designated agency.
- B. Compliance with federal, state, and local laws. The rural health clinic and its staff shall comply with all applicable federal, state, and local laws concerning the operation of rural health clinics. These include, but are not limited to, the following: licensure, certification, registration, location, organization, staffing, service provision responsibilities, the maintenance of health records, and program evaluation.

8.744 PHYSICIAN RESPONSIBILITIES

A physician must provide medical supervision and guidance for the physician assistants and nurse practitioners, prepare medical orders, and review periodically the services furnished by the clinic. A physician must be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times, by direct means of communication, for advice and assistance on patient referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.745 SPECIAL CONNECTIONS

8.745.1 DEFINITIONS

Assessment means an evaluation by a certified drug/alcohol treatment counselor that is designed to determine the level of drug/alcohol abuse or dependence and the comprehensive treatment needs of a drug/alcohol abusing pregnant client.

Case Management means services provided by a certified drug/alcohol treatment counselor to include Medicaid and non-Medicaid service planning, linkage to other service agencies and monitoring, and those actions necessary to obtain both Medicaid and non-Medicaid reimbursable services for the eligible client with multiple treatment needs.

Drug/Alcohol Individual Therapy means substance abuse counseling services provided by a certified drug/alcohol treatment counselor to a client in a licensed drug and alcohol treatment program.

Drug/Alcohol Group Therapy means substance abuse counseling services provided by a certified drug/alcohol treatment counselor to a group of not more than twelve clients in a licensed drug and alcohol treatment program.

Health Maintenance Group means services facilitated by a certified drug/alcohol treatment counselor to help a client develop health and life management skills.

8.745.2 DETERMINATION OF CLIENT ELIGIBILITY

8.745.2.A. To receive an Assessment, the client shall be:

1. Medically verified to be pregnant.
2. Determined either presumptively eligible or eligible for Medicaid.
3. Self referred or referred by a health care practitioner as being at risk of a poor birth outcome due to substance abuse during the prenatal period and in need of special assistance in order to reduce such risk.

8.745.2.B. To receive drug/alcohol treatment services, the client shall meet the following conditions:

1. Received an Assessment and met the screening criteria as determined by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services.
2. Be prior authorized by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services to receive services.

8.745.3 PROVIDER ELIGIBILITY

8.745.3.A. The Alcohol and Drug Abuse Division of the Colorado Department of Human Services shall be the only provider to receive reimbursement for Assessments and drug/alcohol treatment services provided to Program enrolled clients.

8.745.3.B. The Alcohol and Drug Abuse Division of the Colorado Department of Human Services shall contract with certified and approved drug/alcohol treatment programs for the delivery of services.

8.745.4 REIMBURSABLE SERVICES

8.745.4.A. Special Connections Program services are limited to:

1. One Assessment per pregnancy.
2. Drug/alcohol treatment services including Case Management, Drug/Alcohol Individual

Therapy, Drug/Alcohol Group Therapy and/or Health Maintenance Group Services.

3. Urine screening and monitoring.

8.745.4.B. All services must be prior approved by the Alcohol and Drug Abuse Division of the Colorado Department of Human Services. Services may be provided as outpatient or residential. Room and board are not covered services.

8.745.5 REIMBURSEMENT

Reimbursement for services provided shall be the lowest of:

1. Submitted charges; or
2. Fee schedule as determined by the Department.

8.748 PRENATAL PLUS PROGRAM

8.748.1 CLIENT ELIGIBILITY

8.748.1.A. A client shall meet all the following conditions to be eligible for a Prenatal Plus Risk Assessment:

1. Medically verified pregnancy including a 60-day postpartum period.
2. Determined either presumptively eligible or eligible for Medicaid.
3. Self-referred or referred by a health or human service practitioner as having risk behaviors that might negatively impact the pregnancy outcome.

8.748.1.B. To receive Prenatal Plus services other than Risk Assessment, the client shall also have been determined qualified for the program by the Prenatal Plus Risk Assessment provider.

8.748.2 PROVIDER ELIGIBILITY

Providers wishing to participate in the Prenatal Plus Program shall complete an application developed by the Colorado Department of Public Health and Environment. The provider shall demonstrate how they will meet the specified service requirements including at a minimum:

1. Identify and target pregnant women with risk factors potentially requiring the Prenatal Plus service package.
2. Deliver Prenatal Plus services to pregnant women who pass the Risk Assessment.
3. Refer clients for other services as necessary and coordinate with other community agencies.
4. Track, document and report risk resolution and pregnancy outcome. Application review and provider selection is conducted at the Department of Public Health and Environment. Only providers who have received training for the Prenatal Plus Program and meet the service requirements determined by the Department of Public Health and Environment will be eligible for reimbursement for Prenatal Plus services.

8.748.3 REIMBURSABLE SERVICES

8.748.3.A. Reimbursable Prenatal Plus services shall specifically address the psychosocial behaviors

that impact pregnancy outcome and are in addition to medical prenatal care. They are limited to:

1. Risk Assessment: Identification and documentation of client medical, psychosocial, nutritional and behavioral strengths and risk factors that could negatively impact pregnancy outcome.
2. Prenatal Care Coordination: Services provided by a Prenatal Plus provider that includes service planning and coordination, referral, follow-up and monitoring.
3. Home visitation: A 30-90 minute face-to-face contact with a client at the client's residence or alternative non-provider site by the Prenatal Plus provider to address issues identified through the Risk Assessment.
4. Nutrition counseling: Nutrition intervention services provided by a registered dietitian including ongoing nutrition assessment, client counseling and referral to other health professionals as needed.
5. Psychosocial counseling: Services provided by a mental health professional including ongoing assessment of the client's psychological and social situation, brief psychotherapy, crisis intervention and referral to additional mental health treatment as needed.

8.748.4 REIMBURSEMENT

Reimbursement shall be the lower of:

1. Submitted charges; or
2. Fee schedule as determined by the Department.

8.750

Rehabilitative services as defined below rendered by licensed community mental health centers or clinics shall be a benefit of the Colorado Medical Assistance Program for categorically eligible individuals and for individuals under the Modified Medical Program.

8.750.10 DEFINITIONS

For purposes of this Section 8.750, the following definitions shall apply:

- A. Community Mental Health Center means a community-based agency licensed by the Colorado Department of Health pursuant to Section 25-3-102 CRS as meeting the standards, rules, and regulations promulgated by the Colorado Department of Institutions for such facilities.

Such agency shall consist of either a physical plant or a group of services under unified administration or affiliated with one another to provide at least the following services for the prevention and treatment of mental illness in persons residing in a particular community in or near the facility so situated: inpatient, outpatient, other 24-hour care, partial care, 24-hour emergency, and consultation and education services.

- B. Community mental health clinic means a health institution licensed in the same manner as community mental health centers above, and which is planned, or organized, operated, and maintained to provide basic community services for the prevention, diagnosis, and treatment of emotional or mental disorders; such services to include outpatient, consultation and education, and 24-hour emergency services.

- C. Case management means case review, setting of treatment goals, design of treatment plan,

coordination of the necessary components of the plan, monitoring of the treatment and retention of responsibility for the clients' treatment, performed by a professional staff of the community mental health center or clinic with the objective of assuming an integrated system of care for the client.

- D. Outpatient services involve a face-to-face encounter between a center/clinic client(s) and a health professional providing services reimbursable under the program. Outpatient services are treatment services which are generally less intensive and of shorter duration per treatment episode than partial care.
- E. Partial care services refer to treatment services which are generally of a more intensive nature than outpatient services and which involve two or more hours of treatment activity each day. The purpose of partial care is to provide a supportive, highly structured environment and intervention focused upon stabilization of clients whose capacity to cope with normal life circumstances is severely impaired.
- F. Significant others means persons who have an emotional or functional relationship with the client, such as, but not limited to, friends, parents, extended family members, and landlords.
- G. 24-hour emergency (crisis) care means a short term stabilization service to a client in crisis. This service is to be available on a 24-hour a day basis and is to be provided in the appropriate supportive environment and involve client, family and/or significant others.

8.751 INCLUDED REHABILITATIVE SERVICES

"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. Such services shall be provided to Medicaid eligible individuals by a licensed community mental health center or clinic under the direction of a physician when deemed to be medically necessary. Such services include, but are not limited to, partial care, outpatient services, 24-hour emergency care, and case management. Such services do not include consultation and education, inpatient hospitalization, and other 24-hour care except as permitted elsewhere in these regulations.

8.752 REIMBURSEMENT

Reimbursement shall be made according to the following:

- A. Payment for covered services shall be made on the basis of prospective rates set for each participating community mental health center or clinic. Prospective rates shall be determined by the Department of Social Services on the basis of audited unit cost work sheets submitted by the centers/clinics to the Division of Mental Health of the Colorado Department of Institutions, in compliance with appropriate federal regulations (42 CFR 447.321).
- B. Participating community mental health centers or clinics shall use billing and reporting forms specified by the Division of Medical Assistance of the Colorado Department of Social Services.

8.753 CERTIFICATION

- A. Certification Procedures. Community mental health centers or clinics licensed by the Colorado Department of Health will be denied to meet the standards for certification under Medicaid.
- B. Compliance with federal, state, and local laws. The community mental health center or clinic and its staff shall comply with all applicable federal, state, and local laws concerning the operation of community mental health centers or clinics. These include, but are not limited to, the following: licensure, certification, organization, staffing, service provision responsibilities, the maintenance

of health records, and program evaluation.

8.754 CLIENT CO-PAYMENT

Except for those categories of individuals and/or services specifically exempted in these regulations, Medical Assistance recipients shall be responsible for paying directly to the providers outlined in 8.754.10 a set portion of the cost of services according to the fee schedule outlined in 8.754.10. This charge to the recipient will be called co-payment.

8.754.10

Co-payment shall be charged only for services rendered by the providers listed in this section subject to the limitations outlined in Section 8.754.11. The amount of the co-payment to be charged is based on the average payment which the State makes to that provider group, so the co-payment amount any provider charges will not vary depending on the cost of the specific service being rendered, except in the case of pharmacy services, where a co-payment differential is established for generic or multi-source versus single-source or "brand-name" drugs.

Each provider listed in this section shall be responsible for collecting the appropriate co-payment amount from the recipient at the time the provider renders the service. A provider participating under Medicaid may not deny services to an individual on account of such individual's inability to pay the co-payment amount. This requirement on the Medicaid provider does not extinguish the liability of the individual to whom the care or services were rendered for payment of that co-payment amount to the provider rendering the service.

<u>Service to Which Co-Payment Applies</u>	<u>Client Co-Payment Amount</u>
A. Hospital outpatient visit	\$3.00 per visit
B. Physician home or office visit (M.D.orD.O.)	\$2.00 per visit
C. Rural health clinic visit	\$2.00 per visit
D. Brief, individual, group, and partial care community mental health center visits (except services which fall under Home and Community Based Service programs)	\$2.00 per visit
E. Pharmacy	\$1.00 per prescription or refill for generic or multi-source drugs and \$3.00 per prescription for single-source or brand name drugs
F. Optometrist visit	\$2.00 per visit
G. Podiatrist visit	\$2.00 per visit
H. Inpatient hospital	\$10.00 per day up to 50% of the Medicaid rate for the first day of care in the

	hospital.
I. Psychiatric services	\$.50 per unit of service (defined as 15 minute segments)
J. DME/Disposable Supply Services	\$1.00 per date of service
K. Laboratory Services	\$1.00 per date of service
L. Radiology Services	\$1.00 per date of service

8.754.11 Exemptions

The following categories of recipients and/or services are exempt from the co-payment requirements:

- A. All services to children under the age of 19 (through the entire eligibility cycle month in which they attain the age of 19).
- B. All services to women in the maternity cycle. The maternity cycle is defined as (1) pregnancy (2) labor (3) birth and (4) the immediate postpartum period not to exceed six weeks. The recipient must inform the provider of her pregnancy or postpartum condition at the time of service, and all providers must indicate pregnancy on the claim form in order to claim this exemption: In the case of prescription drugs, the prescribing physician should note pregnancy or postpartum on the prescription. Providers may request oral or written verification of pregnancy or postpartum condition by contacting the physician. If the provider questions the recipient's statement that she is pregnant or postpartum and the provider is unable to obtain verification of the pregnancy or postpartum condition, then the provider may collect the co- payment amount imposed by this regulation from the recipient. If the recipient feels that she has been wrongly denied an exemption due to an unverified pregnancy or postpartum condition, she has the right of appeal through the regular appeals process as outlined under 8.057.
- C. All services to institutionalized recipients. Recipients defined as institutionalized include those in skilled nursing facilities (SNF's), intermediate care facilities (ICF's), ICF's for the mentally retarded, recipients under age 21 in inpatient psychiatric hospitals, and recipients 65 and over in institutions for mental diseases.
- D. Family planning services and supplies furnished to individuals of child-bearing age. This exemption will be identified by the fiscal agent from information on the Medicaid claim form.
- E. All services furnished by a health maintenance organization (HMO) to categorically needy recipients enrolled in the HMO plan. This exemption will be identified by the fiscal agent.
- F. All emergency services. Emergency services are defined for all Medicaid recipients in the same way as they are defined for the Primary Care Physician Program in Section 8.253.6 as "care for any condition which is life threatening or requires immediate medical intervention." Emergency treatment can be given in the emergency room, the outpatient department, or a physician's office. The attending medical personnel shall define the emergency nature of the recipient's condition. For cases where it is not clear if an emergency exists, a triage of the recipient may be conducted as defined under 8.253.6. There will be no co-payment charge for the triage.

Drugs administered during emergency treatment shall be considered part of the treatment and not subject to co-payment. All prescriptions for drugs, whether written in the emergency room or elsewhere, shall be subject to co-payment.

Non-emergency services in the emergency room are considered to be outpatient hospital services and

will be subject to the same co-payment amount as a hospital outpatient visit. It is the provider's responsibility to identify emergency on the claim form so that the fiscal agent can exempt the service from co-payment

G. Two-cycle at end of year.

H. All services provided under the Medicaid Mental Health Capitation Program.

8.754.12 Claim Filing Procedures

When billing Medicaid, providers affected by these co-payment regulations shall continue billing their usual and customary charge. For any service for which a co-payment amount is imposed by this regulation, the fiscal agent shall deduct the appropriate co-payment amount from the payment to the provider.

Physicians providing laboratory or radiology services in their office shall be responsible for collecting co-payments for the office visit and for the laboratory or radiology services provided.

8.754.13 Cumulative Maximum for Individual Co-payments

Those individuals whose co-payments reach a limit of \$150.00 within a January 1 through December 31 calendar year will be exempted from further co-payments during that year. When claims received by the fiscal agent indicate that the limit has been reached, a temporary exemption card will be issued automatically to the recipient by the State which will be valid until the exemption is indicated on the Medicaid Authorization Card, and no more co-payments will be required during the calendar year. The exemption will begin on the date of payment for the claim which indicates that the cumulative maximum has been reached. Additional services rendered prior to that date will still be subject to co-payment.

Because claims are often received several months after the date of service, a recipient who has reached the limit may apply directly to the State Department of Social Services for an exemption by writing or calling the Department. The Department will respond to this request within ten working days from the date it is received. The Department may require verification of service received and co-payments charged. If the exemption is approved, the Department will issue an exemption card, effective the date the State verifies that the maximum has been reached. If the exemption is denied the recipient has the right of appeal through the regular appeals process, as outlined under 8.057.

It Will be a recipient responsibility to present the card noting the exemption to the provider at the time a service is rendered in order to claim exemption from co-payment for that service.

8.760 TARGETED CASE MANAGEMENT SERVICES

Targeted case management services are a Medicaid benefit when provided in accordance with the provisions of the following sections on TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES AND CASE MANAGEMENT-MENTAL-HEALTH.

8.761 TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

8.761.1 DEFINITIONS

.11 "Developmental disability" means a disability that is manifested before the person reaches twenty-two years of age; constitutes a substantial handicap to the affected individual; and is attributable to mental retardation or related conditions which included cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons.

.12 "Person with developmental disabilities" means a person with a developmental disability and may include a person less than five years of age who is at risk, of having a developmental disability and requires treatment or services similar to those required by persons who are mentally retarded.

.13 "Community centered board" means a private corporation, for profit or not for profit, which, when designated pursuant to C.R.S. 27-10.5-105, as amended, is authorized to determine eligibility of persons with developmental disabilities within a specific geographic catchment area for services authorized under C.R.S. 27-10.5, as amended, provide case management services to such persons, and provide authorized services to such persons either directly or by purchasing such services from local service agencies.

- a. Persons receiving targeted case management services may not be restricted from requesting, on a statewide basis, which community centered board will provide them with targeted case management services.

.14 "Targeted Case Management services for persons with developmental disabilities" consist of at least one activity every other month, by the community centered board which is providing targeted case management services to the individual, for one or more of the following purposes:

- a. coordinating the completion of assessments for the determination of the need for services;
- b. facilitating the development of the Individual Habilitation Plan (IMP) and ensuring the development of related Individual Program Plans (IPP);
- c. monitoring and reviewing the goals and services identified in the Individual Habilitation Plan and individual program plans developed in response to the IHP;
- d. coordination of the services being provided as identified in the IHP to ensure continuity of service provision;
- e. advocate for the entry of persons receiving services into the services and/or programs identified in the IHP;
- f. provide counsel and support to the person receiving services and other appropriate parties as necessary to prepare them for entry, transfer or termination from a program;
- g. providing notification and documentation of intended actions, transfers or terminations; or,
- h. for persons who no longer require services from the developmental disabilities system or whose needs would be better served in alternative services options, termination from services or transfer to other necessary services.

8.761.2 DETERMINATION OF CLIENT ELIGIBILITY

.21 To receive targeted case management services individuals must meet the following criteria:

- a. be determined to be eligible for Medicaid by the Department of Social Services in the county in which the person resides;
- b. be determined by the designated community centered board to have a developmental disability; and.

c. be actively enrolled in one of the following programs under contract with the Division for Developmental Disabilities, hereafter referred to as the Division:

1. adult residential services
2. adult day services
3. early childhood services
4. family resource services.

.22 The specific programs listed in 8.761.21 (C)(1) through (4) are the only programs which are eligible for targeted case management services.

8.761.3 PROVIDER ELIGIBILITY

.31 Only designated Community Centered Boards may be reimbursed for targeted case management services for persons with developmental disabilities.

8.761.4 REIMBURSEMENT

.41 Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at 42 C.F.R. 447.205, and shall be based on the following:

- a. Full month. Services provided to individuals who are eligible for targeted case management services for sixteen (16) days or more within any calendar month shall be reimbursed for two (2) units of service.
- b. Partial month. Services provided to individuals who are eligible for targeted case management services for fifteen (15) days or less within any calendar month shall be reimbursed for one (1) unit of service.

.42 Targeted case management services may not be claimed prior to the first day of enrollment into a division program nor prior to the actual date of eligibility for Medicaid benefits.

.43 Targeted case management services will become reimbursable as of July 1, 1989.

8.761.5 EXCLUSIONS

.51 Case management services provided to any individuals enrolled in the following programs are not billable as targeted case management services for persons with developmental disabilities as specified in section 8.760:

- a. Persons enrolled in the Home and Community Based services for the Developmentally Disabled (HCB-DD) program as described in section 8.500 herein.
- b. Persons enrolled in the Home and Community Based services for the Elderly, Blind and Disabled (HCB-EBD) program as described in section 8.484 herein.
- c. Persons residing in a Class I nursing facility.
- d. Persons residing in an Intermediate Care Facility for the Mentally Retarded (ICF-MR).
- e. Persons receiving services from the community centered board which are not under

the state contract with that community Centered board for division programs.

8.762 CASE MANAGEMENT — MENTAL HEALTH

.10 Case Management Services — Mental Health are a Medicaid benefit statewide when provided in accordance with the provisions of the following sections.

.20 DEFINITION

Case Management Services are defined as those services which will assist mentally ill individuals eligible under the state plan, in gaining access to needed medical, social educational, and other services. These services are separate from those services defined under the clinic options services in Section 8.750.

.30 DETERMINATION OF CLIENT ELIGIBILITY

In addition to Medicaid eligibility, individuals must be determined by the community mental health centers to be mentally ill (see section 8.400b.) and in need of case management services as defined above.

.40 PROVIDER ELIGIBILITY

Only community mental health centers and clinics designated by the Department of Institutions and licensed by the Department of Health shall be reimbursed for case management services under these provisions.

.50 REIMBURSEMENT

Reimbursement shall be on a prospective fee for services basis in accordance with Federal requirements at 42 CFR 447.321 and Section 8.752.

8.765 REHABILITATIVE SERVICES IN RESIDENTIAL TREATMENT CENTERS

.10 Rehabilitative services in Residential Treatment Centers are a Medicaid benefit statewide when provided in accordance with the provisions of the following sections.

.11 DEFINITION

Rehabilitative Services in Residential Treatment Centers are defined as those services which are recommended by a licensed practitioner, as defined in 26-4-527, C.R.S., will assist mentally ill individuals eligible under the state plan, and will reduce mental disabilities and restore a recipient to his or her best possible functional level. These services are separate from those services defined under the clinic options services in Section 8.750.

.12 CLIENT ELIGIBILITY

In addition to Medicaid eligibility, individuals must be determined by a licensed professional person to be mentally ill (see subsequent section 8.76220) and in need of rehabilitative services as determined by the Peer Review Organisation (PRO).

.13 CLIENTS' RIGHTS

Clients' rights are defined in subsequent section 8.765.44 to provide the fullest possible measure of privacy, dignity and other rights to persons undergoing care and treatment in the least restrictive environment.

.14 PROVIDER ELIGIBILITY

Only facilities designated and certified by the Department of Health Care Policy and Financing based on a recommendation by the Division of Mental Health, shall be reimbursed for rehabilitative services under these provisions.

Facilities designated by the Division of Mental Health, Colorado Department of Human Services to meet all of 27-10-101 through 110, C.R.S. criteria shall be deemed eligible for Residential Treatment Center certification.

Facilities must participate in the Child Welfare and/or Division of Youth Services systems of the Colorado Department of Human Services.

8.765.20 DEFINITIONS

- A. Assessment: The process of collecting and evaluating information for the purpose of developing a client profile on which to base service planning and referral. The assessment process is both initial and ongoing.
- B. Case Management: Activities that are intended to ensure that clients receive the services they need, that services are coordinated, and that services are appropriate to the changing needs and stated desires of clients and families over time. The goals of case management are: (1) to bring about positive changes in clients' status. (2) to assist clients in reaching their highest potential, and (3) to achieve the best possible quality of life for clients and their families in the community. Goals are developed to the extent possible among case managers, referral sources, families and clients. Case management activities are community-based, and are delivered either in the authorized facility or in the client's environment by a designated person or team.

Treatment services include, but are not limited to, treatment modalities, discharge planning, referral, monitoring/follow-up, advocacy, and crisis management.
- C. Client or Resident: An individual who is receiving rehabilitative services in a Residential Treatment Center pursuant to 26-4-527, C.R.S., et seq. The individual must be placed by Child Welfare and/or the Division of Youth Services of the Colorado Department of Human Services.
- D. Department: The Colorado Department of Human Services acting on behalf of the Colorado Department of Health Care Policy and Financing.
- E. Authorized Facility: A facility authorized by the Department under these regulations, pursuant to the recommendation of the Division of Mental Health, as a Residential Treatment Center treatment and evaluation facility.
- F. Discharge: The termination of services by the authorized facility.
- G. Drug: A substance intended for use in the diagnosis, care, mitigation, treatment, or prevention of disease or other condition. See 12-22-102(11), C.R.S.
- H. Investigational Drugs: Drugs approved by the federal Food and Drug Administration for investigational use. These are drugs which have not been approved for sale in interstate commerce by the federal Food and Drug Administration because their toxicity and efficacy have not yet been sufficiently evaluated. They are drugs which are presently in the clinical stages of evaluation.
- I. Legal Guardian: A person appointed by a court of competent jurisdiction pursuant to the provisions of 15-14-201 C.R.S., et seq. or 15-14-301, C.R.S., et seq., 19-1-103(18A), C.R.S., et seq., 19-2-101(3), C.R.S., et seq., or a person assuming such status under other provisions of law. A legal guardian has such powers as are provided by statute or court order. The term "legal guardian" or "guardian" shall not include one appointed as guardian ad litem. The legal guardian may be

appointed through the Division of Youth Services, Colorado Department of Human Services or through the local county department of social services.

- J. Licensed Professional Person: A physician licensed pursuant to Article 36 of Title 12, C.R.S., a psychologist licensed pursuant to part 3 of Article 43 of Title 12, C.R.S., a clinical social worker licensed pursuant to part 4 of Article 43 of Title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of Article 43 of Title 12, C.R.S., or a professional counselor licensed pursuant to part 6 of Article 43 of Title 12, C.R.S.
- K. Medication: A drug as defined by 12-22-102(11), C.R.S. and these regulations.
- L. Mentally Ill Person: A person with a substantial disorder of the cognitive, volitional, or emotional processes that grossly impairs judgment or capacity to recognize reality or to control behavior as defined by a licensed professional person.
- M. Order: A “prescription order” is any order, other than a chart order, written or transmitted by other means of communication by a practitioner, authorizing the dispensing of drugs or devices, and including the name or identification of the patient, the date, and sufficient information for compounding, dispensing, and labeling.

A “chart order” is an order for inpatient drugs or medications entered on a patient's chart or medical record, to be dispensed by a pharmacist, or pharmacy intern under the direct supervision of a pharmacist, and which is to be administered by an authorized person only during the patient's stay in a Residential Treatment Center facility.

An order contains the name of the patient and the medicine ordered, and such directions as the practitioner may prescribe concerning strength, dosage, frequency and route of administration. See 12-22-102, C.R.S.
- N. Client Representative: A person designated by a Residential Treatment Center to process complaints or grievances, including representing clients who are minors.
- O. Referral Agency: The agency that refers the client to the Residential Treatment Center Program. It is either the County Department of Social/Human Services or the Colorado Department of Human Services, Division of Youth Corrections.

8.765.30 ASSESSMENT OF MEDICAL NECESSITY/LEVEL OF CARE

- A. Clients will be assessed by each Residential Treatment Center facility upon admission. Information on client Medicaid eligibility, client diagnoses and characteristics and presenting problem will be transmitted to the Referral Agency for determination of medical necessity for rehabilitative services and the appropriate Level of Care.
- B. The assessment instrument used to determine the Level of Care will be the Colorado Client Assessment Record (CCAR).
- C. Level of Care assessment will occur upon admission, discharge, and/or to move from each Level of Care.

8.765.31 CRITERIA FOR DETERMINATION OF CLIENT ELIGIBILITY

In order to be eligible for Medicaid rehabilitative services in Residential Treatment Centers an individual must be Eligible for Medicaid services and meet all of the following criteria:

- A. The individual has a psychiatric disorder as described in Diagnostic Statistical Manual (DSM-IV-TR) as

determined by a licensed professional person.

- B. The individual is being treated in the most appropriate and least restrictive setting.
- C. The individual has had an initial assessment to determine that she/he is capable of benefiting from the program. The assessment must be completed or approved by a Colorado licensed professional person as defined above in this Section.
- D. As a result of the disorder, the individual is experiencing psycho-social disruption which interferes with his/her functioning.
- E. The parent/guardian accepts responsibility to participate in the treatment program and/or discharge planning.
- F. The client must have specific treatment goals which must include:
 - 1. Expected resolution of the problem that necessitated this Residential Treatment Center treatment and the specific functional achievement to be obtained in measurable terms.
 - 2. The anticipated duration and frequency of treatment in the identified Level of Care.
 - 3. Indications why the planned services can reasonably be expected to improve the child's condition.
- G. All of the following must be provided while the child/adolescent receives Residential Treatment Center services:
 - 1. Psychological therapeutic services (for example, milieu therapy, behavior modification, group therapy, or psychotherapy for the child/adolescent and/or family/significant other).
 - 2. Supervision of the treatment by a licensed professional person.
 - 3. Involvement of parent, legal guardian, family member or custodian as scheduled in the treatment plan.
 - 4. Documentation by a multi-disciplinary team at least every month, including a statement of progress toward established goals.
 - 5. Documentation by the licensed professional person at least every month that the individual will benefit from continued Residential Treatment Center rehabilitative therapy.

Indicators for the staff to use in determining when a client shall be discharged from the program are:

- A. The individual is not benefiting from the service or is not progressing toward goals and the treatment plan has not been revised accordingly within a month.
- B. The individual has attained treatment goals with no further need for Residential Treatment Center services.

.41 To be eligible to provide Medicaid rehabilitative services a provider must continuously meet the following criteria:

- A. Facilities which may apply for designation as Residential Treatment Centers must have sufficient staffing, structure, supervision and therapeutic milieu available on a 24-hour-a-day basis. The facility must be licensed by the Colorado Department of Human Services as a residential child

care facility. The facility may serve clients in the Child Welfare Division and/or the Division of Youth Services systems of the Colorado Department of Human Services.

- B. Facilities shall have a licensed professional person, either employed or under contract, to be responsible for the evaluation and treatment administered to each client. Staff privileges shall be an acceptable form of contractual arrangement. The professional person may delegate any part of his/her duties, except as limited by statute or these regulations, but he/she shall remain responsible at all times for the quality of the mental health treatment administered to the client. Facilities shall have a single identifiable organization responsible for their scope of operations.

8.765.42 PROVIDER CERTIFICATION

.421 Initial Certification: The Division of Mental Health shall review and recommend certification of Residential Treatment Centers to the Department. The Division shall receive and review applications and make on-site visits as necessary for initial certifications of facilities. Certification shall be based on a capability of providing safe, high-quality rehabilitative services according to the regulations in this Section.

.422 Ongoing Certification: The Department or its designee shall evaluate, at least annually, all Residential Treatment Center facilities for compliance with these regulations. The Department, or its designee, shall investigate all complaints related to these regulations.

.423 Revocation or Provisional Certification: If the Department finds, based on an annual review or pursuant to a complaint, that a Residential Treatment Center service provider is not in compliance with these regulations, the Department shall notify the facility and the Department of Human Services in writing within 10 working days of the date the facility was found to be out of compliance. Further, the Department shall notify the facility and the Department of Human Services within 45 days of the initiation of the review.

.424 The provider has 30 days from the receipt of the notification to submit written information supporting a plan and schedule for achieving full compliance with the items found not in compliance.

.425 The Department, after reviewing the provider's response, may take the following actions:

- A. Approve the proposed plan and schedule for achieving full compliance, or
- B. Approve a modified plan and schedule for achieving full compliance, or
- C. Revoke, suspend, limit or modify the certification of the provider.

.426 In cases where the Department approves a proposed or modified plan and schedule for achieving full compliance, the Department shall grant provisional certification for up to 90 days. At the end of the provisional certification period, the Department may:

- A. Approve full certification, or
- B. Extend the provisional certification for another 90 days, if needed to achieve full compliance, or
- C. Revoke the certification.

.427 At the end of this second 90 day provisional certification, the Department shall fully certify or revoke the certification.

.428 Notwithstanding any of the above provisions, if the Department has reasonable grounds to believe and finds that the facility has been guilty of deliberate and willful violations of these regulations, or that the public health, safety, and welfare imperatively requires emergency action and incorporates such

information in its report, the Department may summarily suspend the certification. Proceedings for suspension or revocation shall be promptly instituted according to 24-4-105, C.R.S.

.429 The provider shall have thirty (30) days from the mailing date of the termination notice in which to request a hearing to the Division of Administrative Hearings, pursuant to this section. The hearing shall be conducted in accordance with 24-4-105, C.R.S. and is subject to judicial review in accordance with 24-4-106, C.R.S.

8.765.43 FACILITY POLICIES AND PROCEDURES

Residential Treatment Centers must adopt and adhere to the following policies and procedures at all times.

.431 Conflict of Interest: Each authorized facility shall establish policies regarding conflicts of interest which shall include the circumstances under which any current resident may be transferred to the private practice of an employee of the facility.

.432 Quality Assurance:

- A. Each authorized facility shall be reviewed annually by the Department for compliance with the rules and regulations concerning the Residential Treatment Center Program.
- B. Each authorized facility shall adopt and implement a written quality assurance program.
- C. A review process, including senior staff, shall be established to determine the appropriateness and effectiveness of treatment. The process shall include review of selected case records at least every three (3) months.
- D. A physician shall review the medical status of each client at least every twelve (12) months for those residents in treatment for twelve (12) months or longer. There shall be documented follow-up of identified medical problems.
- E. At least every six (6) months, a licensed professional person shall review the records of each client who has been in treatment six (6) months or longer and document this review in the client's record.
- F. Each facility shall establish policies and procedures for reviewing all deaths and other critical incidents involving client of the facility.

.433 Staff Training and Development: All staff who participate in the provision of care and treatment for clients admitted under the Residential Treatment Center Program shall receive training on these rules and regulations.

8.765.44 RESIDENT RIGHTS

.441 Advisement of Resident Rights: Each authorized facility shall have written policy and procedures which address and insure the availability of each of the following rights for clients in residence.

.442 All clients receiving evaluation, care or treatment under the Residential Treatment Facility Program shall be advised in writing of the following rights on admission. Every resident receiving evaluation or treatment shall be furnished by the facility a written copy of his/her rights and a list of such rights shall be posted prominently in the facility and translated into Spanish or any other appropriate language as needed.

- A. Every client has the right to freedom of thought, conscience and religion.

- B. Every client has the right to reasonable privacy.
- C. Every client has the right to have his or her opinions heard and be included, to the greatest extent possible, when any decisions are being made affecting his/her life and treatment
- D. Every client has the right to receive appropriate and reasonable adult guidance, support and supervision.
- E. Every client has the right to be free from physical abuse and inhumane treatment Every client has the right to be protected from all forms of sexual exploitation.
- F. Every client has the right to receive adequate and appropriate medical and psychiatric care in the least restrictive setting possible, suited to meet individual needs.
- G. Every client has the right to receive adequate and appropriate food, clothing and housing.
- H. Every client has the right to live in clean, safe surroundings.
- I. Every client has the right to participate in an educational program which may maximize his/her potential.
- J. Every client has the right to communicate in privacy, in writing or on the telephone, with "significant others" outside the facility.
- K. Every client has the right to have frequent and convenient opportunities to meet with visitors. Each client may see his/her custodial parent or his/her children at any time.
- L. Every client has the right to wear his/her own clothes, keep and use his/her own personal possessions, and keep and be allowed to spend a reasonable sum of his/her own money.
- M. A facility shall not bar a client's attorney, clergyman, physician, client representative, legal custodian or an authorized representative of the responsible placing agency from visiting, corresponding with or telephoning the client
- N. No client admitted to or in residence at a Residential Treatment Center shall be finger printed unless required by law.
- O. A client may be photographed upon admission for identification and administrative purposes of the facility. Such photographs shall be confidential and shall not be released by the facility except pursuant to court order. No other nonmedical photographs shall be taken or used without the written consent of the clients parent or legal guardian.
- P. Every client has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex. political affiliation, sexual orientation, financial status or disability.
- Q. Every client has the right to be given the names and professional status of the staff members responsible for their care.
- R. Every client has the right to receive assistance from the resident representative in making complaints and to receive copies of the complaint procedures.
- S. Every client fifteen (15) years of age and older has the right to request to see his or her own medical records, to see the records at reasonable times, and to be given written reasons if the request is denied.

T. Every individual fifteen (15) years of age and older, who is not in the custody of Social Services, has the right to accept treatment of his/her own free will and may sign in as a voluntary resident if he or she agrees to being in the facility. The client has the right to refuse to sign the consent for voluntary treatment at the time of admission or may take back the consent at a later date (27-10-103, C.R.S.).

.443 Only client's rights in Section 8.765.442(J)(K)(L) may be denied for good cause only by the licensed professional person providing treatment for that client. If the residential child care facility enforces any restrictions upon the client's rights, the facility shall:

- A. Inform the client of the conditions of and reasons for restriction or termination of his/her rights.
- B. Place a written report summarizing the conditions of and reasons for restriction, denial or termination of the client's rights in "that client's treatment record. Information pertaining to a restriction, denial or termination of a client's rights contained in the client's treatment record shall be made available upon request to the client or the client's attorney and legal guardian.
- C. When a restriction of a client's right(s) affects another individual, the individual shall be informed of the conditions of and reasons for the action.
- D. Review any denial or limitation, other than those provided for in subsection 8.765.444, at least every seven (7) days and document in the clinical record.

.444 Written policies pertaining to visitation, communication, dress and personal possessions may be established and implemented. These policies shall only limit residents' rights to ensure the protection of the client, staff and program from unreasonable and unnecessary intrusions and disruptions and from health and safety hazards. Minimum policies shall include:

- A. Plans for regular visits of the client with relatives, friends, or others interested in his/her welfare, both within and outside of the facility, unless in the judgment of treatment staff and placement agency it would be detrimental to the client and/or his/her family.
- B. Plans for telephone and written communications.
- C. Plans for extenuating circumstances and emergency situations affecting the client and his/her family.
- D. Any policy limiting a resident's rights shall be communicated in writing to the resident at the time of admission and signed by the resident and his/her parent or guardian.

.445 The residential child care facility shall establish a written grievance procedure which provides adequate due process safeguards, spells out the appeal process and assures that residents and legal guardians are entitled to report any grievance and shall not be subject to any adverse action as a result of filing a grievance.

- A. Grievance procedures shall be processed without alteration, interference, or unreasonable delay.
- B. This grievance procedure shall be made available to all clients as provided for in the resident rights.
- C. If a client files a grievance, it shall be recorded in the client's record along with the investigative findings and resulting action taken by the facility.

.446 A list of the resident rights, the grievance procedures, the name, address and telephone number of the resident representative as well as a list of agencies where complaints may be filed shall be prominently posted in all facilities in areas frequented by residents and legal guardians.

.447 The authorized Residential Treatment Center will meet all rules and regulations issued by the Office of Child Care Services, Colorado Department of Human Services relative to Medical and Health Services.

.448 The obligation to ensure availability of emergency medical services shall not be construed as the obligation to pay for such services.

.449 The following rules govern employment of residents and compensation:

- A. Work, including all labor, employment or jobs involving facility operation and maintenance or used as labor-saving devices which are of an economic benefit to the facility shall be treated as work and shall be compensated according to applicable minimum wage or certified wage rates.
- B. Maintaining a minimum standard of cleanliness and personal hygiene and personal housekeeping, such as making one's bed or cleaning one's area shall not be treated as work and shall not be compensated.
- C. Residents shall not be forced in any way to perform work.
- D. Training programs must comply with all applicable federal and state laws.
- E. All work assignments, together with a specific consent form, and the hourly compensation received, shall be noted in the resident's record.
- F. Privileges or release from an authorized facility shall not be conditioned upon the performance of work.

.450 (Reserved for future use)

8.765.46 PRESCRIBING, HANDLING, DISPENSING MEDICATION

.461 In all instances where prescription medications are to be ordered as part of a treatment program, the following information shall be provided to the client and her/his custodian or legal guardian:

- A. The name of the medication being prescribed.
- B. The proper use of the medication.
- C. The reasons for ordering the medication for this client
- D. A description of the benefits expected.
- E. The common side effects, if any.
- F. The major risks, if any.
- G. The probable consequences of not taking the medication explained in language that is easily understood by the client/family/legal guardian.
- H. The facility shall have policy and procedures for documenting that the required information was given to the client/legal guardian before the client took the medication. When information is given to the client, the documentation shall include an assessment regarding whether the client understood.
- I. Drugs that entail a substantial risk and drugs that are experimental require a special procedure for consent following the informed consent procedure 8.765.490.
- J. No involuntary medications shall be administered.

.462 The physician, or their representative, shall make a reasonable effort to explain why it is important for the child to take the prescribed medication to the client/family/legal guardian.

.463 The attending physician, or his or her representative, shall be available to answer inquiries regarding this medication.

.464 The client may refuse to take his/her medication at any time. The facility must document the refusal in the client record.

.465 If after all of the above have occurred, and the client refuses to accept medication, the appropriate treatment alternatives, if any, shall be presented to the client by the Residential Treatment Center staff.

.466 No client shall be threatened with or experience adverse behavioral consequences by staff action solely due to refusal of medication.

.467 Handling and Dispensing Medication: The Residential Treatment Center will follow the Office of Child Care Services, Colorado Department of Human Services rules and regulations Staff Manual Volume VII, Section 7.705.31. The Residential Treatment Center shall have procedures on the areas in accordance with those rules and the following:

A. Documentation and administration of medication, medication errors, and drug reactions.

B. Discontinuing and disposing of medication.

C. Acceptance of verbal medication orders, confirmed by written or electronic transmittal.

.468 The Residential Treatment Center shall maintain records of all prescription medications dispensed to clients for five years.

.469 Only persons authorized by Colorado Department of Human Services regulations shall administer medications. All direct-care staff shall be trained in the recognition of common side effects of medication.

8.765.47 LOCKED QUIET ROOM

The locked quiet room shall meet all physical and procedural requirements for locked quiet rooms under the Colorado Minimum Rules and Regulations for Residential Child Care Facilities, Colorado Department of Human Services regulations.

.471 The designated facility shall have and shall implement written policies and procedures that describe the situations in which the use of seclusion is considered appropriate within each specific program component and the staff members who can order its use. The written policies and procedures for the use of seclusion shall include the requirements in the Residential Child Care Facility regulations.

.472 Physical Intervention: Holding shall be the only means of restraining a client. Mechanical restraints are not allowed. The Residential Treatment Center shall have written policies regarding the use of any physical interventions. All staff using physical intervention shall be trained in the use of these procedures. All training shall be documented.

Physical interventions shall be applied only if such restraint imposes the least possible restriction consistent with the purpose of preventing such body movement that is likely to result in imminent injury to self or others, and only if alternative techniques have failed.

8.765.49 SERVICE PLAN: CONTINUITY OF CARE

.491 Service Plan: Each client must have a written service plan as follows:

- A. The authorized facility is responsible for assuring the formulation and implementation of an individualized, integrated, comprehensive written service plan designed with the purpose of promoting the child's highest possible level of independent functioning and to reduce the likelihood of returning to a restrictive confinement
- B. As soon as possible, but within seventy-two (72) hours of admission, an initial service plan shall be formulated which shall address the immediate and/or emergency needs of the child.
- C. If a child is discharged during a the first seventy-two (72) hours of admission, and a service plan has not been completed, then available pertinent information shall be included in the discharge summary.
- D. The service plan shall be developed by a multi-disciplinary team within ten (10) days after admission.
- E. The service plan is based on the child's assessed clinical and other relevant needs including the child's presenting problems, physical health, emotional status, behavior, and support system in the community, and available resources.
- F. The service plan contains specific goals that are based on the assessment
 - 1. The service plan contains specific objectives that relate to the goals, are written in measurable terms, include expected dates of achievement, and specific criteria to be met for termination of treatment
 - 2. The type, frequency and duration of services are specified in the service plan.
 - 3. The plan assures the provision of or the referral for the needed services.
- G. The service plan identifies the appropriate Level of Care that the client is to receive. The service plan specifies all services necessary to meet resident needs. The following services are included in the service plan when indicated by resident needs:
 - 1. Clinical Treatment Services
 - 2. Case Management Services
 - 3. Rehabilitation Services
 - 4. Residential Services
 - 5. Vocational Services
 - 6. Emergency Services
 - 7. Medication Management Services
- H. The child and the legal guardian shall participate in the formulation, review and revision of the service plan. If the child or legal guardian is unable to participate, or when their participation is clinically contraindicated, the reasons shall be documented in the resident's record. In addition, other persons selected by the child, the guardian, or the treating professional person may also be included in the formulation, review, and revision of the service plan.
- I. The resident shall sign the service plan and shall be offered a copy of the plan. The record shall contain an explanation whenever a service plan is not signed.

- J. The facility shall appoint a clinical staff person to be responsible for the formulation, implementation, review, and revision of the service plan. The name of the responsible staff person shall be specified in the plan and that person shall sign the plan. The plan shall also be signed by the treating professional person, if the treating professional person is not the responsible staff person.

The resident shall be given the name and telephone number of the facility's resident representative to contact should the resident have a question or complaint or wish to file a grievance. This shall be noted in the chart.

- K. A physician shall be responsible for the component of the plan requiring medication management services.
- L. The facility is not responsible for providing non-psychiatric medical care, but shall facilitate access to proper medical care and shall be responsible for coordinating mental health treatment with medical treatment provided to the resident.
- M. The service plan shall be reviewed, and revised if necessary, at least monthly by the staff person responsible for the plan and by the treating professional person.
- N. The service plan shall specify criteria for discharge, including provisions for transitional, aftercare and follow-up services based on the needs of the child. At the time of transfer of responsibility for the resident from one facility to another, there shall be sufficient inter-facility communication to make continuity of care feasible.
- O. Service plans shall be readily identifiable and shall be maintained in a place readily accessible to treatment staff.
- P. All members of the clinical staff shall be trained annually in the development and review of service plans.

.492 Continuity of Care:

- A. Each authorized facility shall adopt and implement a written policy for continuity of resident care which shall include at a minimum the following:
 - 1. Ease-of resident movement from one element of service to another within the facility.
 - 2. Aftercare planning, to be included with the resident's discharge summary which describes any recommendations for the resident to follow after discharge from the facility.
 - 3. Referrals to other agencies and follow-up of such referrals.
- B. The placement alternative selected shall be conducive to the optimum restoration of the resident's mental and physical functioning, with due regard for the safety of the resident and those around him/her and the availability of placement alternatives.
- C. Residents shall only be transferred to the care of another authorized or placement facility when adequate arrangements for care by the receiving facility have been documented. This shall include at least one discharge planning conference, face-to-face or by telephone, with participants from both facilities of which the resident shall be immediately informed. At least twenty-four (24) hours advance notice to the resident and the legal guardian unless waived in writing or an emergency condition exists. Actions taken under this section shall be documented in the clinical record.

.493 Treatment Records:

A. Care of Records

1. Authorized facilities shall maintain an organized, written, current record on each resident which can be easily reviewed for compliance.
2. All treatment entries shall be signed and dated by the author, with his/her degree and title or position, at the time they are written.
3. Records shall be kept in a secure location at the facility and only be released in accordance with Section 8.765.494., Confidentiality.

B. Admission Data records shall include:

1. Resident identification and demographic data, source of referral, and previous history, including substance abuse and vocational, if indicated.
2. Documentation of resident's legal status such as guardianship, conservatorship, court orders, as to custody, certifications, advisement and consent
3. Medical history and physical examination reports.
4. Initial impression, differential diagnosis, or diagnoses in standard terminology (e.g., Diagnostic and Statistical Manual, III R/IV, or International Classification of Diseases and Ailments).
5. Treatment Plan. Initial impression, and diagnosis document, treatment plan, modifications and monthly progress reports shall be provided to the county/placement agency in a timely manner.

C. Treatment Progress records shall include:

1. The individual service plan, to include clinical treatment services and, as pertinent: Case Management Services, Rehabilitation Services, Medication Management, Emergency services, Community Support Services, Vocational Services, and Residential Services.
2. Documentation that the child and legal guardian, and the family where appropriate, was/were included in developing and updating the service plan.
3. Documentation that the resident was offered a copy of the service plan.
4. Ongoing progress on a chronological basis at least monthly for outpatient treatment and weekly for residential service.
5. Documentation of resident's response to treatment approaches and changes in the treatment plan with the reasons for such changes.
6. Documentation of all treatment procedures including brief physical holding, locked time out, and specific therapies.
7. Information regarding the serious injury of or by the resident and the circumstances.
8. Documentation of support services provided.
9. Correspondence to and from relevant agencies and individuals.
10. Documentation of all transfers and reasons for transfer within the authorized facility.

D. Discharge or Transfers Between Facilities records shall include:

1. A discharge summary outlining treatment received, progress made.
2. For transfers between facilities, documentation of appropriate clinical information and coordination of services between the two facilities.
3. Documentation of unplanned discharges and discharges against the professional person's advice.
4. Information regarding the death of a resident and the circumstances.

E. Clinical records shall be retained as follows:

1. Seven years beyond age 18 for minors receiving outpatient care;
2. Ten years beyond age 18 for minors receiving residential care.

.494 Confidentiality:

A. School records shall be transmitted according to state law, pursuant to 24-72-204, C.R.S., and the Individuals with Disabilities Education Act as amended by Public Law No. 94-142.

B. Residents and legal guardians may have access to their records subject to 25-1-801, C.R.S., et seq. and 24-72-201, C.R.S., et seq. and rules and regulations of the Department of Health, if applicable.

C. The authorized facility and the responsible professional person shall have the responsibility to insure that all information obtained and records prepared in the course of treatment shall be maintained as confidential and privileged matter and shall not be subject to public disclosure except as may be provided in paragraphs E through I and K of this section.

D. The authorized facility shall provide sufficient privacy to maintain confidentiality of communication between a resident and spouse, staff member, attorney, certified public accountant, and/or clergy.

E. Information and records shall be made available to a residents attorney or personal physician upon the resident's (over age 15) and his legal guardian's written authorization. Information and records may otherwise be disclosed outside of the authorized facility only:

1. When the resident or his/her parents), if the resident is a minor, designates persons to whom information or records may be released and signs appropriate release of information form. Whenever a resident has a legal guardian or conservator and his/her legal guardian or conservator designates, in writing, persons to whom records or information may be disclosed, such designation shall be valid in lieu of the designation by me resident. "Individual authorization for release of information shall be time limited, shall indicate who shall receive the information and what information shall be released.

2. When the treating professional person or his/her designee authorizes the release of information in the absence of consent:

- a. To physicians for the purpose of seeking advice and expertise concerning a specific medical problem to assist in the ongoing treatment of a resident in a facility.

- b. To any other qualified professional persons or agencies needing the information because of a life-threatening emergency or in a situation where there is a high

likelihood of an imminent life-threatening situation.

- c. In communications between qualified professional personnel in the provision of services or appropriate referrals.
 - d. To persons authorized by court order after there has been notice and opportunity for hearing to the person to whom the records pertain and the custodian of the records.
- F. Claims made on the behalf of the resident by the provider, for aid, insurance or medical assistance, shall be limited to information required for the payment of the claim. Unless otherwise specified in Medicaid/Medicare regulations, such disclosure may be made only if a statement is included that the information may not be re-released to any other agency including a centralized computer history agency accessible by others.
- G. Records shall be released to the staff of the governor's designated Protection and Advocacy System for Persons with Mental Illness for a resident with mental illness:
 - 1. Receiving publicly-funded mental health treatment, or
 - 2. Receiving residential treatment, or
 - 3. Having been discharged from residential treatment, or
 - 4. Having died while in residential treatment
- H. Nothing in this Section shall be construed to limit the access of duly authorized representatives of the Department access to confidential material for purposes of assuring compliance with the provisions of these rules. Such duly authorized representatives of the Department and the Department of Human Services are obligated to protect the confidentiality of any resident information reviewed.
- I. Whenever a family member or other informant (not including a facility) requests that information revealed to treating personnel remain confidential, such information shall not be released unless otherwise provided by law or court orders.
 - 1. Whenever confidential information provided by a family member of an informant is ordered released, attempts shall be made to notify the family member or informant of the release of information by the person who has obtained the court order.
 - 2. The fact that confidential information is being withheld may be disclosed to persons requesting the information, but if the resident's attorney has requested the information, the fact that confidential information is being withheld shall be disclosed.
- J. Any information concerning observed behavior which reasonably appears to constitute a criminal offense committed on the premises of a authorized or placement facility or any criminal offense committed against any persons while performing or receiving services is not considered privileged or confidential,
- K. All researchers conducting clinical research must sign an oath of confidentiality. All information identifying individual residents by name, address, telephone number and/or social security number collected for research purposes, shall not be disclosed.
- L. When names are deleted and other identifying information is disguised or deleted, material from case records may be used for teaching purposes, development of the governing bodies' understanding

and knowledge of the facilities' services or similar educational purposes

- M. Information regarding treatment for alcohol or drug abuse may be released only in compliance with the Federal Regulations on Confidentiality of Alcohol and Drug Abuse Resident Records, 42 CFR, Part 2. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the Mowing address: State Publications Depository Library, 201 East Colfax Avenue, Denver, CO 80203.

8.765.50 RESIDENTIAL TREATMENT CENTER RATES AND REIMBURSEMENT

.501 Residential Treatment Centers shall be reimbursed pursuant to a three Level of Care rate schedule. The rates will be prospective and based on allowable costs as ascertained by the Department and shall be determined based on available funds effective July 1 of that year.

1. Residential Treatment Center rates will be set using actual cost data from the most recent fiscal year of that Residential Treatment Center submitted by the providers within the legislative appropriation. If the appropriation is less than the actual costs, then the rates shall be set using the previous year's rates, and increased or decreased to stay within the appropriation.
2. Allowable costs will be determined in accordance with generally accepted accounting principles as defined by "Accounting and Auditing Guidelines", as published by the Colorado Department of Human Services, Division of Mental Health.
3. Each provider will submit cost data to report their allowable costs. Publicly owned providers must submit a letter quarterly to the Departments of Health Care Policy and Financing and Human Services which states the Certification of Public Expenditures associated with the reimbursement. The Departments must receive this letter within 30 days following the last day of the quarter in which the payment was made. Each provider will be assigned three different rates for each level of care. The three Levels of Care represent the mental health rehabilitative service needs of children referred to the Residential Treatment Center Program. The rates assigned to each Level are based upon the type and frequency of mental health services provided at that specific level or care.
 - A. Level C care represents children with the most severe mental health needs and who need the most services. This level may be assigned by CCAR override for an intensive professional assessment period up to 45 calendar days, upon the request of the County Department of Human/Social Services or youth corrections region, and agreement of the residential treatment center where the child is placed.
 - B. Level B care represents children with moderate mental health needs and services. Each year, providers will include a statement of specific intervention services (other than milieu) included in the standard treatment package, Level B care. This statement of services will accompany the annual cost data report described in section .501(1).
 - C. Level A represents children needing transitional/after-care mental health services. Level A services may be provided off-site or within the RTC Program and are provided to transition the child to a less restrictive setting.
4. Level B services shall be the standard from which Levels A and C are derived. Prospective Cost data as reported by the providers shall be used in establishing the Level B rates on an annual basis. The Level B rates shall be set according to section .501(1). Level C services are priced 20% more than Level B and Level A services are priced 20% less than Level B.
5. Expenditures and rates shall be monitored, and rates may be adjusted to reflect budget neutrality.

6. The Colorado Client Assessment Record identifies the presence and severity of qualities associated with mental health issues. Children who are rated severe to extreme are eligible to receive Level C Services pursuant to the Colorado Client Assessment Record. Children rated as moderate are eligible to receive Level B Services pursuant to the Colorado Client Assessment Record. Children rated as moderate to slight are eligible for Level A Services pursuant to the Colorado Client Assessment Record.

.502 The following components are included in the treatment rate and are Medicaid reimbursable.

- A. Direct Therapy Staff: Responsible for those activities that occur between a professional (bachelor's degree or above in the mental health discipline) staff member and the client or the client's family which are based upon a specific treatment plan and are aimed at making changes in the client's/family's maladaptive behavior, intra-psychic conflict, or development impediments. Direct therapy includes the ongoing evaluative function which is part of a therapist's role. Speech therapy is included in this category.
- B. Other Treatment Staff: Responsible for the treatment of the client or family including:
1. Evaluation Services: Evaluation Services are those formal activities which are directed toward an understanding or diagnosing of the reasons for a client's maladaptive functioning. In addition to evaluation of the client, evaluation may involve contact with the client's family, other important persons in the client's life, community institutions, and the evaluation of records or other written information that pertains to the client. Evaluation services result in a written report or other documentation related to this function. Evaluation includes intake evaluation which results in a decision to
 2. Treatment Supervision: Treatment Supervision is the function of supervising the treatment activities of other staff members. Include conducting staff training in this category.
 3. Treatment Liaison: Treatment Liaison are those client-related activities that are directed toward the State Department of Human Services, County Departments of Social Services, courts, medical providers, and other community agencies that serve to further the care and treatment which the client receives from the provider. Such activities may involve information-giving, coordination of programs, and interagency problem-solving resulting from the client's behavior.
 4. Medical Services: Medical Services are those activities that are directed toward prevention or elimination of physical illness or dysfunction. This may include physical therapy in this category.
 5. Direct child Care Staff: All child care functions by direct child care staff are categorized as treatment Staff responsible for implementing the treatment plan in the daily living situation, creating a therapeutic milieu and helping residents learn more satisfactory ways of coping with the daily living process.
- C. Administration: Staff responsible for the overall direction of the organization. This includes accounting, general record keeping, business management, budgeting, community relations and clerical functions. This does not include costs spent in fund raising. This is distributed based on percentage of treatment staff.
- D. Administrative Overhead: A fixed allowance for costs associated with the overall direction of the Facility including but not limited to: accounting, general record-keeping, business management, budgeting, community relations, clerical functions, leased office equipment, and supplies necessary to conduct the administrative function. This is distributed based on percentage of treatment staff.

- E. Transportation Component: A variable allowance for, but not limited to: mileage payments, vehicle rental/leasing, vehicle depreciation, maintenance, insurance, parking charges, licenses, registration fees tires, gas, oil, public transportation and other expenses pertaining to travel including client travel.
- F. Therapeutic Leave Days: The facility may be reimbursed for up to 52 therapeutic leave days per calendar year. Therapeutic leave days are days of leave addressed in the child's service plan and may include visits to family, friends, guardians or other approved rehabilitative visits.
- G. Therapeutic Recreation: An amount for the therapeutic recreational activities of the client in a facility as related to the client's mental health diagnosis and service plan.
- H. Community Liaison Staff: Responsible for coordinating the vocational/educational transitional services of a client between the facility and the community, including public/private school. Obtains public or private educational services for the client.
- L. Therapeutic Recreation Staff: Responsible for planning, organizing and leading recreation therapies. Monitors the client's progress; informs the licensed professional of current client needs and treatment interventions.

.503 The following components are included in the room and board rate and are not allowable costs under Medicaid but are Title IV-E claimable.

- A. Support Staff: Staff whose primary job is building maintenance. janitorial, janitorial, housekeeping, laundry, food preparation functions and transportation.
- B. Sleep-Over Staff: At night, there may be one staff person within each physically separate building. The sleep-over staff can be summoned in case of emergency and must be within hearing distance of the children.
- C. Administration: Staff responsible for the overall direction of the organization. This includes accounting, general record keeping, business management, budgeting, community relations, and clerical functions. This does not include hours spent in fund raising. This is distributed based on percentage of room and board staff.
- D. Child Maintenance Component: A variable allowance based on the current family foster care rate for the respective age group served by the facility. This provider allowance will be determined by the average age of residents reported and will apply to all residents in the facility. This allowance includes Food, Clothing, Shelter, Personal Needs and Allowance.
- E. Administrative Overhead: A fixed allowance for costs associated with the overall direction of the facility including but not limited to: accounting, general record-keeping business management, budgeting, community relations, clerical functions, leased office equipment, and supplies necessary to conduct the administrative function. This is distributed based on percentage of room and board staff.
- F. Support Overhead: A fixed allowance for space, supplies, and other items related to building maintenance, janitorial, housekeeping, laundry, and food preparation services.
- G. Absence without Leave: Absence without leave days are not reimbursable.

.504 Reimbursement will be made only to licensed and certified providers. Providers will be reimbursed when the child enters care (first day) but not for the last day care. Providers will be reimbursed on a daily rate basis through the Medicaid Management Information System (MMIS) for the rehabilitative treatment. Providers may also be reimbursed through the Child Welfare Eligibility and Services Tracking (CWEST)

system or the accounts payable system for the Division of Youth Services for the room and board. Medicaid shall not pay for room and board. Education costs for approved on-grounds schools will be reimbursed through the Department of Education and not by Human Services or Medicaid.

.505 Medicaid reimbursement is not available for services until and unless a medical necessity determination for the individual client has been made by the Referral Agency.

.506 Residential Treatment Center providers will be responsible for collecting reimbursement from all other third party payees, including other states, prior to billing Colorado Medicaid for reimbursement.

.507 All Residential Treatment Centers shall complete and submit cost data as specified by the Department by April 10th of each year of operation. Cost data shall include actual allowable costs from the year and prospective costs for the next fiscal year.

Failure to submit timely cost data shall place a facility at the lowest Residential Treatment Center reimbursement rate, as determined by the Department, for a period of 60 days. At the end of the 60 days, if the completed cost data has been submitted, such data shall be reviewed for reasonable and allowable costs as determined by the Department. A new rate shall be determined based on available funds effective July 1 of that year. If the cost data has not been received in a complete form by the end of the 60-day period, the lowest reimbursement rate will continue for the remainder of the fiscal year.

.508 A new Residential Treatment Center, as defined below, shall receive a per diem rate equal to the most recent average weighted rate. This per diem rate shall remain in effect until a new rate is established based on the first cost data submitted as specified above. The average weighted rate is calculated by the Department once a year and shall be effective on July 1 of the current fiscal year.

A. A new Residential Treatment Center means a facility:

1. Which has not previously been certified for participation in Medicaid (Title XIX).
2. Which has not participated in Medicaid (Title XIX) for a period in excess of 30 days prior to the effective date of the current Medicaid certification.
3. Residential Treatment Centers which have undergone a transfer of ownership are not "new" provided the previous owner had participated in Medicaid (Title XIX) in the last 90 days prior to the ownership change.

B. New facilities shall submit cost data during their initial year of operation as follows:

1. New Residential Treatment Centers shall submit their first cost data, as specified by the Department, for a period covering their first day of operation through the state fiscal year end and prospective allowable costs for the next state fiscal year. Cost data must contain actual data for a minimum of 4 months.
2. The next cost data shall be submitted by April 10th, as required by 8.765.508.
3. New Residential Treatment Centers receiving the interim weighted average rate or the lowest reimbursement rate shall reimburse the Department for amounts paid over the actual treatment costs during the initial operating period. An audit will be conducted to determine these amounts. Reimbursement to the Department shall be sent within 30 days of the date notice has been provided by the Department to the Residential Treatment Center. If such reimbursement has not been received, the Department may recover the amount from current payments.

.509 Cost Reporting and Audits: The department or its designee may perform a desk review of cost data

and may conduct on-site audits of provider records. On-site audits may be made to assure validity of reports, cost and statistical information. Audits will meet generally accepted auditing standards. Audits of provider's cost data, financial records and other pertinent data will be adequate to verify that the provider has included only those expense items that are included services, and that the provider's included costs are reasonable in accordance with "Accounting and Auditing Guidelines", Colorado Department of Human Services, Division of Mental Health.

A provider may object to audit findings through the Department of Health Care Policy and Financing administrative review process. The department, or its designee, will determine whether overpayment or underpayment has resulted. The provider will be notified of the department's findings and the disallowed payments shall be recovered.

.510 Residential Treatment Centers shall submit an annual audit completed by an independent Certified Public Accounting firm. The audit will supply documentation attesting that Medicaid funds received by the Residential Treatment Center were used in their entirety to finance care of Medicaid clients and not other clients or non-Medicaid related services.

RTC audits will comply with the accounting and auditing guidelines published by the Colorado Department of Human Services, Mental Health Services Division.

Audits shall be submitted annually to the Department of Health Care Policy and Financing. The audit shall cover one year's expenditures. For those providers operating on a calendar fiscal year, the audit shall cover this period. The first audit shall be submitted for the period of January 1, 1997 to December 31, 1997. The audit shall be received by the Department no later than 120 days after the calendar year end. For those providers operating on a State fiscal year basis; i.e., July 1 to June 30, the audit shall cover this period. The first audit shall be submitted for the period of July 1, 1996 to June 30, 1997. The audit shall be received no later than 120 days after the State fiscal year end.

Medicaid allocated funds not spent on allowable Medicaid treatment costs as identified by this audit shall be refunded to the State in accordance with Section 8.040, Recoveries From Providers.

8.800

Prescribed drugs within certain limitations are a benefit of the Medical Assistance program.

DEFINITIONS

.01 Retail Pharmacy is a pharmacy whose sole pharmacy purpose is to provide drugs and related services to non-hospitalized people and is not subsidized by any governmental entity.

.02 Institutional Pharmacy is a pharmacy for which a majority of the overhead costs are included in the inpatient rate and whose primary function is to provide drugs and services to hospitalized patients and others receiving health care provided by the facility within which the pharmacy is located with which the pharmacy is associated.

.03 Government Pharmacy is a pharmacy whose primary function is to provide drugs and services to a facility whose operating funds are appropriated directly from a governmental body.

.04 Dispensing Physician is a duly licensed physician who prepares, dispenses and instructs patients to self-administer medication on a regular basis.

.05 Legend Drug is a drug bearing the statement: "Caution — Federal Law Prohibits Dispensing without a Prescription."

.06 Over-the-Counter Drug (O.T.C.) is a drug that can be purchased without a physician's prescription.

.07 Prescribed Drug is a drug which is ordered by a physician to be used by a patient to treat a disease or condition.

.08 Usual and Customary Charge is the reimbursement amount the general public is requested by the provider to pay for a good or service.

.09 Reimbursement Charge is the amount of payment requested for a provided benefit service. It shall be the lesser of the provider's usual and customary charge or any amount the provider will accept from any other third party program or from the public in the form of discounts, special rebates, incentives, or coupons.

8.820 CONDITIONS OF PARTICIPATION

.01 A pharmacy provider must be duly licensed or certified by the appropriate regulatory body in the state in which it is located.

.02 Any pharmacy or dispensing physician whether in-state or out-of-state who wishes to submit claims for payment must submit an application for participation to the Division. The Division will review the application and notify the submitting provider whether or not they are accepted as a provider and, if accepted, the effective date. An application may be denied, terminated or not renewed for any of the grounds set forth in 8.051 or 8.130. An accepted application for participation must be on file with the Division of Medical Assistance before any reimbursement for any item or service will be made.

.03 An out-of-state pharmacy may participate and receive payment for dispensed drugs only if the recipient has been injured or suffered a disease or illness while temporarily absent from Colorado. The State will then reimburse for drugs dispensed on an emergency basis only. Chronic or maintenance drugs are not a benefit in such cases. Exceptions to this requirement are for those pharmacies located in towns outside but bordering the State of Colorado that provide regular services to Colorado recipients or those pharmacies who provide drugs for foster care children or other recipients that permanently reside in other states and are wards of the State of Colorado.

8.830 DRUG BENEFITS

A. Only those drugs supplied by companies participating in the federally approved Medicaid drug rebate program are regular drug benefits.

B. The following drug categories may be excluded from being a drug benefit or may be subject to prior authorization:

1. Agents when used for anorexia or weight gain
2. Agents when used to promote fertility
3. Agents when used for cosmetic purposes or hair growth
4. Agents when used for symptomatic relief of cough and colds
5. Agents when used to promote smoking cessation
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
7. Non-prescription drugs
8. Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer

or its designee

9. Less-than-effective drugs (LTE) identified by the Drug Efficacy Study Implementation (DESI) program

10. Barbiturates

11. Benzodiazepines

C. The following over-the-counter drugs are drug benefits:

- a. aspirin,
- b. insulin, and
- c. prior authorized.

D. Covered drugs for which prior authorization has been deemed necessary to address individual instances of fraud or abuse are drug benefits.

E. Drugs not covered by rebate agreements may be reimbursed only if the Department has made a determination that the availability of the drug is essential, such drug has been given 1-A rating by EDA, and prior authorized.

F. Generic drugs shall be prescribed to clients in fee-for-service and the primary care physician programs unless:

- 1. Only a brand name is manufactured
- 2. A generic drug is not therapeutically equivalent to the brand name
- 3. Brand name drug is less expensive to the Department
- 4. The Department shall grant an exception to this requirement if the client 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.
- 5. The drug is in one of the following exempted classes for the:
 - a. treatment of biologically based mental illness defined in 1.6-16-104(5.5) C.R.S
 - b. treatment of cancer
 - c. treatment of epilepsy
 - d. treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome

8.831 DRUGS ADMINISTERED OR PROVIDED IN PHYSICIAN OFFICES

Injectable drugs administered in a physician's office are considered part of the physician's services and shall be billed on the physician claim form. An exception to this are allergen extracts provided by the physician. They shall be submitted as a service on the physician's claim form.

8.832 COMPOUNDED PRESCRIPTIONS

Compounded prescriptions containing only drugs, which are regular benefits, shall be billed by submitting a separate claim for each ingredient in the prescription. The provider will be reimbursed for each ingredient of the prescription according to 8.850.02, and will also be reimbursed for the dispensing fee according to 8.850.1. A compounding fee, over and about the stated dispensing fee, will not be paid.

8.833 OVER-THE-COUNTER (O.T.C.) DRUGS

.01 In the absence of prior authorization, over-the-counter drugs, except for insulin and acetylsalicylic acid (aspirin), are not benefit drugs and shall not be reimbursable by the Department. Prior authorized OTC's shall be limited to certain categories of drugs which shall be provided based upon the advice of the Drug Use Review Board

.02 Reimbursement for insulin and aspirin is available subject to the following conditions:

Insulin shall be provided in quantities sufficient for a minimum of 30 days of therapy.

Aspirin 325 MG (5gr) coated or uncoated shall be provided in a minimum quantity of 100 tablets.

.03 Reimbursement for over-the-counter drugs shall be the same as for legend drugs.

.04 Certain over-the-counter drugs shall be provided by nursing homes as required by the Department's regulations governing reimbursement to nursing home providers and described in 8.442,B, (7).

8.834 PRIOR AUTHORIZATION REQUIREMENTS

Prior authorization shall be obtained before drugs which are subject to restrictions may be provided as a benefit except for injectable drugs administered in physicians' offices described in 8.831 or for emergency drugs. The prior authorization request shall be made to the Fiscal Agent and include the following:

- A. Recipient name, state identification number, and birth date;
- B. Patient diagnosis, prognosis, and other pertinent information;
- C. Other drugs currently prescribed for the patient;
- D. Name of the drug(s) requested — (can be single or multiple request);
- E. Requesting physician's name and address.

When the request is received, it will be reviewed and a determination made whether or not to add the drug as a limited benefit for the recipient.

If the prior authorization request is incomplete or additional information is needed, an inquiry to the physician will be initiated within one working day from the day the request was received. If no response is received from the physician's office within 24 hours, the prior authorization will be denied. The physician's office will be notified of the approval or denial of the prior authorization via telephone, at the time the request is made. The verbal decision will be confirmed in writing. The provider may dispense at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation.

Emergency prior authorization may be given retroactively if the drug had to be dispensed immediately for the patient's well-being. The physician must call in a prior authorization the next business day and must include a description and justification of the emergency and follow the same procedure as discussed above.

The Department shall solicit and maintain a list of any interested parties that wish to comment on proposed changes to prior authorized classes of prescribed drugs. The list of interested parties shall be notified of any proposal and shall be given a reasonable time, not to exceed 30 days, to comment or recommend changes before a class is prior authorized.

8.836 CLARIFICATION OF CERTAIN BENEFIT LIMITATIONS

The following are not benefits of the Medicaid Program:

- A. Spirituous liquors of any kind;
- B. Dietary needs or food supplements unless prior authorized within Department guidelines;
- C. Personal care items — i.e., mouth wash, deodorants, talcum powder, bath powder, soap (of any kind), dentifrices, etc.;
- D. Medical supplies unless due to their therapeutic or diagnostic characteristics are essential for care in the home which the physician has ordered for the treatment and diagnosis of the recipient's illness or injury. Prior authorization may be required to obtain Medicaid reimbursement;
- E. I.V. equipment (i.e., venopaks) dispensed without the I.V. solutions to an out-patient (Nursing homes must furnish I.V. equipment for their patients);
- F. Drugs classified by the Food and Drug Administration as “investigational” or “experimental”;
- G. Drugs for which there is no federal financial participation.

8.837 PRESCRIPTION REQUIREMENTS

Reimbursement shall be made for prescribed drugs provided to eligible recipients when the following conditions are met:

- A. The item dispensed is a covered prescription drug by a participating company, a compounded prescription as described in 8.832, or has been prior authorized;
- B. The person prescribing the item is authorized to do so by appropriate Colorado statutes;
- C. The prescription is dispensed in accordance with applicable federal and state laws, rules, and regulations;
- D. The prescription is dispensed in accordance with the law, rules, and regulations governing the Colorado Medical Assistance Program.

.01 Participating pharmacy providers must maintain the original copy of all prescriptions for which payment from the Medical Assistance Program is requested. The original prescription shall be a hard copy either written by the prescriber or reduced to writing when received by the pharmacist by telephone or other electronic means. Information required by the Colorado State Board of Pharmacy shall be recorded on each prescription but must include, name of patient, name of drug, quantity ordered, directions, name of prescribing practitioner, date written and date filled, and initials of pharmacist filling the prescription or responsible for its contents.

.02 In addition, if a substitution for a prescribed brand name drug is made or the prescription is written generically, the name and manufacturer of the drug dispensed shall be recorded on the face of the prescription. A copy of a label which is created to accompany the drug will not suffice as the prescription.

Any refill prescription records shall be maintained in accordance with Colorado State Board of Pharmacy requirements and contain the same information as required above.

Such files and records shall be maintained in an orderly manner and shall promptly be available for inspection by authorized personnel of the Colorado State Department of Health Care Policy and Financing, the U. S. Department of Health and Human Services, and the Colorado Medicaid Fraud Control Unit.

8.838 DRUG USE REVIEW

8.838.1 PATIENT RECORDS

The pharmacist shall be responsible for assuring that reasonable efforts have been made to obtain, record, and maintain the following patient information generated at the individual pharmacy and from the patient or his/her apparent agent for each new prescription:

- A. Name, address, telephone number, date of birth or age, and gender;
- B. Individual history where significant, including known allergies and drug reactions, and a comprehensive, chronological list of medications and prescribed relevant devices; and
- C. Additional comments relevant to the patient's pharmaceutical care as defined in Section 8.838.2, Prospective Drug Review, and Section 8.838.3, Patient Counseling of this staff manual.

.11 CONFIDENTIALITY OF PATIENT RECORD INFORMATION

All patient information collected by an individual pharmacy for the purpose of performing drug use review and patient counseling shall be considered confidential. Pharmacies shall establish safeguards which prohibit access to this information by unauthorized individuals.

8.838.2 PROSPECTIVE DRUG REVIEW

- A. A pharmacist shall review the available patient record information with each prescription drug order presented for dispensing for purposes of promoting therapeutic appropriateness by considering the following:
 - 1. over-utilization or under-utilization;
 - 2. therapeutic duplication;
 - 3. drug-disease contraindications;
 - 4. drug-drug interactions;
 - 5. incorrect drug dosage or duration of drug treatment;
 - 6. drug-allergy interactions;
 - 7. clinical abuse/misuse.
- B. When in the pharmacist's professional judgement a potential problem is identified in the above review, the pharmacist shall take appropriate steps to avoid or resolve the problem which may, if necessary, include consultation with the prescriber.

8.838.3 PATIENT COUNSELING

- A. A pharmacist or pharmacist designee shall offer counseling regarding the drug therapy to each Medicaid patient with a new prescription. The offer to counsel shall be face-to-face communication whenever practicable or by telephone.
- B. If the offer to counsel is accepted, and following a review of the patient's record, a pharmacist or pharmacy intern shall personally discuss matters which enhance or optimize drug therapy with each patient or caregiver of such patient. Such discussion shall be in person, whenever practicable, or by telephone and shall include those matters listed below that in the exercise of his or her professional judgment, the pharmacist considers significant as well as other matters the pharmacist considers significant:
 - 1. the name and description of the drug;
 - 2. the dosage form, dose, route of administration, and duration of drug therapy,
 - 3. intended use of the drug and expected action;
 - 4. special directions and precautions for preparation, administration, and use by the patient;
 - 5. common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;
 - 6. techniques for self-monitoring drug therapy;
 - 7. proper storage;
 - 8. prescription refill information;
 - 9. action to be taken in the event of a missed dose; and

Alternative forms of patient information shall not be used in lieu of the personal discussion requirement for patient counseling but may be used to supplement this discussion when appropriate. Examples to include written information leaflets, pictogram labels, video programs, etc.

- C. Patient counseling by a pharmacist or pharmacy intern, as described above shall not be required for patients of a hospital or institution where other licensed health care professionals administer the prescribed drugs pursuant to a chart order.
- D. A pharmacist shall not be required to counsel a patient or caregiver when the patient or caregiver refuses such consultation. The pharmacist shall keep records indicating when counseling was not or could not be provided.

8.838.4 DRUG USE REVIEW BOARD (DUR BOARD)

The DUR Board shall serve in an advisory capacity to the Department and is responsible for making recommendations in three areas: application of standards (as described in Section 8.838 of this manual), retrospective DUR, and ongoing interventions with pharmacists and physicians concerning therapy problems identified in the course of the DUR program.

.41 The DUR Board shall consist of nine members appointed by the executive director based upon recommendations of relevant professional associations. Membership on the Board shall consist of four physicians, four pharmacists who are licensed and actively practicing in the State of Colorado and one non-voting representative from the pharmaceutical industry.

The membership of the DUR Board shall include health care professionals who have recognized

knowledge and expertise in one or more of the following:

- A. the clinically appropriate prescribing of covered outpatient drugs;
- B. the clinically appropriate dispensing of outpatient drugs;
- C. drug use review, evaluation and intervention;
- D. medical quality assurance.

.42 DRUG USE REVIEW BOARD ACTIVITIES

A. Application of Predetermined Standards

The DUR Board shall perform the following activities:

1. Review and make recommendations of predetermined standards submitted to it by the department or the department's contractor.
2. Evaluate the use of the predetermined standards, including assessing the operational effect of the predetermined standards in use and make recommendations to the department or department's contractor concerning modification or elimination of existing predetermined standards or the addition of new ones.
3. Recommend guidelines governing written predetermined standards that pharmacies not using approved software must use in conducting prospective DUR.

B. Retrospective DUR

The DUR Board shall perform the following activities:

1. Review and make recommendations on predetermined standards submitted to it by the department or department's contractor.
2. Make recommendations to the department or the department's contractor concerning the modification or elimination of existing predetermined standards or the addition of new ones.

C. Education Intervention Program

1. The DUR Board must establish an educational program under the direction of the Department or the Department may contract with accredited health care educational institutions (e.g. pharmacy or medical schools, retrospective DUR contractor, pharmacy associations, medical societies, for the purpose of educating practitioners with regard to common therapy problems to improve prescribing and dispensing practices.
2. This program may include the following intervention activities:
 - a. Information dissemination;
 - b. Written, oral or electronic reminders;
 - c. Face to face discussions; and
 - d. Intensified review or monitoring.

3. The DUR Board, based upon the Department's reports on the application of standards shall:
 - a. Identify general education topics and develop educational materials;
 - b. Share information on general education topics with other entities involved in continuing education of pharmacists and physicians;
 - c. Determine circumstances for use of each type of provider specific intervention method (e.g. written, oral, electronic reminders, face to face discussion, etc.); and,
 - d. Reevaluate no less often than semiannually the appropriateness of existing intervention methods and make changes when appropriate.
4. The DUR Board under the direction of the Department may delegate to the retrospective DUR contractor the responsibility of preparation of continuing education programs and the conduct of interventions.

D. Drug Use Review Board Annual Report

The Board is responsible for preparing and submitting a report to the State on an annual basis. This report shall contain the following information:

1. A description of the activities of the Board, including the nature and scope of the prospective and retrospective drug use review programs;
2. A summary of the interventions used;
3. An assessment of the impact of these educational interventions on quality of care
4. An estimate of the cost savings generated as the result of the program.

8.840 BILLING PROCEDURES

Charges for prescribed drugs which are a benefit of the Medical Assistance Program shall be submitted on an appropriate pharmacy claim form. All entries shall be legible. The signature of an owner/employee pharmacist must appear on each claim form. A rubber stamp or other facsimile signature is not permitted.

Each claim must identify the recipient, prescribing physician, date of service, National Drug Code number of the drug actually dispensed as it is listed in the formulary, its supplements or a prior authorization request, prescription number, quantity dispensed and the reimbursement charge as defined in 8.800.09. The Medicaid program is to be considered the same as a private pay patient who immediately pays for the prescription.

An exception to the requirement for submitting claims for reimbursement on a pharmacy claim form may be made when claims are submitted electronically in a State approved format.

8.850 BASIS FOR REIMBURSEMENT

Benefit drugs shall be reimbursed at the lesser of the Medicaid allowable reimbursement charge, or the provider's reimbursement

The Medicaid allowable reimbursement charge is the sum of the ingredient cost of the drug dispensed and the provider's dispensing fee.

8.850.01 DISPENSING FEE

The dispensing fee is a pre-determined amount paid to a provider for dispensing a prescription. It is established and periodically adjusted within appropriated funds based upon the results of a cost survey which is designed to measure actual costs of filling prescriptions. The results of the survey shall be reported to the Medical Services Board at the next regular meeting following delivery of the report to the Department of Health Care Policy and Financing.

The pharmacy dispensing fee for retail pharmacies shall be \$4.00.

Institutional pharmacies shall receive a dispensing fee of \$ 1.89.

Governmental pharmacies that have the cost of dispensing covered as part of an all-inclusive Medicaid payment shall receive no fee.

Dispensing physicians shall not receive a dispensing fee unless their offices or sites of practice are located more than 25 miles from the nearest participating pharmacy.

In the latter case, a fee of \$ 1.89 will be paid.

.02 INGREDIENT COST

Ingredient cost for retail pharmacies (estimated acquisition cost) is the price of the drug actually dispensed as defined in (c) below or the M.A.C. or the high volume E.A.C., whichever is less.

Benefit drugs dispensed in unit of use (unit dose) packaging will be reimbursed based upon the bulk package size of 100 or pints or if not available in those sizes, the most common size which most closely matches the standard sizes defined above.

The ingredient cost for institutional and government pharmacies is defined as the actual cost of acquisition for the drug dispensed or the M.A.C., or the high volume E.A.C., whichever is less.

A. Maximum Allowable Cost (M. A. C.)

The state M.A.C. is the maximum ingredient cost allowed by the Department for certain multiple-source drugs. The establishment of a MAC. is subject, but not limited to, the following considerations:

1. multiple manufacturers;
2. broad wholesale price span;
3. availability of drugs to retailers at the selected cost;
4. high volume of Medicaid recipient utilization;
5. bioequivalence or interchangeability.

When Federal M.A.C. limits for multiple source drugs are announced, they will be adopted if they are less than state M.A.C. or if no state M.A.C. exist.

Section II of the ColoRx shall identify the generic drugs subject to M.A.C.

The ingredient cost of any drug subject to M.A.C. shall be limited to M.A.C. or wholesale price as determined by the Department, whichever is less. Exceptions which will allow reimbursement greater than M.AC. for a drug entity are obtained through the prior authorization mechanism. An exception will be granted if the patient's response to the generic drag is not therapeutic, an allergic reaction is involved, or any similar situation exists.

If a recipient requests a brand name for a prescription which is subject to M.A.C., then he/she may pay the ingredient cost difference between the M.A.C. and brand name drug. The recipient must sign the prescription stating that he/she is willing to pay the difference in ingredient cost to the pharmacy. The pharmacy will be paid M.A.C. plus a dispensing fee or reimbursement charges whichever is lower.

B. High Volume Estimated Acquisition Cost (E.A.C.)

Reimbursement for single source drugs or certain multiple source drugs which are most frequently prescribed will be based upon average wholesale prices or direct manufacturers' prices for package sizes containing quantities greater than 100 dosage units or less if not available in 100's. Basis for inclusion in the high volume estimated acquisition cost list includes but is not limited to:

1. Single source manufacturers;
2. High volume Medicaid recipient utilization;
3. Interchangeability problems with multiple source drugs;
4. Package sizes in excess of 100;

These drugs will be identified in Section III of the ColoRx.

C. Drug Pricing

A drug pricing file will be maintained and updated monthly by the Department. The modified average wholesale price of a drug as determined by the Department, State M.A.C., and Federal Upper Limit (FUL), will be the basis for setting the prices in the drug pricing file.

Modified average wholesale price shall be defined as the average wholesale price less 13.5%, effective July 1, 2002 for name-brand drugs. For generic drugs, modified average wholesale price shall be defined as the average wholesale price less 35%, effective May 1, 2002. The average wholesale price will be determined by the Department and placed in the drug pricing file as follows:

1. By subtracting 13.5% from the average wholesale price for name-brand drugs and 35% from the average wholesale price for generic drugs, as determined by the Department.
2. If the average wholesale price cannot be determined by the Department, then the distributors' or manufacturers' prices will be used to estimate average wholesale price to be modified and used in the drug pricing file as the price of the drug.

The following pricing methodologies are used, noting that the pricing methodology resulting in the lowest price will be used:

1. Average wholesale price (AWP) minus 13.5% for name-brand drugs
2. Average wholesale price (AWP) minus 35% for generic drugs
3. Direct price plus 18%
4. State M.A.C., pharmacy acquisition cost of generic drugs available in the state market place plus 18%.
5. Federal Upper Limit (FUL)

Any pharmacy which is the only pharmacy within a twenty mile radius may submit an invoice to the

Department for the difference in price between AWP minus 13.5% and AWP minus 12% for name-brand drugs and AWP minus 35% and AWP minus 12% for generic drugs. The invoice shall be submitted to the Department, within 30 days of sale, and shall contain all the information set forth in Section 8.840 as well as the difference between prices as set forth above and documentation that the pharmacy is the only pharmacy available within a twenty mile radius. The pharmacy shall be reimbursed for the difference between pricing methodologies.

Information on current pricing may be obtained by contacting: the Rates Section, Medical Assistance Office at the Department.

.01 NEW PRESCRIPTIONS

A new prescription is an order for a drug which is being initially prescribed to treat a current illness or condition. The drug has not been used during the most recent course of therapy. In this case, the quantity prescribed will be at the discretion of the physician. Merely assigning a new prescription number or creating a new prescription each time the drug is dispensed to provide continuous treatment for a condition or illness does not meet the definition of a new prescription, but will be considered and governed by the rules pertaining to refill prescriptions.

.02 REFILL PRESCRIPTIONS

For chronic conditions requiring maintenance drugs, refill prescriptions shall be for quantities sufficient for a minimum 30-day supply. Maximum quantity which can be dispensed is one which will supply drugs sufficient for 100 days.

.03 PAYMENT OF DISPENSING FEE

When prescriptions for the same drug used to treat chronic conditions are dispensed more than twice, only one dispensing fee a month thereafter will be paid to the pharmacy unless the prescription is ordered for an allowable package size as described above which is less than a 30-day supply. Only ingredient cost will be reimbursed for those prescriptions which are not a package size and less than a 30-day supply.

.04 PRESCRIPTION QUANTITIES EXCEPTIONS

The 30-day policy does not apply to drugs prescribed for short-term illnesses.

.05 MINIMUM QUANTITIES

The State may set minimum quantities of certain drugs which shall be dispensed based upon the advice of the Drug Use Review Board.

.06 PRESCRIPTION TRACKING AND CLAM REVERSALS

The pharmacy provider shall keep 1) a chronological log that contains the client's name, his or her signature or agent's signature and date of the receipt of the prescription, or 2) an electronic prescription tracking system that records the status of prescriptions through the fill process including the date and time that the prescription was transferred to a person verified by pharmacy personnel to be the client or agent of the client

Pharmacies using a chronological log shall review all Medicaid prescriptions in will-call status (filled not released to patient or patient's agent) at least weekly. All prescriptions billed to Medicaid for fourteen (14) days or more shall be reversed on the day of review. In no case shall prescriptions be kept in will-call status for more than twenty-one (21) days. The pharmacy shall maintain a record of each reversal for audit purposes.

Pharmacies using an electronic prescription tracking system shall review prescriptions in will-call status on a daily basis and enter a reversal of prescriptions not picked up within ten (10) days of billing. In no case shall prescriptions be kept in will-call status for more than fourteen (14) days. The pharmacy shall maintain a record of each reversal for audit purposes.

Upon receipt of a written request from the Department of Health Care Policy and Financing or the Medicaid Fraud Unit for a record of Medicaid Claims and reversals, the pharmacy may have up to 72 hours or three working days to provide the requested information or to enter into an agreement with the Departments) stating the specific time within which the data will be produced.

8.900 PROGRAM OVERVIEW

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado residents, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to qualified health care providers who serve eligible persons who are indigent. The CICP issues procedures to ensure the funding is used to serve the indigent population in a uniform method. Any significant departure from these, procedures will result in termination of the contract with, and the funding to, a health care provider. The legislative authority for this program was enacted in 1983 and is at 26-15-101, et seq. C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent."

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in Section 10-16-102(22.5), C.R.S. Medically indigent persons receiving discounted health care services from qualified health care providers are subject to the limitations and requirements imposed by article 15, title 26, C.R.S.

8.901 DEFINITIONS

- A. "Applicant" means an individual who has applied at a qualified health care provider to receive discounted health care services.
- B. "Client" means an individual whose application to receive discounted health care services has been approved by a qualified health care, provider.
- C. "Emergency care" is treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 26-15-103, C.R.S.
- D. "Emergent care" is treatment needed because of an injury or serious illness that requires immediate treatment because the client's life or health may be in danger.
- E. "General provider" means any general hospital, birth center, community health clinic licensed or certified by the Department of Public Health and Environment pursuant to section 25-1-107(I)(1)(I) or (1)(1)(II), C.R.S., any health maintenance organization issued a certificate authority pursuant to section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to section 26-15-106(5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the program, "general provider" includes associated physicians.

- F. "Qualified health care provider" means any general provider who is contracted with the Department to provide, and receive funding for, discounted health care services under the Colorado Indigent Care Program.

8.902 DISCOUNTED HEALTH CARE SERVICES

- A. Funding provided under the CICP shall be used to provide clients with discounted health care services determined to be medically necessary by the qualified health care provider.
- B. All health care services normally provided at the qualified health care provider should be 'available at a discount to clients. If health care services normally provided at the qualified health care provider are not available to clients at a discount, clients must be informed that the services can be offered without a discount prior to the rendering of such services.
- C. Qualified health care providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:
1. Emergency care;
 2. Emergent care; and
 3. Any other medical care.
- D. Additional discounted health care services may include:
1. Emergency mental health services if the qualified health care provider renders these services to a client at the same time that the client receives other medically necessary services.
 2. Qualified health care providers may provide discounted pharmaceutical services. The qualified health care provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the qualified health care provider.
 3. Qualified health care providers may provide a prenatal benefit designed to encourage access to prenatal care for indigent women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The qualified health care provider is responsible for providing a description of the services included in the prenatal benefit to the client prior to services rendered. Services may vary among sites.
- E. Excluded Discounted Health Care Services Funding provided under the CICP shall not be used for providing discounted health care services for the following:
1. Non-emergent dental services.
 2. Nursing home care.
 3. Chiropractic services.
 4. Sex change surgical procedures.
 5. Cosmetic surgery.
 6. Experimental and non-FDA approved treatments.
 7. Elective surgeries that are not medically necessary.

8. Court ordered procedures, such as drug testing.
9. Abortions-Except as specified in Section 26-15-104.5, C.R.S.
10. Mental health services in clinic settings pursuant to 26-15-111, C.R.S., part 2 of article 1 of title 27, C.R.S., any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Contract Requirements for Qualified Health Care Providers

1. A contract will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents, of the City and County of Denver, as required by 26-15-106(5)(a)(I), C.R.S.
2. A contract will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver metropolitan area and complex care that is not contracted for in the remaining areas of the state, as required by (5)(a)(II), C.R.S.
3. Contracts may be executed with general providers throughout Colorado that can meet the following minimum criteria:
 - a. Licensed or certified as a general hospital, community health clinic, or maternity hospital (birth center) by the Department of Public Health and Environment.
 - b. At least 3% of the provider's care is charity care.

C. Billing Procedures

Qualified health care providers shall submit timely summary statistics to the Department concerning the use of CICP funding, in accordance with the procedures set forth in the Colorado Indigent Care Program Manual.

D Distribution of Available Funds to Providers

1. Distribution of available funds to qualified health care providers (providers) is limited by the annual legislative appropriation and funds will be proportionately allocated to providers based on the anticipated utilization of services. Hospital providers who participate in the Colorado Indigent Care Program and whose percent of Medicaid days relative to total days is equal to 1% or greater, qualify to receive a Low-Income payment and a High Volume payment. In addition, those State owned hospital providers whose percent of Medicaid days relative to total days that exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association, qualify for a Bad Debt payment if funding exists.

To receive a Low-Income payment, hospital providers must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The rule does not apply to a hospital in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

2. Distribution of available funds for indigent care costs will be calculated based upon historical data. Third-party liabilities and the patient liability will be deducted from total charges to generate medically indigent charges. Available medically indigent charges are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 of each fiscal year. Medically indigent costs are inflated forward to the request budget year using the most recently available Consumer Price Index — Urban Wage Earners, Medical Care Index - Denver as of My. The basis for this calculation will be data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department for each upcoming State fiscal year.
3. State Owned Hospital Providers and Locally Owned Hospital Providers shall submit a letter quarterly to the Department which states the Certification of Public Expenditures associated with the distribution of available funds.
4. Hospital providers will be notified of the distribution amounts for each State fiscal year no later than thirty (30) days prior to July 1 of each State fiscal year. The Department will notify the hospital provider, without prior notice, of any changes in the distribution amounts applicable to the provider for a current State fiscal year that occur after July 1 of that State fiscal year.
5. Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department concerning the use of CICIP funding.
6. Providers shall deduct the full patient liability amount from total charges, which is the amount due from the client as identified in the CICIP copayment table. The summary information submitted to the Department concerning the use of CICIP funding by the provider shall include the full patient liability amount even if the provider receives the full payment at a later date or through several smaller installments or no payment from the client.
7. Beyond the distribution of available funds made by the CICIP, allowable client copayments, and other third-party sources, a provider shall not seek payment from a client for the provider's CICIP discounted health care services to the client,
8. High-Volume Payment, This payment is an allocation of the available Medicare Upper Payment limit remaining for certification of public expenditures (State or Local expenditure) and is available only to hospital providers. As required by federal regulations, there would be three allotments of the upper payment limit: State Owned Providers, Locally (or Non-State) Owned Providers and Privately Owned Providers.

The amount of available funds under the Medicare Upper Payment Limit is distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for qualified providers. This calculation would be separate for state owned, locally owned, and privately owned providers, since the three groups are limited to unique pools of funds.

The available funds under the Medicare Upper Payment Limit are multiplied by the hospital specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for qualified providers to calculate the High-Volume payment for the specific provider. The available funds under the Medicare Upper Payment Limit by provider category are:

- a. Privately Owned Providers. The lesser of the federal fund match available under the Medicare Inpatient Upper Payment Limit for Privately Owned Providers or General Fund plus federal funds match allocated by the Department to this payment.

- b. Locally Owned Providers. The federal funds match available under the Medicare Inpatient Upper Payment Limit for Locally Owned Providers.
 - c. State Owned Providers. The federal funds match available under the Medicare Inpatient Upper Payment Limit for State Owned Providers.
9. Low-Income payment. This payment is an allocation of the available Disproportionate Share Hospital Allotment imposed by the federal Centers for Medicare and Medicaid Services and is only available to hospital providers. The Disproportionate Share Hospital Cap would be distributed by the facility specific Weighted Medically Indigent Costs relative to the sum of all the Weighted Medically Indigent Costs for qualified providers. This calculation is separate for locally owned and private owned providers, since the two provider categories have unique pools of General Fund appropriated each fiscal year.

No provider will receive more than the federal match rate of provider specific inflated medically indigent care costs in federal funds. If the calculation generates a provider specific payment beyond the federal match rate for the specific inflated medically indigent care costs in federal funds, the federal funds will remain under the Disproportionate Share Hospital Allotment.

The available Disproportionate Share Hospital Cap is multiplied by the hospital specific Weighted Medically Indigent Costs divided by the sum of all Weighted Medically Indigent Costs for qualified providers to calculate the Low Income payment for the specific provider category.

- a. Privately Owned Providers. As specified by the Department, the available federal funds under Disproportionate Share Hospital Cap for privately owned providers would be equal to the General Fund available for this payment.
- b. Publicly Owned Providers. The available federal funds Disproportionate Share Hospital Cap for publicly owned (state and local) providers would equal the Disproportionate Share Hospital Cap minus other federal funds designated as a Disproportionate Share Hospital payment under a separate State Plan and the amount of the federal funds distributed to the privately owned providers.

10. Weighted Costs, High-Volume Payment and Low-Income Payment

The request budget year medically indigent costs are increased by the percent of Medicaid (fee-for-service and managed care) days relative to total inpatient days and percent of medically indigent days relative, to total inpatient days to measure the relative Medicaid and low-income care to total care provided. For State Owned Providers, these percentages are not allowed to exceed one standard deviation above the mean for each weight

The request budget year provider specific medically indigent costs are further increased by the Disproportionate Share Hospital Factor, if the provider qualifies, to account for disproportionately high volumes of Medicaid. To qualify for the Disproportionate Share Hospital Factor, the provider's percent of Medicaid days relative to total days must exceed one standard deviation above the mean. If the provider does qualify, then the Disproportionate Share Hospital Factor would equal the provider's specific percent of Medicaid days relative to total inpatient days. For Locally Owned hospitals and Privately Owned hospitals, the Disproportionate Share Hospital Factor is doubled. For State Owned hospitals, the Disproportionate Share Hospital Factor would equal the provider's specific percent of Medicaid days relative to total inpatient days and the percent of Medicaid days is not allowed to exceed one standard deviation above the mean. If the provider does not qualify, then the Disproportionate Share Hospital Factor would equal one, or have no impact

The request budget year provider specific medically indigent costs are further increased by the Medically Indigent Factor, if they qualify, to account for disproportionately high volumes of low-income care

provided. To qualify for the Medically Indigent Factor, the provider's percent of medically indigent days relative to total inpatient days must exceed the mean. If the provider does qualify, then the Medically Indigent Factor equals the provider specific percent of medically indigent days relative to total inpatient days. For Locally Owned hospitals and Privately Owned hospitals, this factor is doubled. For State Owned facilities, the Medically Indigent Factor equals the provider specific percent of medically indigent days relative to total inpatient days and the percent of medically indigent days is not allowed to exceed one standard deviation above the mean. If the provider does not qualify, then the Medically Indigent Factor would equal one, or have no impact

11. **Bad Debt Payment.** A Bad Debt payment is made only if federal funds remain available under the Disproportionate Share Hospital Allotment (or Cap) following the distribution of the Low-Income payment and the Low-Income Shortfall payment. This payment is available to State-Owned Hospital providers whose percent of Medicaid days relative to total days exceed one standard deviation above the mean, participate in the Colorado Indigent Care Program, and report Bad Debt to the Colorado Health and Hospital Association qualify for a Bad Debt payment if funding exists.

The amount of available federal funds remaining under the Disproportionate Share Hospital allotment are distributed by the facility specific Bad Debt Costs relative to the sum of all Bad Debt Costs for qualified providers. Available Bad Debt charges are converted to Bad Debt costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 each fiscal year. Bad Debt costs are inflated forward to the request budget year using the most recently available Consumer Price Index — Urban Wage Earners, Medical Care Index — Denver as of July.

Available funds under the Disproportionate Share Hospital allotment are multiplied by the hospital specific Bad Debt costs divided by the sum of all Bad Debt costs for qualified providers to calculate the Bad Debt payment for the specific provider.

12. **Pediatric Major Teaching Hospital Payment.** Hospitals shall qualify for additional payment when they meet the criteria for being a major teaching hospital and when their Medicaid days combined with indigent care days (days of care provided under Colorado's indigent care program) equal or exceed 30 percent of their total patient days for the most recent year for which data are available. A major teaching hospital is defined as a Colorado hospital, which meets the following criteria:
 - a. Maintains a minimum of 110 total Intern and Resident (I/R) F-T-E-'s;
 - b. Maintains a minimum ratio of 30 Intern and Resident (I/R) F.T.E.'s per licensed bed;
 - c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.
 - d. Has a percentage of Medicaid days relative to total days that exceeds one standard deviation above the mean; and
 - e. Participates in the Colorado Indigent Care Program

The payment will be made prior to the High Volume payment and will equal the Major Teaching Hospital Rate multiplied by the available Medicare Upper Payment Limit for the hospitals that qualified for the Pediatric Major Teaching Payment. Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

E. Audit Requirements

The qualified health care provider shall provide the Department with an annual audit compliance

statement as specified in the CICIP Manual. The purpose of the audit requirement is to furnish the Department with a separate audit report, which attests to the qualified health care provider's compliance with the use of CICIP funding and other requirements for participation.

F. HIP AA

The Department has determined that the Colorado Indigent Care Program (CICP) is NOT a “covered entity” under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the Colorado Indigent Care Program (CICP) is not a part of Medicaid, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a qualified health care provider or client.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an applicant shall satisfy the following requirements:

1. Be a U.S. citizen or a legal immigrant, within the meaning of 26-4-103(8.5), C.R.S.;
2. Be a resident of Colorado;
3. Meet all CICP eligibility requirements as defined by state law and procedures; and
4. Furnish a social security number (SSN) or evidence that an application for a SSN. has been submitted.

B. Citizenship or Immigration Status

An applicant must be a U.S. citizen or a legal immigrant.

1. U.S. Citizen

A U.S. citizen is a person who meets one of the following criteria:

- a. Born in the United States, Puerto Rico, Guam, Virgin Islands of the United States, American Samoa, and Swain's Island. A birth certificate will prove that a person was born a U.S. citizen, OR
- b. Received citizenship through the naturalization process. A certificate of citizenship will prove that a person is an U.S. citizen.

2. Documented Legal Immigrant

A documented legal immigrant is a person who resides in the United States and who meets the definition of “legal immigrant” in 26-4-103(8.5), C.R.S., or who possesses acceptable documentation from the Immigration and Naturalization Service (INS).

A legal immigrant shall agree to refrain from executing an affidavit of support for the purpose of sponsoring an alien on or after July 1, 1997, under rules promulgated by the immigration and naturalization service during the pendency of such legal immigrant's receipt of discount health care

services under available CICIP funding.

C. Residence in Colorado

An applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons;
2. Meet the U.S. citizen or documented legal immigrant criteria, as defined in paragraph B of this section; and
3. Employed in Colorado.

D. Social security number(s) shall be required for all clients receiving discounted health care services under available CICIP funding. The only exception to this is for unborn children. If an applicant does not have a social security number, documentation that the applicant has applied for a social security number must be provided to complete the application to receive discounted health care services under available CICIP funding.

E. Applicants Not Eligible

The following individuals are not eligible to receive discounted services under available CICIP funds:

1. Undocumented immigrants.
2. Persons in institutions or penitentiaries, or persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.
3. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICIP.
4. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.
5. persons who qualify for Medicaid. However, applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICIP eligibility:
 - a. QMB benefits described at section 8.111.1 of these regulations;
 - b. SLMB benefits described at section 8.122, or
 - c. The QI1 benefits described at section 8.123.
6. Individuals who are eligible for the Children's Basic Health Plan. However, individuals who are waiting to become an enrollee in the Children's Basic Health Plan and/or have incurred charges at a participating qualified health care provider, in the 90 days prior to the application date shall not be excluded from consideration for eligibility on a temporary basis. Once the applicant becomes enrolled in the Children's Basic Health Plan, the applicant is no longer eligible to receive discounted health care services under available CICIP funding.

F. Application

1. Regular Application Process

The applicant or an authorized representative of that applicant must sign the application to receive discounted health care services submitted to the qualified health care provider within 90 calendar days of the date of health care services. If an applicant is unable to sign the application or has died, a spouse, relative, or guardian may sign the application. Until it is signed, the application is not complete, the applicant cannot receive discounted health care services under available CICIP funding and the applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

2. Emergency Application

- a. In emergency circumstances, an applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the qualified health care provider shall follow these steps in processing the application:
 - I. Use the regular application to receive discounted health care services under available CICIP funding, but check emergency application on the application.
 - II. Ask the applicant to give spoken answers to all questions and to sign the application to receive discounted health care services under available CICIP funding.
 - III. Assign a discount rating based on the spoken information provided.
- b. An emergency application is good for only one date of service, in an emergency room. If the client receives any care other than the emergency room visit, the qualified health care provider must require the client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the client does not support the earlier, spoken information, the qualified health care provider must obtain a new application to receive discounted health care services under available CICIP funding from the client.

G. Applicants

1. Any adult, over the age of 18, may apply to receive discounted health care services under available CICIP funding. If an applicant is deceased, the executor of the estate or a family member may complete the application on behalf of the applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.
2. The application to receive discounted health care services under available CICIP funding shall include the names of all members of the applicant's family household. In determining household size, a family member of any age may be included as long as s/he receives, at least 50% of his/her support from the household.
3. A minor shall not be rated separately from his/her parents or guardians unless, s/he is emancipated. A minor may also be rated separately to receive discounted health care services under available CICIP funding in the special circumstances as outlined in the CICIP Manual. A minor is an individual under the age of 18.

H. Health Insurance Information

The applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

I. Subsequent Insurance Payments

If a client receives discounted health care services under available CICP funding, and their insurance subsequently pays for services, or if the patient is awarded a settlement, the insurance company or patient shall reimburse the qualified health care provider for discounted health care services rendered to the patient.

8.905 FINANCIAL ELIGIBILITY

General Rule: An applicant shall be financially eligible for discounted health care services under available CICP funding if the client's household income and resources (minus allowable, deductions and adjustments) are no more than 185% of the most recently published federal poverty level (FPL) for a household of that size.

1. The determination of financial eligibility for applicants, also known as "the rating process," is intended to be uniform throughout Colorado. The application must be completed with the eligibility technician at the qualified health care provider's site.
2. All qualified health care providers must accept each other's CICP Ratings, unless the rating is a result of a provider management exception.
3. The rating process looks at the financial circumstances of a household as of the date that a signed application is completed.
4. CICP Ratings are retroactive for services received from a qualified health care provider up to 90 days prior to application.
5. Every effort must be made by the qualified health care provider to obtain the necessary documentation needed concerning the applicant's financial status.

8.906 CICP RATING

The federal poverty levels or the ability-to-pay scale is divided into eight ratings. The result of the calculated income and resources and the family household size are used to determine what percentage of the federal poverty level the family meets.

Ability-to-Pay ScaleCICP Rating	Percent of FederalPoverty Levels	Further Descriptions
N	40%	
A	62%	
B	81%	
C	100%	
D	117%	
E	133%	
F	159%	
G	185%	

P	185%	CICP Prenatal Benefit Only
Z	40%	Homeless Clients Only

A qualified health care provider shall assign a CICP Rating or denial and notify the applicant of his status within five working days of the applicant completing the application to receive discounted health care services. Family members receiving discounted health care services under the same application shall all have the same CICP Rating.

The rating letter or letter denying the application to receive discounted health care services shall include a statement informing the applicant that s/he has 15. days to appeal the denial or CICP Rating.

Pregnant women receiving a discounted prenatal benefit shall receive two CICP Ratings: a P-rating for all prenatal care and the normal CICP Rating for all other care.

The CICP Rating determines a family's copayment and client copayment annual cap. CICP Ratings are effective for one year from the date of the rating, unless the client's financial or family situation changes or the rating is a result of a qualified health care provider management exception, according to Section 8.908 (E) of these regulations.

Any family member eligible for the. Children's Basic Health Plan may only receive a CICP Rating on a temporary basis. The CICP Rating is retroactive for services received 90 days prior to the application to receive discounted health care services and valid for a temporary basis from the application date.

A. Determining the CICP Rating

The CICP Rating of an eligible client shall be determined by matching the family's net CICP income and resources to the appropriate bracket on the ability-to-pay scale, taking into account the current federal poverty level for a household of the same size.

CICP Ratings are valid for one year. Each year, all clients, must receive a re-rating.

B. CICP Re-rating

A client may request a re-rating because his/her financial or family situation has changed since the initial rating. To re-rate a client, the qualified health care provider must obtain a new application to receive discounted health care services.' Client re-ratings affect only future charges. Therefore, bills incurred after the initial rating but prior to the re-rating shall be. discounted based on the client's initial rating.

If the client requests a re-rating and can document that relevant circumstances have changed since the initial rating, the qualified health care provider must re-rate the client. Reasons which justify a re-rating include but are not limited to:

1. Family income has changed significantly;
2. Number of dependents, has changed;
3. An error in the calculation; or
4. The. eligibility year has expired.

8.907 CLIENT COPAYMENT

A. Client Copayments — General Policies

A client is responsible for paying a portion of his/her medical bills. The client's portion is called the "client copayment". Qualified health care providers are responsible for charging the client a copayment. The maximum allowable client copayments by service are shown below in the Client Copayment Table. Qualified health care providers may require clients to pay their copayment prior to receiving care (except emergent care).

Client Copayment TableCICP Rating	Percent of Federal Poverty Level	Inpatient Facility Copayment	Inpatient Physician Copayment
N	40%	\$15	\$0
A	62%	\$64	\$27
B	81%	\$103	\$44
C	100%	\$154	\$66
D	117%	\$220	\$94
E	133%	\$297	\$127
F	159%	\$389	\$167
G	185%	\$535	\$230
P	185%	N/A	N/A
Z	40%	\$0	\$0

There are different copayments for different service charges. The following information explains the different types of medical care charges,

1. Inpatient physician charges are for services provided directly by physicians.
2. Inpatient facility charges, are for all non-physician services received while receiving care in a hospital.
3. Outpatient charges are for services received on an outpatient basis. Outpatient charges include charges from outpatient clinics and charges from outpatient services provided in a hospital (i.e., emergency room care, outpatient surgery, radiology).
4. Prescription charges are for prescription drugs received at a qualified health care provider's pharmacy.
5. P-Rating. A discounted prenatal benefit may be offered to pregnant women to encourage the access to prenatal care for a \$50 copayment. Qualified health care providers shall not require pre-payment of the \$50, but may develop an installment payment plan. These women are not eligible for Medicaid or Children's Basic Health Plan and will have another CICP Rating for discounted health care services other than a condition related to their prenatal benefit.
6. Z-Rating. These are homeless clients who are at or below 40% of the Federal Poverty Level (qualify for an N-Rating). Homeless clients are exempt from client copayments. Homeless patients are also exempt from the income verification requirement, verification of denied Medicaid benefits requirement and providing proof of residency when completing the CICP application.

General Definition: A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that, is: (A) a supervised publicly or privately operated

shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

B. Client Annual Copayment Cap

1. For all CICP. Ratings annual copayments for clients shall not exceed 10% of the family's net income and resources.
2. The client annual copayment cap (annual cap) is based on a calendar year (January 1 through December 31), even if a client's rating is for a different year (i.e., April 1 through March 31). Clients are responsible for any charges incurred prior to receiving their CICP Rating. Clients shall track their copayments and inform the provider in writing (including documentation) when they meet their annual cap. However, if a client overpays the annual cap and informs the qualified health care provider of that fact in writing, the qualified health care provider shall reimburse the client for the overpayment.
3. The client's annual cap can change during the calendar year if the CICP. Rating changes during the year. All copayments made toward the old annual cap during the calendar year apply to the new cap.
4. An annual cap applies only to. charges incurred after a client is eligible to receive, discounted health care services, and applies only to discounted services incurred at a qualified health care provider.

C. Determining Client Copayments

The client's copayment shall be determined by matching the client's CICP rating with the corresponding rate on the CICP copayment table.

D. The patient must pay the lower of the copayment listed or actual charges. The provider has the option of charging outpatient surgery patients rated "A" through "G" in one of two ways:

1. As an outpatient service for the outpatient copayment as listed in the above schedule; or
2. As an inpatient service for which the facility collects the copayment associated with an inpatient stay for the patient's rating. The patient is additionally responsible for the participating physician copayment. In the event that the listed inpatient charges are greater than actual patient charges for the outpatient surgery, the facility shall charge the lesser of the amounts in determining the patient's liability.

E. Clients shall be notified at or before time of services rendered of their copayment responsibility.

F. Grants for Client Copayments

Grants from foundations to clients from non-profit, tax exempt, charitable foundations specifically for client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

8.908 APPEAL PROCESS

A. If an applicant or client feels, mat a rating or denial is in error, the applicant/client may challenge the rating or denial by filing an appeal with the qualified health care provider who completes the application to receive discounted health care services, under available CICP funding.

B. Instructions, for Filing an Appeal

The qualified health care provider shall inform the applicant or client that s/he has the right to appeal the rating or denial if s/he is not satisfied with the qualified health care provider's decision.

If the applicant or client wishes to appeal the rating or denial of the application, the applicant or client shall submit a written request for appeal, which includes any documentation supporting the reasons for the request.

C. Provider Management Appeals

An applicant or client may file a provider management appeal if the applicant or client wishes to challenge the accuracy of his or her initial rating.

A client or applicant shall have 15 calendar days from the date of the qualified health care provider's decision to request a provider management appeal.

If the qualified health care provider does not receive the applicant's or client's provider management appeal within the 15 days, the qualified health care provider shall notify the applicant or client in writing that the appeal was denied because it was not submitted timely. At the discretion of the qualified health care provider and for good cause shown, including a death in the applicant's or client's immediate family, the qualified health care provider may review an appeal received after 15 days.

An applicant or client can request a provider management appeal for the following reasons:

1. The initial rating or denial was based on inaccurate information because the family member or representative was uninformed;
2. The applicant or client believes that the calculation is inaccurate for some other reason; or
3. Miscommunication between the applicant or client and the rating technician, cause incomplete or inaccurate data to be recorded on the application.

Each qualified health care provider shall designate a manager to review appeals and grant management exceptions. A provider management appeal involves receiving a written request from the applicant or client, and reviewing the application completed by the rating technician, including all back-up documentation, to determine if the application to receive discounted health care services under available CACP funding is accurate.

If the manager finds that the initial rating or denial is not accurate, the designated manager shall correct the application to receive discounted health care services under available CACP funding and assign the correct rating to the applicant or client. The correct rating is effective retroactive to the initial date of application, and charges incurred 90 days prior to the initial date of application must be discounted. The qualified health care provider shall notify the applicant or client in writing of the results of a provider management appeal within 15 working days following receipt of the appeal request from the client.

D. Provider Management Exception

At the discretion of the qualified health care provider and for good cause shown, the designated manager may grant the applicant or client a provider management exception.

A client may request and a qualified health care provider may grant a provider management exception if the client can demonstrate that there are unusual circumstances that may have affected his or her initial rating. Provider Management Exceptions shall always result in a lower client rating. Provider Management Exceptions shall not be used for applicants who do not qualify to receive discounted health care services.

under available CACP funding due to being over-resourced.

A client may request a provider management exception within 15 calendar days of the qualified health care provider's decision regarding the management appeal, or simultaneously with a provider management appeal.

The facility shall notify the client in writing of the qualified health care provider's findings within 15 working days of receipt of the written request

Designated managers may authorize a three-month exception to a client's rating based on unusual circumstances. After the 90 day period ends, the client shall be re-rated. The qualified health care provider must note provider management exceptions on the application. Qualified health care providers shall treat clients equitably in the provider management exception process.

A rating from a provider management exception is effective as of the initial date of application. Charges incurred 90 days prior to the initial date of application must be discounted. Qualified health care providers are not required to honor provider management exceptions granted by other qualified health care providers.

8.910 NURSING FACILITY SERVICE PROGRAM

8.910.1.A.

Definition: In these rules, "eligible person" shall have the meaning set forth in 26-15-201(1), C.R.S.

8.910.1.B.

Reimbursement to Nursing Facilities Serving Eligible Persons.

1. The estimated statewide average daily Medicaid rate shall be adjusted each year, effective July 1.
2. Nursing facilities serving eligible persons shall provide at least the minimum scope of services furnished within the per diem rate, as specified in section 8.442. No additional reimbursement shall be made for any services not enumerated in section 8.442.

8.910.1.C.

A nursing facility shall not be eligible to receive reimbursement for an eligible person residing in that facility unless the facility is also eligible for Medicaid reimbursement for the services to its Medicaid residents.

8.910.1.D.

Except as otherwise provided in this section 8.910, the rights and responsibilities of eligible persons and nursing facilities under the Nursing Facility Service Program, shall be governed by the rules applicable to Medicaid nursing facilities and their residents.

8.910.1.E.

A nursing facility serving an eligible person under this section shall submit claims by using forms and/or procedures required by the Department or its designee. Those required forms and procedures may include, but are not limited to, the following areas:

1. Enrollment of the provider in the Nursing Facility Service Program through the execution of an

appropriate contract.

2. Reimbursement of the nursing facility.
3. Offset of an eligible person's patient payment during the claimed dates of service. County departments and nursing facilities shall use the "STATUS OF NURSING FACILITY CARE" form (AP-5615) described at section 8.482.34, for this purpose.
4. Time limits for submitting claims and beginning appeals from adverse actions on claims.

8.910 OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

8.911 EXTENT AND LIMITATIONS OF MEDICAL CARE

8.911.1 GENERAL DESCRIPTION — OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

In accordance with the Constitution of Colorado, Title XXIV, Section 7, and the Colorado Social Services Act, an Old Age Pension Health Care Program is established to provide necessary medical care for the Old Age Pension recipients who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. The State Department is designated as the single State agency to administer the program.

The Old Age Pension Health Care Supplemental Program is authorized by Colorado Revised Statutes, Section 26-2-117, CRS. The funding for this program cannot be accessed until all funds in the Old Age Pension Health Care Program are exhausted.

- A. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program provide optional benefits to clients who qualify for (State only) OAP-A and (State only) OAP-B pensions who do not qualify for Federal Financial Participation in the Colorado Medicaid Program. These cases are coded with Supplemental Income Status Code (SISC)C.
- B. Under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program, only the following State funded benefits are provided: managed care programs, physician and practitioner services, inpatient hospital, outpatient services, lab and x-ray, transportation, dental, pharmacy, home health services and supplies, and Medicare cost sharing.
- C. All other medical benefits not listed in paragraph B are excluded under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program. Inpatient care in an institution for tuberculosis or mental diseases, skilled and intermediate nursing facility services, and home and community based services are also excluded.
- D. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program eligibility shall not be retroactive. Eligibility shall begin with the date of application or date eligibility is established, whichever is later.
- E. The Executive Director of the Department of Health Care Policy and Financing, under the direction of the State Medical Services Board, shall manage the Old Age Pension Health and Medical Care fund and the supplemental Old Age Pension Health and Medical Care fund to assure that utilization controls and other mechanisms are in place in order to hold expenditures within the constitutional and statutory limits.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will exceed the available funds, he/she shall take action to reduce expenditures as needed by reducing,

suspending, or eliminating payments for covered benefits.

The Executive Director shall consider reducing, suspending or eliminating benefits, individually or in any combination, based upon the shortest duration of time and considering the least impact on the client. The Executive Director shall report to the Board whenever such action is required, specifying the dollar impact, length of time for the reduction, and the number of clients and providers affected. In addition, the Executive Director shall report to the Board on the feasibility of other cost reduction options.

- F. Counties shall provide information to OAP clients regarding the disposal of excess resources in order to qualify for the Medicaid program. Such information shall include, advisements concerning the prohibition of transfer of assets without fair consideration.
- G. If Medicare pays for a medical service that is a non-benefit for this group, the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program.

8.911.2 DEFINITION

Throughout this section of the rules, all references to “medical” shall mean the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program. Exceptions will be noted in the specific rule. Provider bulletins, claim forms, authorization forms, Medicaid Authorization Card (MAC), and all forms of communication to providers, counties and recipients shall include Medicaid, Old Age Pension Health Care Program, and the Old Age Pension Health Care Supplemental Program components of the Colorado Medical Assistance Program.

8.911.3 GROUPS ASSISTED UNDER THE OLD AGE PENSION HEALTH CARE PROGRAM AND THE OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program benefits are provided to persons receiving OAP-A, OAP-B, and GAP refugees who do not meet SSI eligibility criteria, but do meet the State eligibility criteria for the Old Age Pension Health Care Program. These persons qualify for a SISC Code C.

- A. SISC Code C — this code is for persons eligible to receive financial assistance under OAP-A, OAP-B, or OAP Refugee Assistance, who do not receive an SSI payment, and do not otherwise qualify for the Colorado Medicaid Program. Code C signifies that no FFP is available in medical assistance program expenditures.
- B. Recipients of financial assistance under State AND, State AB or OAP “C” are not eligible for assistance under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program.

8.911.4 FINANCIAL ASSISTANCE

All rules applicable to OAP financial assistance program payments shall apply to the Old Age -Pension Health Care Program and the Old Age Pension Health Care Supplemental Program.

8911.5 CERTIFICATION OF PAYMENT FOR PROVIDERS

All providers of medical services in their submission of claim to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program certify that, “I will accept as payment in full, payment made under the Old Age Pension Health Care Program, and certify that no supplemental charges have been, or will be, billed to the patient, except for those non-covered items, or services, if any, which are not reimbursable under the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program.”

8.911.6 GENERAL EXCLUSIONS

In addition to any specific exclusion defined in this manual, the general exclusions from coverage of the Colorado Medical Assistance Program defined by the rules of the Colorado Department of Health Care Policy and Financing (10 CCR 2505-10) are also excluded.

8.911.7 OUT-OF-STATE MEDICAL CARE

All requirements for out of state medical care as defined by the rules of the Colorado Department of Health Care Policy and Financing (10 CCR 2505-10) apply to the GAP Health Care Program and the Old Age Pension Health Care Supplemental Program for covered services with the exception that any reduction, suspension or elimination of benefits must be applied.

8.911.8 SUBMISSION OF CLAIMS

Rules governing the submission or payment of claims, provider or recipient appeals, third party liability, overpayment, fraud and abuse, and State identification numbers as defined by the Colorado Department of Health Care Policy and Financing (10 CCR 2505-10) apply to the OAP Health Care Program and the Old Age Pension Health Care Supplemental Program for covered services with the exception that any reduction, suspension or elimination of benefits provided must also be applied.

8.912 CHANGE OF SUPPLEMENTAL INCOME STATUS CODE (SISC) TO MEDICAID

8.912.1 MEDICAID QUALIFICATION

When a recipient of OAP-A or OAP-B and the OAP Health Care Program or the Old Age Pension Health Care Supplemental Program subsequently qualifies for Medicaid, his/her SISC code must be changed to indicate Medicaid benefits. Additionally, the county must backdate the Medicaid benefits to the date the individual became eligible for Medicaid even if the recipient was eligible for the OAP Health Care Program or the Old Age Pension Health Care Supplemental Program at the time. Some reasons for Medicaid eligibility are: receipt of Supplemental Security Income, receipt of Social Security disability benefits, attainment of age 65, changes in alien status or reduction of resources that caused the individual to be ineligible for Medicaid.

8.920 NURSING FACILITY PROVIDER FEE AND QUALITY OF CARE GRANT PROGRAM

8.920.1.A.

Calculation of the Provider Fee

1. For each calendar quarter, the amount of the patient day provider fee shall be sufficient to generate the pro rata, quarterly share of the General Assembly's legislative appropriation for medical services premiums related to 26-4-410.2, C.R.S., during the corresponding state fiscal year.
2. To the minimum extent necessary to satisfy federal waiver requirements, fees shall be reduced for one or more nursing facilities. Those federal waiver requirements are set forth in 42 C.F.R. §433.68 through §433.72 (10-1-02 Edition) of the Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services. No later amendment or edition of this material is included. Information about obtaining or examining the incorporated material is available at the office of the Manager, Nursing Facilities Section, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. The incorporated material may also be examined at any state publications depository library.

8.920.1.B.

Beginning July 1, 2003, the fee shall be assessed on a quarterly basis, effective the first day of each calendar quarter during the Colorado State Fiscal Year. The fee for the quarter beginning July 1, 2003, shall be payable in full by providers and due to the Department no later than forty-five (45) calendar days after federal approval of the Department's waiver request. The fee for each subsequent calendar quarter shall be due to the Department no later than forty-five (45) calendar days from the effective date of the assessment

1. The calculation of each quarterly assessment shall be based upon the total, non-Medicare census figures reported by nursing facilities to the Department for the one-year period which ended with the next-to-last calendar quarter prior to the effective date of the assessment. For example, the census reports for the period between April 1, 2002, and March 31, 2003, shall be used for the purpose of calculating the fee assessment effective July 1, 2003.
2. Each nursing facility shall report quarterly census figures in accordance with procedures prescribed by the Department, and such census figures shall be subject to audit by the Department or its designee. In the case of a nursing facility which fails to report required census figures, other appropriate data sources shall be used for calculating the fee assessment. In addition, in the discretion of the Department, the delinquent nursing facility shall be subject to a 10% reduction of the grant it would have otherwise received for the calendar quarter in question.

8.920.1.C.

In addition to all other remedies for non-performance set forth in this staff manual, and at law, at the discretion of the Department, any fees outstanding from a provider as of the quarterly due date shall be recouped prospectively from Medicaid payments at a rate of 100% per remittance. Additionally, for each month (or part of a month) that any portion of a fee remains unpaid, any nursing facility subject to this recoupment remedy shall forfeit 10% of the grant it would have otherwise received under the Nursing Facility Quality of Care Grant program for the quarter at issue. For example, a facility whose fees are not paid until five calendar days after the due date shall be subject to a 10% reduction of its grant for that quarter, and a facility whose fees are not completely paid until 75 calendar days after the due date shall be subject to a 30% reduction.

8.920.1.D.

Nursing Facility Quality of Care Grant Program

1. The grants for each calendar quarter shall completely distribute the aggregate amount of provider fees received as of the due date for that quarter, as well as any penalties retained for the current quarter or a previous quarters) under paragraph 8.920.1.B.2 or 8.920.1.C above. The grants shall be apportioned among the eligible facilities on the basis of each facility's percentage of total Medicaid patient days for the one-year period used in calculating the provider fees for that quarter, and other statistical criteria set forth in the federal waiver, in accordance with requirements cited in paragraph 8.920.1.A.2 above. In no case shall any provider be held harmless for the impact of the fee, on either a direct or indirect basis.
2. The calculation of the quarterly grants shall be based upon the data sources described in paragraph 8.920.1.B above.
3. No grant shall be paid to a facility, until its fees for the corresponding quarter have been collected in full by the Department. After a delinquent facility's fees have been paid in full,

any remaining grant owed to the facility for that quarter shall be included with the next regular grant distribution. The portion of a grant forfeited by a delinquent provider shall be distributed in full to other, compliant providers with the next regular grant distribution.

8.930 COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM

The Comprehensive Primary and Preventive Care Grant Program is authorized by the addition of Part 10 to the Medical Assistance Act, 26-4-1001 through 26-4-1007, C.R.S. This program was established to provide grants to health care providers in order to expand primary and preventive care services to Colorado's low-income, uninsured residents. Beginning with FY 00-01, the program shall be funded through the Comprehensive Primary and Preventive Care Fund established pursuant to the tobacco litigation settlement referred to as the Master Settlement Agreement as defined in 8.930.1 below.

.1 DEFINITIONS

- A. Comprehensive Primary Care: 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. At a minimum, comprehensive primary care 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.
- B. Master Settlement Agreement: 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 Group Inc.; Lorillard Tobacco Company; Phillip 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. 97CV3432, in the District Court for the City and County of Denver.
- C. Medically Underserved Area or Population: An area designated by the Secretary of the U.S. Department of Health and Human Services as an area with a shortage of health care professionals or health services or a population or group designated by the Secretary as having a shortage of such services.
- D. Service Grant: A grant by the State Department to a qualified provider pursuant to 26-4-1003(6), C.R.S.
- E. State Department: Unless otherwise specified, the State Department refers to the State Department of Health Care Policy and Financing.

.2 COMPREHENSIVE PRIMARY AND PREVENTIVE CARE GRANT PROGRAM CRITERIA

A. Clients to be Served

In order to be served under this program, clients must be receiving services from a qualified provider as defined in paragraph B. below. In addition, clients must also meet the following criteria:

1. Have a yearly family income below two hundred percent (200%) of the federal poverty level; and

2. Be ineligible for Medicaid, Medicare, the Children's Basic Health Plan, or any other type of governmental reimbursement for health care costs, such as through Social Security, the Veterans Administration, Military Dependency (CHAMPUS), or the United States Public Health Service; and
3. Cannot be receiving third-party payments for comprehensive and primary care from private resources including, but not limited to, a commercial or individual health insurance policy, a Health Maintenance Organization, an automobile or worker's compensation policy.

B. Qualified Providers

In order to be eligible for the Comprehensive Primary and Preventive Care Grant Program, a health care provider must be an entity that provides comprehensive primary care services that:

1. Accepts all patients regardless of their ability to pay and uses a sliding fee schedule for payments or does not charge uninsured clients for services;
2. 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. Section 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. Copies of the Act are available for public inspection or shall be provided at cost by the Office of the Executive Director, Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library. No later amendments to or editions of the regulations are included in this reference.
3. Has a demonstrated track record of providing cost-effective care which can be assessed from information provided by the grantees that describes established processes that are in place to ensure the delivery of appropriate comprehensive primary and preventive care.
4. Provides or arranges for the provision of comprehensive primary care services to persons of all ages. Arranging for the provision of comprehensive primary care services 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 they can demonstrate that there are no providers in the community to provide one or more of the comprehensive primary care services.
5. Completes an initial screening evaluating eligibility for the State Medical Assistance Program, the Children's Basic Health Plan (CHP+), and the Colorado Indigent Care Program and refers potentially eligible patients to the appropriate agency for eligibility determination if they are not qualified to make such determinations.

8.930.3 APPLICATION AND GRANT AWARD PROCEDURES

8.930.31 Application

- A. Grant awards shall be made through an application process. The Application Form shall be issued by the Department and posted for public access on the Department's website at least 30 days prior to the Application due date.

- B. An advisory council appointed by the Executive Director of the Department shall review the draft Application Form prior to its issuance and make recommendations to the Department. The advisory council shall include a representative of the Department, a representative of the Department of Public Health and Environment, a representative of a qualified provider as defined in 8.930.2, B, two consumers who currently receive health care services from a qualified provider, a health care provider who is not affiliated with a qualified provider or an agency of the state, but who has training and expertise in providing comprehensive primary care services to medically underserved populations, and a representative of a nonprofit, community-based health care organization or business.

In addition to the advisory council, other parties may also be asked by the Department to review the draft Application Form prior to its issuance and make recommendations to the Department.

8.930.32 Evaluation of Grants

- A. An Application Evaluation Committee shall be established by the Department for the purpose of reviewing the grant applications and recommending which applications should receive awards directly to the Executive Director.

No parties other than the Application Evaluation Committee shall be involved in evaluating applications and recommending awards. The Application Evaluation Committee may, at its option, call upon subject matter experts to review applications and provide analysis of those applications regarding their area of expertise. However, such experts shall not reveal the contents of those applications to any other parties, nor shall they participate in the formal evaluation or award recommendation processes of the committee. In no case shall a member of the Application Evaluation Committee or any subject matter experts have a conflict of interest, or the appearance of a conflict of interest, in the recommending of awards created by their participation.

- B. The applications shall be evaluated in accordance with the terms stated in the Application Form and as set by the Department. Criteria used to evaluate applications shall include, but not be limited to:

1. Whether the applicant meets all criteria for qualified provider;
2. The degree to which the work plan meets the "Conditions for Use of Grants" listed in Section 8.930.34;
3. The technical and financial feasibility of the project;
- 4 The appropriateness of the proposed program/services budget for the proposed project; and
5. The plan presented for evaluating and reporting results.
6. The geographic distribution of funds among urban and rural areas in the State.

8.930.33 Awarding of Grants

- A. The Executive Director, or his/her designee, shall make the final grant awards to applicants for the purpose of providing preventive and primary care services to Colorado's low-income, uninsured residents.
- B. The Department reserves the right to change grant amounts, depending on the final number of grants awarded, the availability of funds and/or the goals stated in each grant application.
- C. The Department will establish a process for applicants to appeal the Departments grant awards. This

process will be outlined in the Application Form.

8.930.34 Conditions for Use of Grants

A. Grants shall be used:

1. To increase access to comprehensive primary care services for uninsured or medically indigent patients who are served by such providers;
2. To create new services or augment existing services provided to uninsured or medically indigent patients; or
3. To establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations.
4. To maintain increased access, capacity or services previously funded by Comprehensive Primary and Preventative Care (CPPC) Grants.

B. Grants shall NOT be used:

1. To supplant federal funds traditionally received by such qualified providers, but shall be used to supplement such funds;
2. For land or real estate investments;
3. To finance or satisfy any existing debt; or;
4. Unless the qualified provider specifically complies with the definition of qualified provider contained in Section 26-4-1003(5), C.R.S. and Section 8.930.2, B of these regulations.

8.930.4 EVALUATION AND REPORTING

Provider Annual Reports to Department

Each qualified provider who receives a grant under this program shall provide an annual report to the Department which must include, at a minimum:

1. The number of additional uninsured and medically indigent patients served;
2. The types of services provided;
3. Results achieved, and the criteria used to measure their effectiveness in achieving stated goals.
4. Other information that may be required by the Colorado Department of Public Health and Environment.
5. Cost reports may also be requested.

8.930.5 AUDIT PROCEDURE

The Department shall develop audit procedures to assure that grants awarded under this program are used to provide services to uninsured and medically indigent patients. Each qualified provider who receives a grant under this program must agree to abide by the audit procedures developed by the Department.

8.940 OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE

SUPPLEMENTAL PROGRAM

8.941 EXTENT AND LIMITATIONS OF MEDICAL CARE

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM AND OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

In accordance with the Constitution of Colorado, Title XXIV, Section 7, and the Colorado Social Services Act, an Old Age Pension Health Care Program is established to provide necessary medical care for the Old Age Pension recipients who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. The State Department is designated as the single State agency to administer the program.

The Old Age Pension Health Care Supplemental Program is authorized by Colorado Revised Statutes, Section 26-2-117, C.R.S. The funding for this program cannot be accessed until all funds in the Old Age Pension Health Care Program are exhausted.

- A. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program provide optional benefits to clients who qualify for (State only) OAP-A and (State only) OAP-B pensions who do not qualify for Federal Financial Participation in the Colorado Medicaid Program. These cases are coded with Supplemental Income Status Code (SISC) C.
- B. Under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program, only the following State funded benefits are provided: physician and practitioner services, inpatient hospital, outpatient services, lab and x-ray, transportation, dental, pharmacy, home health services and supplies, and Medicare cost sharing. As of January 1, 2004 the inpatient hospital benefit is suspended until June 30, 2004.
- C. All other medical benefits not listed in paragraph B are excluded under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program. Inpatient care in an institution for tuberculosis or mental diseases, skilled and intermediate nursing facility services, and home and community based services are also excluded.
- D. The Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program eligibility shall not be retroactive. Eligibility shall begin with the date of application or date eligibility is established, whichever is later.
- E. The Executive Director of the Department of Health Care Policy and Financing, under the direction of the State Medical Services Board, shall manage the Old Age Pension Health and Medical Care fund and the supplemental Old Age Pension Health and Medical Care fund to assure that utilization controls and other mechanisms are in place in order to hold expenditures within the constitutional and statutory limits.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will exceed the available funds, he/she shall take action to reduce expenditures as needed by reducing, suspending, or eliminating payments for covered benefits.

The Executive Director shall consider reducing, suspending or eliminating benefits, individually or in any combination, based upon the shortest duration of time and considering the least impact on the client. The Executive Director shall report to the Board whenever such action is required, specifying the dollar impact, length of time for

the reduction, and the number of clients and providers affected. In addition, the Executive Director shall report to the Board on the feasibility of other cost reduction options.

- F. Counties shall provide information to Old Age Pension Health Care Program clients regarding the disposal of excess resources in order to qualify for the Medicaid program. Such information shall include advisements concerning the prohibition of transfer of assets without fair consideration.
- G. If Medicare pays for a medical service that is a non-benefit for this group, the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program.

8.941.2 DEFINITION

Throughout this section of the rules, all references to “medical” shall mean the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program. Exceptions will be noted in the specific rule. Provider bulletins, claim forms, authorization forms, Medicaid Authorization Card (MAC), and all forms of communication to providers, counties and recipients shall include Colorado Medical Assistance Program, Old Age Pension Health Care Program, and the Old Age Pension Health Care Supplemental Program.

8.941.3 GROUPS ASSISTED UNDER THE OLD AGE PENSION HEALTH CARE PROGRAM AND THE OLD AGE PENSION HEALTH CARE SUPPLEMENTAL PROGRAM

Old Age Pension Health Care Program and the Old Age Pension Health Supplemental Program benefits are provided to persons receiving OAP-A, OAP- B, and OAP refugees who do not meet SSI eligibility criteria, but do meet the State eligibility criteria for the Old Age Pension Health Care Program. These persons qualify for a SISC Code C.

- A. SISC Code C - this code is for persons eligible to receive financial assistance under OAP-A, OAP-B, or OAP Refugee Assistance, who do not receive an SSI payment, and do not otherwise qualify for the Colorado Medicaid Program. Code C signifies that no FFP is available in medical assistance program expenditures.
- B. Recipients of financial assistance under State AND, State AB or OAP “C” are not eligible for assistance under the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program.

8.941.4 FINANCIAL ASSISTANCE

All rules applicable to Old Age Pension financial assistance program payments (as set forth in the Department of Human Services rules at 9 CCR 2503-1) shall to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program.

8.941.5 CERTIFICATION OF PAYMENT FOR PROVIDERS

All providers of medical services in their submission of claim to the Old Pension Health Care Program and the Old Age Pension Health Care Supplemental Program certify that, “I will accept as payment in full, payment made under the Old Age Pension Health Care Program, and certify that no supplemental charges have been, or will be, billed to the patient, except for those non-covered items, or services, if any, which are not reimbursable under the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program.”

8.941.6 GENERAL EXCLUSIONS

In addition to any specific exclusion defined in this manual, the general exclusions from coverage of the Old Pension Health Care Program and the Old Age Pension Health Care Supplemental Program defined by the rules of the Department of Human Services (9 CCR 2503-1) are also excluded.

8.941.7 OUT-OF-STATE MEDICAL CARE

All requirements for out of state medical care as defined by the rules in this manual apply to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program for covered services with the exception that any reduction, suspension or elimination of benefits must be applied.

8.941.8 SUBMISSION OF CLAIMS

Rules governing the submission or payment of claims, provider or recipient appeals, third party liability, overpayment, fraud and abuse, and State identification numbers as defined in this manual apply to the Old Age Pension Health Care Program and the Old Age Pension Health Care Supplemental Program for covered services with the exception that any reduction, suspension or elimination of benefits provided must also be applied.

8.941.9 REIMBURSEMENT TO PROVIDERS

As of January 1, 2004 providers shall be reimbursed at 50% of the appropriate Medicaid reimbursement for physician and practitioner services, outpatient services, lab and x-ray, transportation, dental, medical supply and home health services and supplies. Pharmacy services are paid at 100% of the appropriate Medicaid reimbursement. In accordance with 8.941.1(E), the Executive Director may alter the reimbursement for any service with the condition that expenditures remain within the constitutional and statutory limits.

8.941.10 CLIENT CO-PAYMENT

Recipients of benefits under the OAP Health Care Program or Old Age Pension Health Care Supplemental Program shall be responsible for paying directly to providers a set portion of the cost of services according to the regulations and fee schedule as defined for the Medical Assistance and described in section 8.754 of this manual. This charge to the recipient will be called co-payment.

Those recipients whose co-payments reach a limit of \$300.00 within a January 1 through December 31 calendar year will be exempted from further co-payments during that year. The exemption will begin on the date of payment for the claim, which indicates that the cumulative maximum has been reached.

It will be a recipient responsibility to present the Medical ID Card to the provider at the time a service is rendered in order to claim exemption from copayment for that service.

8.942 CHANGE OF SUPPLEMENTAL INCOME STATUS CODE (SISC) TO MEDICAID

8.942.1 MEDICAID QUALIFICATION

When a recipient of OAP-A or OAP-B and the OAP Health Care Program or Old Age Pension Health Care Supplemental Program subsequently qualifies for Medicaid, his/her SISC code must be changed to indicate Medicaid benefits. Additionally, the county must backdate the Medicaid benefits to the date the individual became eligible for Medicaid even if the recipient was eligible for the OAP Health Care Program or the Old Age Pension Health Care Supplemental Program at the time. Some reasons for Medicaid eligibility are: receipt of Supplemental Security Income, receipt of Social Security disability benefits, attainment of age 65, changes in alien status or reduction of resources that caused the individual to be ineligible for Medicaid.

Pharmacy Name

Address

Provider # _____

Phone _____

MED-11E (Rev. 6/84)

COLORADO STATE DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE

APPLICATION TO PARTICIPATE IN THE MEDICAL ASSISTANCE PHARMACY PROGRAM

_____, a duly licensed Pharmacy, (Name of Pharmacy) hereinafter referred to as the Applicant, hereby makes application to participate in the Medical Assistance Program administered by the State Department of Social Services, hereinafter referred to as the Department, to the benefit of recipients of the medical benefits thereof. The applicant desires to participate in said program as a vendor of medical services, benefits, and/or goods within the scope of authority as is vested by the aforesaid license as a Pharmacy issued by the _____ of the _____ (Regulatory Agency) State of _____ on _____. (Date Issued)

If approved as a participating provider, the applicant agrees:

1. To perform its pharmaceutical duties and obligations in conformance with provisions of Title XIX of the Social Security Act, all other relevant Federal laws and regulations, the Colorado Social Services Code 26-1-101, et. seq., C.R.S. 1973, as amended, and especially the Colorado Medical Assistance Act, 26-4-101 et seq., C.R.S. 1973, as amended, and all pertinent rules and regulations of the Colorado Department of Social Services, as all of the foregoing are in effect at the date of the approval of the provider's application to participate, or as they may later be amended.
2. To submit billings for authorized services and/or goods in accordance with the form, manner, and amounts provided by the aforementioned statutes and rules and regulations, and provide such services and goods on the basis of being compensated therefore in accordance with said rules and regulations. It is further agreed that in the event the applicant should receive payment for medical services, benefits, and/or goods in an amount in excess of that permitted by said law and rules and regulations, such excessive payments may be deducted from future payments on behalf of recipients otherwise payable to said applicant and/or recovery of such payments may be made otherwise at the option and discretion of the Department in accordance with its rules and regulations pertaining to recoveries or other legal means.
3. Not to submit bills, or otherwise attempt to collect from the recipients, relatives of recipients or others for medical services, benefits, and/or goods which are provided recipients by said Applicant under said medical program and which benefits, services, and/or goods are paid for by the Department. Said applicant further agrees to accept the payment under the said medical program as payment in full from the Department. This statement in no way relieves the applicant of responsibility as defined by law or rule or regulation to obtain payment from legally responsible persons, as is required by said law or rule or regulations.
4. To provide the Department with at least 30 days prior notice in the event of termination of participation in said medical program. (Termination of participation in the Medicaid Program, unless otherwise agreed to in writing by the Department, shall arise from voluntary or involuntary cessation of

business; election to no longer participate; transfer of title and property to another party, corporation or partnership; any foreclosure, bankruptcy or receivership action.) However, this provision shall not apply in the case where an amendment to the rules of the Department is determined to be unacceptable to the eligible provider and for said reason he elects to discontinue participation in the program. In such event, the eligible provider shall forthwith notify the Department in writing of its intent to discontinue and the eligible provider and the Department shall forthwith negotiate the termination date. In no event shall said date be longer than 60 days from the effective date of the rule amendment.

5. To provide acceptable assurance to the Department of compliance with all Federal and State laws concerning discrimination and unfair employment practices, including but not limited to Title VII of the Civil Rights Act of 1964, ss 504 of the Rehabilitation Act of 1973, and ss 24-34-301, C.R.S. 1973, as amended.
6. To give full cooperation to the Department and its duly authorized agents, in the administration of said medical program, and to maintain all records necessary to disclose the extent of services furnished to recipients as may be provided for in the said rules and regulations. The applicant further agrees to furnish representatives of the Department or its duly authorized agents, the Department of Health and Human Services or the Medicaid Fraud Control Unit, with all information regarding reimbursement claimed by the provider for furnishing services.
7. To abide by all processing or reimbursement requirements mandated by the Department of Social Services, either directly or through the Fiscal Agent. Fiscal Agent means an entity that processes or reimburses vendor claims for the Department.
8. That approval of this application by the Department authorizes the applicant to participate in the Medicaid program. However, neither this application nor its approval in any way alters, amends, or abrogates the legal responsibility of the applicant to execute a subcontract if it later agrees to provide medical services for Medicaid recipients through a Health Maintenance Organization or similar program.
9. That reimbursement by the Department to the applicant shall be made in accordance with the aforementioned Departmental rules and regulations as applied to the pharmacy claim form submitted by the provider.
10. Any violations of the above conditions may result in withdrawal of approval of this agreement to participate.

DECLARATION OF OWNERSHIP OF PHARMACY

1. Name of pharmacy: _____
2. Pharmacy's legal name: _____
3. Is the owner of the pharmacy the same as the owner of the real property on which the pharmacy is located? _____ Yes _____ No
4. If "No", state date of lease agreement _____ and name of the lessor _____. (Attach a copy of the lease agreement unless previously submitted and no changes.)
5. Applicant's type of business: (Check One)
____ Individual Proprietorship _____ Partnership _____ Nonprofit Corp.
____ State/Local Subdivision _____ Profit Corp.
____ Other (Specify) _____

6. If applicant is a sole proprietor or partnership, provide the following:
The owner(s) name(s) and addresses of this sole proprietorship/partnership:

<u>Name</u>	<u>Address</u>	<u>% Ownership</u>	<u>General or Limited</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If additional partners are involved, list on attached page. Attach a copy of current partnership agreement if not previously submitted.

7. If applicant is a corporation:

a. Corporate Name _____

Address _____ City/State _____ ZIP _____ Telephone _____

- b. A copy of Bylaws and Articles of Incorporation must accompany applications unless they have been previously submitted and there are no changes since last submission.

c. List names and addresses of all officers of the corporation.

_____ President	_____ Address
_____ Vice President	_____ Address
_____ Secretary	_____ Address
_____ Treasurer	_____ Address

d. List names and addresses of all stockholders of the corporation who have five percent or more interest in the ownership, indicating actual percentage of ownership. If space is insufficient below, attach an additional sheet with name of corporation at top of sheet.

<u>Name</u>	<u>Address</u>	<u>Percent of Ownership</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I do hereby swear that all statements made in this application are made for the purpose of participating in the Medicaid Program and that these statements are true and correct to the best of my knowledge.

Pharmacy Name

The State of Colorado
Richard D. Lamm, Governor

Authorized Agent

Title

Approved:

COLORADO DEPARTMENT OF SOCIAL SERVICES

By _____
Executive Director

Date: _____

**COLORADO DEPARTMENT OF SOCIAL SERVICES
STATUS OF NURSING HOME CARE**

ORIGINAL COPY	☐
CORRECTED COPY ONLY	☐
COUNTY TRANSFER ONLY	☐
CHANGE PT. PMT ONLY	☐

I. PATIENT INFORMATION:

(1) PATIENT: _____ (2) CO _____ (3) STATE ID _____ (4) HOUSEHOLD NO. / CAT _____
(LAST NAME) (FIRST NAME) (INITIAL)

(5) NAME AND ADDRESS OF RELATIVE OR RESPONSIBLE PARTY: _____ (6) DATE OF BIRTH _____ (7) SEX _____
 _____ (8) DATE OF APPLICATION _____

(9) SS CLAIM NO. / SUFFIX _____ (10) RR CLAIM NO. _____ (11) VA CLAIM NO. _____ (12) PT. LEVEL OF CARE _____

II. FACILITY INFORMATION:

(1) NURSING HOME: _____ (2) PROVIDER NUMBER: _____
 (3) ADDRESS: _____

III. FINANCIAL ARRANGEMENT:

A. <u>PATIENT INCOME</u>	B. <u>PATIENT PAYMENT</u>	C. <u>CHANGE IN PATIENT PAYMENT</u>
(1) SS _____	(1) \$ _____ ADMIT MONTH	(1) MONTH _____ \$ _____
(2) RR _____	(2) \$ _____ 1st FULL MONTH	(2) MONTH _____ \$ _____
(3) VA _____	(3) \$ _____ 2nd MONTH	(3) MONTH _____ \$ _____
(4) ASA _____	(4) \$ _____ DISCHARGE MONTH	(4) MONTH _____ \$ _____
(5) OTHER _____		
(6) SUBTOTAL _____		
(7) LESS PM _____		
(8) TOTAL _____		

IV. WE REQUEST AUTHORIZATION FOR MEDICAID NURSING HOME CARE FOR THE ABOVE PATIENT:

(1) ADMITTED _____, 19____ * FROM _____
 (2) RE-ADMITTED _____, 19____ * PRIOR DISCHARGE DATE _____
 (3) DISCHARGED _____, 19____ * TO _____
 (4) DIED _____, 19____ * PLACE OF DEATH _____

(5) ATTENDING PHYSICIAN _____ * INDICATE NAME OF HOSPITAL OR NURSING HOME;
 ALSO CHANGE FROM PRIVATE OR MEDICARE STATUS
 AND DATE OF DISCHARGE PRIOR TO READMIT.

(6) DATE _____, 19____ (7) _____
SIGNATURE OF NURSING HOME ADMINISTRATOR

V. COUNTY TRANSFER:

(1) DATE TRANSFERRED OUT _____, 19____ TO _____ COUNTY
 (2) DATE TRANSFERRED IN _____, 19____ FROM _____ COUNTY
 (3) NEW HOUSEHOLD NUMBER _____

VI. ACTION:

(1) APPROVED _____ (5) COMMENTS: _____
 (2) DISCONTINUED _____
 (3) DENIED _____
 (4) EFFECTIVE DATE _____, 19____

DATE _____, 19____
SIGNATURE OF COUNTY DIRECTOR
 NURSING HOME

DEPARTMENT OR AGENCY NUMBER
CONTRACT ROUTING NUMBER

CONTRACT

THIS CONTRACT, made this _____ day of _____, 19____, by and between the State of Colorado for the use and benefit of the Department of "Social Services, 1575 Sherman Street, Denver, Colorado 80203" hereinafter referred to as the State, or the Department, and _____ hereinafter referred to as the contractor, or nursing home, or nursing facility.

WHEREAS, authority exists in the Law and Funds have been budgeted, appropriated and otherwise made available and a sufficient unencumbered balance thereof remains available for payment in Fund Number _____ G/L Account Number _____, Contract Encumbrance Number _____; and

WHEREAS, required approval, clearance and coordination has been accomplished from and with appropriate agencies; and

WHEREAS, the state has established a Colorado Medical Assistance Program, hereinafter referred to as the "program", by which to participate in Title XIX of the Social Security Act, hereinafter referred to as "Medicaid", through the Department; and

WHEREAS, Contractor is licensed to operate • health care facility and is certified to operate a(n) (skilled) (intermediate) care facility through the Colorado Department of Health, pursuant to Medicaid and Medicare statutes and regulations, • d desires to participate in the program and provide nursing services and care to eligible recipients; and

WHEREAS, Contractor has demonstrated • quantitative and qualitative need for Contractor's services to its geographic region, consistent with comprehensive health planning goals and data, for the duration of this contract; and

WHEREAS, as of the date of the execution of this contract, Contractor meets all other qualifications for participation in the program.

NOW THEREFORE, it is hereby agreed that

1. Contractor agrees to perform its duties and obligations hereunder in conformance with the provisions of Title XIX of the Social Security Act, other relevant federal law, all pertinent federal regulations promulgated pursuant to federal law, the Colorado Social Services Code, C.R.S. 1973, 26-i-101, et seq., including the Colorado Medical Assistance Act, C.R.S. 1973, 26-4-101, et seq., other relevant State law, the Colorado State Plan for medical assistance under Title XII, and all pertinent regulations of the Colorado Department of Social Services, as all the foregoing are in effect as of the date of the execution of this contract, or as they may later be amended.
2. This contract shall be for a term of commencing _____, and continuing to and including _____, unless earlier terminated by the Department under any of the following circumstances and for any of the following reasons:
 - (a) The Colorado Department of Health/United States Department of Health and Human Services has issued a conditional or short-term certification to contractor, dated _____, 19____, which specified the discovery of certain enumerated deficiencies in Contractor's facility. Unless said deficiencies are corrected on or before the _____ day of _____, 19____, this agreement will • tomatically expire on said date.
 - (b) In the event that Contractor should lose its license or certification from the Department of Health, this contract shall terminate as of the date of censure or decertification occurs.

- (c) In the event that Contractor should lose its certification to participate in the Title XVIII Program, the Department shall take such action concerning Title XIX certification as is consistent with law and regulation.
- (d) In the event that Contractor fails to comply with any of the provisions of this contract or statutes, rules, or regulations described herein at paragraph 1, this contract shall be terminated for "good cause" as defined in Staff Manual, VIII, Provider Appeals and Hearings Section.

3. Records and Information

- (a) Contractor agrees to keep such records as are necessary to disclose the extent of the services provided to individuals receiving Colorado medical assistance. Such records shall include, but not be limited to, dietary services, nurse staffing, drug use, and financial records relating thereto.
- (b) Contractor agrees to keep all records, plans and programs required by law and Department rules and regulations.
- (c) Contractor agrees to keep all records pertaining to personal needs accounts, including but not limited to bank statements and bank books.
- (d) Contractor agrees to keep all records of patient income received by Contractor and amounts due the Contractor on behalf of said patients.
- (e) Contractor agrees to keep all personal needs and medical records and supporting documents at the nursing home facility operated by Contractor.
- (f) Contractor agrees to make available, at all reasonable times during the contract period and five (5) years thereafter, all records and documents' pursuant to this agreement for inspection, audit, or reproduction by any authorized representative of the Department or appropriate federal agencies.
- (g) Contractor shall provide the Department with the same, complete and current ownership information required by and provided to the Department of Health pursuant to that Department's licensure regulations.

4. Contractor agrees to allow the Department of Health and Human Services, the Department and its designated and duly authorized representatives, including the Colorado Department of Health and the Medicaid Fraud Control Unit access to the health care facility at any time reasonable under the circumstances for purposes of conducting surveys, inspections, or audits as permitted or required by state and federal statutes and regulations and to allow medical review of the care received or being received by any recipient/patient who is or has been in the care and/or custody of the Contractor.

5. Contractor agrees to comply with the requirements of Title VI of the Civil Rights Act of 1964.

6. Payment Rate

- (a) Contractor shall be reimbursed by the Department in such amounts as shall from time to time be set by the Colorado Department of Social Services pursuant to the Medicaid statute, the Colorado Medical Assistance Act, and the rules and regulations promulgated thereunder.
- (b) Contractor agrees to accurately report to the Department on Form MED-13 (Financial and

Statistical Report for Nursing Homes) all patient related expenses and all sources of income. The contractor shall, in addition to its own signature, secure the signature of every accountant who in any way assists in the construction or completion of every Department Form NED-13 submitted to the Department.

- (c) All billings for reimbursement shall be submitted in a form. Banner, and amount provided for by Department rules and shall contain such information as may be required by the Department.
- (d) Contractor agrees to accurately report to the Department all money received on behalf of each patient. Contractor further agrees that no charges other than those made under the term of this contract and in accordance with law and Department rules shall be made to patients, their relatives, estates or any other person for Medicaid reimbursable services.
- (e) All warrants endorsed by and presented to a bank by Contractor shall constitute payment in full, except when endorsed under good faith protest pursuant to Title IV, C.R.S. 1973.
- (f) Contractor agrees to allow the Department or its designated representatives access to all information necessary to determine Contractor's reimbursement rate.
- (g) In the event that under or over-payments were administratively made in error by the State to the Contractor, the parties agree that adjustment shall be made pursuant to procedures established by the Department.
- (h) No advance payments shall be made by the Department pursuant to this contract. "Advance payments" are those made prior to the actual rendition of services by the Contractor.

7. Reapplication

In the event that Contractor intends to apply for a new contract upon the termination of this contract. Contractor agrees to reapply for said new contract by completing and submitting its application upon an approved contract form (MED-11A) not less than sixty (60) days prior to the termination date of this agreement to the Department of Social Services, Division of Medical Assistance. The Division of Medical Assistance may, on its own initiative, provide blank reapplication forms to the Contractor prior to the termination date of this contract, provided that, failure to so provide shall not constitute the state's waiver of or an estoppel to the Contractor's responsibilities under this paragraph.

8. Notice of Change of Ownership or Premature Termination of Contract

After the effective date of this contract, contractor shall notify this Department in writing of any change of ownership, as defined by Department regulations, not less than thirty (30) days prior to the effective date of that change. Contractor shall also provide the Department with sixty (60) days prior written notice of the date of termination of this contract in the event that date precedes the termination date described in paragraph 2 herein.

9. Declaration of Responsibility

The Contractor agrees to furnish a current Declaration to the Department which shall list the specific individual(s) who is (are) authorized to execute agreements on behalf of the Contractor. The Declaration, attached as Exhibit A to this contract, shall be signed and attested by an authorized corporate officer, a general partner, or the sole proprietor, as appropriate.

10. Surety Bond

Where applicable pursuant to law, the Contractor agrees to purchase and maintain a surety bond in the

amount of ten thousand dollars (\$10,000) to protect its patients' personal needs trust funds. A current copy of such bond shall be provided to the Department and must be on file prior to contract effective date.

- (a) Contractor agrees to replace any shortages determined by audit of the personal needs trust fund by the Department.
- (b) Contractor agrees to keep records of each patient's personal Deeds trust fund for a period of three (3) years from the date of the patient's discharge from the facility or until such records have been audited by the Department, whichever occurs last.
- (c) Contractor agrees, in the event of cancellation of the current surety bond, to give the Department written notice within five (5) days of such cancellation. Contractor further agrees to undertake a new bonding agreement within ten (10) days of such cancellation.
- (d) All bonding requirements set forth in this paragraph shall remain in effect until written release is made by the Department, pursuant to paragraph 15 of this contract.

11. Subcontracts

No subcontract for management or operation services shall be made by the Contractor with any other party for furnishing any work or services under this contract without the prior written consent and approval of the Department. This prior written consent shall be granted within thirty (30) days of the Department's receipt of written request unless for good cause shown.

12. Prohibition of Assignment

Neither the benefits nor the burdens of this contract may be assigned by the Contractor, either in whole or in part. The contract is void and automatically cancelled by the Department upon change of ownership of the health care facility or in the parties to the operational lease of a health care facility.

13. Insolvency

The contract is voidable and subject to immediate cancellation by the Department upon the Contractor's insolvency, including the filing of proceedings in bankruptcy.

14. Transfer of Patient Property

In the event of the termination or nonrenewal of this contract, all records, funds, and personal property of each patient-recipient, including personal needs trust monies, shall be transferred with the recipient to his/her new facility in a manner consistent with Department regulations. Any records not so transferred shall, at the written option of the State, either be transferred to the State or retained by the Contractor until written release by the State. All bonding shall remain in effect until written release is made by the State.

15. Integration

This agreement is intended as the complete integration of all understandings between the parties. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever, unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written contract executed and approved pursuant to the State Fiscal Rules.

16. Parties Relationship

The parties of this Contract intend that the relationship between them completed by this Contract is that of independent contractor. No agent, employee, or servant of Contractor shall be or shall be deemed to be

an employee, agent, or servant of Social Services. Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of this contract.

17. Indemnification

Contractor shall indemnify Social Services against all liability and loss, and against all claims and actions based upon or arising out of damage or injury, including death, to persons or property caused by or sustained in connection with the contractor's performance of this Contract or by conditions created thereby, or based upon any violation of any statute, ordinance, or resolution are the defense of any such claims or actions.

18. Payment

Payment pursuant to this Contract will be made as earned, in whole or in part, from available State funds for the purchase of nursing care services. It is agreed that the maximum amount of State funds available for the fiscal year is in the amount appropriated. The liability of the state, at any time, for such payments shall be limited to the unencumbered amount remaining of such funds.

19. Contingent Funding

This contract is subject to and contingent upon the continuing availability of Federal funds for the purposes hereof.

SPECIAL PROVISIONS

CONTROLLER'S APPROVAL

1. This contract shall not be deemed valid until it shall have been approved by the Controller of the State of Colorado or such assistant as he may designate. This provision is applicable to any contract involving the payment of money by the State.

FUND AVAILABILITY

2. Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted and otherwise made available.

BOND REQUIREMENT

3. If this contract involves the payment of more than fifty thousand dollars for the construction, erection, repair, maintenance, or improvement of any building, road, bridge, viaduct, tunnel, excavation or other public works for this State, the contractor shall, before entering the performance of any such work included in this contract, duly execute and deliver to and file with the official whose signature appears below for the State, a good and sufficient bond or other acceptable surety to be approved by said official in a penal sum not less than one-half of the total amount payable by the terms of this contract. Such bond shall be duly executed by a qualified corporate surety, conditioned for the due and faithful performance of the contract, and in addition, shall provide that if the contractor or his subcontractors fail to duly pay for any labor, materials, team hire, sustenance, provisions, provender or other supplies used or consumed by such contractor or his subcontractor in performance of the work contracted to be done, the surety will pay the same in an amount not exceeding the sum specified in the bond, together with interest at the rate of eight per cent per annum. Unless such bond, when so required, is executed, delivered and filed, no claim in favor of the contractor arising under this contract shall be audited, allowed or paid. A certified or cashier's check or a bank money order payable to the Treasurer of the State of Colorado may be accepted in lieu of a bond. This provision is in compliance with 38-26-106 CRS, as amended.

INDEMNIFICATION

4. To the extent authorized by law, the contractor shall indemnify, save and hold harmless the State, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the contractor, or its employees, agents, subcontractors, or assignees pursuant to the terms of this contract.

DISCRIMINATION AND AFFIRMATIVE ACTION

5. The contractor agrees to comply with the letter and spirit of the Colorado Antidiscrimination Act of 1957, as amended, and other applicable law respecting discrimination and unfair employment practices (24-34-402, CRS 1982 Replacement Vol.), and as required by Executive Order, Equal Opportunity and Affirmative Action, dated April 16, 1975. Pursuant thereto, the following provisions shall be contained in all State contracts or sub-contracts.

During the performance of this contract, the contractor agrees as follows:

- (1) The contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, marital status, religion, ancestry, mental or physical handicap, or age. The contractor will take affirmative action to insure that applicants are employed, and that employees are treated during employment, without regard to the above mentioned characteristics. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer, recruitment or recruitment advertising, lay-offs or terminations; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth provisions of this non-discrimination clause.
- (2) The contractor will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to race, creed, color, national origin, sex, marital status, religion, ancestry, mental or physical handicap, or age.
- (3) The contractor will send to each labor union or representative of workers with which he has collective bargaining agreement or other contract or understanding, notice to be provided by the contracting officer, advising the labor union or workers' representative of the contractor's commitment under the Executive Order, Equal Opportunity and Affirmative Action, dated April 16, 1975, and of the rules, regulations, and relevant Orders of the Governor.
- (4) The contractor and labor unions will furnish all information and reports required by Executive Order, Equal Opportunity and Affirmative Action of April 16, 1975, and by the rules, regulations and Orders of the Governor, or pursuant thereto, and will permit access to his books, records, and accounts by the contracting agency and the office of the Governor or his designee for purposes of investigation to ascertain compliance with such rules, regulations and orders.
- (5) A labor organization will not exclude any individual otherwise qualified from full membership rights in such labor organization, or expel any such individual from membership in such labor organization or discriminate against any of its members in the full enjoyment of work opportunity, because of race, creed, color, sex, national origin, or ancestry.
- (6) A labor organization, or the employees or members thereof will not aid, abet, incite, compel or coerce the doing of any act defined in this contract to be discriminatory or obstruct or prevent any person from complying with the provisions of this contract or any order issued thereunder; or attempt, either directly or indirectly, to commit any act defined in this contract to be discriminatory.

(7) In the event of the contractor's non-compliance with the non-discrimination clauses of this contract or with any of such rules, regulations, or orders, this contract may be canceled, terminated or suspended in whole or in part and the contractor may be declared ineligible for future State contracts in accordance with procedures, authorized in Executive Order, Equal Opportunity and Affirmative Action of April 16, 1975 and the rules, regulations, or orders promulgated in accordance therewith, and such other sanctions as may be imposed and remedies as may be involved as provided in Executive Order, Equal Opportunity and Affirmative Action of April 16, 1975, or by rules, regulations, or orders promulgated in accordance therewith, or as otherwise provided by law.

(8) The contractor will include the provisions of paragraphs (1) through (8) in every sub-contract and subcontract purchase order unless exempted by rules, regulations, or orders issued pursuant to Executive Order, Equal Opportunity and Affirmative Action of April 16, 1975, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any sub-contracting or purchase order as the contracting agency may direct, as a means of enforcing such provisions, including sanctions for non-compliance; provided, however, that in the event the contractor becomes involved in, or is threatened with, litigation with the subcontractor or vendor as a result of such direction by the contracting agency, the contractor may request the State of Colorado to enter into such litigation to protect the interest of the State of Colorado.

COLORADO LABOR PREFERENCE

6. A. Provisions of 8-17-101 & 102, CRS for preference of Colorado labor are applicable to this contract if public works within the State are undertaken hereunder and are financed in whole or in part by State funds.

B. When a construction contract for a public project is to be awarded to a bidder, a resident bidder shall be allowed a preference against a non-resident bidder from a state or foreign country equal to the preference given or required by the state or foreign country in which the non-resident bidder is a resident. If it is determined by the officer responsible for awarding the bid that compliance with this subsection. (b) may cause critical of federal funds which would otherwise be available or would otherwise be inconsistent with requirements of federal law, this subsection shall be suspended, but only to the extent necessary to prevent critical of the money or to substitute the inconsistency with federal requirements (sections 8-19-101 and 102, CRS).

GENERAL

7. The laws of the State of Colorado and rules and regulations issued pursuant thereto shall be applied in the interpretation, execution and enforcement of this contract. Any provision of this contract whether or not incorporated herein by reference which provides for arbitration by any extra-judicial body or person or which is otherwise in conflict with said laws, rules and regulations shall be considered null and void. Nothing contained in any provision incorporated herein by reference which purports to negate this or any other special provision in whole or in part shall be valid or enforceable or available in any action at law whether by way of contract, tort or otherwise. Any provision negates null and void by the operation of this provision will not invalidate the remainder of this contract to the extent that the contract is capable of enforcement.

8. At all times during the performance of this Contract, the Contractor shall strictly adhere to all applicable federal and state laws, rules and regulations that have been or may thereafter be established.

9. The regulations derived over time they are familiar with 15-6-101, et seq., (Bribery and Corruption Infringement, and 18-6-101, et seq., (Abuse of Public Office), CRS 1973 Replenishment Vol. and that no violation of such provisions is present.

10. The signatories over time to their knowledge, do state employee has a personal or beneficial interest whatsoever in the service of property, designated public.

IN WITNESS WHEREOF, the parties hereto have executed this Contract on the day first above written.

Contractor:

(Full Legal Name) _____

STATE OF COLORADO

JOE ROYER

GOVERNOR

By _____

EXECUTIVE DIRECTOR

Position (Title): _____

DEPARTMENT

OF _____

(If Corporation):

Agent (Sign):

By _____

APPROVALS

ATTORNEY GENERAL

CONTROLLER

By _____

By _____

*INSTRUCTIONS

- (1) Insert official Department designation, e. g., Administration, Local Affairs, etc., as appropriate.
 - (2) Set forth company(ies) or individual(s) name(s) and address(es).
 - (3) Insert a brief statement indicating reason for contract, e. g., "The contractor having special knowledge, experience and skill in diagnosing and treating diseases affecting cattle; and." Use as many "Whereas's" as required. If additional space is required continue to above words "NOW, THEREFORE," and state "continued on page 2" On page 2, state "Whereas continued from page 1" if required.
 - (4) Specify clearly the goods or services contracted for, the consideration moving from one party to the other, the time within which the contract is to be executed, limitations on assignments, if any, and special provisions desired, or required. Seek legal assistance when in doubt. Separate each principal item and number consecutively using as many pages as necessary.
 - (5) If a delegate signs for the Executive Director place the words "FOR THE" before the word "EXECUTIVE"
- Autographic, as distinguished from stamped, signatures should, as a minimum, be affixed to the original, which will be filed by the Division of Accounts and Control, and two counterparts, one of which shall be transmitted to the contractor. If there is more than one contractor a copy so signed will be sent to each, thus requiring additional autographic signatures.

FINANCIAL AND STATISTICAL REPORT FOR NURSING HOMES

NURSING HOME _____ ALPHA-NUMERIC NUMBER _____

ADDRESS _____

PERIOD OF REPORT: FROM _____ TO _____

A. Type of Control (Check one only):

GOVERNMENT

☐ State☐ County☐ District☐ City☐ Other

NON-PROFIT ORGANIZATION

☐ Church operated☐ Church related☐ Other non-profit

PROPRIETARY

☐ Individual☐ Partnership☐ Corporation☐ S* CorporationB. Accounting Basis: ☐ Accrual☐ Modified Cash☐ Cash

C. Statistical data:

1. Number of beds authorized, beginning of period
2. Number of beds authorized, end of period
3. Total bed-days for reporting period
4. Total patient days for reporting period
5. Total Medicaid patient days for reporting period
6. Percent occupancy (item 4 divided by item 3)
7. Number of admissions
8. Number of discharges
9. Private pay rate as of first month in reporting period

Intermediate	Skilled	Total

D. Certification Statement

I understand that this form (MED-13) and its supporting schedules will be filed with the Colorado Department of Social Services and will become part of that agency's records, and that any misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under State or Federal law.

I certify that I have read the above statement and examined this form (MED-13) and its supporting schedules, and that it is a true, correct, and complete statement prepared from the books and records of the nursing home, and in compliance with pertinent State and Federal statutes and regulations. I also certify that all expenses included in Column 12 of Schedule C herein were actually incurred and were necessary, reasonable, and related to the care of patients in this nursing home.

Date_____
Signature of Licensed Owner
(or Corporate Officer)_____
Date_____
Signature of Preparer

The certification must be signed by the licensed owner, (or corporate officer), and the preparer of the MED-13.

NOTE

If the nursing home does not provide all or any part of the requested information in this form (MED-13), the report will be considered incomplete and unacceptable for purposes of reimbursement under Title XIX.

NURSING HOME: _____
PERIOD OF REPORT: _____ TO _____

SCHEDULE A

REVENUES:	GENERAL LEDGER	ENTER IN COLUMN 9, SCHEDULE C	
		AMOUNT	LINE(S) #
Patient Revenue Centers:			
Routine daily service _____	\$		
Pharmacy—drugs and medications _____		\$	
Medical supplies _____			
Laboratory _____			
X-ray _____			
Occupational therapy _____			
Recreational therapy _____			
Professional care—physicians _____			20
Beauty, barber shop _____			23
Personal purchases for patients _____			24
Oxygen _____			
Room Reservation _____			33
Other Revenue Centers:			
Revenue from meals sold to guests and employees _____			4
Rental income _____			8
Income of telephone and telegraph charges paid by patients, guests, and employees _____			1
Purchase discounts, if recorded _____			1
Revenues from supplies employees _____			14, 15
Rebates _____			5, 14
Religious income _____			1
Investment income (see instructions) _____			29
Other _____			
GROSS REVENUE: _____			
Deductions from Revenue:			
Free care and allowances _____			
Provision for uncollectible accounts _____			
Total deductions _____			
NET REVENUE _____	\$	\$	34

NURSING HOME: _____

PERIOD OF REPORT: _____ TO: _____

ME-13 (Rev. 9/87) SCHEDULE B

(ENTER ADJUSTMENTS ON SCHEDULE C ON THE LINE FOR THE EXPENSE CENTER AFFECTED)		ENTER IN COLUMN 10, SCHEDULE C	
		AMOUNT	LINE(S) NO.
NON-REIMBURSABLE EXPENSES:			
Provisions for income taxes	\$		32
Fees paid Board of Directors (1)			3
Non-working officers' salaries (1)			3
Promotion expense			3
Travel and entertainment, other than for professional meetings and direct operations of the Home			2
Donations			1
Expenses of non-nursing home facilities included in expense			3
Fund-raising expenses			14
Pharmacy, drugs and medications — cost reimbursed			15
Medical supplies — cost reimbursed			1
Insurance premiums on life of officer, owner			
Other expenses not related to patient care			
EXPENSE LIMITATIONS: (3)			
Salaries, etc., of owners			
Position	Paid	Allowable	Hrs/Wk
Administrator	\$	\$	1
Assistant Administrator			
Management fees			1
Physicians			1.20
Nursing Director			10
Other			
Advertising expense in excess of the lesser of \$3,600 or an amount computed at 2% of routine daily service revenue			
Depreciation computed under accelerated methods (4)			
\$			
Less straight-line depreciation — Schedule D			
Amount excluded			
Interest expense in excess on loans from partners, proprietors, stockholders, or related organizations (5)			
Expense, \$: Allowable, \$			
Services, facilities, supplies furnished by organizations related to the nursing home by common ownership or control (6):			
	Paid	Allowable	
Rental of facility	\$	\$	31
Rental of equipment			21
Services (describe)			
Supplies (describe)			
EXPENSE ADDITIONS: (7)			
Salaries, etc., of nonsalaried proprietors and partners: members of Religious Orders:			
	Paid	Allowable	(Addition)
Administrator	\$	\$	1
Nursing Director			10
Other			
Amount (added)		\$	
TOTAL (8)		\$	34

NURSING HOME _____
 PERIOD OF REPORT: _____ TO _____
SCHEDULE C—EXPENSES MED-13 (Rev. 9/87)

LINE	EXPENSE CENTERS	1 SALARIES	2 SUPPLIES	3 UTILITIES	4 PURCHASED SERVICES	5 REPAIRS
1	Administrative and General					
2	Travel and entertainment					
3	Insurance, other than property					
	Total administrative & general					
	Room and Board:					
4	Dietary other than food (2)					
5	Food (3)					
6	Laundry and linen (4)					
7	Housekeeping					
8	Plant operation and maintenance (5) (6)					
	Total room and board					
	Health Care: (7)					
10	Nursing service					
11	R.N.'s					
12	L.P.N.'s					
13	Other					
14	Pharmacy (8)					
15	Medical Supplies (8)					
16	Laboratory					
17	X-ray					
18	Therapies					
19	Oxygen Services					
20	Professional care—physicians					
21						
	Total health care					
23	Beauty, barber, shoe					
24	Personal purchases for patients					
	Property and related expense: (9)					
25	Depreciation (from Schedule D)					
26	Amortization, leasehold (from Schedule D)					
27	Real estate taxes					
28	Rent (See Schedule B, instruction 5)					
29	Interest					
30	Insurance, other expense					
31	Total property etc.					
32	Income taxes					
33						
34	TOTALS					
35	Allowance for "compensation"					
36	Total					
37	Per diem cost of patient service (Column 12, line 36, divided by number of patient days)					

[illegible]

MEF-13 (Rev. 7/1/87)

PROVIDER NAME _____

PROVIDER NO. _____

PERIOD OF REPORT - FROM: _____

TO: _____

SCHEDULE D - DEPRECIATION/AMORTIZATION SCHEDULE - COLORADO MEDICAID

Non Fair Rental Property	Appraised Value (1)	Cost At Beginning Of Period	Additions During Period(4)	Disposals During Period(4)	Cost At End Of Period	Depr. Amort Expense	Sch C Line No.	Sch C Col. No.
Departmental Equipment	XXXXXXXX	_____	_____	_____	_____	_____	_____	_____
Other Equipment	XXXXXXXX	_____	_____	_____	_____	_____	_____	_____
Motor Vehicles	XXXXXXXX	_____	_____	_____	_____	_____	_____	_____
Amortizable Items (3)	XXXXXXXX	_____	_____	_____	_____	_____	_____	_____
Total Non Fair Rental Property	XXXXXXXX	_____	_____	_____	_____	_____	XXXX	XXXX
Fair Rental Property (2)								
Fixed Equipment	_____	_____	_____	_____	_____	_____	_____	_____
Building & Improvements	_____	_____	_____	_____	_____	_____	_____	_____
Leasehold Imprv & Amortizable Items	_____	_____	_____	_____	_____	_____	_____	_____
Land (Site) Improvements	_____	_____	_____	_____	_____	_____	_____	_____
Land	_____	_____	_____	_____	_____	XXXXXXXX	XXXX	XXXX
Total Fair Rental Property	_____	_____	_____	_____	_____	_____	XXXX	XXXX

QUESTIONS:

- Does any item included in this schedule pertain to any property that is not patient related to beds listed on page 1 of Med-13? ☐ Yes ☐ No
- Does any item included in this schedule pertain to a lease? ☐ Yes ☐ No
- If 2 is Yes, are the lessor and lessee the same person or group of persons or controlled by the same person or group of persons? ☐ Yes ☐ No
- If 2 is Yes, is this a capital lease and are costs reported on Schedule C in accordance with generally accepted accounting principles? ☐ Yes ☐ No

- Class II & III waived facilities should leave this column blank. All other facilities must fill in this column.
- Property in this section must comply with the definition in CDSS rule 8.448.7. Class II & Class III waived facilities are not required to comply with the rule.
- Amortization of capitalized expense not included in fair rental property (i.e. startup costs).
- Please submit detailed information for any addition or disposal in excess of \$5,000 including: date placed into service or disposed, description and purpose of property, location, and cost basis.

NURSING HOME: _____
 PERIOD OF REPORT _____ TO _____

MED-13
 (Cont.)

SCHEDULE E - COMPARATIVE BALANCE SHEET

(Note—This schedule should be prepared from the
 Home's General Ledger or other general records.)

	BALANCE AT END OF	
	CURRENT YEAR	PREVIOUS YEAR
ASSETS:		
Cash _____	\$ _____	\$ _____
Receivable from patients _____		
Receivable from others _____		
Fixed assets:		
Land _____		
Buildings and improvements _____		
Less reserves for depreciation (per books) _____		
Equipment (including autos) _____		
Less reserves for depreciation (per books) _____		
Investments and other assets _____		
TOTAL ASSETS _____	\$ _____	\$ _____
LIABILITIES AND EQUITY:		
Accounts payable _____	\$ _____	\$ _____
Accrued taxes (payroll and property) _____		
Current financing—Medicare _____		
Other liabilities _____		
Notes and mortgages payable to officers, stockholders, owners, etc. _____		
Notes and mortgages payable to others _____		
Total liabilities _____		
Equity (Corporation):		
Capital stock _____		
Paid-in surplus _____		
Retained earnings _____		
Equity (partnership/proprietorship):		
Partners'/proprietor's capital account(s) _____		
Partners'/proprietor's drawing account(s) _____		
Equity (Non-profit organization) _____		
Total equity _____		
TOTAL LIABILITIES AND EQUITY _____	\$ _____	\$ _____

NURSING HOME: _____
 PERIOD OF REPORT: _____ to _____
 SCHEDULE F - STATEMENT OF COSTS APPLICABLE TO SERVICES, FACILITIES, AND
 SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO THE NURSING
 HOME BY COMMON OWNERSHIP OR CONTROL.

MED-13
 (Cont.)

A. Are there any expenses included on Schedule C which resulted from transactions with related organizations as defined?

☐ No ☐ Yes (If "Yes," complete Parts B and C)

B. Expenses incurred and adjustment required as result of transactions with related organizations:

LOCATION AND AMOUNT INCLUDED ON SCHEDULE C				Adjustment	Amount
Line No.	Expense Center	Expense Items	Amount	Entered on Schedule B	Allowable in Expenses
		(column number)			
1	2	3	4	5	6
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
TOTALS					

C. Interrelationship of nursing home to related organization(s):

Symbol (1)	Name	Percent Ownership of Home	Related Organization(s)		
			Name	Percent of Ownership	Type of Business
1	2	3	4	5	6
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

(1) Symbols - Use the following symbols to indicate the interrelationship of the nursing home to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in nursing home.
- B. Corporation, partnership, or other organization has financial interest in nursing home
- C. Nursing home has financial interest in corporation, partnership, or other organization
- D. Director, officer, administrator, or key person of nursing home or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of nursing home and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in nursing home.
- G. Other (financial or non-financial) specify.

IF THE NURSING HOME DOES NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE REPORT WILL BE CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF REIMBURSEMENT UNDER TITLE XIX.

THIS SCHEDULE PROVIDES FOR THE COMPUTATION OF ANY NEEDED ADJUSTMENTS TO EXPENSES APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED TO THE NURSING HOME BY ORGANIZATIONS RELATED TO THE NURSING HOME BY COMMON OWNERSHIP OR CONTROL. IN ADDITION, CERTAIN INFORMATION CONCERNING THE RELATED ORGANIZATIONS WITH WHICH THE NURSING HOME HAS TRANSACTED BUSINESS SHOULD BE SHOWN.

PART A must be completed by all nursing homes. If the answer to Part A is "Yes," Parts B and C must also be completed.

PART B--Expenses applicable to services, facilities, and supplies furnished to the nursing home by organizations related to the nursing home by common ownership or control are includable in the allowable cost of the nursing home at the cost to the related organization. However, such cost must not exceed the amount a prudent and cost-conscious buyer would pay for comparable services, facilities, or supplies that could be purchased elsewhere.

PART C--This part is used to show the interrelationship of the nursing home to organizations furnishing services, facilities, or supplies to the nursing home. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to the nursing home, a common ownership of the nursing home, or control over the nursing home as defined, must be shown in columns 1 through 6, as appropriate.

Only those columns which are pertinent to the type of relationship which exists should be completed.

Column 1--Enter the appropriate symbol which describes the interrelationship of the nursing home to related organization.

Column 2--If the symbol A, F, E, F, or G, if appropriate, is entered in column 1, enter the name of the related individual in column 2.

Column 3--If the individual in column 2 or the organization in column 4 has a financial interest in the nursing home, enter in this column the percent of ownership in the nursing home.

Column 4--Enter in this column the name of the related corporation, partnership, or other organization.

Column 5--If the individual in column 2 or the nursing home has a financial interest in the related organization, enter in this column the percent of ownership in such organization.

Column 6--Enter in this column the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

8.448.7 ITEMS FURNISHED BY RELATED ORGANIZATIONS OR COMMON OWNERSHIP.

Costs applicable to services, facilities, and supplies furnished by organizations related to the nursing home by common ownership or control are includable in the allowable cost of the nursing home at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

DEFINITIONS CONCERNING RULE 8.448.7

Related to the Nursing Home - Means that the nursing home, to a significant extent, is associated or affiliated with or has control of or is controlled by, the organization furnishing the services, facilities, or supplies.

Common Ownership - Exists when an individual or individuals possess significant ownership or equity in the nursing home and the institution or organization serving the nursing home.

Control - Exists where an individual or an organization has power. Directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

8.448.71 APPLICATION OF RULE 8.448.7

Individuals and organizations associate with others for various reasons and by various means. Some deem it appropriate to do so to assure a steady flow of supplies or services, to reduce competition to gain a tax advantage, to extend influence, and for other reasons. These goals may be accomplished by means of ownership or control, by financial assistance, by management assistance, and other ways.

Where the nursing home obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is owned or controlled by the owner(s) of the nursing home, in effect the items are obtained from itself. An example would be a corporation building a nursing home and then leasing it to another corporation controlled by the owner. Therefore, reimbursable cost should include the costs for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the nursing home shall not exceed the market price.

THIS FORM PRESCRIBED BY THE
COLORADO STATE DEPARTMENT OF SOCIAL SERVICES-DIVISION OF PUBLIC WELFARE
MEDICAL SERVICES SECTION

UTILIZATION REVIEW REPORT

FACILITY - NAME, ADDRESS, CITY AND STATE

PATIENT'S IDENTIFICATION NUMBER AGE SEX ADMISSION DATE DATE OF LAST REVIEW

ADMITTING DIAGNOSIS (ES)

PRESENT DIAGNOSIS (ES)

REVIEW FACTORS	YES NO		EXPLANATORY COMMENTS
	A. THIS ADMISSION WAS NECESSARY..... THIS LENGTH OF STAY WAS NECESSARY.....		
B. THERE WAS APPROPRIATE USE OF ANCILLARY SERVICES, E.G., LABORATORY; X-RAY; PHYSICAL, OCCUPATIONAL, RECREATIONAL THERAPY, SOCIAL SERVICES.....			
C. THERE WAS APPROPRIATE USE OF CONSULTATION E.G., PHYSICIAN, DIETITIAN.....			
D. THE TYPE AND QUANTITY OF DRUG THERAPY WAS APPROPRIATE TO THE DIAGNOSIS (ES)..... THE DRUG THERAPY CONFORMED WITH THE PHYSICIAN'S WRITTEN ORDERS..... THE DRUG THERAPY CONFORMED WITH THE FACILITY'S STOP ORDER POLICIES.....			
F. THIS PATIENT IS CAPABLE OF SELF-ADMINISTERING HIS MEDICATIONS ON A 24 HR. BASIS..... THE ATTENDING PHYSICIAN HAS ORDERED IN WRITING THAT HIS MEDICATIONS ARE TO BE SELF-ADMINISTERED.....			
F. THE PLANNED REGIMEN OF MEDICAL CARE WAS APPROPRIATE TO THE PATIENT'S NEEDS..... THE DIET WAS APPROPRIATE TO THE PATIENT'S NEEDS..... THE NURSING CARE WAS APPROPRIATE TO THE PATIENT'S NEEDS..... THE PATIENT REQUIRES 24 HR. NURSING SERVICE.....			
G. THE PATIENT'S CARE WAS APPROPRIATE TO ANY INDICATED PROBLEMS, E.G., BE- HAVIORAL, SOCIAL, BLADDER-BOWEL, AMBULATION, SKIN AND INFECTION PROBLEMS; INCIDENTS RELATING TO POSSIBLE INJURY.....			
H. THE CLINICAL RECORD WAS ADEQUATE.....			
I. THE CERTIFIED LEVEL OF CARE WAS APPROPRIATE AND TIMELY.....			

(USE ATTACHED SHEET IF NEEDED)

CONTINUED STAY FOR:	RECOMMEND	TRANSFER FOR:
HOSPITAL CARE.....		
EXTENDED CARE.....		
SKILLED NURSING CARE (24 HR. NURSING SERVICE).....		
INTERMEDIATE CARE (WITHOUT 24 HR. NURSING SERVICE).....		
RESIDENTIAL CARE (WITHOUT NURSING SERVICE).....		
HOME HEALTH SERVICES.....		

ADDITIONAL COMMENTS:

SIGNATURE M.D., CHAIRMAN UTILIZATION REVIEW COMMITTEE DATE

PREPARE IN DUPLICATE: ORIGINAL TO BE RETAINED WITH YOUR COMMITTEE MINUTES - COPY TO PATIENT'S FILE.

COLORADO DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES SECTION

NURSING HOME UTILIZATION REVIEW COMMITTEE REPORT

DEAR DR.

THE UTILIZATION REVIEW COMMITTEE HAS REVIEWED YOUR PATIENT: _____
AND RECOMMENDS THAT THE CLASSIFICATION BE CHANGED FROM:

_____ TO _____; FOR THE FOLLOWING REASONS: _____

IF YOU CONCUR WITH THIS ACTION, PLEASE SIGN AND DATE THIS FORM IN THE SPACE PROVIDED BELOW AND
RETURN THE FORM TO THE UTILIZATION REVIEW COMMITTEE.

IF YOU DO NOT AGREE, PLEASE INDICATE YOUR REASONS IN THE SPACE PROVIDED FOR COMMENT AND RETURN
THE FORM TO THE UTILIZATION REVIEW COMMITTEE.

SIGNATURE _____

U. R. COMMITTEE _____
(NURSING HOME)

DATE _____

COMMENT BY ATTENDING PHYSICIAN _____

SIGNATURE OF ATTENDING PHYSICIAN _____

DATE _____

DISPOSITION OF COMPLETED FORM: ORIGINAL TO N.H.-U.R. COMM. & MEDICAL FILE
COPY TO RECIPIENT'S COUNTY DEPARTMENT
COPY TO STATE DEPARTMENT OF SOCIAL SERVICES

COLORADO STATE DEPARTMENT OF SOCIAL SERVICES-DIVISION OF PUBLIC WELFARE
MEDICAL SERVICES SECTION

NURSING HOME UTILIZATION REVIEW PLAN

PHILOSOPHY

UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL PROVIDE A METHOD OF PEER REVIEW BY PHYSICIANS AND DESIGNATED CONSULTING PROFESSIONAL PERSONNEL TO ASSURE QUALITY PATIENT CARE, AND A RANGE AND APPROPRIATE USE OF HEALTH CARE FACILITIES AND SERVICES AND COST CONTROLS. TO PROMOTE EFFECTIVE HEALTH CARE, THE UTILIZATION REVIEW COMMITTEE IDENTIFIES THOSE FACTORS AND MAKES SPECIFIC RECOMMENDATIONS THAT MAXIMIZE MORE EFFECTIVE PATIENT CARE COMMENSURATE WITH THE NEEDS OF THE PATIENTS.

THE UTILIZATION REVIEW COMMITTEE IS A FACT-FINDING EDUCATIONAL INSTRUMENT OF THE HEALTH CARE FACILITY. THE COMMITTEE REPORTS RELEVANT INFORMATION AND MAKES RECOMMENDATIONS TO THE ADMINISTRATION AND GOVERNING BODY, ATTENDING PHYSICIANS, AND COOPERATING REVIEW COMMITTEES FOR APPROPRIATE ADMINISTRATIVE AND PROFESSIONAL CONSIDERATION AND ACTION.

UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL IS DELEGATED TO: (a) ESTABLISHED UTILIZATION REVIEW COMMITTEES IN HEALTH CARE FACILITIES LICENSED AS NURSING CARE FACILITIES, INTERMEDIATE HEALTH CARE FACILITIES, RESIDENTIAL CARE FACILITIES, AND FACILITIES FOR THE MENTALLY RETARDED; (b) COMPONENT MEDICAL SOCIETY UTILIZATION REVIEW COMMITTEES; (c) REGIONAL REVIEW COMMITTEES OF THE STATE MEDICAL SOCIETY; AND (d) THE STATE MEDICAL SOCIETY COMMITTEE ON UTILIZATION REVIEW.

COLORADO STATE DEPARTMENT OF SOCIAL SERVICES-DIVISION OF PUBLIC WELFARE
MEDICAL SERVICES SECTION

UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL COMMITTEE

FACILITY'S NAME

I. OBJECTIVES

FACILITY'S NAME UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL COMMITTEE
IS A FACT-FINDING, EDUCATIONAL COMMITTEE ESTABLISHED TO REVIEW SYSTEMATICALLY THE
QUALITY OF PROFESSIONAL SERVICES RENDERED BY PHYSICIANS AT _____
FACILITY'S NAME
AND THE EFFECTIVENESS OF THE UTILIZATION OF _____
FACILITY'S NAME FACILITIES
AND SERVICES.

THIS COMMITTEE IS ESTABLISHED WITH THE COOPERATION OF _____
APPROPRIATE MEDICAL SOCIETY(IES)
AND, AS NECESSARY, _____ OR _____
HOSPITAL(S) OTHER

IN THE REGIONS.
NURSING CARE FACILITY (IES)

THE COMMITTEE REPORTS RELEVANT INFORMATION AND MAKES RECOMMENDATIONS TO _____

FACILITY'S NAME ADMINISTRATOR AND GOVERNING BODY, ATTENDING PHYSICIANS,
AND COOPERATING REVIEW COMMITTEES FOR APPROPRIATE ADMINISTRATIVE AND PROFESSIONAL
CONSIDERATION AND ACTION.

II. AUTHORITY

_____, GOVERNING BODY _____, 19____
 (FACILITY'S NAME) (MONTH & YEAR)

DESIGNATED THE FOLLOWING UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL COMMITTEE:

_____, M.D. ADDITIONAL OR ALTERNATE PHYSICIAN'S
 _____, M.D. _____, M.D.
 _____, M.D. _____, M.D.

III. ORGANIZATION AND COMPOSITION

THIS COMMITTEE OF _____ PHYSICIANS, NONE OF WHOM MAINTAIN A FINANCIAL INTEREST IN _____
 _____, FACILITY'S NAME HAS DESIGNATED _____, M.D.,
 CHAIRMAN. NO COMMITTEE MEMBER WILL PARTICIPATE IN THE REVIEW OF A CASE IN WHICH HE IS
 PROFESSIONALLY INVOLVED. PROFESSIONAL PERSONNEL, OTHER THAN PHYSICIANS, WHO SERVE
 AS CONSULTANTS TO THE COMMITTEE: E.G. - ADMINISTRATOR, NURSE, SOCIAL WORKER, OR
 OTHERS.

 _____, ETC.

IV. MEETINGS

THE UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL COMMITTEE WILL CONDUCT AT LEAST
 MONTHLY MEETINGS. MORE FREQUENT MEETINGS MAY BE HELD. BETWEEN REGULARLY SCHEDULED
 COMMITTEE MEETINGS, COMMITTEE MEMBERS SHOULD REVIEW CLINICAL CASES AND RECORDS IN
 THE FACILITY AND PRESENT THEIR FINDINGS TO THE COMMITTEE FOR DISCUSSION AND DISPOSITION.
 A SECRETARY, DESIGNATED BY THE ADMINISTRATION, WILL RECORD (EXCLUDING PATIENT AND
 PHYSICIAN NAMES) MINUTES OF THE COMMITTEE'S TRANSACTIONS. MINUTES WILL INCLUDE THE
 TYPES AND NUMBER OF CASES REVIEWED; DISCUSSIONS, FINDINGS, AND DISPOSITION OF THOSE
 CASES, INCLUDING EXTENDED DURATIONS, THAT WERE QUESTIONED; AND APPROPRIATE RECOM-
 MENDATIONS. THE RECORDED MINUTES WILL BE ON FILE IN THE FACILITY. SPECIAL REPORTS
 WILL BE PREPARED ON REQUEST OF THE COLORADO DEPARTMENT OF SOCIAL SERVICES, COLO-
 RADO DEPARTMENT OF HEALTH, AND _____.

✓ WHEN ANY CHANGE IN THE MEMBERSHIP OF THE COMMITTEE IS MADE, IT IS YOUR RESPONSIBILITY
 TO NOTIFY MEDICAL SERVICES SECTION, DEPARTMENT OF SOCIAL SERVICES.

V. FUNCTIONS AND RESPONSIBILITIES

THE UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL COMMITTEE IS RESPONSIBLE FOR SURVEILLANCE OF THE QUALITY OF PATIENT CARE THROUGH REVIEW AND EVALUATION OF CLINICAL MEDICAL CARE AND RECORDS, THE PHARMACEUTICAL AND THERAPEUTIC PRACTICES, INFECTION CONTROL, AND THE UTILIZATION OF FACILITIES AND SERVICES.

(a) CONTINUING REVIEW FUNCTIONS

ON A CONTINUING STATISTICAL BASIS, NECESSITY FOR ADMISSIONS, TRANSFERS, LENGTH OF STAY AND DISCHARGES; (INCLUDING THOSE BY DEATH TO DETERMINE IF PATTERNS EXIST AND WHETHER CORRECTIVE MEASURES ARE WARRANTED) WILL BE STUDIED AND ANALYZED WITH APPROPRIATE REPORTS AND RECOMMENDATIONS THAT WILL PROMOTE THE MOST EFFECTIVE USE OF THE FACILITIES AND SERVICES.

(b) INDIVIDUAL CASE REVIEW FUNCTIONS

INDIVIDUAL CASES WILL BE REVIEWED USING THE COMPLETE MEDICAL RECORD, INTERVIEWS WITH THE ATTENDING PHYSICIAN, AND OBSERVATION OF THE PATIENT. THIS REVIEW INCLUDES THE FOLLOWING:

- (1) NECESSITY FOR ADMISSION AND LENGTH OF STAY.
- (2) APPROPRIATE USE OF ANCILLARY SERVICES, E.G., LABORATORY, X-RAY; PHYSICAL, OCCUPATIONAL, RECREATIONAL THERAPY; SOCIAL SERVICES.
- (3) APPROPRIATE USE OF CONSULTATION, E.G., PHYSICIAN, DIETITIAN.
- (4) DRUG THERAPY, E.G., TYPE, QUANTITY, AND APPROPRIATENESS TO THE DIAGNOSIS(ES); CONFORMITY WITH PHYSICIAN'S WRITTEN ORDERS AND FACILITY'S STOP ORDER POLICIES.
- (5) THIS PATIENT IS CAPABLE OF SELF ADMINISTERING HIS MEDICATIONS ON A 24 HR. BASIS. THE ATTENDING PHYSICIAN HAS ORDERED IN WRITING THAT HIS MEDICATIONS ARE TO BE SELF-ADMINISTERED.
- (6) APPROPRIATENESS OF THE DIET AND NURSING CARE TO THE PATIENT'S NEEDS.
- (7) OTHER FACTORS, E.G., BEHAVIORAL, SOCIAL, BLADDER-BOWEL, AMBULATION, SKIN, AND INFECTION PROBLEMS; INCIDENTS RESULTING IN POSSIBLE INJURY.
- (8) ADEQUACY OF THE CLINICAL RECORD.
- (9) APPROPRIATENESS AND TIMELINESS OF THE CERTIFICATION OF LEVEL OF CARE, I.E.: EXTENDED CARE, SKILLED NURSING CARE OR INTERMEDIATE CARE.

FOR TITLE XVIII, MEDICARE BENEFICIARY CASES,* THE EXTENDED DURATION PERIOD WILL BE 36 CONTINUOUS DAYS OF STAY IN EXTENDED CARE FACILITY. FOR EACH SUCH BENEFICIARY CASE, A REVIEW WILL BE MADE WITHIN 7 DAYS FOLLOWING THE LAST DAY OF EXTENDED STAY.

* APPLICABLE ONLY WHEN THE FACILITY ALSO IS CERTIFIED AS A PROVIDER OF EXTENDED CARE SERVICES UNDER TITLE XVIII, MEDICARE.

TITLE XIX MEDICAID RECIPIENTS WHO RECEIVE SKILLED CARE, WILL BE SO SCHEDULED AS TO PERMIT ANNUAL REVIEW OF EACH CASE. THOSE RECEIVING INTERMEDIATE CARE WILL BE SIMILARLY SCHEDULED FOR SEMI-ANNUAL REVIEW.

UNDER PUBLIC HEALTH LICENSING RULES FOR OTHER CASES, REVIEWS WILL BE MADE ON A SAMPLE BASIS. THE ATTENDING PHYSICIAN'S JUDGMENT WILL BE RESPECTED AND WILL NOT BE REJECTED EXCEPT UNDER UNUSUAL CIRCUMSTANCES. AFTER CONSULTATION WITH THE ATTENDING PHYSICIAN, SHOULD THE COMMITTEE DETERMINE THAT A CHANGE IN THE LEVEL OF CARE IS MEDICALLY INDICATED IN ANY INDIVIDUAL CASE, THE ATTENDING PHYSICIAN, THE PATIENT AND HIS REPRESENTATIVE WILL BE NOTIFIED IN WRITING WITHIN 48 HOURS BY THE ADMINISTRATION.

VI ADMINISTRATIVE RESPONSIBILITIES

TO SUPPORT AND ASSIST THE COMMITTEE, THE ADMINISTRATION WILL:

- (a) MAINTAIN LIAISON AMONG GOVERNING BODY, THE UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL COMMITTEE AND PHYSICIANS WHOSE PATIENTS ARE CARED FOR IN THE FACILITY.
- (b) PROVIDE CURRENT AND PERTINENT INFORMATION AND CONDUCT RELEVANT STUDIES.
- (c) FACILITATE MEDICAL CARE AND RECORD REVIEWS.
- (d) MAINTAIN COMMITTEE RECORDS.
- (e) FACILITATE IMPROVED POLICIES AND PROCEDURES.
- (f) PROMOTE EFFICIENT USE OF AVAILABLE HEALTH SERVICES AND FACILITIES, E.G. TIMELY DISCHARGE PLANNING, POST DISCHARGE CARE WITH OTHER HEALTH FACILITIES OR AGENCIES, PROMPT TRANSFER OF APPROPRIATE MEDICAL AND NURSING INFORMATION, ALTERNATIVES TO IN-PATIENT SERVICES.

RESPONSIBILITIES OF RELATED ADMINISTRATIVE STAFF IN SUPPORT OF UTILIZATION REVIEW.

- (a) ASSISTANCE IN PLANNING OF POST DISCHARGE CARE AND MAKING ARRANGEMENTS WITH OTHER FACILITIES OR AGENCIES WHEN INDICATED.
- (b) SUPERVISION OF ACTIVITIES OF THE RECORD DEPARTMENT IN PROVIDING DATA FOR THE COMMITTEE.
- (c) ASSISTANCE IN IMPLEMENTING AND FOLLOW-UP OF RECOMMENDATIONS OF THE COMMITTEE AS RELATED TO MEDICAL RECORDS.
- (d) OVERALL RECOMMENDATIONS OF THE COMMITTEE. NOTIFY CHAIRMAN AND COMMITTEE MEMBERS AS PER NOTIFICATION REQUIREMENTS.

THIS UTILIZATION REVIEW AND MEDICAL CARE APPRAISAL PLAN WAS ADOPTED BY THE GOVERNING BOARD OF _____ FACILITY ON _____ 1970

SIGNED _____

COLORADO DEPARTMENT OF SOCIAL SERVICES-DIVISION OF PUBLIC WELFARE

AUTHORIZATION TO RECEIPT FOR DRUGS

NAME OF HOME _____

STREET _____

CITY _____

THIS FORM IS TO CERTIFY THAT THE _____
NURSING HOME

DOES HEREBY NOMINATE, CONSTITUTE AND APPOINT THE PERSON OR PERSONS WHOSE NAMES, POSITIONS AND SIGNATURES APPEAR BELOW TO BE ITS TRUE AND LAWFUL ATTORNEY IN FACT, FOR IT, AND IN ITS NAME, PLACE AND STEAD TO RECEIPT FOR PRESCRIPTIONS, DRUGS AND MEDICAL SUPPLIES DESIGNATED FOR RECIPIENTS OF WELFARE BENEFITS UNDER STATE AND FEDERAL MEDICAL ASSISTANCE LAWS FOR THE CATEGORICALLY NEEDY.

NAME	POSITION	SIGNATURE

THIS AUTHORIZATION HAS BEEN DELEGATED BY THE UNDERSIGNED AS ADMINISTRATOR OF THE _____

_____, WHO HEREBY CERTIFIES THAT HE HAS FULL AND COMPLETE AUTHORITY TO SO

DESIGNATE AND DELEGATE THE ABOVE-NAMED INDIVIDUALS TO BE ATTORNEYS IN FACT FOR SAID NURSING HOME FOR THE PURPOSES OF THE AFORESAID DESIGNATION AND WILL NOTIFY THE DEPARTMENT OF SOCIAL SERVICES IN THE EVENT ANY OF SAID INDIVIDUALS LEAVE THE EMPLOY OF SAID HOME OR OTHERWISE ARE NOT AUTHORIZED AS INDICATED IN THIS DOCUMENT.

ADMINISTRATOR

PLEASE REFER TO RULES A-1221.24, A-403.1.22, and A-123a.24.

SURETY BOND
Personal Needs Trust Fund

KNOW ALL MEN BY THESE PRESENTS, That we, _____,
_____ of _____,
as Principal, and _____, a Surety
Corporation authorized by law to transact business in the State of Colorado, as
Surety, are held and firmly bound unto the STATE OF COLORADO, DEPARTMENT OF SOCIAL
SERVICES, hereinafter called the Oblige, in the penal sum of TEN THOUSAND & NO/100
Dollars (\$10,000.00), lawful money of the United States of America to be paid to
said Oblige, for which payment well and truly to be made, we bind ourselves, our
heirs; executors, administrators, successors and assigns, jointly and severally,
firmly by these presents.

Now therefore, the Condition of this Obligation is such, that if the said
Principal shall faithfully observe the provisions of Senate Bill 318, Section 3,
26-4-116, then this Obligation shall be null and void, otherwise to remain in full
force and effect.

"Failure by the Principal to faithfully observe the provisions
of Senate Bill 318 (Session Laws, 1977, C.R.S. 1973, 26-4-116
(3), as amended) shall be determined to occur upon the follow-
ing events:

- (1) An audit or investigation of the Personal Needs Trust
Account established by the Principal determines that there is
a shortage of Personal Needs Trust Funds existing in such ac-
count; and,
- (2) A demand is made by the Oblige and the Principal has
failed to render payment in full of said shortage pursuant
to the promulgated rules and regulations of the Oblige, at
which time the Surety Company will be notified of such short-
age. Upon such failure of the Principal to faithfully observe
the provisions of Senate Bill 318 (Session Laws, 1977, C.R.S.
1973, 26-4-116(3), as amended), the Oblige shall demand in
writing to the Surety payment in full of any unpaid shortage
in the Personal Needs Trust Account. Upon receipt of such
demand, the Surety is obliged to immediately pay the amount of
the demand in full up to \$10,000."

HOWEVER, in no event shall the total aggregate liability of the Surety exceed
the penal sum of \$10,000.

Liability under this bond shall terminate as of the 31st day of December,
19____, as to any acts subsequent thereto, unless said bond is continued in force
from year to year by the issuance of a Continuation Certificate signed by the
Surety.

The Surety may cancel this bond at any time by filing with the Obligee thirty (30) days written notice of its desire to be relieved of liability. The Surety shall not be discharged from any liability already accrued under this bond, or which shall accrue hereunder before the expiration of the thirty day period.

Signed, sealed and delivered this _____ day of _____,
19____.

Principal

By _____

Surety

By _____

Attorney-in-Fact

COLORADO DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL ASSISTANCE
REPORT OF OTHER MEDICAL SERVICES AND PAYMENTS

NAME OF NURSING HOME _____

MONTH OF _____

THIS FORM MUST BE RECEIVED BY THE DIVISION OF MEDICAL ASSISTANCE MONTHLY

[illegible]

CERTIFICATION: I CERTIFY THAT ALL PAYMENTS MADE TO THE ABOVE RECIPIENTS OR TO OTHERS ON BEHALF OF THE RECIPIENTS, ARE REPORTED HEREON.

SIGNATURE OF ADMINISTRATOR

DATE _____

Enter in this column charges to recipients, relatives, or others for necessary medical goods or services to recipients, or for room reservation charges, which are not required by department regulations, when appropriate, were rendered on written certification of the attending licensed physician that such service was required for the medical treatment of the individual. If no such charges were made enter "no additional charges" across the form and sign.

NH-TR-1 (9/81) NOTIFICATION OF NURSING HOME TRANSFER

DATE: _____

RE: Name _____ Social Security # _____
Address _____ Our HH# _____
_____ State ID# _____
Birth Date _____

Dear

The above named recipient moved to _____ Nursing
Home in _____ County on _____.

We propose to discontinue our case effective _____.

If your County is in need of forms or verifications to establish continuing
eligibility, contact _____ at _____.

We will be glad to forward any requested information.

A copy of this letter is being sent to the Nursing Home Administrator.

Your cooperation is appreciated.

Very truly yours,

Eligibility Technician

cc: Nursing Home Administrator

NH-TR-2 (9/81) NURSING HOME TRANSFER FORMS REQUEST

RE: Name _____

Our HH# _____

Your HH# _____

Dear _____

The above named recipient is currently residing in _____
County. In order to establish continuing eligibility and assure retention of
complete information, we are requesting the following information:

- _____ Entire Case Record
- _____ Copy of Original Application
- _____ Birth Verification
- _____ Proof of Social Security Number
- _____ Copy of LTC 101
- _____ Verification of SSA and/or SSI Income
- _____ Copy of Admitting AP 5615
- _____ Verification of Insurance Policies
- _____ Bank Verification (Checking and Savings)
- _____ Other, as Specified

If all eligibility is in order, we plan to approve the case effective

Thank you for your cooperation in this matter.

Very truly yours,

Eligibility Technician

COLORADO MEDICAL ASSISTANCE PROGRAM ("MEDICAID")

APPLICATION FOR PARTICIPATION - HOSPITAL

_____, ("the Applicant"),
hereby makes application for participation in the Colorado
Medical Assistance Program ("Program") to the Colorado Department
of Social Services ("Department"), pursuant to provisions of
Title XIX of the Social Security Act, and Article 12, Chapter
119, C.R.S. 1963, as amended, under which law the Department
is the sole administering agency, and rules of the Department
as promulgated by the Colorado State Board of Social Services.

The Applicant has been granted license number _____
to operate a hospital by the Colorado Department of Health for
the period from _____ to _____.

The Applicant desires to participate in the Program as
a provider of necessary hospital services to recipients of
Program benefits.

The Applicant agrees, if approved as a participating
provider:

1. To provide necessary hospital services within the
scope of its authority as vested by the aforesaid license.
2. To abide by all the provisions of Title XIX of the
Social Security Act and Article 12, Chapter 119, C.R.S. 1963, as
amended, and all pertinent rules of the Department. Mailing of
a copy of such Department rules to the Applicant shall constitute
due notice and knowledge by the Applicant of such rules. Mailing
to the Applicant of new, amended, or revised Department rules
shall constitute due notice and knowledge thereof.
3. To submit billings for authorized hospital services
in accordance with the form, manner, and in the amount as is
provided by Department rules, any subsequent amendments thereto,

and this Application for Participation, and agrees to provide such hospital services on the basis of being compensated therefor in accordance with this Application for Participation and Department rules. In the event the Applicant should receive payment for necessary hospital services in an amount in excess of that authorized by Department rules, whether a result of Applicant's or Department's error, the Applicant agrees to permit the Department the option and discretion either to deduct such excessive payments from future payments, or to recover such excessive payments in accordance with rules of the Department, or to require Applicant to make repayment to Department of said excess payment within sixty (60) days of written demand by Department or to recover such excessive payments by other legal means.

4. To not submit bills or otherwise attempt to collect payments from recipients, relatives of recipients, or recipients' estates for any hospital services provided to recipients which are benefits reimbursable under the Program in accordance with the law and rules of the Department.

5. To provide the Department with at least sixty (60) days prior notice in the event of termination of participation in the Program, including cessation of business, election to no longer participate, or all transfers of the assets, ownership, administration or operation of said business. Provided, however, this provision shall not apply in the case where amendments, revisions or additions to the rules of the Department are determined to be unacceptable to the Applicant and for such reason the Applicant elects to discontinue participation in the Program. In such event, the Applicant shall forthwith notify the Department in writing of its intent to discontinue and the Applicant and the Department shall forthwith negotiate

the termination date. In no event shall such negotiated termination date exceed a sixty (60) day period from the effective date of the rule, amendment, revision, or addition.

6. To provide acceptable assurance of compliance with the applicable requirements of Title VI of the Civil Rights Act of 1964.

7. To give full cooperation to the Department and its duly authorized agents in the administration of the Program. Furthermore, the Applicant agrees to maintain records as required by federal and state law and Department rules and to provide access to such records as may be provided for in the rules of the Department and as may be requested in accordance with such rules.

8. To accept as payment in full without retroactive adjustment a prospective per diem rate of \$_____, based upon reasonable cost, in accordance with the procedures set forth in the rules of the Department. This provision in no way relieves the Applicant of the responsibility to obtain payment from legally responsible persons or entities as required by law and Department rules.

9. To submit with this Application written evidence of the authority of the authorized agent. This may be by copies of the corporate by-laws, resolutions, minutes of meetings, or other sufficient evidence. Such authority must not only empower the authorized agent to legally bind the hospital to all of the terms and conditions contained in this Application, but also must delegate such authorized agent to represent the hospital in all future dealings with the Department of Social Services and to be responsible for the Applicant's compliance with federal and state laws and Department rules.

10. To submit with this Application a current list of the names and addresses of the officers and directors of the corporation or in lieu thereof, a copy of the latest corporate annual report filed with the Secretary of State.

None of the foregoing specifics in this Application shall limit the responsibility of the Applicant to abide by applicable current Title XIX and Colorado Medical Assistance Act, Article 12, Chapter 119, C.R.S. 1963, as amended, provisions and current Department rules as they may be amended or subsequently enacted by the Colorado State Board of Social Services.

The name of the Applicant as listed with the Secretary of State for the State of Colorado is _____; (and the corporation does business in the State of Colorado under the trade name of _____). Articles of Incorporation were first filed in the State of Colorado on the ____ day of _____, 19__.

This Application for Participation in the Colorado Medical Assistance Program is made this ____ day of _____, 19____,
by _____ (name of Applicant.)

ATTEST: _____
Signature: _____
Hospital Administrator
(Authorized Agent)

FOR COMPLETION BY THE COLORADO DEPARTMENT OF SOCIAL SERVICES:

The Applicant having agreed to all of the covenants and conditions herein contained, is hereby certified to be a participating provider in the Colorado Medical Assistance Program for the period extending from 19 to 19 . The Department agrees to make payments to the Applicant in accordance with the law and Department rules which govern the Program, providing that the Applicant complies with the law and rules of the Program and the terms and conditions herein at a prospective reimbursement per diem rate of \$.

COLORADO DEPARTMENT OF SOCIAL SERVICES

Date: _____ by _____

U.S. DEPARTMENT OF HEALTH, SERVICES
HOSPITAL PAYMENT RATE - POLYMER SUBSET

POLYMER SUBSET									
1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30
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991	992	993	994	995	996	997	998	999	1000
1001	1002	1003	1004	1005	1006	1007	1008	1009	1010
1011	1012	1013	1014	1015	1016	1017	1018	1019	1020
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1101	1102	1103	1104	1105	1106	1107	1108	1109	1110
1111	1112	1113	1114	1115	1116	1117	1118	1119	1120
1121	1122	1123	1124	1125	1126	1127	1128	1129	1130
1131	1132	1133	1134	1135	1136	1137	1138	1139	1140
1141	1142	1143	1144	1145	1146	1147	1148	1149	1150
1151	1152	1153	1154	1155	1156	1157	1158	1159	1160
1161	1162	1163	1164	1165	1166	1167	1168	1169	1170
1171	1172	1173	1174	1175	1176	1177	1178	1179	1180
1181	1182	1183	1184	1185	1186	1187	1188	1189	1190
1191	1192	1193	1194	1195	1196	1197	1198	1199	1200
1201	1202	1203	1204	1205	1206	1207	1208	1209	1210
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1231	1232	1233	1234	1235	1236	1237	1238	1239	1240
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1251	1252	1253	1254	1255	1256	1257	1258	1259	1260
1261	1262	1263	1264	1265	1266	1267	1268	1269	1270
1271	1272	1273	1274	1275	1276	1277	1278	1279	1280
1281	1282	1283	1284	1285	1286	1287	1288	1289	1290
1291	1292	1293	1294	1295	1296	1297	1298	1299	1300
1301	1302	1303	1304	1305	1306	1307	1308	1309	1310
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1361	1362	1363	1364	1365	1366	1367	1368	1369	1370
1371	1372	1373	1374	1375	1376	1377	1378	1379	1380

COLORADO DEPARTMENT OF SOCIAL SERVICES
HOSPITAL PAYMENT RATE - PAYROLL SUMMARY

PAYROLL SUMMARY ITEM	PROVIDER NO.	BUDGET PERIOD	WORKSHEET
			B-1
DEPARTMENT	CURRENT YEAR		PAST YEAR
	EMPLOYEES	AMOUNT	EMPLOYEES
	1	2	3
1. ADMINISTRATION AND GENERAL			
2. EMPLOYEE HEALTH AND WELFARE BENEFIT			
3. DIETARY-BOOTH			
4. DIETARY-OTHER EXTENSIVE			
5. CAFETERIA			
6. HOUSEKEEPING			
7. LAUNDRY AND LINEN			
8. MAINTENANCE OF PERSONNEL			
9. OPERATION OF PLANT			
10. MAINTENANCE OF PLANT			
11. NURSING SERVICE			
12. NURSING SCHOOL			
13. MEDICAL/SURGICAL EXPENSE			
14. INTERPRETING SERVICE			
15. OUTPATIENT THERAPY			
16. MEDICAL SUPPLIES AND EXPENSE			
17. PHARMACY			
18. MEDICAL RECORDS			
19. SPECIAL SERVICE			
20. OPERATING ROOM			
21. DELIVERY ROOM			
22. ANESTHESIA			
23. RADIO			
24. LABORATORY			
25. BIOOD BANK			
26. RESEARCH			
27. PHYSICAL THERAPY			
28. NURSERY			
29. OUTPATIENT SERVICE			
30. EMERGENCY SERVICE			
31. OTHER			
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COLORADO DEPARTMENT OF SOCIAL SERVICES

HOSPITAL PATIENT RATE - SUPPLIES AND SERVICES

SUPPLIES AND SERVICES ITEM	PROJ. NO.	BUDGET PERIOD		TOTAL EST C	
		CURRENT YEAR			
		TO DATE	REMAINDER		TOTAL
		2	3	4	BUDGET YEAR 5
1. ADMINISTRATION AND GENERAL					
2. EMPLOYEE HEALTH SERVICES					
3. GIFT BY PATIENT					
4. DENTISTRY-OTHER EXPENSE					
5. CATERING					
6. VOLUNTEERING					
7. LAUNDRY AND LINEN					
8. MAINTENANCE AND REPAIRS					
9. OPERATION OF PLANT					
10. MAINTENANCE OF PLANT					
11. NURSING SERVICE					
12. NURSING SCHOOL					
13. MEDICAL-SURGICAL SERVICE					
14. INTERNAL-RESIDENT SERVICE					
15. DENTAL THERAPY					
16. MEDICAL SUPPLIES & EXPENSE					
17. PHARMACY					
18. MEDICAL RECORDS					
19. SPECIAL SERVICE					
20. OPERATING ROOMS					
21. DELIVERY ROOMS					
22. ANESTHESIA					
23. X-RAY					
24. LABORATORY					
25. BLOOD BANK					
26. RESEARCH					
27. PHYSICAL THERAPY					
28. NURSERY					
29. OUTPATIENT SERVICE					
30. EMERGENCY SERVICE					
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COLORADO DEPARTMENT OF SOCIAL SERVICES
HOSPITAL PAYMENT RATE
MEDICAL PROFESSIONAL FEES

[illegible]

THE BASIS FOR PAYMENT OF PROFESSIONAL FEES IS:

- A - % of diagnosed cases
- B - Continued existence
- C - Killed directly by physician
- D - Saturated
- E - Service purchased from an independent laboratory
- F - Other: attach description

COLORADO DEPARTMENT OF SOCIAL SERVICES					
HOSPITAL PAYMENT RATE-ADJUSTMENTS TO EXPENSES					
ADJUSTMENTS TO EXPENSES ITEM		PROVIDER NO.	BUDGET PERIOD		VOUCHER #
REASON FOR ADJUSTMENT	AMOUNT OR EXPENSE	CURRENT YEAR			BUDGET YEAR
		TO DATE	PERMANENT	TOTAL	
1	2	3	4	5	6
1. TELEPHONE SERVICE (PAY STATION ENCLOSED)					
2. RADIO AND TELEVISION SERVICE					
3. LAUNDRY AND LINEN SERVICE					
4. VENDING MACHINES COMMISSION					
5. EMPLOYEE AND GUEST MEALS					
6. SALE OF DRUGS TO OTHER THAN PATIENTS					
7. SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					
8. SALE OF MEDICAL RECORDS AND ABSTRACTS					
9. SALE OF SCRAP, WASTE, ETC.					
10. RENTAL OF QUARTERS TO EMPLOYEES AND OTHERS					
11. RENTAL OF HOSPITAL SPACE					
12. PAYMENTS RECEIVED FROM SPECIALISTS					
13. TRADE, QUANTITY, TIME, AND OTHER DISCOUNTS ON PURCHASES					
14. REBATES AND REFUNDS OF EXPENSES					
15. GIFT, FLOWER, AND COFFEE SHOPS					
16. INTEREST ON UNRESTRICTED FUNDS					
17. NURSING SCHOOL TUITION, FEES, TEXTBOOKS, UNIFORMS, ETC.					
18. GRANTS, GIFTS, AND INCOME DESIGNATED BY DONOR FOR SPECIFIC EXPENSES					
19. RECOVERY OF INSURED LOSSES					
20. FUND RAISING EXPENSES					
21. DEPRECIATION					
22. OTHER SPECIFY					
23. OTHER SPECIFY					
24. OTHER SPECIFY					
25. TOTAL					

HOSPITAL PAYMENT RATE-HOSPITAL EXPENSE SUMMARY

HOSPITAL EXPENSE SUMMARY ITEM		PROVIDER NO.	BUDGET PERIOD	WORKSHEET G
DEPARTMENT	ESTIMATE CURRENT YEAR	BUDGET YEAR		
1. ADMINISTRATION AND GENERAL				
2. EMPLOYEE HEALTH & WELFARE BENEFIT				
3. DIETARY-P&H FOOD				
4. DIETARY-OTHER EXPENSE				
5. CAFETERIA				
6. HOUSEKEEPING				
7. LAUNDRY AND LINEN				
8. MAINTENANCE AND PERSONNEL				
9. OPERATION OF PLANT				
10. MAINTENANCE OF PLANT				
11. NURSING SERVICE				
12. NURSING SCHOOL				
13. MEDICAL-SURGICAL EXPENSE				
14. INTERN-RESIDENT SERVICE				
15. OXYGEN THERAPY				
16. MEDICAL SUPPLIES & EXPENSE				
17. PHARMACY				
18. MEDICAL RECORDS				
19. SPECIAL SERVICE				
20. OPERATING ROOMS				
21. DELIVERY ROOMS				
22. ANESTHESIA				
23. X-RAY				
24. LABORATORY				
25. BLOOD BANK				
26. RESEARCH				
27. PHYSICAL THERAPY				
28. NURSERY				
29. OUTPATIENT SERVICE				
30. EMERGENCY SERVICE				
31. OTHER				
32.				
33.				
34.				
35.				
36. DEPRECIATION-BUILDING, ETC.				
37. DEPRECIATION-MOVABLE EQUIPMENT				
38. INTEREST EXPENSE				
39. TOTAL EXPENSES				

COLORADO DEPARTMENT OF SOCIAL SERVICES

FUNCTIONAL ASSESSMENT

Please Check Most Appropriate Responses In Space Provided

PATIENT NAME _____ HOUSEHOLD # _____

1) Mobility Level

- ☐ Goes outside the house without help of any kind
- ☐ Goes outside the house with help of equipment or a device (no human assistance)
- ☐ Goes outside the house with human assistance
- ☐ Goes outside the house with help of equipment or a device and human assistance
- ☐ Confined to house

2) Walking

- ☐ Walks without help of any kind
- ☐ Walks with help of equipment or a device (no human assistance)
- ☐ Walks with human assistance
- ☐ Walks with help of equipment or device and human assistance
- ☐ Does not walk

3) Transferring

- ☐ Transfers without help of any kind
- ☐ Transfers with help of equipment or a device (no human assistance)
- ☐ Transfers with human assistance
- ☐ Transfers with help of equipment or a device and human assistance
- ☐ Is transferred - does not participate or is bedfast

4) Stair Climbing

- ☐ Goes up and down flight of stairs without help of any kind
- ☐ Goes up and down flight of stairs with help of equipment or a device (no human assistance)
- ☐ Goes up and down flight of stairs with human assistance
- ☐ Goes up and down flight of stairs with help of equipment or a device and human assistance
- ☐ Unable to go up and down flight of stairs

5) Wheeling

- ☐ Uses wheelchair without help of any kind
- ☐ Uses wheelchair with help of a device - no human assistance
- ☐ Uses wheelchair with human assistance
- ☐ Is wheeled (does not participate)
- ☐ Bedfast or chairfast

6) Bathing

- ☐ Bathes without help of any kind
- ☐ Bathes with help of equipment or a device without human help
- ☐ Bathes with human assistance
- ☐ Bathes with help of equipment or a device and human assistance
- ☐ Is bathed

7) Dressing

- ☐ Dresses without help of any kind
- ☐ Dresses with help of equipment or a device without human help
- ☐ Dresses with human assistance
- ☐ Dresses with help of equipment or a device and human assistance
- ☐ Is dressed

8) Eating/Feeding

- ☐ Feeds self without help of any kind
- ☐ Feeds self with help of a device but no human assistance
- ☐ Feeds self with human assistance
- ☐ Feeds self with help of equipment or a device and human assistance
- ☐ Is spoon fed - Is tube fed

9) Toileting

- ☐ Uses toilet room without help of any kind
- ☐ Uses toilet room with help of equipment or a device without human assistance
- ☐ Uses toilet room with help of another person
- ☐ Uses toilet room with help of equipment or a device and human assistance
- ☐ Does not use toilet room

10) Bladder Function

- ☐ No problem
- ☐ Incontinent
- ☐ External device self-care
Indwelling Catheter self-care
- ☐ External device not self-care
Indwelling Catheter not self-care
- ☐ Ostomy self-care - Ostomy not self-care

11) Bowel Function

- ☐ No problem
- ☐ Incontinent
- ☐ Occasionally less often than once a week
- ☐ Once a week or more often
- ☐ Ostomy not self-care/Ostomy self-care

12) Sight Impairment

- ☐ No problem
- ☐ Impairment compensated with glasses
- ☐ Impairment not compensated with glasses
- ☐ Not legally blind
- ☐ Legally blind

13) Hearing Impairment

- ☐ No problem
- ☐ Impairment one or both ears:
hears loud voice, no shouting
- ☐ Impairment one or both ears:
hears normal no loud voice with hearing aid
- ☐ Impairment one or both ears:
hears only shouting with hearing aid
- ☐ Does not hear

14) Speech Impairment

- ☐ No problem
- ☐ Stuttering with intelligible speech, Not dysarthria
- ☐ Dysarthria with intelligible speech
- ☐ Aphasic, but conveys thoughts
- ☐ Speaks but makes no sense or does not speak

15) Orientation Status

- ☐ Oriented
- ☐ Disoriented, partially or intermittently
- ☐ Frequently or completely disoriented
- ☐ Comatose

16) Behavior Pattern

- ☐ Appropriate
- ☐ Inappropriate: wandering or passive
- ☐ Inappropriate: abusive, aggressive, disruptive (Controlled) (Uncontrolled)
- ☐ Comatose

17) Communication of Needs

- ☐ Communicates needs verbally
- ☐ Communicates needs nonverbally
- ☐ Does not communicate needs

ADDITIONAL INFORMATION

SIGNATURE _____

DATE _____

IF SUBMITTED FROM HOME HEALTH AGENCY ATTACH TO PLAN OF CARE
IF SUBMITTED FROM COUNTY DSS ATTACH TO MH-7